

presentation areas using post codes which could potentially be targeted by community teams. The literature acknowledges notable variations in the specific types of presentations, with an increased proportion being due to self-harm and eating disorders. There may be a link between the environmental factors of being under lockdown with limited social contact and increased online media consumption causing adolescent health to deteriorate in specific ways.

**1836** **ADHD TREATMENT RESPONSE FORM – FOR YOUNG PEOPLE BY YOUNG PEOPLE; EMPOWERING YOUNG PEOPLE TO BE ACTIVE PARTICIPANTS IN THEIR OWN ADHD MANAGEMENT AND HEALTHCARE**

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**Objectives** Historically, ADHD medication efficacy and symptom improvement has been monitored for young people by parents/carers and teachers completing rating scales, which are evaluated by the paediatrician.

In our service, young people felt it was important that they were involved and contributing to the management of their own ADHD treatment. The aim was to co-produce an ADHD treatment response tool for young people to complete.

**Methods** A project group was held with four young people aged 13 – 17 years (boys and girls) who have ADHD and two clinicians.

The group worked together to co-produce a ‘Treatment Response Form’, adapted from DSM 5 ADHD symptoms<sup>1</sup> along with a scoring system,<sup>2</sup> ensuring that the form was easy to use and understand, that the questions were asked in first person, and that the language was suitable and positive, whilst also being clinically accurate as an effective assessment tool.

The group of young people involved in the project group were equal partners in designing the form and were engaged and proactive from the beginning. As well as designing the form, the group discussed the value and benefit of being able to actively contribute to, and participate with their own healthcare, as well as health service improvements more widely.

**Results** The Treatment Response Form is now being used by young people and the community paediatrics service in Bedfordshire and Luton. Young people are able to input their perspective into the monitoring and efficacy of their ADHD treatment and intervention by completing this questionnaire.

The questionnaire is a word document, therefore accessible for free, online electronically or on a printed paper version and is quick to complete.

The Treatment Response Form has a simple scoring system<sup>2</sup> which means the individual responses indicating progress to treatment and interventions of their ADHD condition can be self-monitored by the young person. The form not only encompasses questions relating to ADHD symptoms and behaviour, but also compliance with medication, side effects, and sleep difficulties. It also asks the young person to talk about the positives and things they enjoy doing to offer a holistic perspective.

**Conclusions** When using the Treatment Response Form as an assessment tool in clinic, the paediatrician evaluates the completed form with the young person, thus generating an informed discussion on areas of strength and challenge, to

together agree treatment, interventions and set goals. It has enabled both the young person and clinician to better understand how the young person is feeling and managing ADHD from their perspective. Positive feedback has been received from the young people.

The Treatment Response Form is empowering young people to be actively involved in their treatment, also supporting positive transitions into adulthood. For clinicians, it reinforces the value of patient centred care, and the voice of the young person being central to their treatment and care plan.

**REFERENCES**

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**1840** **EATING DISORDERS IN ADOLESCENTS AND THEIR RELATION TO CONTRACEPTIVE DECISION MAKING**

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**Objectives** These findings are part of a wider study designed to assess clinicians’ contraceptive provision for patients with eating disorders. Contraception provision for patients is a vital role of sexual health clinics across the country. Certain patient groups may have additional factors, symptoms or behaviours that make different contraceptive choices safer or preferable. Adolescents with eating disorders are one such group. Research shows that behaviours such as laxative use or the induction of vomiting alongside pre-existing risk factors can affect contraceptive choice efficacy and safety. Patients with eating disorders have been demonstrated to have a greater number of new sexual partners and decreased condom use.<sup>1</sup> Eating disorders most commonly start in adolescence, with studies estimating the mean age of incidence for anorexia nervosa as 14.6 years<sup>2</sup> and have a much higher prevalence in females.<sup>3</sup> Current advice from the FRS<sup>4</sup> is for clinicians to ask about eating disorders when providing contraception and the recommended contraception for this group is long-acting-reversible contraception (IUS/implants).

**Methods** 25 females aged 15-18 were randomly selected who had come to a regional sexual health centre from October 2021 - May 2022 seeking contraception. Patient records were reviewed to assess the use of the box for history of eating disorders on the ‘new family planning’ history form (this box was not mandatory for clinicians to complete but they were advised to). If an eating disorder was identified, information was then collected on what further history was documented (e.g. classification of eating disorder, relevant behaviours and risk factors). Data was collected on what contraceptive was then given to each patient with/without the eating disorder box completed. Data was collected on recorded BMIs.

**Results** In the age group 15-18 only 76% of the patients were asked about eating disorders. Of these patients, 5 had notes detailing problems relating to eating. The average number of words in the notes on eating disorders was 10.4, with the least being 5. The contraceptive choices given were varied (figure 1). Only 10 of the patients had their BMIs measured, of these 3 were low (<18.5). Only 1 of these 3 had notes detailing eating problems.

**Conclusion** To conclude, there is more research to be done in this field. This study may serve as a prompt to clinicians, including paediatricians, to ask about eating issues/disorders when prescribing contraception. The study assisted with the production of a proforma for clinicians to use when an eating disorder history is elicited.

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## 1841 USE OF AN ELECTRONIC 'LIVE' TRANSITION PLAN IN PATIENT NOTES

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### Objectives

**Background** CQC recommendations for the trust following a visit, included a trust wide consistent and robust approach to assessment and planning of transitional care and a consistent approach to completion and storage of transition medical records. A 'live' transition plan was created in 2018 in the electronic eDMS patient notes. This enabled health professionals to document a summary of transitional discussions addressing key areas and creating a clear timeline, which could then be shared by the transferring team with the receiving adult team. It also ensured that when a young person was under multiple specialities, all involved professionals could rapidly access transitional discussions and plans made.

**Objectives** To audit the use of the live transition plan against standards based on completion of key information in the live plan and whether the plans were transferred to adult specialities during transition of care.

**Methods** Retrospective case note review of the eDMS live transition plan updated in the month of July 2021, for young people with chronic long term conditions that required transition of care to adult services.

**Results** 210 live transition plans were updated between 1<sup>st</sup> and 31<sup>st</sup> July 2021. 55% (n=94) of the plans had an identified key worker<sup>1</sup> documented. In 21%(n=45) a user error was noted because teams were creating duplicate plans instead of updating the existing transition plan, which meant a clear timeline of discussion would not be available at transfer. All plans had completed an answer to the mental capacity act question but professionals had documented uncertainty over this. Documentation indicated that 10 young people had a life-limiting condition and two included documentation of an advance care plan. There was limited use of the snapshot function to share the transition plan with adult services at transition. 17 of the young people had safeguarding alerts in their electronic notes but only 3 had a safeguarding concern documented in the transition plan. 23 different specialities completed the transition plan and 18 of these were within medicine care group. 80% (n=168) of the entries were completed by specialist nurses, 10% (n=20) by consultants and the rest by other healthcare professionals. 75% (n=158) of

the entries had the intended adult team/hospital destination identified.

**Conclusions** This first review highlighted variability in the completion of the 'live' transition plan in patient notes and the need for further education and training promoting use with all members of the multi-disciplinary team. Training to address this is now included in the mandatory trust transition training. This audit also enabled a review of the question on mental capacity act to make it clear and signpost professionals to trust resources. A 'top tips' document was created to share key themes and messages with all health professionals in the trust.

## REFERENCE

1. National Institute for Health and Care Excellence. (2016). *Transition from children's to adults' services for young people using health or social care services.*

## 1842 MAPS: MENTAL HEALTH ADMISSIONS TO PAEDIATRIC WARDS STUDY

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**Objectives** Children and young people (CYP) presenting with a mental health (MH) crisis are frequently admitted to general acute paediatric wards as a place of safety. Prior to the pandemic, a survey in England showed that CYP occupied 6% of general paediatric inpatient beds due to MH crisis, and there have been longstanding concerns about the quality of care to support these patients in this setting.<sup>1</sup> Since the pandemic, there is evidence that both numbers of paediatric admissions and the severity of MH crisis in CYP have increased, and paediatric teams are experiencing challenges delivering safe care.<sup>2</sup> There is a general paucity of published data on CYP with MH crisis admissions to general paediatric wards including total numbers, factors associated with admissions, outcomes for CYP admitted, and the impact of admissions on CYP, parents and healthcare professionals (HCPs).

We aim to generate a Theory of Change (ToC) model to improve the quality of care for CYP admitted to acute paediatric services after presenting in a MH crisis. Our objectives are to investigate: 1) national trends in admissions; 2) characteristics of admissions (sociodemographic factors, diagnoses and reasons admitted) 3) factors influencing decisions to admit CYP; 4) views/experiences of CYP, families and HCPs during admissions.

**Methods** We will conduct a mixed-methods study to inform a ToC framework, alongside a stakeholder group (consisting of patients, families, health and social care professionals and professional groupings). To achieve this, we will: 1) analyse national service level data (hospital episode statistics) of MH admissions to paediatric wards, 2) undertake a rapid literature review and bring together the research team and stakeholder group, using a modified Delphi process, to develop a data