recorded the temperature. The prescription and administration of drugs were recorded in separate places, and admission information recorded on a brief proforma.

Although the job aides received positive endorsement during the EPCP courses there has been some resistance to their use in the wards. A survey of patient notes at one site demonstrated that no staff were using the admission forms or the drug charts adequately. Vital signs charts were more acceptable and 100% were satisfactory.

Healthcare workers considered the job aides useful, but cited poor staffing and lack of time as the reason for limited acceptance. Suggestions included:

- Senior endorsement
- Training for all staff on how to use the job aides
- Explanation to nurses how vital signs charts can be used to monitor patient progress and signal when to get help

Conclusion Job aides can focus the attention of healthcare workers on key signs and symptoms as taught in EPCP. Ongoing training, familiarisation, mentorship and support from senior colleagues will be key for their successful introduction.

**G274(P) STABILISATION, REFERRAL & TRANSFER OF ACUTELY UNWELL CHILDREN IN MYANMAR**

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Aims An Emergency Paediatric Care Programme (EPCP) runs training courses in district hospitals. We describe a strategy to support local leadership and develop teams responsible for devising and fulfilling individual implementation plans.

Methods During EPCP courses, participants review the hospital facilities and make recommendations for improvement. A local EPCP Champion (senior clinician) supported by an EPCP Team is responsible for identifying local priorities and developing an Implementation Plan to achieve these. They are asked to consider: layout, infrastructure, staffing, patient safety and infection control, drugs and equipment, staff numbers and training, patient records, clinical guidelines, and morbidity and mortality meetings. Additional support is provided through Global Link Volunteer (GLV) placements in the hospitals.

Results GLVs, EPCP Champions and Teams representing 7 district hospitals reported on their Implementation Plans at the first EPCP Champion and Team Conference in July 2016. A wide range of topics were described including weekly simulation training, new guideline wall charts, well-equipped resuscitation areas, new admission and observation charts, improved infection control through the repair of broken sinks and provision of hand-gel and multi-disciplinary mortality meetings. Feedback was extremely positive with the teams feeling motivated, empowered and rewarded for their efforts.

Conclusions Successful training depends on its impact in practice; the EPCP Champions and Team Conference demonstrated that the combined efforts of local EPCP Champions and Teams and GLVs in developing the Implementation Plans had led to valuable quality improvements.

**G276(P) NEONATAL MORTALITY IN WESTERN UGANDA**

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Aims Neonatal mortality in Uganda has not improved in the last 14 years and remains between 24 and 27 deaths per 1000 live born infants, which compares poorly to the UK neonatal mortality (2.4 per 1000 live born infants). Our aim...
was to determine the immediate and long-term impact of introduction of low-cost guidelines on neonatal mortality in a low-income setting.

Methods Neonatal mortality was audited for three months prior to the intervention. The intervention consisted of guidelines developed using a literature review and experience from local doctors, nurses and a visiting paediatrician. The guidelines focused on four areas: (i) ensuring all babies requiring oxygen, antibiotics or fluids were cared for on the neonatal unit, (ii) separating infants with infections from premature infants, improving hand washing techniques and teaching parents to perform observations thus reducing cross contamination, (iii) using antibiotic regimens based on microbiology data and lower thresholds to start antibiotic treatment, (iv) acutely unwell infants were not enterally fed and nasogastric tubes were for premature or neurologically compromised infants. The guidelines were disseminated at a ward meeting at the end of the audit and implemented with ongoing ward based teaching. Mortality was re-audited for the three-month period immediately post implementation. The audit was repeated at the same period of the year three years and six years post intervention.

Results Pre-intervention there were 79 neonatal deaths in the three months with 137 admissions to the neonatal unit (0.58 deaths per admission). Forty-nine neonatal deaths occurred in the three months post intervention with 187 admissions to the neonatal unit (0.26 deaths per admission) (p<0.001). Three years post intervention there were 60 neonatal deaths and 233 admissions to the neonatal unit (0.26 deaths per admission, p<0.001). Six years post intervention, there were 53 neonatal deaths and 315 admissions to the neonatal unit (0.17 deaths per admission, p<0.001).

Conclusion These data demonstrate it was possible to produce a sustained reduction in hospital neonatal mortality in Western Uganda.

Background Antibiotic resistance is a global threat that is both harmful to patients and costly for healthcare services. It is exacerbated by the unnecessary prescription of antibiotics for viral infections. One suggested intervention to help reduce inappropriate prescriptions is point-of-care-testing (POCT) for biomarkers. This systematic review aims to identify the role that POCT for inflammatory biomarkers has in antibiotic prescribing in children.

Methods A systematic search of Embase, Medline, Web of Science, Scopus, and Global Health databases was carried out. Studies included POCT for biomarkers in children aged 0–18 years. They also had to include antibiotic prescriptions as a measured outcome. A narrative systematic review of the data was then performed.

Results After duplicates were removed 6461 studies were reviewed. After title and abstract review full text review 5 papers were included. The study periods were from 2000 to 2015 with 4 of the studies being RCTs and 1 study being a cross sectional study. The intervention of all the studies was CRP POCT with non of the studies looking at white cell count of procalcitonin.

Only one paper showed strong evidence that POCT reduced antibiotic prescribing with 64.3% of children in the control group immediately prescribed antibiotics compared with 43.4% in the CRP POCT group (P value<0.0001 and a CI: 0.3 to 0.52). Due to heterogeneity within studies and a lack of robust high quality RCTs the extent of any association is difficult to quantify. What was seen in the majority of papers is that the context in which POCT is performed appears to be very influential on the outcome be it the country, the ambulatory setting or the doctor performing the test. All papers suggested that POCT was a safe and acceptable test for use in children.

Conclusion Based on this review POCT for general biomarkers can not be recommended as a global strategy to improve antibiotic prescribing in children. More high quality research is needed and other biomarkers such as PCT should be researched as well as CRP and WCC. POCT should also be assessed against other antibiotic stewardship interventions and a cost benefit analysis should be performed before any suggest of wider implementation is made.