

treatment. Forming a sexual identity is a key developmental task during this phase, thus understanding the factors that enable the information needs of AYA to be appropriately identified and met is critical. This study expands on previous findings that AYA exhibited significant unmet needs around information provision on sex, body image, and relationships and aims to explore information and support preferences regarding where, how, and from whom AYA want to receive this information.

Methods Four young people aged 24-26 years, with a previous cancer diagnosis at age 14-23 years attended an in-depth four-hour workshop. Participatory activities were employed to identify the questions young people had; their support/information preferences; and, their definition of intimacy. The framework approach was used to analyse workshop transcripts.

Results Young people's preferences of information/support provision varied. They wanted trusted sources of information and while some preferred to have face-to-face discussions with healthcare professionals, others felt embarrassed and would prefer an online platform. All acknowledged that listening to peers with cancer talk about sexuality and relationships would 'normalise' their questions. Feeling embarrassed (professionals and young people) was a barrier to an open discussion about their needs. Triggers for information and support included: partners (pressures/expectations); lack of sexual drive (managing side effects); body image concerns (weight gain/loss); physical constraints; and fertility concerns. Young people wanted access to information tailored to their needs.

Conclusion Findings from this study show cancer-specific sex, relationship and body image issues faced by AYA and provide important direction to the development of interventions – a balance between professional and peer support is needed. Sexual health is a key element of wellbeing and a failure to address it may place AYA at risk for long-term consequences related to sexual, identity and relationships development. This study highlights the importance of conversations relating to sexual consequences of illness and age-appropriate assessment and interventions in other contexts where disease may disrupt young people's development.

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RISK BEHAVIOR AND PSYCHOLOGICAL WELL-BEING OF LEFT-BEHIND ADOLESCENTS IN TWO PROVINCES OF CHINA

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Aims In China around 40 million children and adolescents are left behind in rural areas by parents who migrate to cities to work. This study aimed to investigate the effects of prolonged separation from parents, and different guardianship models, on engagement in risk behaviors and psychological well-being.

Methods A cross-sectional study was conducted in migrant-sending areas of three counties in Zhejiang province and two in Guizhou in 2015. A self-completion questionnaire was administered among adolescents age 6 to 16 from 56 primary

and middle schools, selected through random stratified sampling. Children's demographic characteristics, family and social support, risk behaviors, and psychological wellbeing (using the Strengths and Difficulty Scale) were measured. Logistic regression was used to measure the effect of guardianship types on behavioral and psychological problems.

Results There were 1447 respondents in Zhejiang, and 1773 in Guizhou. The mean age was 12 (SD 2.2). 1238 children were living with both parents, and 1977 were left behind children (LBC). Of these 1025 lived with grandparents, 838 with one-parent and 114 with 'others' (relatives, siblings, alone). After controlling for economic status, age and gender, LBC living with others reported higher prevalence of smoking (aOR=2.01, 95%CI:1.15-3.51), skipping class (2.28, 1.28-4.06) and cheating (2.23, 1.55-3.50) than non-LBC, but there were no significant differences in drinking, going to internet cafés, stealing, bullying and fighting. Among three types of LBC guardianship, adolescents living with one parent reported lowest level of risk behaviors, and those living with 'others' highest. In addition, LBC living with grandparents reported more emotional problems (1.25, 1.02-1.53), LBC living with others more hyperactivity (2.15, 1.41-3.26) and fewer peer problems (0.65, 0.43-0.98), but there were no significant differences in conduct problems. Risk factors for LBC's behavioral and psychological problems were: living in Guizhou, poor study performance, having friends involved in risky behaviors and low social support.

Conclusion Living with parents or one parent led to more favorable behavioral and psychological outcomes. Migrant parents should try to ensure that one of them stays at home to give care and guidance on a daily basis.

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MOVING ON: FROM POND TO SEA – PROVISION OF TRANSITION SERVICES FOR YOUNG PEOPLE WITH NEURO-DEVELOPMENTAL CONDITIONS

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Introduction 'Transition' is the purposeful, planned process that addresses medical, psychosocial and educational needs of Young people with long-term conditions as they move from child-centred to adult-oriented healthcare systems. The importance and challenges of healthcare transition are recognised in UK National Institute for Health and Clinical Excellence (NICE) Guideline and Quality Standard (2016). A new dedicated transition clinic for Young people with neuro-developmental problems was initiated in Carmarthenshire in September 2016

Aims To demonstrate the provision of transition services for children with neuro-developmental conditions; benchmark services against NICE standards and illustrate areas for improvement.

Methods Young people aged 16-19 years who were seen in a transition clinic with diagnosis of neuro-developmental problems in Carmarthenshire. 50 Young people from September 2016 to July 2018 were reviewed.

Results 38 were male and 12 were female. Diagnosis were ADHD 40%, Learning difficulties 34%, ASD 24%, Developmental coordination disorder 16%, Physical disability 14%.

Co-occurrence of ADHD, ASD and/or learning difficulties was prevalent in 74% of cases. Age at first appointment was 16 years 10 months to 18 years 8 months. The only NICE quality standard met was discussion of transition care ideas with cares/parents. Majority had one appointment only. Repeat appointment was given to 5 patients. Outcome from clinic included discharge to GP (64%), referral to adult mental health services (16%), referral to Adult LD team (12%), and review by behavioural team (8%). Social worker involvement was recommended for all cases. All of them were seen in age banded clinic. Written transition plan was provided to all. 24% saw adult team before transfer, 14% had a key worker. 6% had a co-ordinated team. Holistic life skills training were discussed with all those who attended.

Conclusion Start of new transition clinic has facilitated transfer of Young people with neuro-developmental conditions. NICE quality standards were not met in many cases. 'Proposed beneficial features' are suggested in literature to improve outcomes; which we aspire to implement. We aim to start by providing a meeting with the adult team before transfer and providing a key worker/transition manager for all patients to achieve optimum transition.

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HEEADSSS: STANDARDISED ASSESSMENT TO IDENTIFY PSYCHOSOCIAL ISSUES FOR UNACCOMPANIED ASYLUM SEEKING CHILDREN

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Aim Unaccompanied asylum seeking children (UASC) experience psychological traumas, denying them age related cultural and developmental norms. They are at risk of significant psychosocial health problems. Identifying these health issues aids targeted interventions. This study tests feasibility of the HEEADSSS tool to identify psychosocial issues presenting at the Initial Health Assessment (IHA) for UASC.

Method 3 years of IHA reports of UASC were analysed using the HEEADSSS tool (Home & relationships/Education/Eating/Activities/Drugs/Sex/Self -image/harm & depression/Safety), to identify psychosocial risks. Each UASC report was matched by age and sex with one from a non UASC young person in care.

Results IHA reports of 64 UASC and 64 matched non UASC were used. Ethnicities: UASC 48% Afghan Pashtun, 46% Iranian Kurd. Non UASC 60% White British, 35% mixed Black/White British. Ages 11-18 years. Home: UASC 93% no family contact, 62% one deceased parent. Non UASC 95% family contact, 8% one deceased parent. Education: UASC 93% no previous formal education, 90% in UK Education with 95% >90% attendance, 94% indicated a future career. Non UASC 100% previous formal education, 72% in UK education with 65% <80% attendance, 48% indicated a future career. Eating: UASC 6% showed disordered eating, Non UASC 32% showed disordered eating. Activities: UASC 59% gym, 81% music, 37% football, 83% mosque. Non UASC 35% gym, 54% music, 64% football. Drugs: UASC 42% cigarettes, 3% drugs, 12%

alcohol. Non UASC 27% cigarettes, 45% drugs, 59% alcohol. Sex: UASC 2% sexually active, 0% previous sex education, 24% history of sexual abuse. Non UASC 38% sexually active, 100% previous sex education, 15% history of sexual abuse. Self-image/harm: UASC 2% self harm, 61% low self esteem, 43% depression, 82% trauma history. Non UASC 45% self harm, 68% low self esteem, 38% depression, 68% trauma history. Safety: UASC 82% felt safe, Non UASC 56% felt safe. Overall: 87% UASC and 76% Non UASC required intervention.

Conclusion It is feasible to apply the HEEADSSS tool to the IHA report to collate specific psychosocial health risks for UASC, therefore enabling targeted interventions.

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SEEN AND NOT HEARD! A QI PROJECT TO ENHANCE YOUNG PEOPLE'S VOICES IN THEIR OWN CARE

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Aims This QI project aims to increase the number of patients aged 12-16 offered the opportunity to speak to a doctor alone when seen in the Paediatric Assessment Unit of a busy London hospital. Not only does this promote independence and autonomy, but we know that young people don't always share their problems if spoken to with their parents/carers present. Doctors therefore miss key opportunities to identify and address bullying, eating disorders, self-harm, sexual abuse and gang involvement.

Methods By creating a fishbone diagram and process mapping I formulated a list of possible interventions. I have completed two PDSA cycles thus far both of which aimed to raise awareness of good practice and signpost resources. The PDSA cycles currently being planned are: implementation of a new clerking booklet for patients aged 10-16 years old, posters aimed at young people and parents/carers normalising speaking to a doctor alone and detailing the advantages of doing so, and creation of a dedicated space to speak to young people alone.

Results I am using run chart data to identify change in the proportion of young people given the opportunity to speak to a doctor alone. I have demonstrated an increase after my first two interventions but have not yet managed to sustain this change.

By completion of the project I anticipate not only an increase in the number of young people given the opportunity to speak to a doctor alone but also an increase in referrals to other services including child and adult mental health services, youth work and sexual health. Clinicians and young people will become more aware of ancillary services leading to increased access and utilisation ultimately facilitating a reduction in bullying, eating disorders, self-harm, sexual abuse and gang involvement.

Conclusion A considered and multi-faceted approach is required to ensure that doctors consistently offer young people the opportunity to speak without their parent/carer present. Even paediatric doctors lack the confidence and skills to communicate with this group of patients; revision of undergraduate and postgraduate curricula is essential to ensure these skills are developed in current and future doctors.