numbers, different neurological conditions, cost-effectiveness, and patient satisfaction responses were analysed.

Results We started visits to regional hospitals in 2017 and 2018 before upscaling in 2019, to provide quarterly visits to 7 regional and district hospitals who had previously had no access to any paediatric neurology service provision aside from tertiary referral. Altogether, 1327 children with different neurological problems were seen in 2019. This included 712 children (54%) with epilepsy, 155 children (12%) with cerebral palsy and 100 children (8%) with other developmental problems.

The costs of facilitating the clinics were compared to the equivalent cost of the patients travelling to a tertiary centre for the same level of specialist assessment and treatment. Percentage of cost-saving was from 81% to 98% depending on the distance between the regional hospital and Yangon where the tertiary centre is located.

We conducted a small survey of parents attending the clinic. Respondents felt that the outreach clinics provided a more accessible point of care. Many highlighted the lifting of a significant financial burden, particularly in low-income households. The reduction of financial cost is felt particularly in cases such as epilepsy which require multiple clinic visits and ongoing specialist care. Many comments have also identified the quality of specialist care in the new model, comparable to a tertiary hospital.

Conclusions Paediatric neurology outreach and virtual clinics can provide a model for other specialities across many fields of healthcare, especially in countries with good internet, but poor transport. Interval telemedicine services also provided a continuation of care. To achieve specialist care at greater scale new approaches, such as the blended outreach and telemedicine structure described here, should be actively developed and evaluated.

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IMMUNOSUPPRESSIVE THERAPIES IN CHILDREN WITH BIOPSY-PROVEN IGA VASCULITIS NEPHRITIS: A TERTIARY CENTRE EXPERIENCE

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Background IgA Vasculitis Nephritis (IgAVN) can lead to severe presentation including nephrotic syndrome. Data pertaining to the treatment outcomes of IgAVN with persistent moderate or nephrotic range proteinuria in children are, however, limited.

Objectives The aim of this study is to determine the response to immunosuppressive therapies in this patient population.

Methods We conducted a retrospective review on all children presenting with IgAV before 18 years between January 2009 and December 2019 in the Paediatric Nephrology Centre in Hong Kong. Patients with biopsy-proven IgAVN developing persistent moderate or severe nephrotic-range proteinuria despite ACE-inhibitor (ACEi), and followed for 24 months or more were included. Patient demographics, clinical and laboratory data, therapies received, and treatment outcomes were evaluated.

Results Of the 177 patients with IgAV, 42 children developed proteinuria. 21 Chinese patients (76% boy) had persistent proteinuria despite ACEi and kidney biopsy confirmed IgAVN at a median age of 8.5 years (IQR 5.8–11.2). At baseline, 3

(14%), 14 (66%), 3 (14%) and 1 (4%) patients had moderate proteinuria, nephrotic-range proteinuria, nephrotic syndrome and nephritic-nephrotic syndrome, respectively. All patients had normal kidney function, except one child with an estimated GFR of 31 ml/min/1.73 m². Median urine protein to urine creatinine ratio (UPCR) was 4.4 mg/mg (IQR 2.4–9.0) and serum albumin was 32 g/L (IQR 28–33.5). Histological findings were classified according to International Study of Kidney Diseases in Children (ISKDC): Class II (n=5, 24%), Class IIIa (n=9, 42%), Class IIIb (n=6, 29%), Class IV (n=1, 5%).

All patients received corticosteroid at a median time of 33 days (IQR 12–52) since kidney involvement. Whereas 7 children (33%) with severe disease received monthly intravenous cyclophosphamide as induction therapy, 12 patients (57%) and 2 patients (10%) received calcineurin inhibitors and azathioprine, respectively. The maintenance therapy consisted of corticosteroid and one additional immunosuppression, including calcineurin inhibitors (n=16, 76%), azathioprine (n=4, 19%) and mycophenolate mofetil (n=1, 5%).

Over a median follow-up period of 3.6 years (IQR 2.8–5.6), 18 patients (86%) attained complete remission at a median of 139.5 days (IQR 102–225) since immunosuppressants initiation. The other 3 patients achieved partial remission. Three patients (14%) relapsed in 7.5 months (IQR 1.2–16.2) following complete remission but resolved promptly with treatments. At last follow-up, all patients had normal kidney function and the median UPCR was 0.11 mg/mg (IQR 0.10–0.16).

Conclusions Immunosuppressive therapies were associated with favourable renal outcomes in children with biopsy-proven IgAVN presented with persistent moderate or nephrotic range proteinuria despite ACEi. Further studies are required to determine the optimal treatments in this patient population.

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HOW EFFECTIVE ARE WE COMMUNICATING WITH OUR PAEDIATRIC ONCOLOGY PATIENTS?

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Background Given the sensitive and intricate nature of oncological cases, especially in paediatric age group, it is important to have specific and strategic ways of discussing and communicating diagnosis and treatment plan. Especially being aware that to achieve the trust and faith of our patients and relatives in paediatric oncology, effective communication is key.

Thus, emphasis of both verbal and non-verbal communication with oncology patient cannot be over emphasised.

Objectives Our survey highlighted an assessment of how our communication of diagnosis and care has been with emphasis on striving for improvement. Examples of communications asked about includes, how well the diagnosis was discussed the first time, and how much of the information given was fully understood in the easiest possible manner.

Also, emphasis was placed on regular care given with each admission and how well our team communicated our line of management provided at each step of the way.

There were other areas covered in the questionnaire including support from community nurses, tertiary centres, play specialists and medications given.

Methods Our team sent out questionnaires on general satisfaction of patients receiving care in our paediatric oncology shared care centre. Patients and/or parents were encouraged to remain anonymous as much as possible to encourage objective feedback.

Our questionnaire was made into various sections for example, demographics and diagnosis, medications received in our centre and frequency of medications.

Results 75% of the questionnaire sent were returned filled.

Out of those returned survey, 70% felt we communicate with them well while 30% felt we communicate poorly. We also found that most of our patient had a diagnosis of ALL with good prognostic indicators. In our centre, the importance and usefulness of our play specialist was highlighted by 100% of our patients.

All that filled the survey felt community nurses communicate excellently. 100% indicated most of the information are preferred in both written and verbal forms. Some points raised includes diagnosis being rushed or not properly explained.

Conclusions Important emphasis needs to be placed on how we discuss and communicate our treatment but most especially at the first diagnosis of our oncology patients. Communicating in both verbal and written forms has proven effective in delivering necessary information to patients. The need for regular and mandatory training on communication with oncology patient should be mandated for clinicians. In our case, we will continue to work on excellent delivery of diagnosis and discussions with our oncology patients.

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THE IMPACT OF A RAPID ACCESS PHYSIOTHERAPY SERVICE IN A PAEDIATRIC EMERGENCY DEPARTMENT ON PATIENTS DIAGNOSED WITH ASTHMA OR VIRAL INDUCED WHEEZE

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Background Asthma and Viral Induced Wheeze (VIW) are common respiratory conditions in paediatrics. There are currently 1.1 million children in the UK suffering from asthma, which continues to cause a significant burden on the health care system. Viral induce wheeze is another common presentation to paediatric emergency departments with statistics showing around 1 in 3 children having at least one episode prior to the age of 3. Studies have shown that respiratory physiotherapy decreases severity of disease in patients with asthma and viral induce wheeze. This has been demonstrated by an improvement in Asthma Control Test and Nijmegen scores. However, the role of respiratory physiotherapy in the emergency department has never been investigated, despite asthma and viral induced wheeze being common presentations.

Objectives To investigate the impact of a physiotherapy service in an emergency department on patients diagnosed with viral induced wheeze or asthma

Methods Patients were referred to physiotherapy if they met the diagnostic criteria for asthma or viral induced wheeze. Referrals all received a screening telephone consultation to determine eligibility for a face-to-face review. Assessments included detailed history and examination followed by

spirometry and clinically relevant blood tests to determine any allergens or triggers for respiratory decompensation. Interventions included education on inhaler technique, breathing exercises and trigger avoidance, initiation and optimisation of existing medical therapy and development of individualised action plans. Interventions were dependent on each patients' clinical needs. Patients seen by the respiratory team in last 3 months were excluded.

During physiotherapy sessions the patients were asked to fill age appropriate questionnaires at the start and the end of the course. Severity of disease was assessed using asthma control test and Nijmegen score and quality of life through a paediatric quality of life questionnaire. Where patients were too young, quality of life questionnaires were completed by the parent. Only completed pairs of questionnaires were included in the final analysis and paired t-test was used to assess the statistical significance of any differences. Patients were also given a satisfaction surveys at the end of the session. Data was collected on consecutive referrals from June 2019 to January 2020.

Results There was a statistically significant improvement across the 3 questionnaires. In total 60 sets of Asthma control test (ACT) questionnaires were completed. The mean ACT score was 16.5 before physiotherapy and 22.5 after ($p < 0.001$). 13 sets of Nijmegen scores were calculated. The mean score was 26.0 before physiotherapy and 12.5 after ($P < 0.001$). 108 quality of life (QoL) questionnaires were completed. The mean QoL score when completed by patients improved from 64.6 to 78.7 ($P < 0.001$). The mean QoL score when completed by parents similarly improved from 65.5 to 82.1 ($P < 0.001$). Satisfaction surveys showed positive experiences of the service provided

Conclusions This retrospective analysis suggests that patients presenting to an emergency department with asthma or viral induced wheeze may benefit from a decrease in severity of disease and improvement in quality of life if they attend physiotherapy. Larger, prospective studies in different settings are needed to evaluate this finding.

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APPROPRIATENESS OF PAEDIATRIC EMERGENCY DEPARTMENT ATTENDANCES: PATTERNS, PREDICTORS, AND HOW IT CHANGED DURING THE COVID-19 PANDEMIC

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Background Non-urgent emergency department attendances are a pervasive global problem, contributing to delayed treatment, patient dissatisfaction, and increased admissions. In paediatric emergency departments (PEDs), 41–79% of attendances are non-urgent. Nevertheless, parents and primary care practitioners continue to view PEDs as an appropriate place to seek treatment for minor ailments, with a common reason being its convenience in performing laboratory and radiological investigations in the same location. Resource utilisation is a commonly used measure of appropriateness of an attendance, and is a suitable measure in the unique paediatric population.

Objectives Our study aims to assess the appropriateness of PED attendances in a multi-ethnic Asian population, and identify predictors of inappropriate attendances (IAs). To our