

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.

1939

HOW CAN WE IMPROVE THE TRANSITION PROCESS OF CHILDREN AND YOUNG PEOPLE TO ADULT CRITICAL CARE?

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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. Admission to critical care must not occur until this is complete.
3. 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.