Abstract 1749 Table 1

<table>
<thead>
<tr>
<th>Staff Category</th>
<th>n</th>
<th>Kappa</th>
<th>95% CI</th>
<th>Mean self-assessed confidence</th>
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</thead>
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<tr>
<td>All staff</td>
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<td>0.21</td>
<td>0.04–0.38</td>
<td>3.29</td>
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<td>PED nursing staff only</td>
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<td>0.00–0.28</td>
<td>3.36</td>
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<td>0.08–0.61</td>
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<td>Junior doctors &lt;ST3</td>
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<td>0.09–0.65</td>
<td>3.17</td>
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<td>Senior doctors ≥ST3</td>
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<td>0.16–0.68</td>
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<td>CAMHS nurses</td>
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<td>0.70</td>
<td>0.44–0.96</td>
<td>3.40</td>
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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.
**Objectives** To ascertain whether clinicians have adhered to the new guidance on offering thyroid function testing as per the Down Syndrome Medical Interest Group guidance.

**Methods** A retrospective notes review was undertaken of all infants with Down syndrome referred to the three child development centres in Leeds during the period February 2020 – February 2021.

**Results** Electronic case notes of 13 babies with Down syndrome were reviewed. Six infants were offered thyroid function testing between 4–6 months of life. Although two babies had insufficient samples and so did not get a result. At the time of auditing these babies were 26 weeks and 49 weeks old and yet to have repeat blood sampling.

One infant was tested at 7 months and 1 infant was tested at 8 months.

Three infants are yet to have thyroid function tests and are more than six months of life. One infant is only three weeks old and too young to be offered testing but this has been arranged to be taken at 4 months of life.

One infant (male) had thyroid function testing at 21 days of life due to abnormal TSH on newborn screening and has subsequently been diagnosed with congenital hypothyroidism.

One infant had inappropriate thyroid function tests sent at 10 days of life whilst on the neonatal unit.

One baby had a TSH of 6.4 with a normal T4 and the decision was made to repeat the samples in 3 months’ time and not within 1–5 days as per recommended guidance.

Four babies had blood spot TSH (including the two babies with insufficient samples) and 4 babies had venous samples sent.

All babies were offered newborn blood spot screening.

The parents of ten babies were informed on thyroid dysfunction in Down syndrome and the importance of monitoring thyroid function in the initial clinic by the clinician. For the remaining 3 babies there is no documented evidence that this information was conveyed.

**Conclusions** We can do better in terms of timely offering the initial surveillance testing at 4–6 months of life and following up promptly on arranging repeat testing if there are sampling issues.

We must continue to educate parents on thyroid dysfunction in Down syndrome ensuring they are aware of key signs and symptoms.

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**British Society for Rheumatology**

1753 REVIEW OF CORTICOSTEROID INDUCTION PROTOCOLS USED FOR CHILDREN WITH A NEW DIAGNOSIS OF POLYARTICULAR COURSE JIA (PJIA) IN AN EAST OF ENGLAND RHEUMATOLOGY SERVICE

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10.1136/archdischild-2021-rpch.831

**Background** Children with PJIA present with five or more joints affected by pain, swelling and stiffness. Untreated, joint inflammation can lead to irreversible joint damage and disability. Corticosteroids have been used for treatment of JIA since the 1950s. Current clinical practice for treatment of PJIA involves high-dose corticosteroids for a limited period in order to decrease inflammation. The aim is to induce remission whilst systemic treatment, commenced alongside corticosteroids begins to work. No standardised, evidence-based approach currently exists to guide corticosteroid induction regimens in PJIA.

**Objectives**

1. Describe corticosteroid regimens in children newly diagnosed with PJIA.

2. Compare disease activity at diagnosis, with follow-up review after treatment with corticosteroids.

**Methods** Retrospective chart review of children newly diagnosed with PJIA, January 2019 to December 2020, inclusive. Demographic data collected and steroid regimens documented. Disease activity recorded pre-instigation of corticosteroids, and then at a follow-up appointment on average 5.5 weeks into treatment (range 3–12 weeks). Modified JADAS-27 created using active joint count (AJC), C-reactive protein (CRP) and ESR, as physician and patient/parent global assessment scores were missing from the majority of charts. Total score achievable using modified JADAS-27 (mJADAS-27)=47.

**Results** Sixteen children were diagnosed with PJIA between January 2019 and December 2020, (male = 5,15%). Eleven children (69%) had polyarticular RF-negative JIA (RF-), 3 (19%) polyarticular RF-positive JIA (RF+), 1(6%) Psoriatic-JIA (PsA) and 1(6%) HLA-B27 positive enthesitis-related arthritis (ERA). All children were commenced on non-steroidal anti-inflammatory drugs (Naproxen, n=11; Ibuprofen, n=5) and subcutaneous Methotrexate (15mg/m²) alongside corticosteroids.

A three-day course of intravenous methylprednisolone (ivMP) was the initial corticosteroid of choice in 12/16(75%) children. Six children were given a dose of 30mg/kg (maximum 1gram), two children 20mg/kg and four 500mg (weight 30.9–44.2 kg; two children were on oral prednisolone (POPred) prior to admission for ivMP; one child had T1DM). Following 3 days of ivMP, all 12 children were commenced on POPred.

The children that did not receive ivMP were commenced on POPred at a dose of 0.5–1mg/kg, with an initial weaning plan of 5mg/week. Two of these children had RF+, one had ERA and the other PsA. AJC ranged from 5–12.

Starting dose of POPred following 3 days of ivMP ranged from 7.5–40mg, maximum dose 1mg/kg. Weaning instructions varied from 5mg/week (n=6), 2.5mg/week (n=4) or stay on low dose (<0.25mg/kg) until review (n=6).

Median mJADAS-27 pre-corticosteroids was 19.4 (5–43.5). Follow-up mJADAS-27 was calculated about 5.5 weeks (3–12) into corticosteroid treatment. Median follow-up mJADAS-27 was 3.5 (0–8). On average, mJADAS-27 improved by 81% (0–100%) following corticosteroids. Of the four children that did not receive ivMP, one child RF- had 100% improvement in mJADAS-27, the other experienced no improvement. The child with PsA experienced 86% improvement; the child with ERA, only a 20% improvement.

**Conclusions** Corticosteroids lead to improved disease activity in children with PJIA. However, treatment regimens employed vary. Development of a standard operating procedure for corticosteroid induction in PJIA is required. Longitudinal studies would enable evidence-based development of such protocols, and should consider optimal corticosteroid route of administration and dose to achieve maximal benefit, whilst minimising corticosteroid toxicity.