G438(P) TRANSITION FROM PAEDIATRIC NEURODISABILITY TO ADULT SERVICES; A PATIENT CENTRED APPROACH

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The transition from paediatric to adult neurodisability services can be a challenging time for young people and their families. This vulnerable group have complex needs encompassing healthcare, social care and education sectors. A new transition clinic for young people with complex neurodisability was established in 2015. Our aim was to ensure a patient-centred approach in developing and improving the current transition service in accordance with NICE guidelines on transition (2016) and cerebral palsy (2017).

The patient cohort was derived from young people referred from the paediatric neurodisability service to the transition 'spasticity' clinic since its establishment in 2015. We used a two pronged approach in the form of audit and telephone interviews. The audit criteria were derived from NICE guidelines and involved reviewing patients' notes and clinic letters. The structured telephone interviews with patients and parents enabled us to get qualitative feedback on the existing service. Our cohort of 8 patients were transitioned from paediatric to adult services at a mean age of 17.2 years. As well as the adult neurologist, a paediatrician was present in the transition clinic in 7 of 8 cases. An adult physiotherapist was present in 6, but a paediatric physiotherapist was only present in 2. Strengths demonstrated during the clinic included discussing communication and learning needs (7 out of 8). Weaknesses included discussing emotional health and planning future involvement of parents/carers. Communication with GPs was present in 5 out of 8 (formal transition letter with GP CC'd). 6 families gave us qualitative feedback.

Based on our results and responses, we co-produced a leaflet with young people and their families on what to expect from the transition process including information about the transition clinic and possible discussion topics, practical information such as new contact details and where to seek emergency care. We also produced a matching 'Patient Passport' to be used as a checklist in the transition clinic to ensure that all aspects of care are covered in the discussion. We hope these interventions will encourage autonomy and informed decision making in the transition process.

G439(P) WELLCOME HOME – THE WORK OF SHELTER, A CHARITABLE ORGANISATION IN FACILITATING THE DISCHARGE OF CHILDREN WITH MEDICAL COMPLEXITIES (CMiC)

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Aims Our CMiC Team coordinate compassionate care and facilitate a safe discharge for patients with complex medical conditions±social needs (CMiC criteria), whilst linking together patient-focused working for health and social care

services. WELLcome Home aimed to improve the quality of the long journey home.

Methods Shelter established a pilot 7 month housing support service (WELLcome Home) for CMiC families. An onsite Shelter support worker guides families through the social housing pathway, raises the profile where housing prevents discharge, and contributes to CMiC multidisciplinary team meetings, bridging the gap between Health and Social Care.

Abstract G439(P) Table 1

	Score before WELLcome home			Score after WELLcome home		
	1–4	5–8	>8	1–4	5–8	>8
Emotional and Mental wellbeing	47%				58%	
Managing at home	47%	29%			75%	25%
Managing tenancy	24%	41%	18%		58%	42%
Financial worries	12%	41%	18%	17%	58%	25%
Physical health	18%	65%	18%	8%	67%	25%
Social networks and relationships	24%	59%	6%	8%	62%	8%
Confidence	29%	59%			83%	17%

(1 poor, 10 excellent)

Results Service-user evaluation questionnaires provided qualitative data across seven modalities (table 1).

Conclusion The WELLcome home project demonstrated positive qualitative outcomes across all modalities assessed. Between January-June 2017, housing provided discharge barriers for 15 long-stay patients. Additional length of stay due to housing need exceeds 1000 bed-days for this patient subgroup. Funding for Shelter at our Hospital is secured for 5 years. Collaborative, imaginative working is vital to continue supporting our most vulnerable and complex families.

British Society for the History of Paediatrics and Child Health

G440 CHILDHOOD HEALTH PROMOTION DURING 1870–1901

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Aim Taking physical education as an exemplar, the aim of this study is to explore and discuss child health promotion in Britain and the USA during the late Victorian era (LVA), utilising the Children and Youth version of the WHO International Classification of Functioning, Disability and Health (ICF-CY) as a frame for analysis. The ICF-CY describes the interrelationships of body structures and function; of activities and participations and of the contextual influences of environment and personal factors for given health states.

Methods Archival papers were identified from searches of PubMed; the LA84 Foundation and the library search functions of the Manchester Metropolitan University and subject to Framework Analysis as supported by the ICF-CY.

Results The literature of the LVA saw an emphasis on the physical education of boys. In terms of body structures and functions, advances in the physiology of diet and exercise,

with an emphasis on anthropometrical measures as a determinant for athletic prowess and selection, were found. For activities and participations, the 'educative' benefits of physical exercise for the formation of psychological factors such as character, resilience and morality were described. For the influence of contextual factors, such as attitudes and cultural influences, Britain saw the pursuit of a 'selected' ancient Greek ideal of combined intellectual and physical development, with an emphasis on all round activities and 'moderation'. For the USA, 'hard' and sometimes specialised physical training was deemed as important for the development of 'manly' virtues. For both countries the detrimental effect over-training for boys was recognised. Female exercise was promoted in separate learning environments and with activities of a lower intensity than for boys. However, research insights from biomedical sciences such as physiology and neuroscience did not systematically inform physical education practices in Britain and the USA, despite the growth of inter-disciplinary groups and the increasing availability of biomedical publications in the LVA.

Conclusion The ICF-CY supports the historiography of physical education for children and youth during the late Victorian era. This has a parallel with the modern era of health promotion and the knowledge gained from sport and exercise science.

G441 HISTORY OF PAEDIATRIC NEPHROLOGY IN EUROPE – 50 YEARS OF HOPE

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2017 marked the 50th anniversary of the European Society for Paediatric Nephrology (ESPN) foundation meeting in Glasgow. It was also the centenary of the first ever kidney biopsy in a child or adult also in Glasgow. Since then tremendous advances in medical, nursing and psycho-social care have been made.

As part of the anniversary we held and recorded on film a history symposium delivered by early pioneers. Topics included the start of dialysis and transplantation in children, use of renal biopsy to in nephrotic syndrome management, collaborative work of the ESPN and development of the multi-disciplinary team. Creating this opportunity for retired experts to reflect on 50 years of progress gives a unique wide-angled perspective. These journeys of discoveries challenges current thinking and can act like a calibrating device to ensure good past ideas are not lost.

We also created an oral history video repository (www.youtube.com/c/ESPNhistory) where 35 early pioneers recorded their stories for (P)ity. Their voices recount vividly the desperation families and children suffered when treatment was ineffective and transplant or dialysis unfathomable – followed by the era of rapid innovation. We learn from the pioneers their own personal stories of self-sacrifice, heroism and dogged persistence. Of interest to our current generation is the historical

and technological context: the Iron Curtain curtailing travel, no internet, emails or Medline. These pioneers matured research from personal case series to the international collaborations we have today.

Storing oral history is important as most of this rich history was never written up, remembered only in anecdotes. With today's inexpensive technology it is simple and we achieved breath by collaborating internationally. We owe it to future generations to collate a living oral history of medicine of this remarkable bygone age from those who were there. The use of cheap smartphone filming and a customised repository channel on internet video social media opens up new ways to connect history of medicine to future generations.

G442(P) THERAPEUTIC CLOWNING – HISTORY, MEDICINE AND EVIDENCE

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History of clowning There is documented evidence for the role of a 'Jester' figure in most ancient cultures including, Egyptian, Greek, Chinese, Roman and mediaeval Europe. The term 'clown', derived from the Scandinavian word 'cloyne' to describe a 'clumsy person', started to appear in the 1500s to describe foolish characters in Shakespearean plays.

Modern clowns are strongly associated with the tradition of the circus clown which developed from earlier comedic theatre roles during the 19th centuries. Joseph Grimaldi (1778–1837) being the first recognisable ancestor of the modern clown.

Clowns in hospitals/health environments

Dr Hunter Doherty 'Patch' Adams was the founder of clown doctors. He put on a red nose as he worked in hospitals believing that humour and laughter creates an atmosphere of trust and love between staff and patients. Clown doctors now work throughout the world including the Big Apple Circus Clown Care Unit, in USA, the Theodora Foundation in Europe, Africa and Asia and the Humour Foundation Clown Doctor Program in Australia.

Therapeutic clowns are selected for personal qualities such as communication skills, compassion and empathy so they complement clinicians and play an integral role in the paediatric care team using magic, music and storytelling to engage children and enable them to deal with the emotions they may experience while in hospital such as fear, anxiety, boredom and loneliness.

Evidence of effect Clowns may have positive cognitive, physiological, social and emotional effects. A review of the paediatric literature reveals their value in the following areas:

- Reducing stress and anxiety during the pre-operative period, in both children and parents
- Reducing pain during invasive medical procedures
- Reducing anxiety during sexual abuse examination
- Shorter induction time for anaesthesia and faster discharge
- Promoting patient- and family-centred care in PICU
- Positive impact on staff working in disaster area field hospital
- Improving team function

G443(P) FOLLOW-UP BETWEEN 6 AND 24 MONTHS AFTER DISCHARGE FROM TREATMENT FOR SEVERE ACUTE MALNUTRITION IN CHILDREN AGED 6–59 MONTHS: A SYSTEMATIC REVIEW

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Background Severe acute malnutrition (SAM) is a major global health problem estimated to affect 16.9 million children under-5, and confers an increased risk of mortality and morbidity. Community Management of Acute Malnutrition (CMAM) programmes have revolutionised treatment for SAM and significantly reduced associated mortality. Community follow-up after discharge from treatment is variable, as links to supplementary feeding programmes are often weak. This review aimed to draw attention to the uniquely vulnerable period of 6–24 months post-discharge that, until now, has fallen through the gap.

Methods Embase, Global Health and MEDLINE were systematically searched with terms related to SAM, nutritional intervention and follow-up between June and August 2017.

Results A total of 3691 articles were retrieved from the search, 55 full-texts were screened and seven met the inclusion criteria to be included in the review. Loss-to-follow-up, mortality, relapse, morbidity and anthropometry were outcomes reported. Between 45.1% and 0.0% of cohorts were lost-to-follow-up. Mortality ranged from 10.4% to 0.6% at an average of 12 months after-discharge. Two studies reported improvement of weight-for-height (WHZ) from discharge to 12 month follow-up, whilst the three studies that reported height-for-age (HAZ) found either limited or no improvement.

Conclusion This review suggests there is a scarcity of studies that follow-up children for at least 6 months after-discharge. Therefore, there is an urgent need for further follow-up studies investigating a diverse range of outcomes, using control groups and streamlined admission and discharge criteria.

This review has demonstrated that children remain vulnerable to adverse outcomes after discharge from SAM treatment programmes. We must begin to look beyond anthropometric definitions of recovery and the sole focus of reducing mortality. Instead, we should take a holistic view of child nutrition that considers the role of the home and community environment for a complete rehabilitation of these children, and uses CMAM as an opportunity to promote good nutrition and nutritional practices in children for life.

G444(P) MEDICAL STUDENTS EMBRACING CHANGE: HOW DO WE LEARN FROM LESSONS OF THE PAST TO BE GREAT DOCTORS OF THE FUTURE?

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In order to improve clinical practice in the future we have to learn from our past. The issues discussed at the inaugural Great Ormond Street Hospital Advances in Paediatrics Conference 2017 were current and pressing and should be dealt with now to raise the bar of healthcare in the UK. As medical students, we considered the salient messages from this conference and discuss how to apply them to our future training.

Staff were frank and honest about where paediatric medicine was heading. They alluded to mistakes made allowing for reflection and open discussion, whilst suggesting changes we hope would make us more rounded paediatricians.

Key themes that shaped the inquisitive, open mind-set that medical students should have throughout their training and beyond were highlighted. Three points seemed especially important: having a realistic perspective on the 'crisis of the NHS', awareness of the lack of transparency in clinical research and the advancement of technology and associated impact on patient-centred care. If we are able to address some of these issues it might help to not only maintain but also raise the standards of healthcare that we can provide.

Overall, we feel that by embracing change, especially at the beginnings of our education, we can overcome miscalculations made by our predecessors. It is easier to have the right attitude ingrained in you from the start than it is to alter one already set in stone. By shifting focus to patient-centred care we can put patients and families back in the driving seat of their own health. Changes supporting openness in clinical trials approach can ensure that patients are not harmed by poor clinical decisions based on research misconduct and publication bias. To be great future doctors we must be receptive to changes going on around us. Technology is revolutionising medicine; we should embrace it and adapt it into our practice to provide the best care. As Professor Tony Young—Head of NHS Innovation England—said, this will enable the clinicians of now and the future to be 'advisors and navigators' and not just 'gatekeepers to medicine.'

British Paediatric Respiratory Society and British Society for Paediatric and Adolescent Rheumatology

G445 PHYSICAL AND PSYCHOLOGICAL ADAPTATION TO IMPAIRED LUNG FUNCTION IN CHILDREN AND YOUNG PEOPLE WITH SCOLIOSIS

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Aims Scoliosis may impair both lung function and exercise capacity. There is some evidence to suggest lung function is positively correlated with exercise capacity, however the exact relationship between these variables is poorly defined. This study investigated the relationship between exercise variables and lung function in children and young people with scoliosis, looking particularly at whether patients show evidence of improved physical conditioning despite impaired lung function.

Methods Retrospective analysis of data from Spirometry [FEV1, FVC], Whole Body Plethysmography, Cardiopulmonary Exercise Testing [CPET] and patient outcome questionnaires (SRS-22) undertaken prior to spinal fusion. CPET measures included maximal exercise capacity [VO2peak] as well as VO2 at anaerobic threshold [AT] expressed as %predicted VO2max—a measure of physical conditioning, and minute ventilation [VE] from which breathing reserve [BR] could be calculated. Analyses were performed using SPSSv23, and correlations expressed using Pearson's correlation co-efficient.