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

---

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

Priority Dispatch Committee

Meeting Minutes

3rd April 2019, PHECC office @ 10:00am

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

---

1. Chair's Business

The Chair welcomed the assembled members and apologies were noted. David Menzies attended via teleconference. Aisling Ryan, who recently joined PHECC as a support officer, was welcomed to the meeting.

2. Minutes from January 2019 meeting

The minutes of the Priority Dispatch Committee meeting of 9th January 2019 were reviewed.

Resolution: That the Priority Dispatch Committee approve the minutes of the meeting held on 9th January 2019.

Proposed: Martin O'Reilly **Seconded: Anne McCabe**
Carried without dissent

2.1 Matters Arising

John Moody sought an update on the meeting of 16th January to discuss the issues of concern regarding NAS participation in the Priority Dispatch Committee. The Chair informed the members that the meeting took place and the Chair, PHECC Director, Brian Power, the NAS Director, Cathal O'Donnell, Macartan

Hughes, and other representatives from NAS were in attendance. A long discussion was had and NAS expressed concern in relation to losing their ACE Accreditation with the International Academies 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. The NAS Director had to leave the meeting early and a solution could not be reached with those remaining. It was agreed that a second meeting will be organised by NAS, but no proposed dates have been forthcoming. Martin O'Reilly stated that there is no impediment from DFB's point of view with regard to participation in the Priority Dispatch Committee and complying with PHECC's standards.

Brian Power noted that the Priority Dispatch Committee is an expert Committee with representation from both statutory providers. David Menzies suggested that the PHECC and DFB seek clarification from the IAED that the PHECC standards does not preclude compliance with ACE Accreditation. Brian Power will seek this clarification from the IAED and report back to the Committee.

* The PHECC Director joined the meeting.

The Director noted that the initial meeting with NAS was a discussion meeting and the next meeting will be minuted. The Director queried if DFB use the same priority dispatch system as NAS. Martin O'Reilly confirmed that this is the case and that DFB are currently on their fourth accreditation cycle.

Brian Power outlined the Priority Dispatch Standard as set by Council and the role of the Priority Dispatch Committee. Anne McCabe advised that regardless of NAS participation the Priority Dispatch Committee are required to continue their work unless otherwise directed by Council. It was noted that the Priority Dispatch Committee has been a standing Committee of Council for over ten years with no issues arising before this and the work of the Committee is essential to pre-hospital emergency care. The members agreed that this matter be referred to the PHECC Director and Council for advice.

Resolution: That the Priority Dispatch Committee, having discussed the concerns of NAS at length, are referring the matter to the PHECC Director and Council for advice as to how to proceed.

Proposed: John Moody **Seconded: Anne McCabe**
Carried without dissent

3. Terms of Reference for Priority Dispatch Committee

At the January Committee meeting the members agreed that it is timely to review the terms of reference of the Priority Dispatch Committee. TOR013 Priority Dispatch Committee Terms of Reference were included in the meeting papers. Brian Power informed the group that the terms of reference were provided to the Director of NAS as per his request, and it was hoped that NAS Committee members would be present at this Committee meeting to contribute to this review.

Anne McCabe queried her membership under 5.9 National Transport Medicine Programme coordinator (generic), as NTMP is now a service run by NAS and is no longer a programme. She advised that her role has not changed, but she noted that she was not nominated to the Committee by NAS. Brian Power stated that

the Committee is an expert Committee with representatives from both DFB and NAS. Nominations, other than NAS and DFB, do not have to be made by these organisations.

The Director advised the members that he informed the Director of NAS that the terms of reference would be reviewed at this meeting. He requested that if the NAS Committee members were unable to attend this Committee meeting that they submit their suggestions for consideration. No suggestions were received from the NAS Committee members.

The members reviewed the terms of reference and suggestions were made. David Menzies suggested, in order to ensure a broad range of representation on the Committee and a quorum for meetings, to include up to three nominees at Chair's discretion to the membership. He suggested to consider a representative from first responders. Brian Power suggested the addition of a patient representative as the decisions made by the Committee ultimately affect patients. Implications for GDPR was discussed with regard to a patient representative not associated with the pre-hospital emergency care environment. Brian Power advised that all members sign a confidentiality clause. Frequency of meetings was discussed. The terms of reference state that the Committee shall hold at least three meetings in every year and the consensus was that 75% attendance was a little high. It was agreed to amend this to 50%.

Brian Power will make amendments to the terms of reference as agreed.

- 3. Remove the word "time" to read "Provide advice to Council on response KPIs". The rationale for this is that time is included in all response KPIs.
- 5. Additions to Membership:

  5.12 Up to three nominees at Chair of Priority Dispatch Committee's discretion.

  5.13 One patient representative.
- Frequency of meetings: change acceptable attendance of 75% to 50%.

It was agreed to recommend the revised terms of reference to Council for approval at the next Council meeting.

Resolution: That the Priority Dispatch Committee recommend TOR013 Priority Dispatch Committee Terms of Reference to Council for approval with agreed amendments.

Proposed: Martin O'Reilly **Seconded: Anne McCabe**
Carried without dissent

4. Priority Dispatch

4.1 Ambulance Response Programme

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. It was noted that although Sean Brady from NAS was also requested to be part of the visiting team he was not released by NAS Director to

travel. Brian Power presented their findings to the members and a discussion followed. Brian noted that the visit was very worthwhile and informative, and that consideration should be given to adopting a similar clinical response model for Ireland. John Moody endorsed Brian's sentiments.

The Chair thanked Brian on his excellent presentation. He suggested that Brian carry out a scoping exercise on clinical response model and submit a report to the Committee.

The Committee agree the value of continuing engagement with the Scotland Ambulance Service and the value of a scoping exercise on a clinical response model. It was suggested to invite the Scotland Ambulance Service to present to Council. It was agreed that Brian Power will give a presentation to Council and seek a mandate from Council for further engagement with Scotland Ambulance Service to progress this proposal.

Resolution: That the Priority Dispatch Committee seek Council approval for further engagement with Scotland Ambulance Service with a view to explore the introduction of a clinical response model for Ireland.

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

4.2 DCR table update

At the January Committee meeting, 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. Martin O'Reilly requested that a heading for additional high-risk pregnancy be added to the DCR table. A revised document identifying codes that have been changed and new codes, including high risk pregnancy, Fentanyl and Carfentanil overdose/poisoning, was included in the meeting papers for consideration. Brian Power proposed that the new codes be added to the DCR table. Martin O'Reilly noted that FGM is not included in the DCR table, and the members agreed that this will be discussed at the next Committee meeting.

The members agreed that Brian Power will incorporate the new codes into the DCR table, which will become version 9, for recommendation to Council for approval. Revised DCR table version 9 will be circulated following Council approval. John Moody will send the document to Brian.

Resolution: That the new codes as set out in the document presented be added to the DCR table and amended DCR table version 9 be recommended to Council for approval.

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

5. Protocol updates

5.1 New protocols

Brian Power informed the members that there is no further update on new proposed protocols 45, 46 and 47.

6. Call taker and dispatcher training/certification

Brian Power provided an overview. At the January Committee meeting certification for all call takers and dispatchers, while working in an EMS call centre, was agreed in principle by the Committee and recommended to Council. Brian stated that a lot of effort has been put into developing call taker and dispatcher training, but no decision has been made regarding certification. He proposed recommending to Council that call takers and dispatchers be certified by PHECC when operating within an ambulance control centre. Martin O'Reilly noted that there is a move away from ambulance control centres towards call centres where call takers are not certified and have no proper training. A discussion ensued on when pre-hospital emergency care actually begins. The consensus was that that pre-hospital emergency care begins when the call is received by the control centre and the person taking the call is doing so in a competent and responsible way.

The Director sought clarification on the training process, course duration and content, and supervision of call takers and dispatchers, which was provided by John Moody and Brian Power. It was noted that the process for NAS is different to DFB, as NAS courses for call takers and dispatchers are separate courses while DFB train call takers and dispatchers together as one. The Chair advised that to ensure competency of call takers and dispatchers PHECC need to deliver training to a particular standard and certify. The Director noted that with a qualification there may be a fear of walking into any call centre which may cause staff retention issues. The Chair advised that it is a major mistake downgrading ambulance control centres to call centres. John Moody noted that DFB refer to a communications centre and not a control centre, and all staff must be trained to do the job they are there to do as there are multiple streams of communication coming in and going out. Brian Power advised that in order to work in a control/communications centre staff should be certified to operate to the PHECC standard.

Brian Power informed the members that the Medical Advisory Committee are looking at definitions of pre-hospital emergency care and no decision has been reached yet. Brian will update the Committee at the next meeting. The Chair noted that there is a body of work involved in setting out a rationale for why certification is important, and this will be discussed further at the next Committee meeting.

7. Hear and treat standard

7.1 Care Quality Commission (UK) survey on hear and treat

A report from Care Quality Commission (UK) "National findings from the 2013/2014 Ambulance survey of 'Hear and Treat' callers" was included in the meeting papers. At the January Committee meeting 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. It was suggested requesting this information from NAS. Brian Power advised that no response has been received from NAS regarding this request for data.

Martin O'Reilly noted that the current pathways being offered are for patients to make their own way to hospital or go to their GP, and the purpose of hear and treat is to avoid hospital attendance and to avoid sending out an ambulance. Brian Power asked whether there should there be a second parallel number other than 999 for people looking for advice i.e. 113 as this may reduce 112/999 call volume. John Moody suggested a clinical desk as opposed to a LoCall. Brian Power advised that NAS are operating a clinical hub

with software (LoCall) that the software company mandates is staffed by an emergency nurse. It was agreed that taking emergency nurses out of the Emergency Departments to man a clinical hub when there is a shortage of ED nurses is not a good idea.

Ann McCabe noted that the current standard is very loose and suggested benchmarking against international standards. Brian Power stated that the hear and treat process is a sound concept and reduces the requirement to send an ambulance to low acuity calls. He suggested a comparison with the Manchester triage system be made which does not have specific ED nurse restrictions. It was agreed that Brian Power will conduct further research for discussion at the next Committee meeting.

8. AOB

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

The next meeting of the Priority Dispatch Committee will be held on Tuesday 8th October 2019 at 10:00am in the PHECC office.

Signed: Stef Brady **Date:** 11/11/2019

Chair

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	

---

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