Background Electronic Patient Reported Outcome Measures (ePROMs) are validated, digitalised health questionnaires with roots in clinical trials, created as a way of re-establishing and empowering the patient voice. ePROMs are now utilised in over 30 different medical specialties, and it is recognised that their unique abilities for detecting symptomology and other quality of life (QOL) issues directly from the patient make them highly suitable as an adjunct in routine clinical care. Their use, particularly in adult Oncology, has brought a number of benefits to light, however use of ePROMs in child and young adult groups remains limited.

Objectives The literature review is part of a service evaluation at The Christie NHS Foundation Trust, Manchester, to better understand the benefits ePROMs bring to patients, as well as the barriers and facilitators of implementing such a service.

Methods We searched PubMed for the terms: 'Patient Reported Outcome Measure' or 'PROM' or 'PRO' AND 'cancer' or 'carcinoma' or 'onco*' and selected papers relevant to the implementation of ePROM services into clinical care. There were 100 relevant titles.

Results Improved communication:

Improvements have been seen in the quantity and type of symptoms/QOL issues reported, better prioritisation and focussing of the consultation, shared decision-making and treatment goals, patient involvement in care, and as a facilitator of open dialogue and discussion of sensitive topics.

Acceptability:

Patients find ePROM services highly acceptable, tend to prefer electronic over paper questionnaires, and most patients report that ePROMs are a good way to communicate with their medical team.

Symptom Detection and Management:

Evidence suggests that practitioners frequently underestimate patients' experience of symptoms. ePROMs have been shown to consistently improve symptom discussions and onward management, as well as detection of therapy-related adverse events (particularly chemotherapy)

Improved Healthcare Process:

Studies have shown that ePROMs can reduce A&E attendance, unplanned hospital admissions or unnecessary hospital appointments. ePROM completion has been used to tailor the follow-up of patients and also to report symptoms in real-time, enabling the acute medical team to action the outcomes as necessary.

Better QOL:

Several studies have demonstrated improvement in symptom scores as well as global QOL with ePROM use.

Better Overall Survival:

In an oncology population, it has now been shown that successful ePROM services can improve patient survival due to their unique benefits in symptom detection and management.

Barriers and Facilitators to ePROM use: A number of barriers to ePROM use are discussed at the level of the patient, the practitioner and the organisation, as well as approaches to mitigate these.

Conclusions Digitalised personal healthcare is the next generation in patient monitoring; ePROM services are being rolled out across a number of adult specialties but their use in child and young adult groups is limited. Here we present a multitude of benefits that ePROMs are known to have, and share some of the barriers and facilitators when considering establishing a new ePROMs service. The benefits of ePROMs should (and can) be shared by adults and children alike, and

should particularly be considered in paediatric haematology and oncology populations.

Association of Paediatric Emergency Medicine

1749

ASSESSING MENTAL HEALTH PRESENTATIONS TO THE PAEDIATRIC EMERGENCY DEPARTMENT : AN INCONSISTENT PROCESS. EVALUATING STAFF AGREEMENT USING VIDEO VIGNETTES

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Background The rise in mental health presentations to Paediatric Emergency Departments (PED) during the Covid pandemic has been well documented. Whilst it has never been more important to accurately assess the mental health risk posed to young people on their arrival in PED, staff undertaking these assessments often have little formal training or oversight. Whilst physical presentations can be quantified by clinical parameters and evidenced investigations, the accurate assessment of mental health cases is inherently subjective, yet just as crucial.

Objectives To assess the level of agreement between professionals routinely assessing undifferentiated mental health presentations in PED using video vignettes.

Methods We identified mental health-related presentations to a tertiary PED over a one-month period. We selected six cases by random number generation, carefully altered/anonymised the details and engaged actors to re-create the presentations. Using an existing assessment matrix, participating PED and CAMHS (child and adolescent mental health service) staff watched the video vignettes and allocated presentations to 'green', 'amber' or 'red' risk categories. A free marginal multi-rater Kappa was used to assess the level of agreement between responses (0 indicating no agreement and 1 perfect agreement). Staff were asked to rate their confidence in assessing the vignettes on a modified likert scale numbered 1-5 (5 = very confident). This was undertaken as a service evaluation project after discussion with relevant Trust R&D teams.

Results The Kappa for all responses was $K_{free}=0.21$ (95%CI 0.04-0.38). Table 1 outlines Kappa values and self-reported confidence within each staff category.

Conclusions When assessing the severity of mental health presentations on a simple traffic-light system, the agreement between PED staff was very low. This was lowest amongst nursing staff, who may be less familiar with the assessment matrix. Concordance was high amongst CAMHS staff, admittedly with few participants. This likely reflects their greater exposure and training.

Despite the wide variation in responses, each staff group reported their collective confidence in assessing the cases similarly. This may point to a lack of standardised training and staff awareness.

In order to best support young people during mental health difficulties, an accurate, objective and standardised assessment

Abstract 1749 Table 1

Staff Category	n	Kappa	95% CI Kappa	Mean self-assessed confidence
All staff	54	0.21	0.04–0.38	3.29
PED nursing staff only	25	0.14	0.00–0.28	3.36
PED Doctors only	24	0.34	0.08–0.61	3.25
Junior doctors <ST3	11	0.37	0.09–0.65	3.17
Senior doctors ≥ST3	13	0.42	0.16–0.68	3.31
CAMHS nurses	5	0.70	0.44–0.96	3.40

is key. This keeps young people safe, informs the level of support/supervision they require and is crucial to de-escalate crises. This process starts in PED but practice is widely variable in our single-centre study – a level of inconsistency we would not tolerate in the assessment of physical symptoms. We plan to undertake regular multi-disciplinary training led by CAMHS to encourage standardised and robust assessments. We hope to improve the productivity and accuracy of discussions between PED and CAMHS and improve the patient journey for young people. We plan to repeat the vignettes following this intervention.

Paediatric Educators' Special Interest Group

1751

IS THERE STILL A PLACE FOR FACE-TO-FACE SIMULATION COURSES DURING THE PANDEMIC? A COMPARISON OF TRAINEE SATISFACTION OF SIMULATION COURSES PRE- AND POST-COVID

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Background The East of England run two simulation courses for Level 1 trainees aimed at new doctors entering Paediatric training ('ST1 Simulation Day'), and ST3s about to progress to Level 2 training ('Ready for Registrar'). The SARS-CoV-2 pandemic has caused upheaval all over the world, with social distancing fast becoming a norm of our everyday lives. The postgraduate medical education was mostly converted to online teaching. Simultaneously, the reduced patient load seen in Paediatrics during the pandemic highlighted the importance of simulation. Despite restricted funding and limited faculty members, several measures were introduced to ensure the safe delivery of simulation during the pandemic. The introduction of more sessions with smaller groups was one of the many measures implemented.

Objectives To determine whether face-to-face simulation courses were still wanted by trainees during the pandemic and if the courses were as effective as previously despite introduction of social distancing measures.

Methods Prior to the pandemic, candidates attending the simulation courses run in 2019 were given anonymised post-course questionnaires to assess their clinical confidence dealing with emergencies and enjoyment of the course. This was primarily used to improve the delivery of these courses. After the

introduction of modifications due to the SARS-CoV-2 social distancing restrictions, the same questionnaires were given to all candidates in 2020.

Results A total of 74 candidates completed the post-course questionnaires for the simulation courses run for level 1 trainees, 34 of these in 2019 and 40 in 2020. For the 'ST1 Simulation Day' there was an improvement seen in all the questioned parameters in 2020 when compared to 2019, particularly in those 'strongly agreeing' with the usefulness of simulation (increase by 29%) and enjoyment of the day (increase by 32%). The Ready for Registrar day showed similar results in both years, however there was a decline in 2020 trainees 'strongly agreeing' in their confidence in managing emergencies by 18%, and in their communications and delegation skills by 12%, when comparing to 2019 post-course questionnaire.

Conclusions The adaptations made to ensure the simulation courses continued to run during the pandemic were challenging but successful. We believe the smaller groups increased the chances of trainees 'leading a scenario' and their involvement in the guided debrief process, a vital part of simulation training which enhances reflection and maximises the learning taken from each scenario. The slight reduction seen in confidence of managing emergencies, communication and delegation of ST3s may be confounded by the upheaval caused by the SARS-CoV-2 pandemic at a crucial point of their career progression. Many had missed training opportunities in the previous 6 months, such as supported leading of emergencies, 'supervised stepping up', and reduced patient load with a significant reduction in the emergency paediatric healthcare utilisation during the pandemic. Nevertheless, the feedback we had was still very positive. With candidates expressing their gratitude and appreciation at still being able to have face-to-face teaching despite most other learning opportunities being cancelled.

British Society of Paediatric Endocrinology and Diabetes

1752

NEWBORN SCREENING AND SURVEILLANCE OF THYROID DISORDER IN INFANTS WITH DOWN SYNDROME

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Background The Down Syndrome Medical Interest Group U.K. & Ireland published guidelines on thyroid disorders in children and young people with Down syndrome: surveillance and when to initiate treatment in April 2020.

The guidelines recommend that infants with Down syndrome be offered an initial blood spot in the neonatal period in accordance with the current national newborn screening programme for congenital hypothyroidism.

The guidance also recommends that all infants with Down syndrome are offered thyroid function testing at 4–6 months of age and that no additional testing is required in the neonatal period unless thyroid dysfunction is suspected or where additional testing is recommended by the national newborn screening programme.