between 13–15 years. The symptoms experienced included dizziness, near syncope, headaches, palpitations, abdominal pain, fatigue, cold hands and feet and low mood. All 20 patients were managed with non-pharmacological advice and pharmacological treatment. Of the 20, only 5 reported complete resolution of symptoms at an average age of 17 years. 12 cases had only mild symptoms (at 17 years) with intermittent exacerbation but were still on medications. 3 patients still had moderate ongoing symptoms at 17 years with ongoing medical management needing transition to adult physicians.

Conclusions Adolescent POTS have a good prognosis with 85% of the patients reporting significant improvement by their 17th birthday. 15% patients unfortunately still continue to experience disabling symptoms which necessitates ongoing care in adulthood. This information is useful in counselling of children with newly diagnosed POTS and understanding long term outlook.

Association of Paediatric Emergency Medicine

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IMPACT OF THERAPEUTIC LIVE MUSIC ON PAIN AND DISTRESS LEVELS DURING INTERVENTIONS WITHIN THE PAEDIATRIC EMERGENCY DEPARTMENT

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Background Music is known to have therapeutic benefits and is frequently used in healthcare. For children in emergency settings, it may reduce stress and pain. There is little evidence evaluating the effect of live music in an emergency setting. This innovative study explores the effect of live music on children undergoing a painful procedure in a Paediatric Emergency Department (PED).

Objectives

- Whether live music helps to decrease pain and distress in children undergoing a painful procedure in the PED.
- Whether these procedures can be carried out with greater ease from a clinician's perspective and whether staff experience is impacted by the presence of live music.
- Overall impact on the PED experience from the patients, families and clinicians' perspectives.

Methods A mixed methods study, designed with input from the local Young Persons Advisory Group (YPAG). Patients between 6 months - 16 years of age undergoing a painful procedure (eg cannulation) in PED were recruited after written consent. All patients received 'standard' distraction techniques and appropriate analgesia eg Ametop. The intervention group received live music (Musicians playing clarinet & guitar) within the cubicle whilst they underwent the procedure and the control group no live music. Data on physiological measures (Heart rate), self-reported pain (Wong-Baker Faces scale >3years of age) & observed pain (FLACC Scale in younger children) were collected in real time by an independent observer. Following the procedure parents, children & clinicians completed a written questionnaire. Questions included 'How did you feel the music affected the

child's distress before, during & after the procedure' and 'Can you tell me about how the live music helped or hindered the procedure'.

Results 110 participants were included in the study. Qualitative responses were overwhelmingly positive, but quantitative results showed no significant positive interaction between music and reduced pain and distress. Qualitative data indicated that live music in an ED setting is reported to make children, parents and staff feel more at ease, creating distraction and change of focus for children undergoing procedures and enhancing wellbeing in the department. Quotes included: 'Thumbs up and special, I was a little bit worried but the music made me happy. I was really brave' (Child). 'My experience today has been positive, I believe the music is beneficial to the children during stressful times' (Parent). 'I think it makes the A&E department a more pleasant environment. Children and staff love it'(Clinician).

Conclusions A ground-breaking study of this nature looking at the effect of live music on children undergoing painful procedures is possible in a busy PED. The qualitative data is overwhelmingly positive and indicates across all groups that live music is beneficial to children, parents and clinicians. COVID-19 has brought further challenges for musicians working within the healthcare setting but this study shows the positive value of their work in an acute clinical environment and that research in this area is vital to patient and staff wellbeing.

British Academy of Childhood Disability

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RAPID DISCHARGE OF CHILDREN WITH MEDICAL COMPLEXITY (CMIC) FROM A SPECIALIST CHILDREN'S HOSPITAL DURING THE FIRST WAVE OF THE CORONAVIRUS PANDEMIC

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Background CMIC are well described to have high health care use and long lengths of time in hospital.¹ In our specialist children's hospital. Our specialist discharge team usually have 18–30 children with the most complex journeys on our case-load. A significant proportion of these children have non-medical barriers to discharge which include care and commissioning, housing, parental training and need for adaptations.² Many of them were perceived to be at increased risk of deterioration should they have caught the SARS-CoV-2 variant.

Objectives We undertook to provide a rapid discharge for this group of children during the first wave of the pandemic.

Methods Rapid discharge was undertaken using the creation of a virtual telephonic and then zoom space to bring together key stakeholders. It was led by silver command and fed into organisational architecture during the pandemic. Stakeholders included clinical teams across institutional boundaries, therapies, social care colleagues and voluntary sector collaborators. Rapid PDSA cycles enabled us to adapt to the changing landscape. Initially the meetings were three times a week, decreasing in frequency to once weekly until the present time. We relied on existing relationships and built new connections.