British Academy of Childhood Disability

1123 UK CHILDHOOD AUTISM DIAGNOSTIC SERVICES SURVEY 2020: EVIDENCE FOR CHALLENGES AND INNOVATIONS

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Background Assessments of possible autism spectrum disorder ('autism') are completed by multidisciplinary diagnostic teams (MDTs) in paediatric or child and adolescent mental health services (CAMHS). NICE (Guidance and Quality Standards) suggest teams should reach a conclusion about whether an autism diagnosis is appropriate or not, identify other related conditions, and recommend appropriate interventions and a management plan. The NHS England Long Term Plan (2019) sets out the need to improve autism diagnostic services, and reduce waiting times.

Objectives Identify existing models of autism diagnostic assessment and gain an understanding of associated barriers and facilitators to service delivery.

Methods A UK clinical practice survey in a semi-structured format was developed in consultation with clinicians and parents. The survey was distributed online to UK childhood autism diagnostic assessment services between June-December 2020. Participants were recruited through professional and clinical networks.

Results 132 UK childhood autism diagnostic assessment services responded (54% paediatric services (n=72), 35% CAMHS services, n=46). 11% (n=14) were from integrated, or independent services.

One third of teams reported data on referrals and assessments between 2015–19. Referrals rose from median 147 to 300 (104% increase). Autism assessments rose from 110 to 190 in 2019 (58% increase). 48% of teams reported funding stayed constant, whilst 30% of teams reported an increase, and 13% decreased.

68% of teams reported their assessments always or mostly met NICE guidance; 23% of teams met NICE guidance in fewer than half their assessments. Regarding MDT core members most paediatric teams included a paediatrician (97%) and speech and language therapist (SLT) (86%); clinical psychologists were in a minority of teams (44%). Most CAMHS teams included a clinical psychologist (87%); only 67% included a psychiatrist, and only 46% an SLT. Specialist nurses were more likely to be present in CAMHS than paediatric teams (67% and 28% respectively). One third of paediatric and CAMHS teams included an occupational therapist. Both paediatric and CAMHS teams had additional MDT professionals available to them; nevertheless, once this was accounted for, significant gaps in provision remained.

The MDT representation in teams, and whether they were paediatric or CAMHS based directly affected their ability to undertake assessments of other neurodevelopmental and co-existing conditions, and offer recommendations. Many teams reported making onward referrals for this purpose; however, some teams were able to offer a more comprehensive service.

To address challenges, teams described obtaining information following referral e.g. from Early Help Services, or

nursery/school (69%); and using questionnaires prior to referral/pre-first assessment appointment (69%). Some teams changed their MDT mix (56%) and used digital technology e.g. computerised systems/software (44%).

Conclusions Increased referrals and assessments, available funding and MDT limitations meant many teams were not able to comply with NICE guidance. Some changes could be implemented now to address variability and inequalities. In future research, we will identify opportunities and challenges presented by different service models, and evaluate whether they provide the timely, robust and holistic conclusions required by children and parents, and professionals.

British Association of Perinatal Medicine and Neonatal Society

1125 A RETROSPECTIVE COMPARISON OF SHORT-TERM OUTCOMES FOLLOWING SPONTANEOUS INTESTINAL PERFORATION AND NECROTISING ENTEROCOLITIS

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Background Necrotising enterocolitis (NEC) and spontaneous intestinal perforation (SIP) are gastrointestinal pathologies affecting preterm neonates that are associated with significant morbidity and mortality. They can be challenging to differentiate clinically; although improved histological techniques designed to differentiate between the inflammatory, necrotic pathology of NEC and the isolated, often ileal perforation of SIP may explain the apparent recent increase in SIP diagnoses. It is important to be able to distinguish between NEC and SIP to allow the effective evaluation of new prevention and/or treatment strategies.

Objectives To explore differences in presentation, management and short-term outcomes of NEC and SIP in a cohort of infants born at <32 weeks corrected gestational age.

Methods A retrospective review of all neonates with surgical NEC or SIP managed in a single regional neonatal surgical centre over a nine-year period (2012 and 2020 inclusive). Data was extracted from the Badgernet database and medical records. Local Caldicott approval was obtained.

Results 50 infants with NEC and 31 with SIP were identified. Their background demographics are described in table 1. Infants with SIP present significantly earlier (median 6 versus 24 days) and at a younger corrected gestational age (median 26.4 versus 30.7 weeks) than those with NEC (table 1). A high percentage of both cohorts were commenced on maternal breast milk as first milk and those with SIP were more likely to have received a blood transfusion prior to diagnosis. Table 2 describes key short term outcome data for both groups. Mortality is higher in NEC, however rates of ROP requiring treatment, severe IVH and need for home oxygen were higher in SIP survivors (table 2).

Conclusions NEC and SIP are catastrophic diagnoses with recognised adverse outcomes. Our data identifies a higher burden of morbidity in survivors of SIP, potentially reflecting the earlier insult at a time of greater susceptibility to multisystem injury in the most immature infants. It is important to