visited by the GP who developed the tool and clinicians were trained in the use of it. It was then trialled for 8 weeks. In addition focus groups were held with 2 groups of young people (n=25) to assess their opinion of the acceptability and utility of the THT.

Results 2 of the practices completed 51 THT between them. 1 practice did not complete any. The pilot centres who used the THT agreed it was useful and improved the focus on this age group in addition to improving communication. They commented it was feasible to use it within a 10 minute consultation and was also a useful training tool for junior staff. Young people were positive about a professional taking an interest in their health beyond the presenting complaint and agreed the topics covered were relevant and important.

Conclusions Primary care staff and young people confirmed that the THT is an important and useful assessment tool that can be used in primary care. Practices need support and training in how to use the tool and also confidence in what to do with the information uncovered – this requires knowledge about local resources and referral pathways and would benefit from the development of accompanying materials. Wider dissemination would potentially improve young people's experience of primary care leading to better utilisation in addition to the health benefits of earlier intervention and prevention where appropriate.

G525(P) ABSTRACT WITHDRAWN

G526(P) ABSTRACT WITHDRAWN

G527(P) NEONATAL READMISSION RATES: AN AUDIT OF CURRENT PRACTICE

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Aims

- To identify the rate at which neonates (less than 28 days old) are admitted to the children's ward and the indication for admission.
- To highlight potentially avoidable causes for neonatal admissions, with a view to reducing them.

Methods We identified our population by comparing our local birth rate, and or neonatal admission rate to the children's ward. Secondly, we audited all neonatal admissions to the children's ward over a 12 week period. We reviewed electronic records and assessed 5 criteria:

- Reason for admission
- Source of referral
- Day of life of admission
- Duration of admission
- Whether admission potentially avoidable

Results Our local birth rate is 2,000 annually. This equates to approximately 450 livebirths over the 12 week period. 32 neonates out of 450 live births during this timeframe were admitted to the children's ward. A hospital admission rate of 7%.

- **Reason for admission:**
 - 11 (34%) suspected/confirmed sepsis
 - 10 (31%) jaundice
 - 8 (25%) weight loss
 - 3 (9%) other
- **Source of referral:**
 - 17 (53%) community midwives
 - 6 (19%) GP
 - 6 (19%) A&E
 - 3 (9%) other
- **Day of life on admission:**
 - 7 (21%) attended within the first 4 days of life
 - 8 (25%) attended on day 5 of life
 - 8 (25%) attended between days 6–15 of life
 - 9 (28%) attended between days 16–28 of life
- **Length of Stay:**
 - 8 (25%) stayed 1 night
 - 15 (47%) stayed 2 nights
 - 9 (28%) stayed longer
- **Admission avoidable?**
 - 12 (38%) were avoidable
 - 16 (50%) were not avoidable
 - 4 (13%) were not clearly avoidable or unavoidable

Conclusion 7% of babies are admitted to paediatrics in the neonatal period. 38% of admissions were avoidable. Almost all avoidable admissions are breastfed babies admitted with weight loss. Nearly all were referred by the community midwifery team on day 5, co-inciding with newborn blood spot screening. Weight loss >13% was common. All were discharged home within 2 days with a feeding plan.

We are now looking at how to support these families in the community to prevent avoidable neonatal admissions to paediatrics.

Source of referral:

G528(P) HICKAM'S DICTUM, AND A CASE OF INFLAMMATORY BOWEL DISEASE IN THE CONTEXT OF PRE-EXISTING AVOIDANT-RESTRICTIVE FOOD INTAKE DISORDER

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Background 'Occam's razor' is a commonly-cited principle of diagnostic parsimony; that plurality should not be posited with necessity, and that a single unifying diagnosis is likely to be the best one. However, a counterargument can be expressed as 'Hickam's dictum'; that a patient may have as many diseases as he or she pleases.

Case We present a case of a 14-year-old girl who presented with weight loss. She had a background of severe anxiety with agoraphobia and emetophobia, with associated avoidant-restrictive food intake disorder. She was referred to the hospital by community mental health services for dietetic input and management of potential re-feeding syndrome.

Due to her anxiety, the patient wouldn't allow any blood tests or investigations. Engagement with dieticians,

psychologists and paediatricians was extremely limited; she continued to lose weight whilst in hospital.

However, the patient's family mentioned some history which suggested a possible inflammatory bowel disease. Stool calprotectin was >1800 mcg/g.

Following an MDT meeting, psychiatry started aripiprazole to help her anxiety symptoms. Input from Youth Work/Play Therapy helped the patient to undergo blood tests, the results of which supported a diagnosis of inflammatory bowel disease. A referral was made to Paediatric Gastroenterology, who organised an endoscopy; the endoscopy showed focal active colitis with mucosal ulceration consistent with Crohn's disease, confirmed on histology. Upper GI endoscopy showed chronic gastritis, positive for *Helicobacter pylori*.

Treatment for Crohn's disease was commenced with methylprednisolone and infliximab. She also received *Helicobacter* eradication therapy. The patient continued on aripiprazole, and was able to engage with CAMHS whilst an inpatient. She was discharged after 5 weeks in hospital. She continues to receive treatment from both CAMHS and Gastroenterology, and is doing well.

Conclusion Whilst diagnostic parsimony remains a prudent approach to diagnosis, patients may have multiple pathologies contributing to the same presentation. Clinicians should keep an open mind regarding the possibility of co-existing illnesses, even once the first diagnosis has been confirmed.

G529(P) AN EXPLORATORY ANALYSIS OF BARRIERS TO ACCESSING HEALTH CARE AMONG YOUNG PEOPLE IN 30 LOW-MIDDLE INCOME COUNTRIES

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Aims The importance of good health in young people and the currently poor health outcomes of this group are well documented. Qualitative studies in Low and Middle Income Countries (LMICs) indicate that these poor outcomes are partly due to young people facing additional healthcare barriers compared to other age groups and that tackling these barriers may make an important contribution in improving young people's health. This paper aimed to investigate the prevalence of healthcare barriers in a quantitative manner amongst young people (10–24) and older adults (25–49) across 30 LMICs to identify if young people face additional healthcare barriers compared to older adults.

Methods Secondary analyses of survey data from young people (10–24) and older adults (25–49) across 30 countries was performed using 6 selected survey questions within the Demographic and Health Surveys, a multinational database.

Results On average, young people reported significantly greater barriers to accessing evidence-based care compared to older adults across all survey questions measured with an average of 8.4 percentage point difference across the 6 questions. During question specific analysis, wide variation was seen between countries, with some countries reporting insignificance between the two groups. The range seen between countries varied between questions, with a difference of up to 33 percentage points between younger people and older adults. 7 countries showed no differences between groups across 2 or more survey questions. In particular, Rwanda showed insignificance

across all survey questions data was present for. A more positive response to a question by a country does not appear to correlate with insignificance between younger and older adults.

Conclusion Our results, whilst supporting the previously published qualitative data that young people in LMICs face additional health barriers, clearly highlights a wide variation between countries. This indicates country specific barriers to accessing healthcare, which prevent young people having optimum use of the resources available. The insignificance between groups in certain countries indicate that barriers to healthcare access for young people are not inevitable. This report highlights the need for more in-depth country specific analyses of healthcare barriers and further research into causative factors that can affect healthcare access for young people.

G530(P) DO YOUNG PEOPLE WITH EPILEPSY DISENGAGE WITH HEALTHCARE FOLLOWING TRANSITION TO ADULT SERVICES?

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Introduction There is a concern that young people with epilepsy will disengage with healthcare following transition to adult services. The aim of this review was to identify from the medical literature any evidence to support or refute these concerns.

Methods Markers of engagement were identified as scheduled care attendance, unscheduled care attendance, medication adherence, mortality, healthcare costs and health behaviours. A literature review was carried out for each of these areas. Studies published in the period 2008–2018 were included.

Results There is good evidence that there is no increase in emergency care use in young adults with epilepsy compared to children or older adults. There are no studies comparing scheduled care use by children, young people and older adults. There is evidence that young people with epilepsy attend their GP twice as frequently as age matched peers, but it is unclear how much of this is related to epilepsy and how much to co-morbidity. There is conflicting evidence around medication adherence and therefore no conclusion can be drawn as to whether transition has an impact on this.

Young adults with epilepsy have higher rates of unexpected death than children or older adults. They are more likely to have uncontrolled epilepsy than older adults. In a deprived population, death by accident is more likely in adults with epilepsy. People with childhood epilepsy have been found to have a lower level of education than age matched controls, as well as higher unemployment levels and increased reliance on state welfare programmes.

Conclusion There is a paucity of evidence to show whether or to what extent young people with epilepsy disengage with healthcare following transition to adult services. There is no evidence that young people have different scheduled care attendance or medication adherence following transition. There is good evidence that young adults do not have higher emergency care attendance or admissions to hospital. There is evidence that young people have an increased risk of unexpected death around the time of transition and this should be addressed.