Going forwards the following work streams were identified:

- Develop YP steering board
- Creation of policy and guidelines with regular audit and PPIE review
- Identify transition leads and key workers to support each service
- Recognise where specialist support from psychology, social work and learning disability teams required
- Develop and improve use of resources to engage and prepare YP
- Develop staff training and education programme

## Abstracts

### 1934

A BRIGHTER MORE HOPEFUL FUTURE – JOURNEYING BESIDE YOUNG PEOPLE FOLLOWING A REACHABLE MOMENT

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10.1136/bmjpo-2022-RCPCH.57

**Objectives**

In June 2021 the RBFT joined the Hospital Navigators pilot project, funded by the Thames Valley Violence Reduction Unit. This offered young people attending A+E the opportunity to have support from a matched Mentor, with the intention of starting support at a critical point in time. Research shows that change is most likely to be initiated in these reachable moments but depends upon a person’s available support.

A review of the available data will reveal the opportunity to influence young people attending hospital to improve their health and wellbeing over a 12 month period.

**Methods**

- Database of young people seen by Navigators, including gender, locality, and cause for attending A+E (1).
- Electronic patient record to determine reattendance rates.
- Case vignettes and feedback

**Results**

- Inclusion Criteria:
  - 13 – 24 years of age inclusive
  - Attending A+E
  - Attendance reason/comorbid factors identified included injury, self-harm, risk taking behaviours, young people with learning disability and/or autism.
- Volunteers: 26 recruited and trained, consistently cover Friday and Saturday night.
- Referrals: (June 2021–22): 120 young people supported:

<table>
<thead>
<tr>
<th>July 21</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Total</th>
</tr>
</thead>
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<tr>
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<td>2</td>
<td>-1</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
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<td>7</td>
<td>15</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>9</td>
<td>59</td>
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<tr>
<td>Clients signposted</td>
<td>7</td>
<td>8</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>42</td>
</tr>
<tr>
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<td>2</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td>30</td>
</tr>
</tbody>
</table>

**Conclusion**

43% of young people referred engaged on positive pathways, highest number in Thames Valley out of the 5 sites.

- Of those who discussed their mental health with a Navigator, 90% said they struggled with it
- Of those asked, 100% found it helpful having a conversation with a Navigator in hospital and 100% were glad that they were able to have a conversation with a Navigator
- RBH evaluation shows reduction in ED attendance.
- Navigators - low levels of turn over and allowed for wide range of diversity.
- Qualitative data from Case vignettes will demonstrate impact upon individuals of the timing of meeting with the navigators.

### 1935

TELEPHONE CONSULTATIONS IN ADOLESCENT GYNAECOLOGY DURING THE COVID-19 PANDEMIC: A RETROSPECTIVE COHORT STUDY CONSIDERING IMPACT ON OUTPATIENT FOLLOW-UPS

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10.1136/bmjpo-2022-RCPCH.58

**Objectives**

In response to the COVID-19 pandemic all paediatric and adolescent gynaecology (PAG) outpatient appointments in a tertiary teaching hospital were temporarily converted to telephone consultations.

Telemedicine is a developing area with on-going research into its safety and effectiveness. The cohorts of patients attending PAG clinics have unique needs and requirements, both due to their own individual characteristics, and their presenting symptoms. There is currently a paucity of data regarding the utility of telemedicine in PAG. This study therefore aimed to review the impact on PAG outpatient follow up journey looking specifically at the patient journey from a first remote appointment by analysing number of follow ups required.
Methods A retrospective cohort study was completed of patients presenting to the general paediatric and adolescent gynaecology clinics from April 2019–April 2020 aged 11–18 years at their first appointment. Those referred to specialist PAG clinics for complex congenital gynaecology or differences of Sex Development were excluded.

Patients managed pre-pandemic with their first appointment with the PAG service in person were compared to those with a telephone first appointment as part of the COVID-19 response.

The first 30 patients from each clinic list who met inclusion criteria were included in the study.

The electronic patient notes were reviewed with data collected on age, referring issue, number of follow ups, and whether still under PAG follow up collected. Data was collected and analysed using Excel.

Results Median age in both cohorts were similar; 12 years old (11–17 years) face to face (F2F) and 13 years old (11–18y) in the telephone cohorts. Problems were categorised to those affecting the vulva or vagina (17/30 in telephone; 21/30 F2F), menstrual concerns (15/30 telephone; 14/30 F2F), or ovarian cyst (2/30 telephone; 0/30 F2F).

Patients with an initial telephone appointment during the pandemic had a significantly greater number of follow-up appointments compared to those with an in-person clinic appointment initially (chi-square, p = 0.044). Patients with an initial telephone appointment were significantly more likely to require follow-up compared to those seen first to face (OR 0.18 [95%CI 0.05–0.65]). Patients referred with vulval or vaginal issues (clear indication for clinical examination) were more effected by greater follow up requirements than those seen F2F first.

Conclusions Patients who had a first telephone clinic consultation were more likely to need follow-up than those seen face to face, and if follow-up was required, they had a greater number of follow up appointments than those seen first in person.

In Paediatric and Adolescent Gynaecology (PAG) remote consultations are compromised by the lack of examination and reliable privacy for an adolescent to have time alone in the consultation without their parent/care-giver.

The potential need for an intimate examination cannot be replicated with a remote review. It is not appropriate for video review live or review photos of an adolescent’s genitals— even if technology means it can be sent securely.

Whilst there is scope for the use of telemedicine for follow up consultations, further dedicated studies considering this are needed to confirm their role in the PAG setting.

Objectives Paediatric critical care medicine has evolved, and 50% of admissions include children with life limiting diagnoses; a proportion of these will extend into adulthood.

Adolescents are under the management of several multi-professionals in primary, secondary and tertiary care. The transition processes for adolescents requiring critical care varies greatly throughout the UK.

We developed standards and recommendations to guide professionals in improving the experiences and care of adolescents who require management under adult critical care services.

Methods A working group was set up with representation from paediatric and adult critical care, paediatric palliative care, Hospice UK, together with patient and family representatives. This work was shared between the Intensive Care Society and the Paediatric Critical Care Society.

Our work started pre-pandemic with two face to face meetings, followed by remote meetings to consolidate the guidance produced.

Results Standards and recommendations have been published as guidance in order to support the developments of pathways for paediatric to adult critical care transition in all Hospital Trusts. We know this will vary and a more tailored approach may be more relevant.

Standards
1. All young persons who are likely to require future input from adult critical care services must be identified in a timely manner.
2. A suitable transition pathway to adult critical care services must be initiated and followed for all eligible young persons.
3. Admission to critical care must not occur until this is complete.
4. A bespoke Critical Care Transition Pathway must be in place to ensure clear documentation and communication throughout the process.

Recommendations
1. The transition process for critical care should be led by children’s services.
2. The transition process for critical care should occur in parallel to other speciality transition needs.
3. There should be an Adult Critical Care Transition Lead within each Trust to co-ordinate the transition process.
4. A multi-professional approach should be taken throughout the process.
5. Where appropriate, multi-professional meetings should include the young person, families and carers.
6. All Adult Critical Care Units should facilitate a visit or visits for young people, their families, and carers prior to their first admission.
7. Where appropriate, parallel planning should be in place with the Palliative Care Team.
8. The transition process should include involvement of the Play Specialist Team, Family Support Workers or school.
9. A profile of the young person should be transferred between services and should form an essential part of their care.
10. Changes in the consent process should be explored and discussed with all young persons and carers. The need for any future deprivation of Liberty Safeguards should be reviewed.
11. Feedback should be sought from young persons, families, carers and the Adult Critical Care team during the transition process and after transfer of care.

Conclusions The above guidance will help support the establishment of transition pathways into adult critical care. This process will be challenging as the move from parent/legal guardian consent for that of the young person/medical team holds great significance for all involved.