heart rate >90 bpm; 1 point for seizures or 2 points for seizures with known diagnosis of Epilepsy; 1 point for Age <40 years or 2 points for age <30 years; 1 point for headache with known diagnosis of Migraine; 1 point for FAST-ve. A score of ≥2 on STEAM predicted SM diagnosis in the derivation dataset with 5.5% sensitivity, 99.6% specificity and positive predictive value (PPV) of 91.4%. External validation (n=1,848, 33% SM) showed 5.5% sensitivity, 99.4% specificity and a PPV of 82.5%.

Conclusion STEAM uses common clinical characteristics to identify SM patients with high certainty. The benefits of using STEAM to reduce SM admissions to stroke services need to be weighed up against delayed admissions for stroke patients wrongly identified as SM.

REFERENCES

Conflict of interest None declared
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8 RAPID ANALGESIA FOR PREHOSPITAL HIP DISRUPTION (RAPID)
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Aim Pain relief in prehospital care is a challenge in trauma, especially for those with hip fractures, whose injuries are difficult to immobilise and whose long term outcomes may be adversely affected by administration of opiates. Fascia Iliaca Compartment Block (FICB) is routinely undertaken by hospital clinicians, but has not been fully evaluated for use by paramedics in prehospital care.

Method Nineteen paramedics were trained; they randomly allocated eligible patients to trial arms using audited scratch-cards. Patients were followed up to assess availability of outcomes including quality of life, length of admission, pain scores, and adverse events. Findings were analysed against prespecified progression criteria.

Results Seventy-one patients were randomised by paramedics (28/6/16 – 31/7/17); 57 consented to follow up. The only outcome which reached a statistically significant difference between groups was the proportion of participants who received morphine (38% difference between groups 95% CI: –61.88 to –15.79). There was a difference of approximately nine days in the length of admission between trial arms (mean difference 9.12 (95% CI: –20.51 to 2.27).

Conclusion RAPID met its pre-specified progression criteria; a funding application for a fully-powered RCT will therefore be submitted. We will consider the use of length of stay as the primary outcome, as findings indicated a difference between groups without reaching statistical significance.

Conflict of interest None
Funding Academic EMS in Stockholm.

9 THE SAME BUT DIFFERENT – VARIATIONS IN STAKEHOLDERS’ PRIORITIES, VIEWS ON RANDOMISATION AND FUNDING OF PREHOSPITAL CRITICAL CARE FOR OUT-OF-HOSPITAL CARDIAC ARREST
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Aim Prehospital critical care for out-of-hospital cardiac arrest (OHCA) is a complex and largely unproven intervention. During research to examine this intervention, we noted significant differences in stakeholders’ views about research,
randomisation and the funding of prehospital critical care for OHCA.

**Method** We aimed to answer the following questions: What are stakeholders’ priorities for prehospital research? What are stakeholders’ views on randomisation of prehospital critical care? How do stakeholders consider allocation of resources in prehospital care? We undertook a qualitative framework analysis of interviews and focus group with five key stakeholder groups: patients and public, air ambulance charities, ambulance service commissioners, prehospital researchers and prehospital critical care providers.

**Results** Despite sharing a common appreciation of the concepts of scientific enquiry, fairness, and beneficence, the five relevant stakeholder groups displayed divergent views of research and funding strategies regarding the intervention of prehospital critical care for the condition of OHCA. The reasons for this divergence could largely be explained through the different personal experiences and situational contexts of each stakeholder group. Many aspects of the strategies suggested by the stakeholder groups only partially aligned with principles of traditional evidence-based medicine, but were held with strong conviction.

**Conclusion** Analysis of the views of five stakeholder groups regarding research and the funding of prehospital critical care for OHCA revealed shared values, but a variety of different strategies to achieve these. This knowledge can help researchers in similar fields in the planning and presentation of their research, to maximise impact on decision making.

**Conflict of interest** Johannes von Vopelius-Feldt and Jonathan Benger work as prehospital critical care physicians with the Great Western Air Ambulance.

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**Abstracts**

**1 QUALITY OF BYSTANDER CPR BY LAY FIRST RESPONDERS: TRAINING VERSUS REAL-WORLD USE OF A NOVEL CPR FEEDBACK DEVICE IN SINGAPORE**

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We undertook a qualitative framework analysis of interviews and focus group with five key stakeholder groups: patients and public, air ambulance charities, ambulance service commissioners, prehospital researchers and prehospital critical care providers.

**Aim** Data on the quality of lay person CPR during emergencies are sparse. We present compression quality data derived from use of a novel CPR feedback device during actual cases prior to ambulance arrival.

**Method** The credit-card sized CPRcardTM device provided visual indication of compression depth and rate in real-time, and stored the data. Median rate, depth; proportion within targets (100–120/minute; depth:4–6 cm); and flow-time were used to determine compression quality. Bystanders’ emergency performances were compared to their training performances.

**Results** Median depth during emergencies vs trainings was 39 mm (95% CI: 30 to 49 mm, p=0.028) vs 55 mm (95% CI: 50 to 57 mm, p=0.028); and median rates were 114 cpm (95% CI: 109 to 120 cpm, p=0.104) vs 109 cpm (95% CI: 105 to 112 cpm, p=0.104). Of total emergency vs training delivered compressions, 6% (95% CI: 0% to 49%, p=0.008) vs 63% (95% CI: 56 to 90%, p=0.008) were within target depth; 54% (95% CI: 32% to 79%, p=0.028) vs 94% (95% CI: 81 to 97%, p=0.028) were within target rate. Of the lay bystanders’ during emergencies vs trainings, 4 (50%, p=0.398) vs 5 (71%, p=0.398) met both compression and depth targets. Emergency vs training compression flow-time was 95% (95% CI: 85% to 99%, p=0.099) vs 100% (95% CI: 96 to 100%, p=0.099), respectively. Lay bystanders overall reported positive experience using the card but some