stumbling block to the identification of LCP and it is retro-
spectively believed that many cases of LCP were incorrectly
diagnosed as hip infection, tuberculosis, slipped upper femoral
epiphysis, and osteochondritis.

Rontgen’s discovery of X-rays in 1895 revolutionised ortho-
paedics to what it has become today. From 1909 to 1910 the first
formal descriptions of LCP dutifully followed from A. Legg in the USA, J. Calve in France, and G. Perthes in Ger-
many. While united in their radiographic descriptions, they
differed greatly in the pathophysiology they postulated. Trauma, abnormal osteogenesis and inflammation were all pro-
posed, but are now considered incorrect. Rather it was histo-
logical studies by Phemister in Chicago, in 1921, that first
suggested an aseptic cause of necrosis of the femoral head.
This concept was furthered by Konjetzny in 1926, who demo-
strated a compromised vascular supply to the femoral head
of patients with LCP.

In the next stage of radiographic assessment, Waldenstrom
in 1922 was able to build on the work of Phemister and
described four radiographic stages of LCP disease: initial, frag-
mentation, re-ossification and healed. These stages still hold
ture today, demonstrating remarkable insight, and have only
recently been modified in 2003 by Joseph et al, giving rise to
the modified- Waldenstrom classification system. Later work
by Stulberg in 1981 resulted in the Stulberg classification, an
important prognosticating classification used today.

The management of LCP has evolved from two early
schools of opinion: unloading of the hip to allow neovascular-
isation and containment of the hip. Early approaches focused
on the former and resulted in prolonged bedrest, long admis-
sions and poor compliance. Later efforts focused on contain-
ment and were first applied by Harrison et al, who in 1969
introduced the Birmingham hip abduction splint. Further
orthoses by Petrie in 1971 and Curtis et al in 1974 followed,
however suffered high complication and failure rates. Simulta-
neously, operative containment was being established and
Soeure and De Racker introduced the femoral varus osteot-
omy in 1952, soon followed by Salter’s innominate osteotomy
in 1962.

Conclusions The history of LCP demonstrates the importance
of ongoing research and debate to obtain sound understanding
and improved outcomes in child health. Future work contin-
ues to optimise and advance existing knowledge.

British Academy of Childhood Disability

1082 PATHWAYS: TRANSFERRING YOUNG PEOPLE WITH
COMPLEX NEEDS FROM A CONSULTANT
PAEDIATRICIAN TO A CONSULTANT ADULT PHYSICIAN

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Background The number of young adults with complex medi-
cal needs living into adulthood is increasing as a result of
early detection, advances in medical treatments and improved
health. Upon leaving children’s services, they and those who
care for them, must learn to navigate new and unfamiliar
adult healthcare systems. For those with complex multi-system
disease, many with physical and cognitive disabilities, this can
involve multiple sub-specialty appointments: care that has been
well-coordinated by generalist and community paediatricians
can become complicated and fragmented. As children, many
of these young people will have had established routes to
emergency hospital admission to well-known wards and
healthcare teams. In adult services these admissions procedures
can feel less bespoke with poor experiences being reported on
busy admissions units involving unfamiliar wards and staff.

Objectives We describe steps taken to improve the experiences
of young adults and their carers accessing adult secondary
healthcare and achieve recommendations from NCEPOD Each
and Every Need: a handover clinic, review of admissions
procedures and provision of a single-point of contact at the
hospital.

Methods Clinicians from Community Paediatrics, Palliative and
General Medicine formed a working-group and applied quali-
ity-improvement methodology to create a transition clinic for
young people with complex medical needs. Qualitative data
for service development was collected through semi-structured
interviews with carers, an online survey completed by the
multi-professional team and via patient feedback forms.

Quantitative outcomes were used to characterise the com-
plexity of the clinic attendees as well as demonstrate the
diversity of the multidisciplinary team (MDT) involved. These
included tracking clinical concerns using the health, function-
ing and wellbeing score, prospective data collection of involve-
ment of other medical specialties, changes to medication,
discussion of advance care plans and admission prevention.
Finally, data on A&E attendances, hospital admissions and
length-of-stay were collected for patients in the transition
clinic and a comparison group.

Results 14 clinics took place for 30 young people over 39
appointments in 9.5 months. The average age was 18.83 years
(range 17.45–20.12 years) and the average number of diagno-
ses/patient was 5.36 (range 3–10) with neurological diagnoses
being most frequent. Clinics were attended by professionals
and carers from >14 disciplines/agencies. Health, Functioning
and Wellbeing scores showed the average number of carers
reporting ‘no concerns’ increased at each time-point while the
average numbers reporting ‘some concerns’ and ‘serious con-
cerns’ decreased from the first appointment to the second but
the changes were not statistically significant. Professionals
reported participation in the clinic was an effective use of
their time, that it promoted MDT working and that it
improved patient care. Data on A&E attendances, hospital
admissions and length of stay for patients in the pathways
clinic and comparison group did not show any statistically sig-
ificant differences.

Conclusions The steps taken to improve the experiences
of young adults with complex medical needs, as well as those
that care for them, accessing secondary healthcare services had
a positive impact and were welcomed including by the multi-
professionals involved. Well-coordinated and appropriate sec-
ondary healthcare is vital for the continued health and quality
of life of this vulnerable group.