ED presentations, and one or more further 999 calls at 6 months as a composite primary outcome.

Results Data on 1,220 people were submitted for linkage; 37 people were lost to follow-up or excluded from analysis, leaving 1,183 (550 intervention; 633 control) included in analysis. Baseline demographics and service use were similar between intervention and control arms, except median age (60 years intervention; 69 control).

No statistically significant differences between study arms were detected for the composite primary outcome (95.6% intervention; 94.9% control; adjusted odds ratio=1.013, 95% CI=0.748-1.372), mortality (10.5% intervention; 14.1% control; aOR=0.713, 95% CI=0.465-1.093), emergency admissions (67.5% intervention; 66.7% control; aOR=1.114, 95% CI=0.831-1.492), ED presentations (76.9% intervention, 73.9% control; aOR=1.088, 95% CI=0.763-1.551) and further 999 calls (87.8% intervention; 86.1% control; aOR=1.197, 95% CI=0.794-1.805).

Conclusion Emerging findings suggest no clear overall effects on service use or mortality between study arms. Mortality was high in this group. Analysis of secondary outcomes (including case management referral and conveyance rates), health economics and qualitative analyses are ongoing.

STRENGTHS High linkage rate for included people allows a more complete picture of outcomes than 999 data alone.

LIMITATIONS Not a randomised trial – other local confounding factors may be important.

OP07 TEMPERATURE MANAGEMENT OF BABIES BORN IN THE PREHOSPITAL SETTING: AN ANALYSIS OF CALL-HANDLER ADVICE AND STAFF AND PATIENT VIEWS

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Background Following prehospital birth, babies can become hypothermic within minutes, sometimes before paramedics arrive. The risk of the baby dying increases by at least 28% for every degree that their temperature drops below <36.5°C. The earlier we can provide effective warming interventions, the lower the risk of poor outcomes. The aim of this project was to 1), examine the neonatal temperature management advice given to people calling 999 about a prehospital birth in the UK and 2), explore NHS staff and patient views about the content and accessibility of advice given.

Methods All 999 calls between January 2021-January 2022 were searched by the Clinical Information and Records teams at two ambulance services using the two different triage systems (AMPDS and NHS Pathways). Thirty eligible calls were selected from postcodes with varying levels of deprivation and passed to the study team for content analysis. Nine focus groups were held with 18 NHS staff (paramedics, midwives, neonatal nurses/doctors, call-handlers), and 22 members of the public who had experienced prehospital birth, to discuss the content and accessibility of the advice given.

Results Five themes were identified as potential barriers to good quality neonatal temperature management: confusing or conflicting advice on where the baby should be placed following birth, vague or unclear instructions on warming the baby, the timing of temperature management advice, the priority given to other instructions, and a lack of importance placed on neonatal temperature. Participants suggested a number of simple changes to advice, including increased focus on the importance of neonatal temperature, encouraging skin-to-skin contact, and providing specific advice on warming the baby.

Conclusions There is an opportunity to improve the neonatal temperature management advice given by 999 call-handlers during calls related to prehospital birth. This could reduce the number of babies arriving at hospital hypothermic, therefore improving outcomes.

Elevator Presentations

EP09 FEASIBILITY OF METHODS AND INTERVENTION FOR ADMINISTRATION OF TAKE-HOME NALOXONE IN EMERGENCY SETTINGS: A CLUSTER RANDOMISED TRIAL

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10.1136/emermed-2023-999.8

Background Opioids kill more people than any other drug. Naloxone is an opioid antagonist which can be distributed in take-home 'kits' for peer administration (THN). We aimed to determine the feasibility of carrying out a definitive randomised trial of THN in emergency settings.

Methods We carried out a randomised feasibility trial clustered by site, in paired ED and Ambulance Service (AS) catchment areas. Usual care was administration of naloxone by paramedics or ED staff. In addition to usual care at intervention sites THN was offered to adults in ED or by paramedics for a problem related to opioid use. We assessed feasibility of intervention and trial methods based upon predetermined progression criteria: site sign-up; training of staff; identification of eligible patients and the proportion given kits. We planned to retrieve anonymised outcomes for people identified as being at high risk of opioid-related death.

Results Four sites participated in the trial and 278 clinical staff were trained (ED1: 107, ED2: 25, AS1: 100, AS2 46). Sixty THN kits were supplied to patients during the 1-year recruitment period (ED1: 36, ED2 16, AS1: 4, AS2: 4). Eligible patients were not offered THN kits 164 times (ED1: 159, AS1, 2, AS2: 3). Reasons included: 'forgot' (n=136); 'too busy' (n=15); suspected intentional overdose (n=3). 626 people were considered but recorded as ineligible (ED: 532, ED2:4, AS1: 49, AS2:41). Reasons included: uncooperative (n=55); lacked capacity (n=35); reduced consciousness (n=41); in custody (n=21); absconded (n=161).

Conclusions This study did not meet progression criteria for intervention feasibility, so outcomes were not followed up and a fully powered trial is not planned. The emergency setting was a challenging environment in which to provide THN kits, although it may be possible to design a less restrictive