Priority Dispatch Committee

Meeting Minutes

11th November 2019, PHECC office @ 10:00am

Present:	Apologies	In Attendance
Stephen Brady (Chair)	Cathal O'Donnell	Brian Power, PHECC PDO
Andrew McCrae	Sean Brady	Margaret Bracken, PHECC Support Officer
Robert Howell	Derek Scott	
Martin O'Reilly	Peter O'Connor	
John Moody	Anne McCabe	
Teleconference:	**Absent**	
David Menzies	Brian Byrne	
	Illona Duffy	

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1. Chair's Business

The Chair welcomed the assembled members and apologies were noted. David Menzies attended via teleconference.

2. Minutes from April 2019 meeting

The minutes of the Priority Dispatch Committee meeting of 3rd April 2019 were reviewed and approved.

Resolution: That the Priority Dispatch Committee approve the minutes of the meeting held on 3rd April 2019.

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

2.1 Matters Arising

2.1.1) John Moody sought a progress update on NAS participation in the Priority Dispatch Committee. The Chair relayed that, as agreed at the April Committee meeting, the matter was referred to the PHECC Director and Council for advice as to how to proceed. The PHECC Director has met with senior management of NAS and these meetings were very productive. The matter is progressing. Two NAS members have given their apologies for this meeting, one member is out of the country on annual leave. It was noted that Sean Brady is currently on sick leave. The Committee pass on their best wishes to Mr Brady for a speedy recovery.

2.1.2) At the April meeting the Committee agreed to recommend the revised Priority Dispatch Committee Terms of Reference to Council for approval with agreed amendments. Brian Power relayed that Council approved the revised terms of reference at their April meeting. A revision of the terms of reference for all PHECC Committees is currently being carried out as part of a governance review of Council and Committees. Council have requested that the revised Priority Dispatch Committee terms of reference be put on hold until the governance review is complete. A report of the governance review is to be presented to Council in December.

2.1.3) International Academies of Emergency Dispatch Accreditation/Re-Accreditation Application & Self-Assessment documentation was included in the meeting papers. At a previous meeting NAS expressed concern in relation to losing their ACE Accreditation with the International Academy of Emergency Dispatch if NAS comply with PHECC standards. Brian Power assured NAS that PHECC's requirements would not interfere with their ACE Accreditation in any way. John Moody supported the view expressed in relation to the ACE accreditation and stated that DFB has gone through three accreditations and he could not see any difficulty complying with PHECC standards. He did express concern however if new pre-entry questions were introduced. He noted that potential cardiac arrests can be identified within the first couple of questions of priority dispatch. John Moody stated that DFB have a very thorough and robust accreditation process in place. If standards are not met accreditation can be removed or suspended.

2.1.4) As a result of PHECC's authority being challenged legal advice was sought by PHECC in relation to the statutory function of PHECC to set standards of operation for licensed CPG providers and in particular standards for priority dispatch. This legal advice was included in the meeting papers. The advice is that PHECC has a statutory entitlement to set standards of operation for pre-hospital emergency care providers so as to support best practice by PHECC registered practitioners. Brian Power stated that it is the function of the Priority Dispatch Committee to set standards of operation for recommendation to Council for approval. The Chair stated that this confirmation is gratefully received by the Committee and that it gives clarity for all concerned.

3. Priority Dispatch Standard

A revised and updated Draft Priority Dispatch Standard was included in the meeting papers for review by the Committee. Brian Power provided an overview. At the April Committee meeting members were informed that Brian Power and John Moody recently visited the Scotland Ambulance Service on behalf of the Priority Dispatch Committee to see their clinical response model in operation. They relayed that they were very impressed with the model and process they are using. The Committee agreed that consideration should be given to adopting a similar clinical response model for Ireland. The Chair suggested that Brian carry out a scoping exercise on clinical response models and submit a report to the Committee. The Committee sought Council approval for further engagement with Scotland Ambulance Service with a view to explore the introduction of a clinical response model for Ireland. Council, at their May meeting, approved in principle to invite the Scotland Ambulance Service to make a presentation to Council and the Committee regarding their clinical response model. Council advised to look at other response models also.

Brian relayed that the draft Priority Dispatch Standard is focused on evidence based standards that include Irish data which the Committee can stand over. Cardiac arrest data from the Out-of-Hospital Cardiac Arrest Registry and academic evidence from University of Sheffield School of Health and Related Research, Scottish

Ambulance Service, and Ambulance Victoria, Australia, have been utilised in the development of the standard.

There was a robust discussion and suggestions and amendments were agreed.

Objectives;

1. Delete 'more' before 'clinically appropriate response' and add '(s)' after 'resource'
   'To provide a clinically appropriate response by targeting the correct resources for the patient.'

Emergency call handling times;
John Moody stated that obtaining and verifying contact number and address is a priority and he requested that 'Verify address of incident' be moved to 'Time 2' and 'Identify possible cardiac arrest' be moved to 'Time 3'. The primary objective is to ensure a response and it is essential to get a location first. The Committee agreed.

Trying to beat the clock by dispatching ambulances ahead of establishing a chief complaint was noted as a concern. It was noted that current CAD systems do not display locations automatically but technology is progressing and moving in the right direction. With the ProQA software if a definitive answer is not received from the caller the programme prompts the call taker to ask the question again in order to get more detail from the caller. It was noted that this can make a stressful situation more stressful for the caller. The importance of the correct sequence of questions and identifying potentially serious incidents within the delta range was noted. It was stated that from a caller perspective breathing can be unverifiable and call takers need to work with the caller to verify breathing. Scene safety protocols and how to measure possible cardiac arrests was discussed. All other content on page 2 was agreed.

Dispatch Cross Reference Table;
Amend 'Orange' to 'Amber'. All other content on page 3 was agreed.

Principles for Dispatchers;
Discussion ensued on 'reasonable expectation of making patient contact' and 'informing the caller of estimated time of arrival'. It was advised that it is not possible to give an estimated time of arrival and to do so would be creating an expectation that cannot be met. It was suggested that callers could be informed what priority they are being allocated so that they will have an estimated time of arrival. Brian will look at alternative wording for this.

It was stated that it is not reasonable to dispatch an ambulance from Dublin to Cork for an incident and that a good dispatcher would know when an ambulance will be coming free in the area. It was stated that ambulance crews are frustrated by being dispatched to locations they know they cannot get to in a reasonable timeframe and typically resulting in being stood down. This process was regarded as a box ticking exercise in control. It was noted that there is no process in place currently for dispatchers to ring Emergency Departments and check if an ambulance is free.

Including a clinical desk in the control centre operated by practitioners and other clinicians on a rotational basis was suggested and considered by the Committee. It was stated that there should be clinical expertise available in the control centre and receiving intervention from an expert can alter the level of priority. It was noted that NAS have a LoCall desk operated by a nurse and the Scotland Ambulance Service LoCall desk is

operated by the equivalent of an advanced paramedic. David Menzies stated that the report of the Trauma Steering Group recommends that the NAS should ensure a PHECC registered Advanced Paramedic (AP), with appropriate additional training, is present in the National Emergency Operations Centre (NEOC) 24/7 with support from a consultant level doctor with significant pre-hospital trauma experience, to ensure timely and accurate identification of major trauma in the pre-hospital setting. This report is endorsed by the Department of Health. Brian will contact Dr Keith Synnott of the Trauma Steering Group for advice. The Committee agreed to include the addition of a 'clinical resource in the control centre' to the draft priority dispatch standard. Brian will look at alternative wording for 'estimated time of arrival'.

A discussion ensued in relation to private or voluntary services ringing control for advice or assistance. It was recommended that a number other than 112/ 999 should be considered for this purpose and perhaps linked to the clinical desk.

Table 1 EMS Response;

Add 'Minimum' before 'Response requirement' in heading box.

Purple: Life threatening – Cardiac or respiratory arrest

BLS capabilities on scene: It was stated that Median < 6 minutes with 90th percentile under 15 minutes is not achievable with current resources. It was agreed to add a footnote with the definition for BLS. It was stated that the EMS response must be patient centred and that the practitioners, medications and equipment are the most important components. The practitioner on scene makes the call on whether additional resources are required.

Amber: Serious not life threatening

Response requirement; It was agreed to move 'Paramedic transporting vehicle on scene < 19 minutes' from 'Response' to 'Minimum response requirement' and delete 'Median under 15 minutes with 90th percentile of 18 minutes'.

Yellow: Non serious or non-life threatening

John Moody noted concern that a median of under 60 minutes is not adequate for some Yellow responses. Brian outlined that this timeframe is based on UK evidence. Following discussion, the members agreed that further review is required with a possibility of upgrading some of Yellow to Amber responses.

* David Menzies left the meeting.

Dispatch on Disposition;

The three pre-entry questions (PEQs) 'is the patient breathing', 'is the patient awake' and 'is the patient breathing noisy' were discussed. Concern was noted that repeating these questions when the AMPDS system is activated may cause distress to the caller. It was agreed that further review of pre-entry questions is required.

Appendix 1 DCR Table;

John Moody relayed that DFB tend to dispatch by code rather than colour. Brian Power advised that this process was introduced as an oversite and without reference to the standard of the principles of dispatch, outlined by Clawson et al (2015), which specifically states that the code should not be utilised for dispatch. Dispatching by colour will require an information process for both control staff and practitioners.

Amendments were agreed to the Amber priority determinants;
'(ii) had a < 1% incidences of reported cardiac arrest on arrival (or an EMS witnessed cardiac arrest)'
It was agreed to change < 1% to > 0.1% as this is more reasonable.
(iii) It was agreed to replace 'had a 1% incidences of confirmed time critical requirement i.e. STEMI or stroke with 'default when cardiac arrest < 0.1%'

Deployment and resources were discussed.

Advanced Paramedic deployment;
It was agreed to add 'Consider AP deployment' after 'Multiple patient incidents'.

EMT Deployment;
It was stated that an EMT level ambulance should be deployed if they are free and in the vicinity. From a patient centred point of view, for serious trauma, the aim is to get the patient onto the ambulance and transport to the nearest trauma centre. If an EMT crew have successfully treated and packaged the patient and are closer to an Emergency Department it is not appropriate to ask that vehicle to wait for a paramedic crew to arrive. The Chair cautioned that the standard cannot be lowered because of resource issues and further discussion is required regarding EMT deployment.
It was agreed to add 'specific' before 'Yellow determinants'.

Emergency interfacility transfer (Protocol 37);
Protocol 37 Emergency Interfacility Transfer for Mode 2, 3 and 4: It was agreed to delete '2'.
It was noted that when requested to transfer patients between hospitals, practitioners sometimes have no awareness of the severity of a patient's condition as they are not always informed by the transferring hospital staff. Brian informed the members that NAS is managing Protocol 37. When questioned, Brian confirmed that a copy of the PHECC Protocol 37 report is available.

Protocols for GPs and mental health patients was discussed. Brian relayed that an education piece for GPs will need to put in place before introducing this protocol. It was advised that the GP should call the control centre directly and not the GP's receptionist, who does not always have the appropriate information required.

Brian Power was instructed by the Committee to make the amendments to the Priority Dispatch Standard as agreed. A revised draft Standard will be presented for further review at the January Committee meeting. Brian advised that there will be a requirement for an implementation phase following approval by Council of the updated standard. The Committee acknowledged and commended Brian on the excellent work he has carried out updating the standard.

4. DCR Table

Revised and updated DCR Table was included in the meeting papers for review. Brian Power provided an overview. The DCR codes from AMPDS V13.1 were matched up with the codes in the DCR Table. All response colours were set to the default colours except for evidence of stroke (< 4 hrs) were maintained at a Red response. Changes to code or description and new codes are highlighted in the Table in the meeting papers. All cardiac arrest incidents for 2017 and 2018, received from OHCAR, were matched against DCR codes and the mean proportion of arrests per code for both years was included in the table for information. It was

agreed to apply the rules outlined in the papers for the Purple, Red and Amber, in relation to the percentage of cardiac arrests, to inform the dispatch colour against each code. It was also agreed that the dispatch colour for 10D04 and 10D05 be reverted to Red.

Following discussion and suggestions the Committee approve the DCR Table in principle. Brian Power was instructed to make the changes as agreed to the DCR Table and circulate to NAS and DFB for implementation.

Resolution: That the Priority Dispatch Committee approve the DCR Table subject to the agreed changes and to disseminate it to both NAS and DFB.

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

5. AOB

Brian informed the Committee that he is due to retire at the end of May 2020. In order to progress the business of the Committee he advised that the Committee needs to meet more frequently. The members agreed.

There being no other business the Chair thanked everyone and the meeting concluded at 14:30.

The next meeting of the Priority Dispatch Committee will be held on Monday 13th January 2020 at 10:00am in the PHECC offices.

Signed: Stef Brady **Date:** 13/1/2020
Chair