Quality Improvement and Patient Safety

1636 REMOTE CONSULTING IN THE PAEDIATRIC OUTPATIENT CLINIC – THE CLINICIANS' PERSPECTIVE

Katherine Longbottom. *Greater Glasgow and Clyde*

10.1136/archdischild-2021-rcpch.761

Background During the COVID-19 pandemic remote consulting has been used throughout the NHS in order to minimise the risk of spread of SARS-CoV-2 infection. Telemedicine has been used first-line for outpatient clinics, unless clinical or practical reasons have necessitated a face-to-face consultation. Remote consulting is not a new concept and offers other advantages that may be of benefit beyond the pandemic. Previous studies in primary and secondary care have demonstrated acceptability and feasibility. Remote consultations have not been associated with increased adverse events or service use. The NHS Long Term Plan includes plans to re-design outpatient services and to make digitally enabled primary and outpatient care mainstream by 2024.

Objectives We aimed to review the accessibility, acceptability and feasibility of remote consulting in the paediatric outpatient clinic and to identify areas for improvement.

Methods We reviewed the process against guidance from NHS England, the British Medical Association and the Royal College of General Practitioners. We reviewed clinician satisfaction, and explored whether clinicians felt able to elicit patients'/parents'/carers' ideas, concerns and expectations, diagnose patient problems and communicate effectively with patients'/parents'/carers. Clinicians were emailed a link and asked to complete one questionnaire for each type of outpatient clinic. We did a pilot in August and sent a follow-up questionnaire in September 2020.

Results We received nine responses to the pilot and fourteen to the subsequent questionnaire. Results showed that clinicians were adhering to good practice points. Around half were experiencing technical difficulties during video consultations. Only 64% felt able to fully explore the patient'/parents'/carers' ideas, concerns and expectations. Barriers included lack of non-verbal cues, language barriers, lack of confidentiality, distraction and lack of patient/parent/carer engagement with the process. 38% did not feel able to identify problems such as acute exacerbations of a chronic condition, and not all felt able to explain and discuss the working diagnosis and management plan. 35% felt that patient care was compromised in comparison with face-to-face consulting and over half subsequently arranged for a face-to-face assessment as they felt the remote consultation was inadequate. All respondents were happy to use remote in place of face-to-face consultations in the future for selected patients only. The model worked best with long-term patients and those with less complex problems. Clinicians in general paediatrics and paediatric allergy were more confident with remote consulting, those in paediatric oncology and child development less so. Not being able to examine and do investigations on the same day, especially for the paediatric allergy team, increased the number of health-care contacts and delayed time to diagnosis and definitive management, reducing efficiency and relying on good safety netting to maintain patient safety. Importantly several clinicians reported that the child was not involved, or that their

views were not heard. Clinicians also reported advantages, notably convenience.

Conclusions Careful patient selection, administration and IT support and efforts to overcome communication barriers are required to improve this model of care. It is vital that the child remains at the centre of their care and that every effort is made to ensure their voices are heard.

British Paediatric Allergy Immunity and Infection Group

1637 SPECTRUM OF CASES OF INBORN ERRORS OF IMMUNITY AND THEIR CLINICAL AND LABORATORY PROFILE: A CASE SERIES FROM A TERTIARY CARE HOSPITAL IN SOUTH INDIA

¹Abhilasha Sampagar, ²Sudeep Gaddam, ²Anushree Cm. ¹Division of Hematology and Oncology, Dept of Pediatrics, KAHER'S JN Medical College, Belagavi, India; ²Post graduate, Dept of Pediatrics, J N Medical College, Belagavi, India

10.1136/archdischild-2021-rcpch.762

Background Inborn errors of immunity remain underdiagnosed in developing countries. Despite several limitations and challenges, there has been significant progress in diagnosing and managing these conditions.

Objectives To study the clinical & laboratory profile of children with inborn errors of immunity in a tertiary care center in South India.

Methods Case records of children diagnosed to have inborn errors of immunity over a period of 36 months at KLE Prabhakar Kore Hospital in South India were reviewed in detail. The details included clinical history, examination findings, laboratory parameters, and genetic tests.

Results A total of forty-six children with a mean age of 3.04 ± 4.07 years were diagnosed with inborn errors of immunity. The male-to-female ratio was 3.6:1. A positive history of consanguineous marriage was present in 32.7%. Immunodeficiency affecting cellular and humoral immunity (n=8): 6 had SCID, 1 had DOCK-8 deficiency, 1 had CARD 11 deficiency; Combined immunodeficiency with associated or syndromic features (n=5): 3 had Wiskott Aldrich syndrome, 1 had Ataxia telangiectasia and Hyper IgE syndrome; Predominant antibody deficiencies (n=5): 4 had CVID and 1 had CARD11 deficiency; Diseases of Immune dysregulation (n=15): 9 Children had familial hemophagocytic lymphohistiocytosis, 5 had autoimmune lymphoproliferative syndrome, and one T-CRD (T cell receptor immunodeficiency); Congenital defects of phagocyte number/function (n=9): 4 had CGD, 3 had severe congenital neutropenia (Kostman syndrome) and 2 had LAD; Defects in intrinsic and innate immunity (n=2): 1 had IRF8 gene deletion and another had Osteopetrosis; Autoinflammatory disorders (n=1): 1 had Familial periodic fever; Bone marrow failure (n=1): 1 child had Fanconi anaemia.

Conclusions From a single-center, 46 children with inborn errors of immunity could be identified by chart review suggesting a high index of suspicion for the diagnosis of inborn errors of immunity. Children presenting with repeated infections, with a background of consanguinity, atypical courses of infections, poor response to conventional treatment should be evaluated for inborn errors of immunity. We can improve the