for the rotas and the Consultant Champion for LTFT working. Together we agreed to update our department's practice in line with the most recent guidance from the RCPCH and BMA.

We wrote a guide summarising LTFT training in our department. This included a timeline of events leading to a trainee's rota being confirmed, typical average hours, nights and weekends a trainee would work based on their training percentage, and information on calculating leave.

We developed a spreadsheet to make it easier to develop slot share rotas. It is prepopulated based on the training percentage and automatically calculates the average hours and numbers of each different shift each slot share partner works. It has enabled more complex slot shares for example three LTFT trainees sharing two rota slots.

A LTFT trainee representative management role was introduced from August 2019. They contact each new LTFT trainee prior to their rotation, act as a point of contact for queries, and signpost trainees to other resources and support networks when needed.

After these changes were implemented a repeat survey was carried out to assess their impact on trainees' experiences.

Results

1. Initially, 50% of LTFT trainees were confident or very confident at calculating their total hours. After our changes this increased to 75%.
2. In 2019, 20% of LTFT trainees felt supported with their rota development. After our changes, 87.5% of trainees felt supported or very supported.
3. 75% of trainees found the LTFT guide and spreadsheet helpful or very helpful. 80% found the LTFT representative role very helpful and 20% found it helpful.

Conclusions The largest improvement was that LTFT trainees felt much better supported. There were also improvements in LTFT trainees' confidence in calculating their hours and leave.

In addition to the improvements assessed by our survey, the changes we made led to fewer rota gaps, and less 'doubling up' of two slot share partners working the same shift, which has benefitted the whole Paediatric Department.

British Association of General Paediatrics

| 483 | '3 IS THE NEW 4' – A QUALITY IMPROVEMENT PROJECT FOR 2–5 YEAR OLDS WITH WHEEZE AND EARLIER DISCHARGE. WHY WAIT 4 HOURS? |

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Background The current British Thoracic Society (BTS) guideline (SIGN 158, 2019) states that children with wheeze or asthma can be discharged when stable on B-agonists every 3–4 hours (hrs). Anecdotally, standard UK practice is B-agonists every 4hrs before discharge. There is limited published evidence to support the BTS guideline (SIGN 158, 2019) which references 2 studies from 1999 (n=63) & 2003 (n=359). These have debatable relevance to current practice as these children were discharged home on nebulisers, an uncommon UK practice.

Objectives Implement a change in practice to discharge children aged 2–5 years from our paediatric assessment unit (PAU) and ward deemed well by a clinician 3hrs after their last inhaled B-agonist.

Methods Children referred via PAU and either discharged or admitted were reviewed monthly 01/12/18 – 31/01/20. Any child treated with B-agonists with a respiratory attending complaint of 'cough', 'wheeze', 'asthma' or 'upper respiratory tract infection' was included in analysis. Initial treatment is standardised to burst therapy for all (3 x 10 puffs or 5mg nebulised salbutamol x 20 minutes apart) with clinician review after this and hourly until discharge. The percentage of children discharged 3hrs after their last B-agonist was plotted on a run chart with the median calculated pre-intervention (December 2018 – March 2019). Re-presentations within 72hrs via the Emergency department (ED) or PAU were recorded. Interventions included posters in ED, PAU & ward, along with a formal data presentation (July 2019). Illness severity, oxygen requirement, medications used and direct ED discharges were not recorded.

Results There were 7279 PAU attendances over the study period with 271 included in analysis. Median age was 3yrs with an interquartile range (IQR) 3–4yrs. Discharge from PAU 3hrs post B—agonist treatment increased from baseline median 46% to 100% by December 2019. A definitive shift in practice (PAU) occurred from April 2019. Ward discharges did not show a consistent shift in practice likely due to confounding factors (low patient numbers, staff clinical practice/preference and patient acuity). Re-presentations within 72hrs were low (n=8). Discussion around discharge 3hrs post B-agonists began in early 2018 with some clinicians possibly become 'early adopters' as the pre-intervention median is above 0% (46%), suggesting a shift in practice occurred before formal intervention. No data is available before December 2018 due to record storage issues and prevents deeper analysis of when the shift occurred.

Conclusions We successfully implemented a change in practice such that the proportion of children discharged from PAU at 3hrs (rather than 4hrs) after B-agonist treatment increased over the study period to near 100%. This practice follows current national guidelines; we recommend other institutions consider adoption of this practice.

British Association of Perinatal Medicine and Neonatal Society

| 486 | MAINTAINING PRETERM ADMISSION TEMPERATURES IN AN ERA OF DEFERRED CORD CLAMPING AND DELIVERY ROOM CUDDLES: A QUALITY IMPROVEMENT PROGRAMME |

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Background Admission hypothermia is an independent risk factor for death in preterm babies. During implementation of deferred cord clamping at preterm birth, we had experienced an increase in the rate of admission hypothermia. We have also implemented a policy of improving the quality of immediate care by encouraging cuddles in the delivery room, which