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

Röntgen's discovery of X-rays in 1895 revolutionised orthopaedics 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. Calvé in France, and G. Perthes in Germany. While united in their radiographic descriptions, they differed greatly in the pathophysiology they postulated. Trauma, abnormal osteogenesis and inflammation were all proposed, but are now considered incorrect. Rather it was histological 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 demonstrated a compromised vascular supply to the femoral head of patients with LCP.

In the next stage of radiographic assessment, Waldenström in 1922 was able to build on the work of Phemister and described four radiographic stages of LCP disease: initial, fragmentation, re-ossification and healed. These stages still hold true today, demonstrating remarkable insight, and have only recently been modified in 2003 by Joseph et al, giving rise to the *modified*-Waldenström 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 neovascularisation and containment of the hip. Early approaches focused on the former and resulted in prolonged bedrest, long admissions and poor compliance. Later efforts focused on containment 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. Simultaneously, operative containment was being established and Soeure and De Racker introduced the femoral varus osteotomy 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 continues to optimise and advance existing knowledge.

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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 medical 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 quality-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 complexity of the clinic attendees as well as demonstrate the diversity of the multidisciplinary team (MDT) involved. These included tracking clinical concerns using the health, functioning and wellbeing score, prospective data collection of involvement 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 diagnoses/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 concerns' 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 significant 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 secondary healthcare is vital for the continued health and quality of life of this vulnerable group.