A JOINT MDT CLINIC MAY IMPROVE ADHERENCE TO SURGERY IN ADOLESCENTS AND YOUNG ADULTS (AYA) WITH REFRACTORY TO MEDICAL TREATMENT INFLAMMATORY BOWEL DISEASES (IBD)

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Objective: IBD is a chronic inflammatory disease of the GI tract which in 25% of cases presents in the paediatric age group and the incidence continues to increase, suggesting a great proportion of patients will need to transition between paediatric and adult services. Transitioning patients have been shown to engage less well to healthcare services and may struggle with adherence. Moreover, paediatric IBD may be shown to engage less well to healthcare services and may present to paediatric and adult services. Transitioning patients have been a considerable proportion of patients will need to transition between paediatric and adult services. Transitioning patients have been a dire need for clear information about accessing online or phone consultations. The AYA can be overwhelming, making the appropriate approach by the healthcare team enormously crucial although equally challenging.

Methods: We developed a structured multi-disciplinary (MDT) based pathway for AYA patients who suffer from debilitating and refractory to medical treatment IBD that necessitates surgery and aimed to measure patients’ acceptance and eventual adherence to the recommended surgery.

Patients with refractory IBD and ongoing IBD related symptoms were discussed in the IBJ MDT. Where medical therapy had failed, AYA patients were referred to the adolescent IBD clinic. The joint MDT clinic consists of a face to face appointment with an adolescent IBD gastroenterologist, an IBD colorectal surgeon and a specialist IBD surgical CNS as well as direct access to an adolescent IBD dietitian. During the appointment, AYAs and their carers have the opportunity of a thorough discussion on their symptoms, nature and phenotype of their disease and the rationale and details of the recommended surgery. The CNS connects them with other patients with similar types of surgery and acts as a direct point of contact throughout their time of comprehension and decision making.

Results: From January 2020 to June 2022, 38 patients between the age of 14 and 22 years old were referred to the joint adolescent clinic for a recommendation of surgery. 7 (18%) had refractory ulcerative colitis and the rest had refractory Crohn’s disease. The majority of patients (7 with UC and 18 with refractory colonic and perianal Crohn’s) would need to have a potentially lifelong stoma bag following the operation whereas the remaining patients were also consented for a risk of a stoma formation. 16 patients (42%) needed to have more than one joint consultation prior to making their decision.

32 (84%) patients adhered to the recommended surgery even though importantly the majority of patients (26; 69%) were averse to this before initially coming to the clinic.

Longer term outcomes of those patients are being prospectively measured.

Conclusions: Our cohort of young complex IBD patients adhered to the recommended surgery to a significant percentage of 84%. A structured MDT approach we believe helped in establishing trust between the young patient with IBD and the healthcare team and promoted patients’ engagement to healthcare services, hence an initial refusal of surgery was significantly converted to acceptance. More data on patients’ views through satisfaction forms will provide additional information on how to further improve transitioning services.

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YOU’RE STILL WELCOME VIRTUALLY

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Objective: The COVID-19 pandemic accelerated the adoption of virtual solutions to enable continuity of health services for those with acute or long-term medical conditions. Doctors needed to rapidly change their ways of working to continue to provide good access to health care via in person appointments, phone or video consultations. Organisations such as NHSE and RCGP rapidly produced guidance to support professionals in the principles of safe video consulting, however these did not fully explore the issues which more pertinent to children and young people, including access, consent and confidentiality, or potential safeguarding risks including those associated with virtual examinations, receiving, capturing and storing images. The YPHSIG worked with interested organisations to produce a statement to raise these issues with clinicians but there was still a gap in the information available for children, young people and their families. The NHS COVID-19 project on life in the pandemic, also identified that there was a need for clear information about accessing online or phone appointments.

Methods: Doctors from RCPCH, RCGP, RCPsych and BASHH worked with young people from Central Beds Youth Voice and RCPCH &Us to create a leaflet for young people. Initial drafts, produced by clinicians and informed from COVID-19 Book Club, contained large amounts of information, but with the help of young people who said ‘It’s too long, it needs to be shorter, colourful and really clear to understand’. It was refined and key messages teased out. The design ideas provided by young people were then taken forward and the final leaflet produced.

Results: The two-page leaflet has been widely publicised and well received. Young people involved in the work said ‘This is so much better than the first version, I think it will help people my age loads, it’s great to see things changed from what we said before’. Clinicians have said ‘Great resource launched by @RCPCH and Us providing useful information on health appointments for young people’.

Conclusions: The pandemic saw a change in the way health services are offered to children and young people. It is important that the principles of accessibility, patient choice, consent, confidentiality and confidentiality, environment, attitudes, values and safety are as understood by clinicians and children, young people and their families for virtual as they are for in person appointments and this collaborative leaflet will support with this.

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Abstracts

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1933 YOUNG PEOPLE AT A TERTIARY HOSPITAL – HOW TO IMPROVE THE INCONSISTENCIES IN CARE

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Objectives To assess current transition practice in a London foundation Trust delivering secondary, tertiary and quaternary care to young people (YP) 13–18 years, with >43,000 outpatients/episode. To determine whether the services meet quality standards for care of YP.

Methods A retrospective review of developmentally appropriate healthcare (DAH) and transition process was performed against the DoH ‘You’re Welcome’ quality criteria(1) and NICE guideline ‘Transition from children’s to adults’. A questionnaire was co-designed by a YP steering group; a multidisciplinary team across paediatric, adolescent, and adult services, which was circulated and completed electronically. Results 56 services across the Trust responded. 68% of respondents reported that they provided a Transition service, 35% of services had a transition lead (consultant 48% ; CNS 35%), with 57% running multidisciplinary team (MDT) clinics for YP.

The average age for transition process to start was 13 years (13–20) into adolescent services, 17 years into adult services. Transfer to adolescent service mean age 17 years (13–17), and to adult services 18 years (16–24yrs).

Despite transition clinics being held, 8/25 services describe only 10% will go into the pathway and 90% will be transferred with letter only.

Table 3 describes issues identified with the transition process.

Table 4 describes adherence to ‘You’re welcome criteria’ (young person’s centred approach).

No service had a clear idea of how to support YP with learning difficulties. There was no common trust policy regarding adolescents DNAs. 21% had involved YP in designing their process and 18% had asked for feedback on their services.

Conclusion Many services reported offering a transition service, and there were areas of excellent practice in dedicated young people’s services, including developmentally appropriate healthcare practices.

However transfer into adult services is often occurring without adequate transition, DAH is not universal. Engagement with YP is low.