Establishing Community Paediatric Services in Sri Lanka – Translation of Knowledge and Skills from United Kingdom to a Lower- and Middle-Income Country

Aims

The role of the Community Paediatrician focuses on minimising health inequities in the community which is quite challenging in Lower and Middle Income Country (LMIC) setting.

Objective of this paper is to describe the overview and challenges in service establishment of Community Paediatrics in a secondary level centre in Sri Lanka (SL) through gained experience from United Kingdom (UK).

Methods

The author has worked in UK for two years as a Community Paediatrician (CP) before returning to SL as the first sub-specialty trained CP. This paper describes the initial experience of establishing CP clinic in secondary level hospital in one of the capital districts in country. Data was obtained from the clinic records of the CP clinic and no patient identifiable data are used.

Results

The District under the CP has a population of about 150,000 under 5 children. Having the country’s only tertiary level disability and safeguarding centres in the same District, the CP clinic was established as a secondary centre affiliated to a Base Hospital. CP is conducting the developmental and safeguarding services in the secondary clinic while visiting tertiary centres regularly.

The secondary centre has received 33 referrals within first 2 months. Majority were from hospital Paediatric unit (15/33, 45%) and the community (12/33, 36%). The clientele consisted mostly of autism spectrum disorder (6/33, 18%), developmental delay (6/33, 45%), learning disability (5/33, 15%), cerebral palsy and other neuro-motor disorders (5/33, 15%) and Trisomy 21 (4/33, 12%).

A high-risk infant follow up program was initiated for developmental surveillance, recruiting infants from Newborn units. Seven infants are in this program and has a follow up according to International Guidelines, with General Movement Assessment, Hammersmith Infant Neurological Examination, Visual Assessment, and appropriate Early Interventions.

Four safeguarding referrals were received, two from Paediatric Units and Community. Two were sexual abuses and the others were due to neglect. According to the National Guidelines, three case conferences were held.

Several in-service training programs were initiated.

Conclusion

The clientele is similar in both settings. SL is in primary stages of establishing CP teams, infrastructure, and referral systems for CP services, compared to the well-established system in UK. Dedicated CP team should be in each district to cater the community. The country doesn’t have tiers of development care support system for families as in UK, so the future directive should take in establishing this service. However, parents are highly motivated and deeply involved with CP team in delivering interventions.

Safeguarding referral system needs to be strengthened in Community level, according to the National Guideline. In the absence of major role of social services and foster system, CP service must play a huge role in psycho-social rehabilitation and re-integration.

CP teams need opportunity for professional development activities as in UK to update on this novel sub-specialty. Capacity building is the cornerstone for solid foundation and the networking and learning from UK are important assets. Nevertheless, adapting the service structure in culture and country specific way and financial constraints are the challenges ahead.

Service Evaluation of a Tailored Approach to Diagnosis of Children With Possible Autism

Aims

Introduction

Demand for autism diagnostic assessment has increased locally from 60 to over 200 children/year, between 2015 and 2019, mirroring our national data (Parr, Arch Dis Child, 2021) finding doubling of referrals over the same period. Resulting waiting times have increased from less than 6 months to 18 months, with over 300 children on our waiting list.

Some children, particularly preschool, present with very obvious signs of autism, leading the likes of Whitehouse (CRC Australia, 2018), and Zwaigenbaum (Autism Research, 2021) to question why they mostly go through the same length of assessment as children with greater diagnostic complexity, e.g. comorbidity such as ADHD, or possible early developmental trauma. They further suggest such children may be suitable for a shorter ‘tiered’ or ‘tailored’ diagnostic approach.

Locally we have introduced a ‘tailored’ pathway for children who at initial assessment (developmental history taken by an experienced paediatrician, and developmental play and social communication assessment by Specialist Early Years Practitioner (EYP) present with clear signs of autism. They subsequently undergo nursery observation by EYP or SALT, and SALT report scored against DSM 5 criteria is provided. Further information is gathered by liaison with others involved, e.g. Portage. This is followed by feedback session with paediatrician and EYPS, including updating developmental history.

Objective

To evaluate the efficacy and acceptability of this approach.

Methods

Data was collected (Oct 1st 2021 to Feb 2nd 2022) on children completing the ‘tailored’ pathway including demographics, information available, time taken from referral to diagnosis, diagnostic outcome, clinician confidence in outcome (Likert scale from very confident to very uncertain), and parental feedback on process.

Results

11 children (mean age at diagnosis 42 +/- 11 months: 8/11 male) have completed the tailored assessment, out of a total of 55 completed assessments (20%) in same time period. Median time from triage clinic to diagnosis was 24 weeks (IQR 19-40wks) compared with 79 weeks (65-106wks) (Mann
DO I LAC ANYTHING? – LOOKING AT REASONS WHY A CHILD IS PLACED INTO CARE – A SINGLE CENTRE STUDY

Tapornay Banerjee, Amjad Khan, Samira Ajmal, Rishi Arora, Dominika Przyborek, Callum Fernando. Cambridgeshire Community Services NHS trust

Aims Children and young people (CYP) who are looked after (LAC) by local authorities are seen by community paediatricians for their initial health assessments (IHA). They come into the care of local authorities because of various reasons and according to the latest Government statistics (1), 80,850 children and young people are in care in England which is an all-time high (up by 1% from 2020 data). The objective of our current project was to look at the primary reasons for CYPs coming into care in our locality (Bedford borough and part of Central Bedfordshire).

Methods We looked at the SystmOne records for all LAC CYPs who were seen between 01/11/2020 to 31/10/2021 by community paediatricians in our department for their IHA. After obtaining necessary permissions from the trust, a list of these CYPs were prepared and authors looked at their records to access referral letter and IHA reports. Reasons for being looked after were documented in Microsoft Excel and data analysis was also done in Microsoft Excel.

Results We have completed the IHA of 199 children and young people during this one year. Out of them, we could not access the necessary information in 6 of them. 30 (15.5%) of them were unaccompanied asylum seeker children and young people who were placed locally by authorities and they were not included in this study. In most of the cases, multiple reasons were documented in the referral letter and report. Out of 163 CYPs Domestic violence (80.49%) and neglectful parenting (79.48%) was recorded in majority of cases followed by parental mental health problems (56-34.35%), parental substance abuse (42-25.7%), physical abuse (36-22.08%), sexual abuse/at risk of sexual abuse (20-12.26%), learning difficulty in parents (9.5.69%) and others (21-12.89%) (Series 1). Educational neglect (1), teenage mother (1), drug use in young person (3), criminal activity by the young person (3), unable to keep the young person safe from gangs and violence (4), honour-based crime against the young person (1) and parents unable to cope with child’s behaviour (4) were noted among other reasons.

Conclusion The authors conclude that the majority of looked after children and young people in our area, end up in care for reasons beyond their control. Domestic violence, neglectful parenting, mental health problems in parents and parental substance abuse are the predominant reasons in our area. A small proportion of them had to be taken into care because of their behavioural difficulties, involvement with gangs and violence or substance use. Local authorities and other agencies working with children and vulnerable families should implement appropriate strategies to reduce these factors. We have also noted that 15.5% of looked after children in our area were unaccompanied asylum seeker children.

Identification and catch-up of incomplete childhood immunisations for looked after children at the initial health assessment

Jack Sims, Naomi Sherwood. ST5 Paediatrics; Manchester Foundation

Aims To improve the identification and catch-up immunisation of children attending for an Initial Health Assessment (IHA) with an incomplete childhood immunisation record.

Methods This is a re-audit, retrospectively looking at the immunisation records of the eligible children and young people.

All children and young people who attended for an IHA in Manchester between January and April 2021 were included.

Cases were identified using the central LAC Database. There were a total of 103 patients which included 25 UASC (Unaccompanied asylum seeking children). The results were compared with local standards.

The children identified as having incomplete immunisation status had their child health record reviewed to see whether they had received catch-up immunisations.

Results 44 children and young people had incomplete immunisations which was 12% increase compared to the results of the audit in 2020. There was an improvement in the proportion of children with incomplete immunisation status with their missing immunisations listed clearly in documentation to their General Practitioner. There was also an improvement in the proportion of children who had a specified time-frame for their catch-up immunisations in the IHA report.

25 children identified were UASC and all had unknown immunisation status. Child health records could not be found for one young person so he was not included in the review. All children required immunisation as per the Public Health England ‘Vaccination of individuals with uncertain or