guidance states that before carrying out a CPME you must be satisfied that it is necessary and appropriate. You must be clear about what will be achieved and whether or not the outcome is likely to affect the proposed course of action.

We therefore call for clarity between all agencies with regard to the threshold required for a CPME to occur following referrals received for physical abuse allegations.

We recommend that in preschool and younger children with limited verbal skills social workers should refer for a CPME to be undertaken where there is an allegation of physical abuse regardless of whether an injury is seen. In verbal children a CPME should be done when there is a significant allegation even if no injury is seen to ensure there are no hidden injuries.

Association of Paediatric Emergency Medicine

1354 SAFEGUARDING SIXTEEN AND SEVENTEEN-YEAR-OLDS IN THE EMERGENCY DEPARTMENT: DO PAEDIATRIC LED SERVICES IMPROVE OUTCOMES?

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10.1136/archdischild-2021-rcpch.581

Background *'Working together to Safeguard Children' (2018)* is a document outlining government guidance for all professionals working with children. It states that 'children who need help and protection deserve high quality and effective support as soon as a need is identified', reminding us that 'health practitioners are in a strong position to identify welfare needs or safeguarding concerns'.

Paediatric departments regularly manage safeguarding cases; strategies to identify concerns are built into everyday practice. However, as we assume capacity to consent from the age of sixteen, 16 and 17-year-old adolescents may be managed by either adult or paediatric services, therefore could be seen by healthcare professionals with less experience safeguarding children. Nevertheless, concerns must be dealt with promptly and according to national guidance.

Our Emergency Department (ED), an inner-city major trauma centre, previously looked after 16 and 17-year-olds in the adult department. However, due to additional pressures during the COVID-19 pandemic, the paediatric ED has taken over their care.

Objectives To determine if there were improvements in how effectively safeguarding concerns were identified and acted upon when young people (YP) were managed by paediatric ED, compared to adult ED.

To use results to create sustainable change and improve services: firstly by providing targeted education for our workforce; and secondly by designing new ED pathways for YP which enable safeguarding concerns to be effectively managed.

Methods This was a retrospective study of all sixteen and seventeen-year-old patients discussed in ED safeguarding meetings in September and October 2019/2020. Patients were identified and their notes reviewed by the auditing team.

Results Our results showed that safeguarding concerns were more effectively managed in 2020 by paediatric services (table 1). The values in table 1 are expressed as percentages of the total for each year. Thirty-three patients were discussed in safeguarding meetings in 2019, and ninety-one in 2020.

Abstract 1354 Table 1

	2019	2020
% Children's Social Care (CSC) involvement documented at triage	41%	55%
% acute safeguarding concerns discussed in real time with CSC when necessary	17%	56%
% of appropriate CSC referral/notification completed by ED team	74%	88%
% referral to violent crime reduction services made if appropriate	67%	59%
% school/college documented	42%	48%
% HEADSSS assessment documented	10%	19%

Conclusions Our results show that three times as many children were discussed in 2020, when paediatric ED led YP's care, and we saw improvements in all areas audited.

We presented our results to ED staff to highlight areas for improvement, and we are collecting feedback from the wider MDT to identify why safeguarding concerns are dealt with differently and what barriers staff are facing.

We are further investigating the discrepancy in numbers of YP discussed in safeguarding meetings between 2019 and 2020 by auditing specific discharge diagnoses that require safeguarding involvement (e.g. assault). This will allow us to identify whether lower numbers in 2019 were due to YP not being referred to the safeguarding meeting, or fewer patients presenting to the department.

Our results are helping to shape new ED pathways that increase involvement of paediatric staff with greater safeguarding experience in the care of YP, to ensure they are appropriately supported and protected.

Paediatric Mental Health Association

1355 OPENING UP IN LOCKDOWN: MAPPING CHILD & ADOLESCENT MENTAL HEALTH CRISES IN PAEDIATRIC A&E DURING COVID-19

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10.1136/archdischild-2021-rcpch.582

Background During the Sars-CoV2 pandemic, emergency care settings have continued to act as key contact points between healthcare professionals and young people experiencing acute mental health crises. Despite growing concerns that the psychosocial health and wellbeing of young people across the United Kingdom have been adversely affected by increasing social isolation, uncertainty and emotional trauma during successive national lockdowns, we are only now beginning to appreciate the impact of this phenomenon.[1]

Objectives 1. Determine whether lockdown correlated with any significant difference in the number or nature of Child & Adolescent Mental Health Services (CAMHS) referrals in the Paediatric Emergency Department (PED).

2. Identify any health inequalities affecting young people referred to CAMHS during lockdown.

Methods We audited every patient aged 0–17yrs who attended PED at King's College Hospital during all three national lockdowns in England (n=5072) in 2020–2021, gathering data on age, gender, time of presentation, ethnicity, borough, source of referral, pre-existing safeguarding alerts, diagnosis, discharge

destination, safeguarding outcomes for all CAMHS referrals (n=115). We compared this to corresponding data from all patient attendances (n=13,451) and CAMHS referrals (n=106) during the same time periods in 2019. Patient demographics were compared to national secondary school 2019 census data from the Department of Education[2].

Results The proportion of CAMHS referrals among <18yr-olds in PED during each lockdown was significantly greater than during 2019 (Chi squared L1=$5.1x10^{-4}$; L2=$2.3x10^{-4}$; L3=$1.7x10^{-4}$), representing an almost 3-fold increase overall. Fewer than one in five of these children triggered pre-existing safeguarding alerts at triage.

The second lockdown coincided with the greatest proportion of CAMHS referrals (<18yr-olds 3.1%; <13yr-olds n=7 and 13–17yrs n=49), representing a significant increase compared to the first lockdown (p=$1.4x10^{5}$). There was no significant difference between the second and third lockdowns.

Up to one third of 13–17yr-olds referred to CAMHS were unaccompanied during the third lockdown, coinciding with the highest proportion of admissions and transfers in this age group (n=12; 36%).

Consistently, the most common indication for CAMHS referral among <13yr-olds was depression and/or anxiety, while among 13–17yr-olds it was intentional overdose (IOD) or deliberate self-harm (DSH). While an upward trend in the number of 13–17yr-olds presenting with DSH and IOD was observed between the first and second lockdowns, our current sample size is insufficient to establish statistical significance.

While the majority of CAMHS referrals among 13–17yr-olds across all three lockdowns were from ethnic minority groups (L1 74%; L2 76%; L3 56%), this was consistent with the general paediatric population in Southwark & Lambeth. However, our sample size was insufficient to establish significant differences between individual ethnic groups. The majority of 13–17yr-olds referred to CAMHS were female (L1 63%; L2 85%; L3 87%) across all three lockdowns.

Conclusions Our findings suggest there was a significantly higher proportion of acute mental health presentations in PED during lockdown, especially amongst 13–17yr olds, and an upward trend in DSH and IOD. This has significant implications for the future provision of child and adolescent mental health services in hospitals and the community and the ramifications of this phenomenon post-lockdown have yet to be seen.

British Association for Community Child Health

1356 'BUT WHAT DOES THAT MEAN FOR ME?' DEVELOPING EVIDENCE-BASED STATEMENTS FOR HEALTH PRACTITIONERS TO REDUCE VARIATION IN ADOPTION MEDICAL ADVICE

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10.1136/archdischild-2021-rcpch.583

Background Services relating to children and young people in care (CYPiC) are one of the key areas in which community paediatricians work which includes supporting the adoption process. The term 'Medical Advisor (MA) for Fostering and Adoption' denotes a doctor with additional knowledge, skills and experience that has a particular role in assessing the well-being of Looked After Children and providing medical advice to the local authority and other agencies. This includes written advice regarding the child's health, development, emotional presentation, past experiences and in utero exposures. However, this advice is not currently uniform, and it is of great value and interest to adoptive parents and adopted children. As services change it may become less common for all adoptive parents to meet with a MA in person to discuss the child and this increases the need for detailed information to be available.

Objectives We aimed to create a series of statements for common situations and conditions in the areas of mental health, substance misuse, autism and attention deficit hyperactivity disorder. The expectation was that they should be used in adoption reports by MAs across the region. The aims for these statements are that they should be:

- evidence-based
- understandable to the lay person
- relevant to looked after children
- acceptable both to prospective adopters and to MAs

Methods We created a list of common conditions and scenarios that are seen in the family history and background of adopted children. Statements for these were then developed using literature searches, discussion with MAs from across the region, and patient and public involvement (PPI) via a focus group of adopters and adopted people.

Results Feedback from the PPI group was extremely positive highlighting the value, impact and importance of this project.

Some comments included:

'A really good idea to have standardised information'

'it will be extremely valuable for adopters, social workers and panel'

'I believe adopters should have as much information as possible….I wish I had received information on the possible future difficulties..'

Discussions with the Regional Adoption Advisory Panel and MAs concluded this project works towards an evident need for quality consistent information for adopters.

Conclusions We expect that these standardised statements will not only reduce the workload of MAs and lead to a standardised process across the region but, more importantly, improve the experience of prospective adopters and enable them to feel prepared and supported as they go through the adoption process. We also hope that this preparation and support will have a positive impact on the ability of the family to care for an adopted child, whatever needs they may have. We plan to produce more statements for physical health conditions, evaluate the current statements and develop patient information resources to extend this project further.

RCPCH Trainees Committee

1357 ZOOMING IN ON THE SILVER LINING: A COLLABORATIVE VIRTUAL EDUCATION NETWORK FORMED DURING THE COVID-19 PANDEMIC

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10.1136/archdischild-2021-rcpch.584