requiring resuscitation. 6 infants had pacemaker placement in the neonatal period (day 3–21) due to severe bradycardia, heart rate <50 or presence of arrhythmias. One child had pacemaker insertion at age 5 years when her average heart rate dropped to 25–30 bpm.

Conclusion Congenital heart block is associated with significant morbidity and mortality. In our cohort, indications for pacemaker placement included a neonatal baseline heart rate less than 50 bpm or presence of arrhythmias (Ventricular tachycardia) on 24 hour ECG monitoring.

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G209(P) DELIVERING EVIDENCE BASED PRACTICES IN PRETERM INFANTS; A SINGLE CENTRE AUDIT OF PRACTICE

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Background Large population data including that of the EPICE consortium has shown high variation in implementation of evidence based practices (EBP) among units, and this can explain some of the variation in outcomes observed between units.

Aims To measure the rate of four EBPs in our preterm population and compare performance with large population data from the EPICE cohort.

Setting Level 3 NICU with approximately 8000 births per annum, with 100 births of <1500 g.

Population All live born babies 23⁺⁰ and 31⁺⁶ weeks gestation receiving neonatal intensive care, born between 1 st Jan 2014 and 31 st December 2016.

Exclusions Babies born prior to arrival at hospital and babies who did not survive to NICU admission.

Four EBPs were; Born in an appropriate level neonatal unit for gestation of baby (all babies); Any antenatal steroids prior to delivery (inborn babies); Avoidance of hypothermia, measured by admission temperature $\geq 36^{\circ}\text{C}$ (inborn babies); Early CPAP or intubation and surfactant within first 2 hours of life (If gestation <28 weeks, inborn babies).

Abstract G209(P) Table 1 Comparison of demographic and EBP data

	Our centre	EPICE
Demographics		
Birthweight, mean, g	1217	1224
Gestational age at birth, mean	28 ⁺⁵	28 ⁺⁵
Evidence-based practices		
Born in right place, %	91.4	88.2
Any antenatal steroids prior to delivery, %	91.8	89.2
Admission temperature $\geq 36^{\circ}\text{C}$, %	99.4	74.4
Appropriate respiratory management if GA < 28 w, %	100	83
All evidence-based practices eligible, %	88.8	58.3

EPICE- Effective Perinatal Intensive Care in Europe data published population data in 2016

Methods Ethical approval was not sought, as this was a retrospective audit of practice. Data was collected from the electronic medical records system.

Results There were a total of 396 babies admitted between 2014 and 2016, and 333 were inborn. Across all domains, in house practice was higher than that of EPICE, and infants receiving all EBPs were 88.8% vs 55.3% (table 1).

Conclusion Benchmarking against large population data can be valuable in assessing performance and identifying areas for continuous quality improvement.

G210(P) PERINATAL PREDICTORS OF NEONATAL HYPERINSULINISM: LENGTH AND COST OF STAY

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Aims To identify perinatal factors associated with neonatal hyperinsulinism (HI) and to investigate the predictive value of insulin levels and the maximum glucose infusion rate (GIR) on the length and cost of admission for neonatal HI.

Methods In this single-centre study, infants born between 1/1/2012 and 31/12/2015 above 35 weeks gestation, who were admitted for hypoglycaemia were retrospectively identified. Hypoglycaemia was defined as a glucose level <2.6 mmol/L. The infants were divided in two groups: HI and non-HI. HI was diagnosed if there was detectable serum insulin concordant with hypoglycaemia (blood glucose level <3.5 mmol/L) or a glucose requirement >8 mg/kg/min. Maternal and perinatal factors were compared between the two groups. In the HI group, the predictive value of insulin levels and maximum GIR on length and cost of admission was explored.

Results There were 474 babies with hypoglycaemia, 42 of whom were identified as having HI. The HI group more often had hypoglycaemic symptoms (45.5% versus 26.5%, $p=0.009$) and lower median (IQR) glucose levels on admission [1.75 (1.4–2.1) versus 2.10 (1.8–2.4) mmol, $p<0.001$]. The recorded symptoms included an altered level of consciousness, poor feeding, tachycardia, respiratory distress and abnormal movements. The median (IQR) length of stay was higher in the HI group [8 (3–22) versus 3 (2–5) days, $p<0.001$], as was the cost of stay [£5629 (1239–16372) versus £1239 (826–2995), $p<0.001$]. In the HI group, the maximum GIR was positively related to the length ($r=0.831$, $p<0.001$) and cost of stay ($r=0.833$, $p<0.001$). In comparison, insulin levels demonstrated a weaker correlation to both ($r=0.386$, $p=0.006$ and $r=0.390$, $p=0.006$ respectively). Receiver operator characteristic curve analysis demonstrated that the maximum GIR predicted a length of stay >21 days and cost >£16 000 with an area under the curve of 0.93 for both. A maximum GIR >13.9 mg/kg/min predicted an admission length >21 days and a total cost >£16 000 with 88% sensitivity and 82% specificity.

Conclusion Hypoglycaemic symptoms and lower glucose levels on admission were more common in infants with hyperinsulinism. The maximum GIR was a good predictor of the length and cost of care.