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.