

consent to assess whether there was a need for a more formal consent system and to identify local good practice to share with other units.

Methods This qualitative project was based at Great Ormond Street Hospital. Semi-structured interviews were completed with nine members of ICU staff and fifteen parents of children recently admitted to ICU. A phenomenological approach was used during analysis with themes emerging until saturation.

Results Themes from staff included inconsistency and protecting parents from the burden of consent. Themes from ICU-parents included maintaining control and feeling empowered. Overall, mutual trust between families and ICU teams underpins satisfaction with the current system and neither group expressed a strong desire to introduce written consent for ICU-care. However, some conflicting views emerged between staff and parents: whilst staff judged consent to be an emotional burden for families, parents found decision-making processes a means of coping, empowerment and maintaining control. Staff were divided about which ICU-interventions it was deemed necessary to obtain written consent for, and for which ideally this should be the case.

Conclusions Parents want to be updated regularly on ICU and share decision-making but do not want to explicitly consent.

89 THE PSYCHIATRIC AND COGNITIVE PROFILES OF CHILDREN AND ADOLESCENTS WITH HYPOTHALAMIC HAMARTOMAS

¹E Caredda, ¹R Wilkinson, ¹S Bennett, ^{1,2}JH Cross, ¹M Tisdall, ¹Helen Spoudeas, ¹S Harrison, ¹S Varadkar, ^{1,2} Heyman. ¹Great Ormond Street Hospital, London, UK; ²UCL Institute of Child Health, London, UK

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Background Hypothalamic hamartomas are rare brain malformations characterised by a syndrome of seizures, central precocious puberty, behavioural, emotional and cognitive difficulties. Behavioural and emotional symptoms often present the greatest burden of morbidity for patients and families. Due to the rarity of the disease, the heterogeneity of the presentation, and the multifactorial aetiology, prognosis is varied and management strategies are yet to be standardised.

Methods The notes of 46 paediatric cases with hypothalamic hamartomas were examined retrospectively. Demographics, behavioural and emotional symptoms, cognitive functioning, epileptic profiles, and pubertal status were recorded. ICD-10 codes for psychiatric disorder were assigned to applicable cases.

Results 61% of cases were male. The mean age at diagnosis was 4.2 years (0–14 years). 71.7% of the cases met criteria for ≥ 1 ICD-10 Axis 1 diagnosis (psychiatric disorder). ADHD, Generalised Anxiety Disorder and ASD were most frequent. 46% experienced characteristic rage attacks. 50% had some degree of intellectual disability, most commonly mild. 63% of cases experienced seizures. 40% had precocious puberty.

Conclusion This dataset represents one of the largest in the paediatric hypothalamic hamartoma literature. A significant proportion demonstrate psychiatric disorders and intellectual disability. Aetiology relates to a range of interacting biological and psychosocial factors. The major biological components are direct brain-behaviour effects from disrupted hypothalamic functioning and frequent seizures, alongside influence from

antiepileptic medications. Psychosocial factors are those common to all chronic neurological conditions including low self-esteem, disrupted schooling and impact from family/social functioning. Currently, there are limited non-surgical evidence-based treatments for these complex cases. Defining the clinical presentation for a disease is a prerequisite to developing effective treatments. This data contributes to international efforts with this aim in mind.

90 JUNIOR DOCTOR PERSPECTIVES ON EXCEPTION REPORTING – A SNAPSHOT OF CURRENT OPINION AND PREDICTED THEMES

GLP Manning, D Das, I Yeop, J Hassell, E Rawlinson. Great Ormond Street Hospital, London, UK

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Background Following divisive contract negotiations, with significant pressure on the NHS, and an inflexible postgraduate training system, there is growing concern for junior doctor (JD) morale and engagement. The new JD contract introduces a powerful tool for positive change – the Exception Report (ER). Initial rates of ER have been low, with concerns of JD disillusionment and potential for dis-engagement if responses to ER are perceived as insensitive.

Methods A focus group was held to characterise current JD opinion on ER. The group was advertised primarily to Junior Doctor Forum (JDF) members, with JDF members asked to invite their JD colleagues. Eight JDs attended a structured focus group. Opinions and ideas were sought on ER triggers and root-causes, and on potential solutions, as well as current feelings on ER and supervisor approaches to ER that were anticipated to be conciliatory or inflammatory. Findings were presented as mind-maps to the JDF to review completeness and validity.

Results Pervasive themes of clinical workload, doctor-specific admin, staff mix and resultant pressure on educational opportunities arose, along with a recognition that these issues transcend staffing groups. ER was strongly felt to be part of constructive departmental system/structural review, rather than a reflection on the reporter. Themes from the focus group are supported by currently submitted ERs.

Conclusions ER should be considered a symptom of a just departmental culture. They should be used positively to identify system issues, with the baseline assumption that the trainee is not at fault. Financial compensation and time-off-in-lieu (TOIL) are recognised as important, fair, and necessary for safe and sustainable practice, however, recognition of effort, work and personal sacrifice are considered indispensable.

91 EXPOSURE AND RESPONSE PREVENTION FOR TICS & OCD: A UK PAEDIATRIC CASE SERIES

Jemma Greenhalgh, Chloe Taylor, Fiona McFarlane, Isobel Heyman, Tara Murphy, Daniel Stark. DCAMH – Psychological Medicine Team, Great Ormond Street Hospital, London, UK

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Background Tourette Syndrome (TS) has high rates of comorbidity, with Obsessive Compulsive Disorder (OCD) amongst the most common (36^{1%}–50%²) resulting from shared genetic

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and neurobiological substrates.^{3,4} Cognitive Behaviour Therapy incorporating Exposure and Response Prevention (CBT-ERP) is a first-line treatment for OCD, and more recent research has established ERP as effective in the treatment of TS.⁵ Principles of ERP apply to OCD and TS, i.e., exposure to a triggering stimulus followed by inhibiting the linked behaviour, leading to habituation and reducing the frequency and intensity of the urges/behaviours. This series aims to evaluate whether using ERP to treat OCD/TS has a corresponding impact on and reduction of co-occurring TS/OCD symptoms.

Method Four children diagnosed with TS and OCD were identified in a specialist outpatient clinic. All children completed two phases of treatment; i) CBT-ERP for OCD followed by ii) ERP for TS. Each phase of treatment started with disorder-specific psycho-education before undertaking ERP. Outcomes evaluated tic severity (YGTSS) and obsessions/compulsions (CY-BOCS).

Results Following OCD treatment, there was a significant decrease in CY-BOCS scores but no decrease in YGTSS scores. Following TS treatment, there was a significant decrease in YGTSS scores and further reductions in CY-BOCS scores. Fewer TS treatment sessions were required compared to standard protocols.

Conclusion All children showed a clinically significant decrease in tics or OCD symptoms following symptom specific treatment. There was no secondary impact on tics following treatment for OCD. There was a continued decrease in OCD symptoms whilst receiving ERP for tics, however it is unclear whether this is a reflection of the ERP treatment for TS, or a continued effect of primary OCD treatment. Encouragingly, all children who received TS treatment required few sessions to reduce symptoms. Further discussion and clinical implications are discussed.

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NEUROPSYCHOLOGICAL ASSESSMENT IN CHILDREN WITH TOURETTE SYNDROME AND CHRONIC TIC DISORDERS: DO FAMILIES FIND THIS USEFUL AND ARE RECOMMENDATIONS IMPLEMENTED?

K MacLellan, T Murphy, F McFarlane, I Heyman, D Stark. *Psychological Medicine Team, Great Ormond Street Hospital, London, UK*

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Background Tourette Syndrome (TS) is a common childhood neurodevelopmental disorder characterised by chronic motor and vocal tics.¹ High-levels of comorbidity are seen in TS,

including elevated rates of specific learning disorders,² cognitive difficulties and language disorders.³

Paediatric neuropsychological assessment includes administration of age-standardised tests evaluating cognitive, behavioural and academic functioning; notably identifying cognitive strengths and weaknesses.⁴ The findings and recommendations are subsequently communicated to children's families, health and education networks. The purpose of recommendations is to facilitate increased support for the child that includes learning advice and home based activities to improve daily-living. There is paucity in literature on parent and child satisfaction of these assessments,^{5,6,7} and no identified literature on whether recommendations are implemented.^{8,9}

This study aimed to assess levels of satisfaction amongst parents and children with TS following neuropsychological assessment, and investigate the proportion of recommendations implemented at home and school.

Method All children who underwent a neuropsychological assessment in a specialist TS clinic from 2013 – 2016 were identified. Parents and children were asked to complete an anonymous questionnaire adapted from a published questionnaire⁶ rating the neuropsychological assessment satisfaction. Follow up telephone contact then identified whether specific recommendations within the report were implemented and if not, what barriers prevented implementation.

Results A response rate of 38% was achieved and both parents and children reported high levels of satisfaction with the assessments. Approximately 60% of recommendations for the home and school were successfully implemented. Barriers preventing implementation into both school and home settings will be presented in full.

Conclusion This study supports the usefulness of paediatric neuropsychological assessments and indicates a high-level of satisfaction from the parent and child perspective. However clinical and educational recommendations for the school appear harder to implement compared to home-based recommendations. Clinical implications for further research are discussed.

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91 Exposure and response prevention for tics & ocd: a uk paediatric case series

Jemma Greenhalgh, Chloe Taylor, Fiona McFarlane, Isobel Heyman, Tara Murphy and Daniel Stark

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