British Association of Child and Adolescent Public Health

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MEETING THE HEALTH NEEDS OF UNACCOMPANIED ASYLUM SEEKING CHILDREN: A SCOPING REVIEW OF ROUTINE HEALTH ASSESSMENT

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Background Approximately, 34 million of 79.5 million forcibly displaced persons globally are minors, many of whom are unaccompanied asylum seeking children (UASC). UASC often experience unmet health needs, physical harm or emotional trauma in their birth country, or during their journey to seek asylum. International guidelines recommend health screening for all migrant children.

Objectives

1. Scope the literature on UASC routine health assessment across Australia, European Economic Area, Canada, New Zealand, Switzerland, United Kingdom and United States (n=36).
2. Analyse health screening programmes to inform future health policy.

Methods Literature published (2010-March 2021) was systematically searched across MEDLINE, Web of Science, Cochrane and CINAHL. Records were screened against the inclusion criteria. A framework analysis across national and international organizations' websites identified additional documents.

Results 33 of 1432 records were included. UASC screening was reported across 13/36 countries, summarised in table 1. Commonly, studies were observational reports lacking references to clinical guidelines.

Tuberculosis disease screening was offered in 12/13 countries. 8/13 countries used a risk-based approach, meaning UASC exposed to risk factors or from areas endemic for conditions (such as tuberculosis, hepatitis or parasites) were screened.

Non-communicable disease screening guidance was present across 10/13 countries. 7/13 proposed blood testing for

anaemia and nutritional deficiencies. Dental checks and developmental assessments were suggested in 7/13. Mental health screening was recommended in 6/13 countries.

Conclusions Studies reporting UASC health assessment were not found for all countries. We found considerable procedural variation, which can exacerbate health inequalities. While we do not assume UASC health needs in these countries are not addressed, it raises concerns of the standards followed. Countries reporting screening may represent settings where optimal assessment is being followed. However, no audit data are available to compare guideline implementation and effectiveness. Frequently, emphasis was placed on infectious disease screening whilst other health components like mental health were less commonly addressed.

UASC health should be prioritised, guidelines must include mental and social wellbeing parallel to communicable disease assessment. The UN Convention on the Rights of the Child recognises children's right to the highest attainable standard of health. Voluntary comprehensive health assessments could ensure no child is deprived of their rights.

Down Syndrome Medical Interest Group

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COMMUNITY FOLLOW UP OF CHILDREN WITH DOWN SYNDROME IS THERE MORE WE CAN DO? EXPERIENCE FROM A SOUTH EAST LONDON COHORT

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Background Timely and comprehensive review of children and young people (CYP) who have Down Syndrome (DS), remains one of the key priorities for our London Community Paediatric Service. A historical audit from 2013 using the Down Syndrome Medical Interest Group (DSMIG) guidelines highlighted gaps in our service with only 54% of children aged 0-19 years with DS were followed up appropriately.

Objectives In 2020 we re-audited our current patient review processes of CYP who have DS (CYP-DS) - looking at areas

Abstract 1321 Table 1

Country	Guideline	Tuberculosis	Hepatitis-B	HIV	Syphilis	Parasites	Other	NCD Screening	Immunisations
Australia	✓	✓	✓	✓	✓	✓	HCV, Rubella, VZV	✓	✓
Canada	✓	✓	✓	✓	✓	✓	HAV, HCV	✓	✓
Denmark	×	×	✓	×	×	×	HAV	✓	✓
Finland	×	✓	✓	✓	✓	✓		×	✓
Germany	✓	✓	✓	✓	×	✓		×	✓
Greece	×	✓	✓	×	×	✓		✓	✓
Italy	✓	✓	✓	✓	✓	✓	HAV, Chagas	✓	✓
Malta	×	✓	×	×	×	×		✓	✓
Spain	✓	✓	✓	✓	✓	✓	HAV, Chagas	✓	✓
Sweden	✓	✓	✓	✓	✓	✓	HCV, Rubella	×	✓
Switzerland	✓	✓	✓	✓	✓	✓	HAV, Chagas	✓	✓
UK	✓	✓	✓	✓	✓	✓	HCV	✓	✓
US	✓	✓	✓	×	×	✓		✓	✓
%	69	92	92	69	62	85		77	100

✓: included ×:unavailable

of good practice as well as areas of need. The information from these audits will inform a business case for a dedicated, local Down Syndrome Clinic.

Methods The current DS Database was updated to include all children living in our borough aged 0–19 years at the time of the audit (April–July 2020). Community folders, Electronic Patient Records (EPR) from hospital and community setting, as well as individual consultants' caseloads setting were reviewed to identify CYP-DS. Each record was systematically reviewed to see if routine medical surveillance as outlined by the DSMIG was being followed.

Results 100 CYP-DS were identified although complete medical records were not available for every child. 51% were girls, with representation from all ethnic backgrounds (71% BAME). Most children attend mainstream primary school (76%) but this decreases considerably at secondary school, when only 4% attend mainstream education.

63% (cf. 54% in 2013) of CYP-DS were reviewed within the recommended time frame – with specific improvements in monitoring of cervical spine instability, growth, sleep disordered breathing, cardiac symptoms and hearing and vision (see table 1). As noted in 2013, CYP-DS attending mainstream or out of borough settings are most at risk of being lost to follow up.

Conclusions There have been improvements in the follow up of our CYP-DS since 2013, due to greater collaboration between hospital and community services as well as improved education and training amongst professionals and families.

There are still shortcomings in specific medical surveillance – particularly of thyroid function and a need to further improve our surveillance of other medical issues such as hearing and vision.

To address these issues and improve the experience of our CYP-DS and their families, we have established a dedicated

Down Syndrome Clinic – primarily to target those in mainstream and pre-schoolers, with the database being maintained on EPR (RIO). Currently the clinic is doctor-led, but it is hoped in the future this can be a collaborative clinic with therapists, portage and a DS Support Group representative.

Quality Improvement and Patient Safety

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MOVING ON UP – ESTABLISHING A TRANSITION SERVICE FOR YOUNG PEOPLE WITH EPILEPSY

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Background Moving from paediatric to adult services is a worrying and challenging time for young people with long-term conditions. Evidence suggests effective transition between paediatric and adult services has shown to improve long-term outcomes. However, national data from the Epilepsy12 Audit in 2019, showed that for most paediatric epilepsy services there are no agreed pathways for young people to transition to adult services. This is a particular problem within secondary care settings, however there is a successful, generic transition programme 'Ready, Steady, Go', that has been implemented and adapted in many UK Hospitals, enabling young people to effectively transition to adult services.

Objectives This quality improvement project aimed to ensure that all 14–17 year olds with epilepsy will have at least one discussion about moving to adult services with the help of the Ready, Steady, Go transition programme, by the end of February 2021.

Methods A total of 28 patients aged 14 years and over with epilepsy were identified and included in the project. Those aged ≥ 16 yrs who had been referred to and were awaiting an appointment with adult services were excluded. Diagnostic tools including a process map, fishbone and histogram were completed to help define the problem further. Eligible patients had their most recent clinic letter reviewed for evidence of discussion about transition. Following this, change ideas were generated and several PDSAs were undertaken through a patient questionnaire, and setting-up a virtual transition-focused clinic, in which key areas could be impacted on (responsibility with medications, being seen alone, signposting to online resources and exploring young person and parent concerns about moving to adult services).

Results Baseline measurement showed that 54% of young people did not have any evidence of discussion about moving from paediatric to adult services, with parental concerns being the most common documented subtopic. A total of 7 questionnaires were completed, either in a general epilepsy clinic or at the beginning of a virtual transition clinic. Results showed that all patients wanted to know more about the differences between paediatric and adult services and wished to be signposted to online resources for young people with epilepsy. Importantly, the majority did not know the names, doses or frequency of their medications. Following the implementation of a virtual transition clinic, the baseline measurement increased to 57%.

Conclusions Although changes may not have been significant, there has been measurable progress in establishing a transition-focused clinic, which will now continue monthly. The focus of this clinic has enabled the paediatric epilepsy team

Abstract 1322 Table 1

Education	2013 Audit (%)	2020 Audit (%)
Mainstream Primary	64.3	76
Mainstream Secondary	0	4
DSMIG recommendations		
Timely medical review	54	63
Growth recorded	55	61
Thyroid surveillance	82.5	56
Vision	59	83
Hearing	61	75
Cervical spine enquiry	27	60
ECHO at 6 weeks	79	86
Cardiac symptoms enquiry	66.7	84
Sleep disordered breathing enquiry	77.8	88
Comorbidities		
Feeding difficulties	50.8	47
Constipation	33.3	44
Hearing aid	11.1	30
Cardiac defect on ECHO	58.7	51
Leukaemia	1.6	3
Diabetes	0	4
Social communication difficulties	20.6	33
Autism Spectrum Disorder	15.9	19