model may improve the use of NHS staff resource and patient access to specialist services.

**Abstract 76 Table 1** ACP combined patient outcome data (total of 358 patients reviewed over a 12-month period)

<table>
<thead>
<tr>
<th>Category</th>
<th>Outcome (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further diagnostic investigation</td>
<td>63.4%</td>
</tr>
<tr>
<td>Medicines optimisation</td>
<td>35.5%</td>
</tr>
<tr>
<td>Discharge</td>
<td>17.6%</td>
</tr>
<tr>
<td>Another specialty referral</td>
<td>12.3%</td>
</tr>
<tr>
<td>Elective cardiac intervention referral</td>
<td>10.6%</td>
</tr>
<tr>
<td>Outcome amended by consultant lead</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

Conflict of Interest None

77 WHAT MODIFIABLE FACTORS DELAY INITIATION OF BYSTANDER CPR IN OUT-OF-HOSPITAL CARDIAC ARREST? RESULTS FROM AN ANALYSIS OF 200 RECORDED AMBULANCE CALLS

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**Introduction** Worldwide, out-of-hospital cardiac arrest (OHCA) is common with high mortality (~90%). Immediate CPR reduces mortality but is often delayed or not provided by bystanders, even when ambulance call-takers provide instructions.

**Aim** To identify potentially modifiable behavioural barriers to CPR in recorded OHCA ambulance calls

**Method** We performed a content analysis of 200 randomly identified, pseudonymised, transcribed ambulance call-recordings involving OHCA (Jan 2019-Dec 2020). Data was extracted about (i) the OHCA patient (ii) the caller (iii) ‘time to get patient flat’ and (iv) ‘time from instructions to CPR initiation’. Barriers to CPR were coded (10% double-coded, confirmed reliability) and potentially modifiable behavioural barriers identified.

**Results** OHCA patients were mostly male (61%), aged 0-90+ (most 40-80). Callers were mostly female (62%) and known to the patient, the spouse a third of the time.

CPR was achieved in 94% (n=188) of cases and performed from 1 second to 23 minutes (mean: 6 minutes [SD: 4.4]). The maximum duration of CPR by a single rescuer was 23 minutes.

Median time from identification of cardiac arrest to CPR initiation was 152 seconds (IQR=110). Median time to get patient flat was 40 seconds (IQR=67). Median time from instructions to initiation of CPR was 50 seconds (IQR=59). Time to get patient flat was significantly longer when callers expressed they didn’t know how to do CPR (t: 2:15.87, p<.01) and felt physically unable ( t: 2:9.45, p<.05)

**Conclusion(s)** Behavioural barriers are associated with longer delays getting OHCA patients flat (a crucial first step) and achieving initiation of CPR. Behaviour-change techniques may be helpful in addressing these barriers and achieving CPR sooner. Work with behavioural experts and call-handlers to develop appropriate scripting to address these issues is underway and offers an important potential route to reducing mortality from OHCA.

**Conflict of Interest** No

78 IMPLANTABLE LOOP RECORDERS: A CARDIAC PHYSIOLOGIST LED EXPLANT SERVICE

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**Introduction** British Heart Rhythm Society has published standards for the insertion, follow up and explant of implantable loop recorders (ILRs). Although an increasing number of UK centres have developed services for ILR implantation by non-medical staff, there are very few published data regarding ILR explants performed by non-medical staff. We describe our experience of establishing a Cardiac Physiologist-led ILR explant service.

**Methods** Previously, patients wanting ILR explantation in our centre had to be placed on a Consultant Cardiologist’s cathe ter lab list. This increased procedural cost and resulted in long waiting times (up to 3 years) for explant once the ILR had reached end of service.

To address this, a Highly Specialised Cardiac Physiologist, who was already trained in ILR implantation, received further training in ILR explant technique. Training involved attending a surgical skills course (Royal College of Surgeons), followed by a minimum of 20 ILR explants under supervision of a Consultant Cardiologist. The Trust-approved non-medical provider pathway that was already established for Physiologist-led ILR implantation was used as no additional drugs were required for the explant procedure, nor was there felt to be additional operative risk involved.

Patients were triaged for suitability for the Physiologist-led pathway. Patients requiring sedation for ILR explant, patients with legacy Medtronic Reveal devices, patients with complex needs, and pregnant women were excluded from the pathway.

On the day of the procedure the Physiologist obtains informed consent from the patient (1% overall risk of infection and bleeding complications). The explanting Physiologist is supported in the procedure room by one other Physiologist. The ILR is located by palpation. The skin is cleaned with chlorhexidine solution and a surgical drape is applied. Using aseptic non-touch technique up to 10ml lidocaine is administered. An incision is made along the old scar and down onto the ILR. Any tissue that has grown around the explant is supported in the procedure room by one other Physiologist. The ILR is then easily removed. For the initial 46 explants the wound was sealed with glue only. However, after one patient experienced a bleeding complication it was decided to close the wound with Caprosyn absorbable suture and glue. Since then, there have been 132 uncomplicated explants.

**Results** From October 2019 to January 2023, 186 ILR explants of Medtronic Linq and Abbott Confirm devices were performed by the Cardiac Physiologist. The first 26 procedures were performed under direct supervision by a Cardiology Consultant. The other 156 explants were performed...