clinical consequences. This research aimed to develop a novel, user-centred and theory-driven behavioural intervention to support young people (aged 13–18) with IBD adhere to their treatment plan.

Methods Findings from a systematic review evaluating treatment adherence interventions for young people with IBD were synthesised with findings from exploratory, qualitative interviews with young people with IBD, parents of young people with IBD and healthcare professionals. Findings were then mapped to psychological constructs from relevant behaviour change theories and behaviour change techniques selected. Following a Behaviour Change Wheel approach, a novel intervention was developed, specifically addressing the treatment adherence needs of young people (aged 13–18) with IBD. A series of co-development workshops were conducted with young people (aged 13–18) with IBD. Within these workshops, young people provided feedback on the proposed intervention’s components and delivery, using a variety of participatory methods. Young people’s ideas were incorporated into a revised version of the intervention, aiming to improve its acceptability and feasibility. Further revisions were made in response to feedback collected from parents of young people with IBD.

Results A prototype behavioural adherence intervention was co-developed with young people and parents to support treatment adherence in young people with IBD. Ten interactive online modules aimed to increase young people’s confidence to adhere to their treatment plan, support resilience to overcome adherence barriers, assist in the development of health communication skills and generate optimism about the future. Interactive online modules and components within each module can be tailored by the user to suit their own personal adherence challenges. Within each module young people are supported to develop user-centred action plans to improve their treatment adherence behaviours. These plans and corresponding behaviour change strategies are retained within the intervention modules, providing a personalised approach. A parent version of the intervention was also developed to support incremental transfer of responsibility for treatment adherence to young people themselves, as part of their transition to adulthood and adult services.

Conclusions The Behaviour Change Wheel approach can be effectively used to co-create a user-centred and theory-driven behavioural intervention with young people. The developed intervention can be tailored to individual needs to support young people’s adherence. Further research is needed to establish the intervention’s feasibility and preliminary effectiveness.

REFERENCES

EVALUATION OF SOCIAL CARE, SPECIAL EDUCATIONAL NEEDS AND NON-ENROLMENT & EXCLUSION OF CHILDREN IN ALL ENGLISH STATE SCHOOLS: ADMINISTRATIVE DATA COHORT STUDY

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PATIENT EXPERIENCE OF TRANSITIONING FROM CHILD TO ADULT SERVICES WITHIN PAEDIATRIC GASTROENTEROLOGY

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Objectives All children have a right to education, but research indicates that those receiving children’s social care (CSC) and special educational needs (SEN) services are at increased risk of non-enrolment in school, including through off-rolling (illegal exclusion), and through formal exclusion for disciplinary reasons. We aimed to use administrative data to estimate the association between CSC history and (1) non-enrolment and (2) exclusion in secondary school.

Methods Using the National Pupil Database (data on all English state school enrolments), we identified a cohort of 1,059,781 pupils in aged 11 in 2011 and 2012. Children were categorised as having a history of being children in need (CIN), on child protection plans (CPPs) or looked after (CLA) using linked data from CSC services. SEN status (Action/Action+/Support or Statement/Education, Health & Care Plan) was identified from school records. We estimated the proportion of children (1) not enrolled and (2) formally excluded across ages 12 to 16 by CSC and SEN history. We then assessed with regression modelling the associations between CSC and SEN history and non-enrolment and exclusion in years 10/11. We also examined variation in overall non-enrolment and exclusion rates between local authorities and regions.

Results Of children without CSC history, 3.8% had 1 or more non-enrolments across ages 12 to 16. This proportion was higher among children with a history of being CIN (8.1%), on a CPP (9.4%) or being CLA (10.4%). The odds of non-enrolment in years 10/11 were higher among those with CLA history vs non-exposed peers (OR 4.76, 95% CI 4.49–5.03) as well as in those with CPP (3.60, 3.39–3.81) and CIN history (2.53, 2.49–2.58). SEN history further increased non-enrolment odds. These associations and interactions persisted after adjusting for confounders. Non-enrolment rates were highest in the London region and varied significantly between local authorities. In total, 40% of CLA and those with CPP history were formally excluded at ages 12 to 16, as were 32% with a history of being CIN, compared to 12% of the non-exposed group. A similar interaction between CSC and SEND history for as non-enrolment was observed for formal exclusions.

Conclusions Our findings show that children with CSC history (especially those with SEN) are more likely to be non-enrolled and to be formally excluded in secondary school than other children. Work is needed to understand the non-enrolment and exclusion mechanisms, which may include illegal off-rolling and other exclusionary practices, to improve the education of children with CSC and SEN history.

Abstracts
Methods Telephone interviews with focused questions on transition experience was used to obtain the data. The sample contained patients with IBD that had already been transitioned from 2020 onwards. The questions that were used was derived from the ready steady go criteria (Nagra, 2015) and NICE guidance (NICE, 2016) but condensed to 11 questions for the child and 3 for the parent/guardian. Qualitative data was obtained to understand more about the transition process.

Results 10 patients and 10 carers were contacted, of those people 6 patients and 3 carers responded. 4 patients remembered transition being introduced at the age of 15–16 years old and 2 by 17–18 years, 5 patients had a face to face consultation, 1 had a telephone call due to COVID-19 restrictions. 5 could name a healthcare professional they could contact for transition support, one person who did not. All 6 were confident on their knowledge about the condition and also to be seen independently in clinic. Only 1 patient stated to not lead a healthy lifestyle but everyone understood the risks of drugs, alcohol and smoking on their health and their condition. All 6 reported a happy mood. 2 patients rated their overall experience as very good, 2 rated their experience as good and 2 rated their experience as neither good or bad. The qualitative data reflected positive feedback from both parties. COVID restrictions was the main cause of complaint.

Conclusions Overall, this study shows an overwhelming satisfaction in the transition services offered. NICE guidance was met in providing a named service provider for all and building confidence in patients. All patients were introduced to transition much later than 13–14 years of age recommended by NICE (NICE, 2016). We need to start early with preparation for transition. In some cases pandemic disruptions have affected transition due to the reduced availability of face to face appointments. Coincidentally, 2 of the 4 patients who did not answer when contacted came from South Asian backgrounds, both with a longstanding history of missed appointments. A look into ethnic backgrounds and transition needs and attitudes may help improve the process for ethnic minorities.

REFERENCES

YOURSTANCE: TEACHING YOUNG PEOPLE AT RISK OF SERIOUS YOUTH VIOLENCE BASIC LIFE SUPPORT AND HAEOMORRHAGE CONTROL

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Objectives Serious youth violence (SYV) is a significant cause of injury and death among young people. YourStance is a preventative education project which endeavours to minimise morbidity and mortality caused by SYV by teaching basic life support and haemorrhage control to young people. The objectives of this evaluation are to identify characteristics of young people that attend YourStance sessions, to understand their reasons for attending, and to assess whether training sessions are beneficial for participants.

Methods Healthcare professionals delivered interactive teaching sessions to young people in prisons, pupil referral units and youth hubs in London boroughs with high rates of SYV. Participants completed feedback surveys at the end of each session. Data from completed surveys from June 2019 until December 2021 were analysed.

Results 197 participants completed feedback forms. The majority were male (75%) and black, Asian, and minority ethnic (78%). Whilst the average age was 21 years, two thirds were <15 years old (61%). Over a quarter had experienced SYV (29%) and the majority of participants in prison were SYV victims (79%). The predominant reason for attending was to gain medical skills (63%), and over half (58%) had previously been in situations where YourStance training would have been useful. Benefits of the sessions included: medical training (81%), feeling better prepared to respond to emergencies (80%), and 83% would recommend the sessions.

Conclusions The results provide useful information about participant demographics and motivation for attending YourStance teaching, which will help tailor future sessions towards those most at risk of SYV. YourStance is successfully preparing young people to be emergency responders in their communities, and participants find the sessions beneficial. Further research is required to investigate whether these skills are retained, and whether morbidity and mortality from SYV is affected.

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TRENDS IN MENTAL HEALTH PRESENTATIONS OF ADOLESCENTS TO A PAEDIATRIC EMERGENCY DEPARTMENT OVER THE COVID-19 PANDEMIC

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Objectives The aim of this study is to observe the trends in the mental health presentations of 10 to 16-year-olds to the paediatric emergency department (ED) in Belfast over a two year period, capturing the onset and peak of the COVID-19 pandemic.

Methods Data was gathered on attendances to a paediatric ED between October 2019, prior to the announcement of the COVID-19 pandemic, until October 2021. Data was collected on demographics including postcode, as well as trends of the presentations including reasons for presentation, timing of presentations, and outcomes following emergency department attendance.

Results There were 488 presentations between the start of October 2019 and the end of October 2021, of which the ratio of male-to-female was 19.7%:80.3%. A majority (76.0%) of cases presented out-of-hours. The peak number of admissions were in May 2021 with a total of 33. The overall admission rate was 26.8% of overall presentations. Of the 131 cases which resulted in admission, 3 patients (2.3%) were referred directly to the paediatric intensive care unit (PICU). The most common cause of presentation and admission was overdose which made up 40.0% of cases.

Conclusions During the pandemic, the hospital saw an increase in the number of young people with mental health difficulties in ED. Peaks in presentations were noted initially at the ease–ment of restrictions around 5 months following onset of lockdown. The data also allowed us to look at demographic