

process, was used as a proxy transfer document in the remaining 42. In 25.6% of the young people, a formal transition process had been initiated. The result of the analysis of 43 clinic letters or transition transfer documents can be seen in table 1.

The questionnaire response rate was 14.1% (9/64) for GPs and 81.8% (9/11) for paediatricians. 66.6% of paediatricians and 77.8% of GPs rated the TTD exemplar ³ 3 out of 5 for helpfulness in practice. Qualitative data collected showed that lack of time and lack of joint services were common issues identified by both groups.

Conclusions Transition transfer documents are neither routinely nor consistently created for young people with complex neurodevelopmental needs. There is inconsistency identified in the details provided by clinic letters or TTDs in young people of transitioning age and only one 17-year-old in the population had a completed TTD. The transition transfer documents were deemed useful in theory by the majority of clinicians, however the lack of routine use of TTDs limits their impact. The use of a TTD exemplar can be improved and thus facilitate a smooth transition to adult services for young people with complex neuro-disabilities.

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THE EFFICIENCY OF HUMIDIFIED HIGH-FLOW NASAL CANNULA (HHFNC) WEANING IN BRONCHIOLITIS PATIENTS

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Background Humidified high-flow nasal cannula (HHFNC) has become an increasingly common treatment modality, used to provide respiratory support for bronchiolitis patients. In our UK paediatric unit, we have seen the proportion of bronchiolitis patients receiving HHFNC increase from 3% in 2016/17 to 13% in 2017/18 to 21% in 2019/20. However, at the time of initiating this project, guidelines on how HHFNC weaning should be performed were not provided at a local or national level. This is of particular importance in the current SARS CoV-2 pandemic as HHFNC is categorised as an aerosol generating procedure, so it is advantageous to minimise the length of time patients spend on HHFNC through efficient weaning.

Objectives We investigated how efficiently patients were weaned from HHFNC, and whether providing a specific weaning plan was associated with more efficient weaning.

Methods The medical records of all patients presenting to our centre under 1 year of age diagnosed with bronchiolitis between 01/10/2019 and the 11/02/2020 were reviewed (n=70). Of these, 14 patients (20%) were placed on HHFNC for longer than 3 hours. For these patients, we calculated the total length of time on HHFNC and time taken to wean from HHFNC. We then assessed whether a specific weaning plan was documented for each patient, judging a specific weaning plan to be one in which there were instructions as to how the flow rate or fraction of inspired oxygen (FiO₂) should be reduced with respect to time.

Results The median time spent on HHFNC was 2.1 days. A median of 1.0 day was spent weaning from HHFNC, however there was a large range in weaning time, from 3.5 hours to 4.0 days. We found specific weaning plans were documented for 4 patients. Patients who had a specific weaning plan

documented were weaned from HHFNC more quickly (mean = 14.75 hours) than those who did not (mean = 34.6 hours); Welch's t-test, $t(11.93) = 2.26$, $p = 0.043$.

Conclusions This project showed a high proportion of time spent on HHFNC, in our unit, was spent weaning. It provided evidence that weaning can be more efficient when specific guidance is provided. Therefore, we created new Trust guidelines for standardised HHFNC weaning in bronchiolitis patients. These guidelines are in-line with the RCPCH guidance published on the 18/09/2020, in light of concerns about HHFNC and its classification as an aerosol generating procedure. It is planned to repeat the data collection for the 2020/21 bronchiolitis season to assess whether this new guidance both improves the efficiency of HHFNC weaning whilst remaining safe. However, this may be challenging with the unusually low rates of bronchiolitis we are seeing so far this season!

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COVID-19 LOCKDOWN AND ITS IMPACT ON EMERGENCY DEPARTMENT VISITS OF CHILDREN WITH ACUTE WHEEZING

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Background Measures to address coronavirus (COVID-19) pandemic have included worldwide strict containment measures, informally known as 'lockdown'. Acute severe episodes of wheezing are one of the commonest presentations to paediatric emergency departments (PED). The 2020 coronavirus pandemic has dramatically changed the pattern of PED attendances.

Objectives To assess the impact of COVID-19 lockdown on the number of children presenting to PED with acute wheezing.

Methods A single-centre prospective observational cohort study, comparing the total number of children aged 0 – 18 years presenting to PED of University Hospitals of Leicester between January 2018 to June 2020. Demographic data including age at presentation and gender were extracted. The patient group were further divided to under 5 years (aged 1 month to 5 years) and above 5 years (aged 5 year 1 month to 18 years).

Results An average of 2892 children presented to PED per year with acute wheeze between 2018 and 2019 (62% male), of which 73% (n = 2112) were aged < 5 years. Following COVID-19, we noted a total of 641 PED attendances for acute wheeze from January to June 2020 (63% male), with children under 5 years representing 65% (n = 418) of the cohort. Between April-June 2020, there has been an 85% decrease in total number of PED presentations and 95% decrease in total number of hospital admissions of children with acute wheezing when compared to the mean of April-June 2018 and 2019. There was 90% decrease in PED presentation for children under 5 years, whereas 70% decrease for children above 5 years. Between January-March 2020, the number of PED presentations and hospital admissions of acute wheezing did not substantially differ compared with January-March 2018 and 2019.

Conclusions Strict containment measures secondary to COVID-19 lockdown has had a positive impact in children with respiratory conditions. Whilst the current restrictions are not