Priority Dispatch Committee

Meeting Minutes

13th January 2020, PHECC offices @ 10:00am

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

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1. Chair's Business

The Chair welcomed the assembled members and wished everyone a happy new year. Apologies were noted. David Menzies attended via teleconference. An email request from Dr Illona Duffy, Committee member representing ICGP, was brought to the members attention. Dr Duffy suggested that future meetings might be held over lunchtime with a Zoom option where a GP presence is required, as attending meetings in person can be difficult due to unavailability of locum cover. It was noted that the teleconference facility is available in these circumstances to enable members to dial in remotely. Following consideration it was agreed that it would be problematic for the Committee to change how meetings are currently conducted. Brian Power will discuss the options available with Dr Duffy.

2. Minutes from November 2019 meeting

The minutes of the Priority Dispatch Committee meeting of 11th November 2019 were reviewed and approved.

Resolution: That the Priority Dispatch Committee approve the minutes of the meeting held on 11th November 2019.
Proposed: Martin O'Reilly **Seconded:** John Moody
Carried without dissent

2.1 Matters Arising

A progress update was sought on NAS participation in the Priority Dispatch Committee. The absence of some NAS members was noted. It was noted that Sean Brady is currently on sick leave. The Chair stated that the current situation is not satisfactory, and further discussions between NAS and PHECC is required.

3. Draft EMS Priority Dispatch Standard

Following changes agreed at the November Committee meeting, Brian Power revised and updated the draft EMS Priority Dispatch Standard which was included in the meeting papers for further review. Brian highlighted the changes. He stated that the draft Standard is patient centred, is focused on evidence -based international standards and that Irish data would be utilised in the decision making process. He emphasised that there will be a need for an implementation phase following approval by Council.

The content on pages 1, 2, 3, 5, 6, 11, 13, 14 and 16 of the draft Standard was agreed.

Following discussion further amendments were agreed to the following sections.

5. Dispatch standards (page 4);

A discussion was had regarding estimating time of arrival. The consensus was that it is not possible to specify a time of arrival, call takers should be honest and transparent and inform callers that there is a queue in place and an ambulance will get to them as soon as possible. Providing regular updates puts minds at ease and allows callers to make their own decisions, giving them the option of making alternative arrangements where possible.

The following amendments were agreed to 5.1 - Principles for dispatchers;

5.1.7 - delete 'and an approximate time of arrival' and add '(high, medium and low)'

> 'When a response is delayed Call-takers/Dispatchers shall inform the caller of their priority rating (high, medium and low).'

Add a footnote to define high, medium and low.

5.1.8 - delete 'The Dispatcher shall make'; add 'shall be made'; delete 'ambulance'

> 'Contact shall be made with the caller if the response is delayed (> 20 minutes) for Red and Amber determinants to verify patient's condition and review priority of the incident.'

Table 1 EMS Response (page 5);

Red determinant minimum response requirement for EFR capabilities on scene was discussed. It was stated that a response time of < 7 minutes is difficult to achieve due to ambulance resource issues. EFRs are being dispatched because an ambulance is not available, lack of resources is the issue and not location. It was suggested to check international standards and look at resources available in other jurisdictions. It was stated that NAS ePCR data would be beneficial. It was agreed that the minimum EFR response requirement of < 7 minutes, as set out in the draft Standard, is based on best international practice. It was agreed there will be an implementation phase based on identification of appropriate level of resources. A footnote is to be added in this regard.

5.2 Dispatch on Disposition (page 6);
As included in the meeting papers, email correspondence from Brian Power to Priority Dispatch UK and their response was discussed. The NHS England has recommended the introduction of Dispatch on Disposition which involves permitting the call-taker 180 seconds to allocate a determinant code for incidences other than cardiac arrest. It also involves three specific pre-registration questions to identify cardiac arrests; is the patient breathing? is the patient awake? is the patient breathing noisy? Confirmation was sought from Priority Dispatch UK that these developments if implemented will not affect the Academy Accredited Centre status of a control Centre. The advice from Priority Dispatch UK is that if implemented there may be an increase in call time length which may delay hands on chest time.

Scene safety protocols and asking for a location was highlighted and discussed. It was stated that obtaining a partial location is sufficient in order to dispatch an ambulance in the right direction and the address can be verified on route.

It was stated that this process, if implemented, would ensure an automated response and would not rely on the call taker to determine whether the patient is having a cardiac arrest or not. If embedded into every call the process would ensure that cardiac arrests are not missed.

Following discussion the Committee identified a requirement for further research regarding the recommendation from NHS England, based on the advice received from Priority Dispatch UK. It was agreed not to include the pre-registration questions until additional evidence is sought and reviewed by the Committee.

6. Clinical Support Desk (page 7);
The establishment of a single clinical support desk to facilitate clinical advice for call takers, dispatchers, practitioners and callers to ambulance control was considered. The members discussed the principles of operating and manning a clinical support desk and what level of practitioner would be required. Following further discussion the Committee accept the principles of a clinical support desk with some members expressing concern that a single clinical support desk for the country may be challenging.

Amendments were agreed as follows:
- delete sentence; 'In the interest of efficiencies, a single Clinical Support Desk operation should be established for Ireland.'
- amend 'Clinical Support Desk' to 'Clinical Support Desks'

The three primary functions 6.1, 6.2 and 6.3 were agreed.

7. Assistance and/or advice for non-statutory ambulance service practitioners (page 8);
It was stated that clear direction needs to be given where non-statutory ambulance service practitioners contact ambulance control for assistance and/or advice. Some practitioners will require assistance, some will require advice, and some will require a higher clinical level to provide care beyond the scope of practice of the practitioner on scene. It was recommended that a number other than 112/999 should be considered for situations where advice and/or assistance is required such as an 1800 number.

Practitioner verification was discussed. It was noted that in certain situations the person calling for assistance might not be a clinical person. It was noted that UK organisations are employing UK practitioners to practice at events here. In addition to PHECC PIN and clinical level it was agreed to include the organisation to ensure the practitioner is working for a PHECC licensed CPG provider.

7.1 - amend as follows;

'Verify the bona fide of the practitioner by requesting their PHECC PIN and Clinical level/Organisation.'

Appendix 1 DCR Table (pages 9 & 10);
The definition of a Red determinant under DCR table rules was discussed. A query was raised regarding OTC medications.

It was agreed to amend as follows:

DCR table rule 3;

- delete '(other than OTC medications)' and add 'as per Medication Annex agreed by the Medical Advisory Committee.'

b) Red;

- (ii) delete '(other than OTC medications)' and add 'as per Medication Annex agreed by the Medical Advisory Committee.'
- (iii) add 'physical' before 'intervention'

Emergency First Response deployment (page 12);
Resource issues and deployment of EFRs in a reasonable timeframe where an intervention is required was discussed. It was stated that EFRs are deployed if intervention is needed quickly and the dispatcher is aware that an ambulance will be delayed. An intervention is definitely required in cases where there is compromised airway for example.

The following amendments were agreed:

- add 'Consider EFR response if'
- replace 'able to get to the scene prior to an ambulance, shall be deployed' with 'ambulance is delayed (> 19 mins)'

'Responders (minimum EFR), if ambulance is delayed (> 19 mins) for all Red determinant codes.'

The Flu Pandemic (Protocol 36), as presented, was agreed.

Emergency Interfacility transfer (Protocol 37) (pages 13 & 14);
It was suggested that Protocol 37 is the most inappropriately used Protocol. It was stated that feedback has indicated that somebody to directly manage Protocol 37 might help to address the issues highlighted. It was also suggested that a clinical desk might help alleviate this issue.

Configuration special definitions (page 15);
It was agreed to add 'FGM' to the list of high risk complications for pregnancy/childbirth/miscarriage.

Brian Power will make the amendments as agreed to the EMS Priority Dispatch Standard.

Subsequent to discussion the following recommendation to Council was agreed.

Resolution: That the Priority Dispatch Committee recommend the updated draft STN001 EMS Priority Dispatch Standard to Council for approval subject to the agreed changes with the cavate that an implementation plan is developed to support its introduction. **Proposed:** John Moody **Seconded:** Anne McCabe Carried without dissent

8. AOB

There being no other business the Chair thanked everyone and the meeting concluded at 13:00 approximately.

The next meeting of the Priority Dispatch Committee will be held on Monday 23rd March 2020 at 10:00am in the PHECC offices.

Signed: **Chair** **Date: 12th June 2020**