

a number of patients with limited language skills. We examined the extent of the problem and the provision of interpreter services to paediatricians across the UK.

**Methods:** Consultant paediatricians in the UK were invited by email to complete an anonymous web based survey. Information was collected on the languages spoken by the paediatricians, the languages needing interpretation, methods of interpretation used and the difficulties faced.

**Results:** Of the 647 responding paediatricians, 462 (76.1%) spoke English as their first language. About 202 (33.9%) can speak only English. French (32.1%), Hindi (15.1%) and German (9.1%) are the languages most commonly spoken by consultant paediatricians across the UK. Polish was the language most commonly needing interpretation (58.1%), followed by Urdu (50.4%), Bengali (44.3%) and Somali (37%). A majority (54.5%) of the paediatricians have 1-5% of their patients with limited language skills. Most (89.4%) paediatricians needed interpreter's upto 4 times a week. The availability of a bilingual family member (78.6%) and bilingual staff (61.3%) and difficulty accessing a professional interpreter (30.4%) were the most common reasons given by the paediatricians for not requesting a professional interpreter.

**Conclusions:** In the UK, Polish, Urdu and Bengali are the languages most commonly needing interpretation. The ready availability of adhoc interpreters and the difficulty in accessing professional interpreters seems to prevent paediatricians from using professional interpreters. Urgent measures are needed to address this growing need.

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**INITIAL RISK SCORE PREDICTS SURVIVAL WITHOUT SEVERE INTRAVENTRICULAR-HEMORRHAGE (IVH) AND/OR PERIVENTRICULAR-LEUKOMALACIA (PVL) IN VERY-LOW-BIRTHWEIGHT (VLBW) OR VERY-LOW-GESTATIONAL-AGE (VLGA) INFANTS**

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**Background:** We showed that a predictive model with eight perinatal risk factors correctly predicts

pre-discharge mortality (ESPR 2009). We aim to predict neonatal survival without severe IVH and/or PVL.

**Methods:** In 2006-07, EuroNeoNet collected data from 5,270 VLBW/ VLGA infants (< 32 weeks), admitted before day 28 to 65 NICUs from 14 European countries. A combined outcome for post-discharge survival without grades<sub>3,4</sub> IVH and cystic PVL was used. Regression models to predict survival and combined outcome were developed adjusted for perinatal factors by step-wise selection. Calibration by Hosmer-Lemeshow and discrimination by area under ROC curve was used, latter validated on a different sample. Models to predict combined outcome adjusted by birthweight and/or gestation were also performed. Comparisons between models were based on non-parametric tests over ROC curves.

**Results:** Mean( $\pm$ SD) gestation was 28.6(2.7) weeks and birthweight 1,178(382) g. Adding the need for resuscitation at birth (more than just O<sub>2</sub> therapy) to previously developed model for survival (gestation, birthweight, gender, prenatal-steroid-use, delivery-mode, 1 and 5-min Apgar scores and major congenital anomalies) correctly predicted survival without severe IVH and PVL (AUC: 0.825; 95%CI 0.81-0.84; H&L: 0.489; validation sample: H&L:0.061, AUC 0.829;95%CI:0.807-0.85). This model performed better than those based on birthweight and/or gestation.

**Conclusion:** Score based on nine initial risk factors adjusted for neonatal survival without severe IVH and PVL can be used as a short-term surrogate for risk of adverse developmental outcome at follow-up. The score could be used to measure quality improvement initiatives.

**Acknowledgements:** EC SANCO grant EuroNeoStat II (2008/1311)