Abstract 1187 Table 1 Summary of time to diagnosis and disease severity of the study population (253 childhood cancer and 187 T1DM incident cases)

	2019		Jan-Mar 2020		Apr-Jul 2020		p-value
	n	%	n	%	n	%	
Childhood cancer (Jan-Jun)	138		59		56		
Diagnostic intervals (median, P25-P75)							
Total diagnostic interval (weeks)	4.5 (2.3–10.9)		5.6 (3.4–15.3)		4.6 (2.7–11.9)		0.351
Patient interval (weeks)	0.9 (0.1–2.1)		2.7 (0.7–4.4)		1.1 (0.3–4.7)		0.006
System interval (weeks)	2.1 (0.6–5.7)		2.0 (0.4–6.1)		2.1 (0.7–8.0)		0.825
ICU stay							
No	120	87%	55	93%	48	86%	0.275
Yes	17	12%	3	5%	6	11%	
Not known	1	1%	1	2%	2	4%	
Type 1 diabetes (Jan-Jul)	98		43		46		
Diagnostic intervals (median, P25-P75)							
Total diagnostic interval (days)	16.0 (8.0–28.0)		21.0 (13.5–31.5)		14.5 (7.0–22.0)		0.119
Patient interval (days)	14.0 (7.0–28.0)		21.0 (14.0–32.0)		14.0 (7.0–22.0)		0.054
Symptom interval (days)	0 (0–1.0)		0 (0–0)		0 (0–0)		0.083
DKA							
No	59	61%	26	60%	27	59%	0.624
Mild/Moderate	25	26%	12	28%	9	20%	
Severe	13	13%	5	12%	10	22%	
ITU stay							
No	90	92%	39	93%	40	87%	0.625
Yes	8	8%	3	7%	6	13%	

lockdown on total diagnostic interval (TDI), patient interval (PI), system interval (SI) and disease severity were evaluated.

Results Children with new diagnosis of CC (n=253) and T1DM (n=187) were included in the analysis. Overall there was a 17% reduction (138 vs 115) in number of incident CC cases and 9% reduction (98 vs 89) in T1DM cases between 2019 and 2020, with some regional variation. No significant differences in gender, ethnic background or age at diagnosis between study periods were observed. The route to diagnosis and severity of illness at presentation were unchanged across all time periods.

Median diagnostic interval for CCs during lockdown was comparable to that in 2019 (TDI 4.6, PI 1.1 and SI 2.1 weeks), except for an increased PI during pre-lockdown period Jan-Mar 2020 (2.7 weeks) (table 1). Median diagnostic interval for T1DM during lockdown was similar to that in 2019 (TDI 16 vs 15 and PI 14 vs 14 days), except for an increased PI in pre-lockdown period Jan-Mar 2020 (21 days) (table 2).

Conclusions There is no evidence of diagnostic delay or increased illness severity for CC or T1DM during the first lockdown in the participating centres. This provides reassuring data for children and families with these life-changing conditions. Data collection at a more comprehensive national level would provide greater clarity on diagnostic intervals.

Paediatric Mental Health Association

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IS IT TIME TO ACT? A QUALITATIVE STUDY OF THE ACCEPTABILITY AND FEASIBILITY OF ACCEPTANCE AND COMMITMENT THERAPY FOR ADOLESCENTS WITH CHRONIC FATIGUE SYNDROME

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10.1136/archdischild-2021-rcpch.460

Background Paediatric Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) is severely disabling and relatively common. Over 15% of children do not recover by 12 months. Cognitive Behavioural Therapy for fatigue (CBT-f) is one of the only approaches with consistent evidence for improving function and quality of life. Acceptance and Commitment Therapy (ACT) is a suggested alternative therapy. It is effective in paediatric chronic pain and functional syndromes, but has not yet been trialled in paediatric CFS/ME.

Objectives We aimed to determine whether ACT is an acceptable and feasible treatment approach for children who are still disabled by CFS/ME after 12 months of treatment. This study is part of pre-trial work to inform the development of an effectiveness randomised controlled trial (RCT) of ACT.

Methods A qualitative design, using semi-structured interviews and focus groups was adopted. We recruited children (inclusion criteria: diagnosed with CFS/ME; not recovered after one year of treatment; aged 11–17 years), their parent/carer and healthcare professionals (HCPs) from one specialist UK paediatric chronic fatigue service. Interviews and focus groups were audio-recorded, transcribed verbatim and analysed using thematic analysis to identify patterns in the data.

Results Twelve adolescents, eleven parents, and seven HCPs were interviewed. All participants thought ACT was acceptable and feasible, and welcomed it as a new possibility for recovery. Participants identified reasons why ACT might be efficacious: the pragmatic approach with acceptance and compassion are valued in chronic illness; the focus on values provides motivation and direction; psychological and physical needs are both addressed; and normalising difficulties is a useful life-skill. Some adolescents preferred ACT to CBT-f as it encouraged acceptance of (rather than challenging) thoughts. However, HCPs were concerned patients might associate 'acceptance' with 'giving up' and called for clear explanations of the goals of ACT to be given to patients and parents. Interviews highlighted differing views on who might benefit from ACT and at which point during treatment it should be offered. It was agreed that ACT should be part of an individualised treatment plan that should be made on a case-by-case basis. Most adolescents said they would consent to a RCT of ACT but a key barrier to recruitment was reluctance to be randomised.

Conclusions Adolescents with CFS/ME, their parents and HCPs from a CFS/ME service thought ACT was an acceptable, feasible, and potentially efficacious treatment approach. They support a RCT of ACT, and most would consent to partake in a trial. We recommend trialling ACT in paediatric CFS/ME.