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 artnership, 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 artnership 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 artnership. Advance design of evaluation instruments and processes which are specific and relevant to the partnership circumstances is crucial for the collection of reliable information.

**REFERENCES**

1. THET

**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 hormone 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 dysfunction 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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10.1136/archdischild-2021-rcpch.592

**Background** Sometimes handover sheet gets to be chaotic and not adequately updated. As a result, it can be time-consuming...
and difficult to find information quickly and, therefore, rely on the handover sheet during the shift.

**Objectives** Assessment of the contribution of icons added to handover sheet to a quicker and easier handover, as well as assessment of the efficacy of the current format of handover sheet.

**Methods** Change idea: Icons next to each team that the patient was under were added to handover sheet (eg: general pediatrics, complex patients, rheumatology, PIMS-TS, surgery, ID, dermatology etc) in order to assess whether it will contribute to a quicker and easier handover.

The QI project was carried out one month after the implementation of icons in the handover sheet. Questionnaires were completed anonymously by the General Paediatric Team of Evelina London Children’s Hospital, with answers ranging from 1 to 5 (5 was the maximum-most helpful and 1 the minimum-least helpful). The questions were the following:

1. How helpful do you find the icons added to handover sheet?
2. Have the icons attributed to a quicker handover?
3. How would you rate the current content of the handover sheet using the SBAR format?
4. How much do you rely on the handover sheet during your shift?
5. How would you think we can improve it?

Each question had a comment section as well.

**Results** 20 questionnaires were completed during the period of 3 weeks. The majority of staff stated that the icons added to the handover sheet were helpful (16/20 rated it with 4–5). More variable were the answers for the attribution of icons to a quicker handover, with 11 people rating it with 4–5, 7 people with 3 and 2 with only 1.

With regards to the content of handover sheet using the current SBAR format, most of the participants ranked it with 4 and 2 was the lowest rating of 4 participants. In terms of rely on the handover sheet during the shift, the vast majority voted 5(16/20) and the rest 4.

Summary of ideas as to what could be done for amelioration of handover (question 5) are the following:

- An effort should be made to update the handover sheet regularly, with only the essential information, avoiding repetition and non-relevant resolved issues. The plan should be clear and highlighted to the night team.
- Have clear problem list, minimal background, only relevant issues and clear plan, especially for the weekend.
- Use specific dates in the handover sheet, especially in the plan.
- Remove old/irrelevant information.
- Switch and have the background column first and then the presenting complain, it will be much easier to read.

Moreover, many participants commented that the icons were great idea, made handover sheet easier to understand as well as more bright and fun. They also mentioned that the icons help to identify patients easily and more quickly.

**Conclusions** To conclude, the majority of participants found the icons helpful and many of them supported that they contribute to a quicker handover. The current format of the handover sheet was satisfactory for most of the participants, but changes need to be made for a more efficient handover.

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**Down Syndrome Medical Interest Group**

**PRELIMINARY REPORT OF HEALTHCARE STATUS IN A COHORT OF YOUNG CHILDREN AGED 1–5 YEARS WITH DOWN SYNDROME**

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**Background** Ireland is thought to have amongst the highest incidence of Down syndrome (DS) in the world. Children with DS have many healthcare needs and associated conditions. DS medical management guidelines have been developed to optimise the health of children with DS. A national Register was established in 2015 to define the incidence of DS in the Irish population and undertake prospective monitoring of health issues and healthcare utilisation.

**Objectives** The purpose of this study is to explore the health issues faced by young children with DS, both resolving and emergent.

**Methods** Parents of children with DS aged between 1 to 5 years who were enrolled on the national DS Register were invited to complete a questionnaire. The questionnaire was self-administered, distributed to families by post between September 17th 2020 and January 28th 2021 and returned by post or email. It contained 15 questions including questions about new diagnoses (medical or surgical), resolved diagnoses, feeding issues, annual screening and hospital admissions in the preceding 12-month period and current parental perception of their child’s health. Ethical approval was obtained for this study.

**Results** A total of 62 questionnaires have been distributed and 28 have been returned to date. Response rate was 45%. Mean age was 4 years (range 1–5 years) with female being 16/28 (57%). The majority of parents who replied rated their child’s health as excellent or very good (18/28 or 64%). In the preceding 12 months: at least one admission to hospital was required by 43%; a new condition was diagnosed in 12/27 (44%); a pre-existing condition had resolved in 11/23 (48%); a pre-existing condition had resolved in 11/23 (48%) such as improved hearing due to grommets or hearing aids and reduced aspiration due to peg insertion and improvement in respiratory issues possibly due to reduced social contact. Some of the reasons for admission were respiratory problems such as croup, bronchiolitis, aspiration pneumonia and also ear infections. Feeding issues were reported in 11/28 (39%) among them difficulty with solids, food aversions, sensory issues choking/aspiration and only one stated that their child had a Videofluroscopy in the last 12 months. Annual blood monitoring was undertaken in 27 out of the 28 patients and thyroid monitoring identified as being taken in 22/28 (78%) and coeliac as 14/28 (50%). The majority expressed concerns 21/28 (75%) regarding health issues, long term outcomes and service access. Services were self-funded by 12/28 (43%) of parents due to long waiting time for public services or due to low frequency of appointments.

**Conclusion** This study demonstrated high levels of parental satisfaction with the health of their children with DS. Despite the SARS-CoV-2 pandemic a large number...