QECH team to ensure they were appropriate to the local context and to reduce communication barriers. Questions focused on specific Partnership education and training activities including bi-directional exchanges, specialty teaching visits and the Paediatric Assessment Skills (PAS) course.

Operational planning involved input from both organisations, scheduling interviews to ensure representative numbers from all multi-professional staff groups, avoiding disruption to clinical care and ensuring interview techniques were empathetic and allowed equitable access to all voices. Practical measures included recruiting an evaluation team with previous knowledge of the partnership, timely advertising of the evaluation, organising rooms and timetabling staff for interviews, sourcing equipment, arranging travel itinerary and accommodation.

Results A quantitative questionnaire consisting of nine closed-answer and Likert scale questions was devised, as well as thirteen questions for the semi-structured individual interviews, to complete in fifteen minutes. Mock interviews were conducted to test for understanding and time management.

Due to the COVID-19 pandemic, a digital questionnaire method of evaluation was used for interviewing BWC.

All aspects of the design and implementation was completed in time for the evaluation. Designing the evaluation and organising the strategic, operational and practical aspects of the evaluation took two months to complete.

Conclusions Evaluation is essential for effectiveness, credibility and accountability of GHP. Planning and perfecting the details of the evaluation to be context specific, capture key components of partnership interventions, address equity, collaboration and governance, requires considerable investment of time and manpower from both partners. Partnerships should take this into account while planning evaluations to ensure success of the process and sustainability of the partnership. Advance design of evaluation instruments and processes which are specific and relevant to the partnership circumstances is crucial for the collection of reliable information.

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British Society of Paediatric Endocrinology and Diabetes

1367

THYROID DYSFUNCTION AT DIAGNOSIS OF TYPE 1 DIABETES IN CHILDREN AND YOUNG PEOPLE-CAN WE SAVE SOME PRICKS AND COSTS?

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Background The NICE guidelines for Type 1 diabetes mellitus (T1DM) in children and young people (CYP) recommends testing for thyroid function at diagnosis and annually thereafter. We observed that there appeared to be a significant number of newly diagnosed CYP, who had initial abnormal thyroid function tests, necessitating repeat blood tests,

sometimes more than once and were eventually found to have normal thyroid function tests. We therefore decided to establish the incidence of true thyroid dysfunction in our newly diagnosed CYP with T1DM population.

Objectives To determine the incidence of abnormal thyroid function tests along with positive Thyroid Peroxidase (TPO) antibodies at diagnosis and whether this required treatment within the first year of diagnosis.

Methods Two district general hospitals collaborated for data collection. We collected data from 2017–2019 of newly diagnosed T1DM CYP, aged up to 18 years, with, at minimum, follow up data of a year. We analysed the abnormal thyroid function test results and TPO antibody status at diagnosis, and whether this was a reflection of true thyroid dysfunction on repeat testing within a year of diagnosis.

Results In total there were 90 patients diagnosed with T1DM over the period of 3 years. 31% of children had abnormal thyroid function results at the time of diagnosis of T1DM. Thyroid function results from the time of diagnosis were not available in 13% of patients. 6.7% of all newly diagnosed had a positive TPO antibody level. When comparing the incidence of abnormal thyroid function with the incidence of DKA, it was noticeable that children presenting in DKA had a higher proportion of abnormal thyroid function tests (14/32), compared to those not presenting in DKA (14/58) – 44% vs 24%. During the study period, only one child eventually was started on levothyroxine, for confirmed hypothyroidism within a year of diagnosis and had both abnormal thyroid function tests and positive TPO antibodies at diagnosis.

Conclusions While this is a small study, this does raise the possibility that CYP, especially those presenting in DKA at the time of diagnosis of T1DM, have transient abnormal thyroid function, attributed to the sick euthyroid syndrome. Hence, we raise the question, should we avoid unnecessary thyroid function tests at diagnosis and only do interval thyroid function tests in those who have high TPO antibodies at diagnosis? This also has cost saving implications due to the greater number of tests required at diagnosis and subsequent repeat if abnormal. We hope to use this pilot study to demonstrate the higher incidence of transient abnormal thyroid function tests in CYP with newly diagnosed T1DM. We are in the process of collecting further data to determine if our results are replicated in a larger population across the region, within the other Paediatric diabetes centres. If we obtain similar findings across the region, it will provide evidence for further review and consideration of a wider policy change in terms of timing of initial screening for associated thyroid disease in children and young people with T1DM.

Quality Improvement and Patient Safety

1368

IN THE SEEK FOR A BETTER HANDOVER- AUDITING THE CASE AT EVELINA LONDON CHILDREN'S HOSPITAL

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Background Sometimes handover sheet gets to be chaotic and not adequately updated. As a result, it can be time-consuming