Priority Dispatch Committee

Meeting Minutes

9th January 2019, PHECC office @ 10:00am

Present:
Stephen Brady (Chair)
Anne McCabe
Peter O'Connor
John Moody
Martin O'Reilly
Robert Howell

Teleconference:
David Menzies

In Attendance
Richard Lodge, PHECC Director
Brian Power, PHECC PDO
Margaret Bracken, PHECC Support Officer

Absent
Brian Byrne
Cathal O'Donnell
Derek Scott

Apologies
Andrew McCrae
Sean Brady
Illona Duffy

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1. Chair's Business

The Chair welcomed everyone to the meeting and wished all a happy new year. Apologies were noted. David Menzies attended via teleconference. The Chair introduced Mr Richard Lodge, the recently appointed PHECC Director, and the members welcomed Mr Lodge to the meeting.

2. Minutes from May 2018 meeting

The minutes of the Priority Dispatch Committee meeting of 29th May 2018 were reviewed.

Resolution: That the Priority Dispatch Committee approve the minutes of the meeting held on 29th May 2018.

Proposed: Martin O'Reilly **Seconded:** John Moody
Carried without dissent

2.1 Matters Arising

Agenda item 6: Hear and Treat Standard

Brian Power advised that no feedback has been received from NEOC on protocols used for hear and treat.

Agenda item 7.1

"The Chair of the Priority Dispatch Committee agreed to speak to the Chair of Council and request that a letter, dated 1st May 2018, addressed to the Director of PHECC from the Director of the National Ambulance Service, advising that the NAS are deferring from participation in the PHECC Priority Dispatch Committee, be included as an agenda item for the next Council meeting, as a matter of urgency."

Brian Power updated the members. Following discussion at the December Council meeting, Council's resolution pertaining to this matter was emailed to all Priority Dispatch Committee members prior to today's Committee meeting.

"Resolution: that Council endorse the work of the Priority Dispatch Committee and expect full cooperation from licensed CPG providers".

Brian tabled a letter dated 8th January 2019 from the Director of NAS to PHECC, informing that NAS have suggested a meeting on Wednesday 16th January to discuss the issues of concern.

This opportunity to meet with NAS to discuss their concerns regarding participation in the PHECC Priority Dispatch Committee is welcomed. It was agreed that Brian Power write to the Director of NAS accepting the meeting invitation and advising that the PHECC Director, Brian and the Chair of the Priority Dispatch Committee, will be in attendance. He is to clarify the agenda and what attendance is expected from NAS at the meeting.

The members discussed the terms of reference of the Priority Dispatch Committee and agreed that it is timely to review the terms of reference.

3. Priority Dispatch

3.1 HIQA Ambulance Times

Brian Power provided the background. He informed the members that PHECC met with HIQA on 23rd October 2018 and emergency response times and standards were discussed. When discussing appropriate standards HIQA stated that the Pre-Hospital Emergency Care Key Performance Indicators for Emergency Response Times no longer applied within HIQA. It was pointed out to HIQA that the KPIs were still displayed on their website. Following discussion at the November Council meeting, Council requested written confirmation from HIQA on this policy.

An email from Brian Power to HIQA requesting confirmation of the status of the Pre-Hospital Emergency Care Key Performance Indicators for Emergency Response Times within HIQA, and the response email from HIQA were included in the meeting papers. HIQA stated that their position remains consistent with recommendations set out in their report which was published in December 2014. Recommendation 7 stated that measures should include the 7 minute 59 second first-response time for all ECHO and selected DELTA calls. They advised that the document on their website has since been removed and apologised for

any confusion caused. Brian Power advised that PHECC has the appropriate authority to specify what Delta incidents should be included in the response time standards.

3.2 Ambulance Response Programme

A final report from the School of Health and Related Research, University of Sheffield, "Ambulance Response Programme Evaluation of Phase 1 and Phase 2" was included in the meeting papers. The report explores changes to the triage of calls modifying the 999 call handling process to incorporate questions that immediately identify the most urgent calls, reviews call categories and the development of a new set of categories, reviews the current Ambulance Quality Indicators and the development of a revised set of indicators linked to the revised call categories.

Brian Power provided a summary document which was tabled on the day. He highlighted that in the report Red 1 classification were equivalent to PHECC Purple determinants and Red 2 were equivalent to PHECC Red determinants. He suggested reviewing the DCR table and identifying which Delta calls should be regraded based on this research. It was noted that if all Delta calls are upgraded there will be an increase in Echo calls that are not necessarily cardiac arrests. Martin O'Reilly expressed his concerns about decreasing the priority of calls. Brian Power stated that some priority Delta calls do not require additional personnel on scene, and by regrading these calls to Echo the 8 minute response time is still achieved.

John Moody advised that rapid response is what is most important for the highest priority, and he stated that the AMPDS codes do not dictate what response is required as that is a PHECC function. He stated that if we want certain Delta calls to have an 8 minute response time we need to distinguish between these and all other Delta calls and the process to achieve this was by giving them a Purple determinant. Brian Power queried how ambulance crews would differentiate between which Delta calls require the 8 minute response and which do not, how would they know that they are not always cardiac arrests, he noted that this might cause confusion for the crews. He stated that it is the function of AMPDS to determine codes not response times.

In relation to identifying cardiac arrest from callers, John Moody noted that the AMPDS system is faster at identifying cardiac arrest than any other international system. He stated that there may be issues with the introduction of a second set of questions. Martin O'Reilly suggested a subset of Delta calls should be included as potential cardiac arrest. The Chair requested that the members read the report for further discussion at the next Committee meeting.

Brian Power informed the members that, following agreement with the Chair, a visit is being arranged by PHECC to visit the Scotland Ambulance Service to see their response model in operation. The Chair agreed with the suggestion that a Committee member from NAS and from DFB along with Brian Power should attend. It was agreed that the control managers from their respective organisations, John Moody from DFB and Sean Brady from NAS, would be appropriate.

4. Protocol updates

4.1 New protocols

A Priority Dispatch Medical Transfer Protocol Suite setting out new proposed protocols 45, 46 and 47 was included in the meeting papers for information. Brian Power noted that the new protocol 45 could be

targeted at GPs who have expressed frustration with the AMPDS process and the volume of questions they are required to answer. He stated that there will be a requirement to educate GPs on any new protocols. A similar process as utilised for protocol 37 could be utilised to inform GPs of any new protocols. It was noted that GPs hold monthly CPD meetings which could be beneficial for this purpose. The members discussed the implications of these new protocols.

John Moody stated that he did not see the benefits of these new protocols for GPs as the questions still have to be answered. Robert Howell noted that protocol 33 is already designed for this purpose and advised that protocol 45 might be more frustrating for GPs. Brian Power advised that protocol 33 was never fully implemented which is why protocol 45 has been designed. It was suggested that protocol 33 be reviewed. Anne McCabe noted the importance of education and training to avoid abuse of the protocols. John Moody stated that GPs have identified a need which must be addressed. He further stated that it is a huge body of work for NAS.

It was agreed that the new proposed protocols, when fully released, will require further discussion by the Committee.

5. Call taker and dispatcher training/certification

Brian Power noted that the question of whether call takers and dispatchers require PHECC certification to practice within the EMS system has not been addressed to date. He noted that other jurisdictions require that call takers and dispatchers be licensed. A discussion ensued on the matter. John Moody stated that DFB have no objection to PHECC certification for call takers and dispatchers. Martin O'Reilly had a concern that call takers and dispatchers would be separated into two functions whereas DFB engage the same control staff to simultaneously call take and dispatch. There was a suggestion of joint certification. Certification for all call takers and dispatchers, while working in an EMS call centre, was agreed in principle by the Committee.

Resolution: That the Priority Dispatch Committee recommend to Council that mandatory certification by PHECC to operate as a call taker or dispatcher within an EMS control centre be agreed in principle.

Proposed: Peter O'Connor **Seconded:** Martin O'Reilly
Carried without dissent

6. Hear and treat standard

Information document from the International Academies of Emergency Dispatch (IAED) certified Emergency Communication Nurse System (ECNS) was included in the meeting papers. Brian Power provided an overview. He stated that a significant number of calls received by AMPDS are low priority and did not necessarily require an ambulance response. He noted that over the years not dispatching any response vehicle to low priority Omega calls had generated a lot of nervousness within the services. He informed the meeting that NAS are operating a clinical hub, using a ProQA software package, which requires that the system is staffed by an emergency nurse. He advised that PHECC has no input into this process and have no knowledge of how this clinical hub operates or to what standard. He noted that there is a shortage of emergency nurses in the country and questioned the need for limiting clinical hub staff to emergency nurses when PHECC registered practitioners, who are trained to a very high clinical level, could also be trained to perform this function adequately. Brian advised that he has visited clinical hubs in other jurisdictions that use appropriately trained ambulance practitioners with excellent results. He questioned whether a software company should dictate national standards for Ireland as it is PHECC's statutory function to do so. He noted that should DFB set up

their own clinical hub it would be different to that of the NAS system and the same clinical process should be in place for both services.

John Moody stated that the NAS clinical hub is only in operation for eight hours per day and he noted that it would be beneficial to see what standard and data are being used and the outcomes. David Menzies suggested requesting this information from NAS. It was suggested that a single clinical hub was appropriate for the country and that all calls deemed appropriate for the clinical hub should be transferred there regardless of the initial source.

Following discussion, the consensus was that there is a need for a clinical hub and that PHECC should develop a hear and treat standard with involvement from all statutory licensed CPG providers.

Resolution: That the Priority Dispatch Committee recommend to Council that PHECC develop and introduce a hear and treat standard of operation following consultation with all statutory licensed CPG providers.

Proposed: Martin O'Reilly **Seconded:** Peter O'Connor
Carried without dissent

7. AOB

7.1 On the request of John Moody, Brian Power circulated a tabled document of new codes from version 13.1 to be added to the DCR table. Mr Moody advised that the opiates Fentanyl and Carfentanil, which can produce a very violent reaction in the user, are causing serious concerns in the UK and the USA. He stated that this poses a serious risk for responders here. Martin O'Reilly requested that a heading for additional high-risk pregnancy be added to the DCR table. John Moody will send the full document to Brian identifying codes that have been changed and new codes, to include high risk pregnancy. Brian advised that the current PHECC DCR table version 8 will be updated to version 9 when the new codes are added and approved.

7.2 Brian Power brought to the members attention a DPER circular regarding travel and subsistence costs for employees of public bodies and that PHECC is following its requirements regarding payments for Committee members.

7.3 Brian Power advised that he had been in contact with Dr Illona Duffy to ascertain if she wished to continue as a member of the Committee in light of her non-attendance to date. Dr Duffy explained that there have been extreme difficulties in obtaining a locum to enable her to attend. She expressed continued interest but will try to identify an alternative GP that might be better placed to attend the meetings.

The next meeting of the Priority Dispatch Committee will be held on Wednesday 3rd April 2019 at 10:00am in the PHECC office.

The meeting concluded at 12:00am approximately.

Signed: Stephen Brady **Date:** 3/4/2019.
Chair