South East Coast Ambulance Service NHS
NHS Foundation Trust

CAD Outage Paper Working Procedure

Contents

1. Scope

1.1. **South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to** providing high quality patient care, and timely responses. This procedure details steps and process to be followed where some or all Emergency Operations Centre (EOC) systems are non-operational and the default fall back system is paper working.

1.2. **This procedure is applicable to all Trust staff**

2. Procedure

3. Computer Aided Dispatch (CAD) Outage

3.1. This Standard Operating Procedure (SOP) applies to planned and unplanned CAD outages.

3.2. Any interruptions in CAD functionality should be reported immediately to the Team Leader (TL) and or Emergency Operations Centre Manager (EOCM).

4. Emergency Operations Centre Manager (EOCM)

4.1. Confirm the scale of the problem with the other EOC and 111 contact centres. Establish whether one EOC or all centres are affected.

4.2. The duty EOCM's should hand out the relevant action cards. (CAD Outage Action Cards) Hard copies are available in their designated locations in each EOC.

4.3. Implement paper working mode on the Avaya telephony system. Using the CAD Outage – Paper Working Mode action card to route 999 and HCP calls locally via BT.

4.4. As per the EOCM action card, contact the lead British Telecom (BT) centre to request the following;

4.5. CAD outage – Request that BT split calls to the primary lines only & to enact verbal handover.

4.6. CAD & telephony outage - Request that BT split calls to the primary lines only

4.7. Assign an appropriately trained member of staff to follow the Fallback Guardian action card and disseminate the printouts to the appropriate area.

4.8. Follow the alerting process as per “EOCM CAD Outage” Action Card

4.9. Assign a Loggist in each EOC to log Operational Commander decisions and ensure the on call Loggists are contacted and asked to co-locate with Strategic & 999/111 Operations Tactical.

4.10. Recall all EOC trained staff into EOC by suspending training, audit and admin tasks.

4.11. The lead EOCM must liaise with the Duty Contact Centre Manager (DCCM) to identify an appropriate number of Health Advisors to assist with the CAD outage at each site, East and West EOCs.

4.12. Consider suspending breaks within EOC as per Business Continuity Incident (BCI) plans. EOCMs can make an informed joint decision if meal breaks can be reinstated and to what degree.

4.13. Receive all completed T-Cards and store them securely behind the EOCM desk in the relevant labelled envelopes:

- Passed to West/East
- Passed to other Ambulance Service
- Dealt with by Clinical Support Desk
- Dispatch Desk
- Already on CAD
- Abandoned Calls

4.14. The EOCM is responsible for ensuring the Cad Outage Board is updated as and when required, this will include outstanding unassigned incidents, a picture will also need to be taken and sent to the EOC Loggist at regular intervals.

5. 111 Duty Contact Centre Manager (DCCM)

5.1. The DCCM must escalate to the 999/111 Operations Tactical on call and notify of the CAD outage to allow for National contingency to be invoked as well as the closure of all relevant Directory of Services (DoS) profiles.

5.2. DCCM to contact IC24 team manager on duty to advise of outage.

5.3. DCCM to ensure HATLs advise all call handlers currently on calls to advise the patients they will need to call back on 111 and be answered by another 111 provider or to call 999 if their conditions is life threatening.

5.4. DCCM and HATL to ensure all calls within the clinical list on the fallback guardian are printed and available for allocation by the 111 CAS Clinical Navigator (CCN).

5.5. DCCM to allocate a single member of call handling staff to 'auto in' on the Avaya phone system for the eventuality of calls still being received by the service (I.e. type talk calls).

5.6. Allocate patient safety callers to support the reduction of patients within the clinical queue.

5.7. For any cases requiring out of hours contact, DCCM to ensure service advisors are available to telephone contact details across if agreed by 999/111 Clinical Tactical on call.

6. 111 CAS Clinical Navigator (CCN)

6.1. CCN must ensure all calls within the clinical list on the fallback guardian are printed and available for call back.

6.2. CCN in collaboration with the 999/111 Clinical Tactical on call to recall agile working staff to site if appropriate.

6.3. CCN to allocate awaiting calls to either clinicians for assessment or patient safety callers who will advise patients to contact their own GP (in hours) recall 111 (out of hours) or attend the nearest treatment centre.

6.4. CCN to ensure all staff working have accessibility to shared spreadsheet to record outcomes following patient contacts.

6.5. CCN to ensure on site back up telephony system is utilised for outbound calls to patients if required.

6.6. CCN to ensure all clinicians utilise Solo and Stand-alone DoS / Service finder to signpost patients to the most appropriate care. If calls are triaged to an ambulance disposition, clinicians must ensure they contact 999 and request the appropriate ambulance service for the patient's location.

7. Fallback Guardian Laptop

7.1. The fallback guardian laptops are located in all contact centres and provide an up-to-date listing of all calls sitting in designated lists on the CAD.

7.2. The lists are updated in real time with basic case data, which at the point of CAD failure, can be printed out to allow transition onto paper operations. This printing can be a manual process with automated functionality where set up.

7.3. The EOCM is the designated role to ensure that the fallback guardian laptops are operational and updating as per design. Where issues are identified this is then managed by the Critical Systems Team with support from the supplier.

8. Everbridge

8.1. Everbridge is a platform that enables the user to send predetermined messages to relevant stakeholders.

8.2. All EOCMs have access to Everbridge and will be responsible for sending the “Technical Issue” message in the event of a CAD outage.

8.3. If due to a network outage, Everbridge is unable to be accessed, the EOCM must request that Critical Systems send the notification on their behalf.

9. Dispatch Team Leader (DTL) Actions

9.1. The DTLs must disseminate Dispatch boards to all RDs.

9.2. Ensure that a group call has been completed on each dispatch desk to advise Operational staff of the CAD outage.

9.3. The DTL must ensure that all RDs continue to monitor the appropriate sharers hailing talk groups with other emergency services.

9.4. The DTL must assign someone appropriately trained to Talk Group 69, National Hailing, to receiving incidents from other Ambulance Trusts.

9.5. DTLs must review how those being mentored can be utilised. The DTLs should avoid using mentees for other roles where possible.

9.6. The DTL must assign a Gate Keeper who will follow the “CAD Outage – Gate Keeper” action card and a Dispatch Runner who will follow the “CAD Outage – Runner” action card.

9.7. DTLs must utilise Terra Track by following the “CAD Outage – Terra Track” action card. This is vital as this will alert the user to crew emergencies activated by private ambulance providers.

9.8. Request via all means available, that all Response Capable Managers (RCM) and admin Operational Team Leaders (OTL) make themselves aware to their dispatcher and provide their availability.

9.9. Assist Resource Dispatchers (RD) with setting up dispatch boards.

9.10. The DTL must collect completed T-Cards from the “completed trays” on dispatch boards to review and sign them off hourly, ensuring that they contain all necessary information.

9.11. All completed T-Cards must then be taken to the duty EOCM who will store them securely.

10. Resource Dispatcher (RD) Actions

10.1. If an RD is remotely dispatching a dispatch desk, the channel must be passed back to the relevant EOC as it is not possible to dispatch remotely when working on paper. The RD must contact the other EOC in the first instance to handover the channel.

10.2. Unless told otherwise, remain using point to point radio transmissions unless completing a general broadcast. RDs must ensure that they pass the incident details as follows:

- Call start time
- Address
- Category of call
- Nature of call
- Patient details
- Any scene safety concerns
- Paper reference number

10.3. If told to utilise open mode, RDs must turn group repeat off.

10.4. RDs must complete general broadcasts to advise operational staff of CAD Outage as documented on the “CAD Outage – Resource Dispatcher” action card

10.5. “EOC is experiencing a total CAD outage, all communications will be via Airwave, all incidents will be passed verbally including incident number, address and problem nature. All status updates must be provided via Airwave”.

10.6. RDs must ensure that Private Ambulance Provider (PAP) resources are informed of the CAD outage.

10.7. Set up dispatch boards using the print outs from the fallback guardian laptop, where available.

10.8. Specialist resources are to return to the domestic dispatch desk.

10.9. RDs must ensure that T-Cards are completed in full before placing them into the “completed tray” on the dispatch board.

10.10. RDs must utilise Terra Track by following the “CAD Outage – Terra Track” action card. This is vital as this will alert the user to crew emergencies activated by private ambulance providers.

10.11. It is the responsibility of the RD to ensure that other emergency services are requested if required.

10.12. When an operational response is moved to another dispatch desk, the home dispatcher must show the resource as out of service. The receiving dispatcher must write out a second call sign T-Card. It is the responsibility of the receiving dispatcher to ensure the resource receives appropriate welfare whilst on duty and their duty OTL is informed where necessary. The resource’s receiving dispatcher is responsible for ensuring that the resource is returned to their home dispatch desk in line with end of shift arrangements.

10.13. The dispatcher must ensure if a resource is utilised in another dispatcher desk from their home dispatch desk the resource changes talk groups.

10.14. Back up requests are to be reviewed inline with the surge management plan.

10.15. When a crew request a clinical call back using the Emergency Crew Advice Line (ECAL), the RD must document the following information on the clinical yellow T-Card located on the rear of the dispatch board:

- ECAL time.
- The paper reference & dispatch desk of the original incident.
- The crew's call sign and an on scene call back telephone number documented in the "notes" section.

11. Response Desk Coordinator (RDC) Actions

11.1. If the RDC is appropriately trained, they must collect the printed T-Cards from the fallback guardian laptop and distribute to the appropriate RD.

11.2. RDCs must contact Community First Responders (CFRs) that are either en route to or on scene at an incident and advise them of the CAD outage. CFRs en route to an incident must be stood down immediately. CFRs on scene must stand down as soon as is safe and practicable.

11.3. The RDC must ensure that RDs are aware that a CFR is on scene where appropriate.

11.4. The RDC must inform the Community Resilience On Call of the CAD outage and that the RDC desk is now suspended.

11.5. If appropriately trained, the RDC should relocate to a desk with an ICCS terminal to monitor the below talk groups to receive incoming incidents from other Ambulance Services, Police and Fire & Rescue.

- Channel 69 – National Hailing
- Channel 343 – SECAmb Hailing
- Channel 344 – SECAmb Sharers
- Channel 351 – SECAmb Interagency
- Channel 650 – Kent Police Interoperability
- Channel 772 – Surrey Police Interoperability
- Channel 778 – Sussex Police Interoperability

11.6. The RDC must stand down all other CFRs via telephone.

11.7. If there are any CFRs local to East or West EOC, in conjunction with the EOCM, the RDC can consider asking them to attend EOC to assist with functional roles such as Runner or staff welfare.

12. Specialist Resourcing

12.1. All specialist resources are to return to the domestic dispatch desk.

12.2. RDs will be responsible for all tasking of specialist resources to incidents with support from the Critical Care Desk (CCD) and HART Tasking Desk (HTD).

12.3. It is the responsibility of the CCD to ensure that there is a Critical Care Desk operating in each EOC as soon as practicable after the CAD outage is identified.

12.4. Any Paramedic Practitioners (PP) working in a PP hub or out of plan must return to front line duties and are no longer out of plan.

12.5. If a resource is provided with advice via channel 16, the CCD must document the advice provided on a yellow clinical T-Card and ensure that it is given to the RD and stapled to the corresponding white 999 T-Card.

12.6. The Helicopter Emergency Medicals Service (HEMS) desk will continue to operate out of EOC and will liaise with domestic RDs for appropriate incidents to task to.

13. Clinical Safety Navigator

13.1. The duty Clinical Safety Navigator (CSN) must ensure the on call 999/111 Clinical Tactical On call (Operations Manager Clinical - OMC) is notified of the outage at the earliest opportunity.

13.2. All remote working clinicians must be recalled to the nearest EOC to assist with the onsite clinical functions. Responsibility for the recall of staff will be agreed between the CSN and OMC.

13.3. The CSN should ensure there is a designated clinical team leader within each EOC. This will be a CSN in the first instance however can be an appropriately trained clinician in the absence of a CSN.

13.4. The clinical team leader must ensure the Clinical Support Desk (CSD) list is printed from the fallback guardian, and all information within the call list transferred to T-cards.

13.5. Calls that were within the CSD when the outage commenced must be split between the clinical teams within both EOCs to ensure all calls are completed as appropriate.

13.6. Staff must be assigned to the required clinical functions in both EOC's as demand across those functions requires – this remains the responsibility of the clinical team leader on each site, who will be responsible for prioritising calls within the CSD as they appear.

13.7. The duty CSN will be required to provide the update of demands within the clinical lists across both sites on any surge or critical incident calls.

14. Clinical Team Leader

14.1. The clinical team leader must 'don' the clinical team leader tabard.

14.2. The clinical team leader must ensure clinical staff are assigned clinical lists to work from according to the demand at the time.

14.3. The clinical team leader at both EOCs are responsible for ensuring any calls passed to the clinical team are reviewed and prioritised as appropriate and aligned with one of the clinical lists for staff to work from.

14.4. At regular intervals (suggested every 30-minutes) the clinical team leader is required to review all cases awaiting dispatch within their EOC for any calls deemed suitable for clinical input. This may be calls that may be suitable for an enhanced clinical assessment, suicide / overdose calls, fallers or those patients who would benefit from a welfare contact.

14.5. Any call that is within a dispatch desk list that is deemed suitable for clinical contact, must have the clinical T-card completed and added to the clinical list for clinical input.

14.6. Any 999 T card removed from the dispatch board must have the top copies of both the clinical and 999 T card stapled and remain with dispatch and the bottom copies stapled and taken to the Clinical board for review and actioned as appropriate.

14.7. In the event any of these cases being downgraded to a hear and treat disposition, the clinical team leader must ensure the appropriate dispatch desk is updated of the non-attendance required, and the T-card removed from their list.

14.8. Any case that is upgraded following the clinical review, the clinical team leader must ensure the appropriate dispatch desk is updated immediately and the original T-card updated as required.

14.9. Clinical team leaders across both sites must ensure they remain in contact for support with demand as required for the duration of the outage.

14.10. Any areas of concern within an EOC must be escalated immediately to the on-call OMC.

15. Major Incident

15.1. There is a major incident board in each EOC. The major incident board can be utilised should a major incident be declared which requires multiple resources.

15.2. The major incident board will be managed by a dispatcher or DTL and will assume the role of incident dispatcher.

15.3. Any resources utilised for the major incident must be shown out of service by the domestic resource dispatcher and a duplicate call sign T-Card written by the incident dispatcher.

15.4. It is the responsibility of the incident dispatcher to ensure the resources are returned to their home dispatch desk following completion of their involvement in the tasking.

16. Gate Keeper

16.1. The Gate Keeper must monitor talk group channel 69 at the start of the CAD failure to receive any incidents being passed from other Ambulance Services. This role would normally be allocated at start of shift to a meal break dispatcher. Once the T-Cards from the fallback guardian laptop have been disseminated, they must then assume their Gate Keeping role.

16.2. The Gate Keeper must locate themselves between the call handling and dispatch function.

16.3. The Gate Keeper must remain alert to the 'runners' bringing T-Cards from EMAs and must check them for the minimum dataset using the template provided:

- Date
- EMA Name
- Phone Extension
- Time of call (In 24-hour clock format)
- Is the patient breathing & conscious
- Reason for the call
- Callers contact number
- Address, including the postcode
- Time of disposition (In 24-hour cock format)
- Disposition written in full if hear and treat

16.4. If the minimum dataset has not been met, the T-Card must be returned to the EMA that took the call to be updated.

16.5. Once the Gate Keeper is satisfied that the T-Card is complete, if the call is an ambulance disposition, they must hand it to the Dispatch Runner who will take the T-Card to the relevant RD.

16.6. Once the Gate Keeper is satisfied that the T-Card is complete, if the call is an ambulance disposition but is out of area they must hand it to the original runner who will take the T-Card to the out of area (OOA) desk

16.7. Once satisfied the T-Card is complete, if the call is a 'hear and treat' disposition, the T-Card must be given back to the original runner and taken to the Clinical Team Leader.

17. Runners

17.1. Runners must don a 'runner' tabard.

17.2. There are two types of 'runners'; dispatch and EMA.

17.3. The EMA runner must locate themselves within the vicinity of EMAs to retrieve completed T-Cards from them and ensure that they have documented the minimum dataset and that the handwriting is legible.

17.4. EMA runners must prioritise Category 1 calls which will be identifiable via the purple laminate cards held in the air by the EMA.

17.5. If the T-Card is completed correctly, start walking towards the Gate Keeper who will be wearing an orange tabard with “Gate Keeper” on their chest and back.

17.6. Once the Gate Keeper confirms the T-card is completed correctly, the EMA runner must either return to the vicinity of EMAs, ready to receive the next T-card or relay the current T-card to relevant onward desk (CSN, out of area, East or West EOC).

17.7. The dispatch runner must position themselves next to the Gate Keeper and be ready to take completed T-Cards to the respective Resource Dispatcher.

18. Emergency Medical Advisor Team Leader (EMATL) (Lead)

18.1. EMATLs must ensure Emergency Medical Advisors (EMA) have access to paper working packs and are using the correct version of NHS Pathways Solo.

18.2. EMATLs must review how staff being mentored can be utilised. The EMATLs should avoid using mentees for other roles where possible.

18.3. EMATLs must assign two members of staff to pass incidents between the two EOCs – 1 person to receive calls and 1 person to pass calls at each EOC.

18.4. EMATLs must assign someone to pass out of area calls to the receiving ambulance Trust and assist with setting up the “passing board”.

18.5. EMATLs must assign an appropriate number of runners to ensure that completed T-Cards are swiftly collected from EMAs and brought to the Gate Keeper.

18.6. EMATLs must set up and disseminate the out of area (OOA) board to handle the passing of calls outside of the respective EOCs.

18.7. EMATLs must set up the EMA break boards and to write out T-Cards for each staff member.

18.8. EMATLs must continue to answer inline support calls and floor walk to provide EMAs with the necessary support.

18.9. Emergency Medical Advisors (EMA)

18.10. Ensure NHS Pathways Solo is open and using the current version.

18.11. Open up Paper Working Pack provided by the EMATL and follow the action card accordingly.

18.12. Ensure all T-Cards are filled out correctly and that handwritten information is legible (capital letters should be used).

18.13. EMAs must ensure that they document the following information as a minimum:

- Date
- EMA Name
- Phone Extension
- Time of call
- Is the patient breathing & conscious
- Reason for the call
- Callers contact number
- Address, including the postcode
- Time of disposition
- Disposition written in full if hear and treat

18.14. Unless otherwise stated within this procedure, EMAs must follow the normal call handling process inline with the call handling procedure.

19. EOC Clinical Function

19.1. Any remote working clinicians (including agile, homeworking and hub) must be recalled to the nearest EOC.

19.2. Clinicians will be assigned by the on-site clinical team leader to support individual lists of calls within the clinical list.

19.3. Clinicians must ensure NHS Pathways Solo is open and displaying the current version. Solo must be amended to either 999 Clinician or PaCCS as appropriate and must be used for all remote patient assessments.

19.4. Clinical T-cards must be used to document any contact with patients and the outcomes of any assessments. All information recorded must be legible (capital letters should be used).

19.5. When managing an incident that is currently awaiting an ambulance dispatch, if the case is retriaged to a hear and treat disposition or a higher category of response, the clinician must ensure they escalate the case immediately to the clinical team leader who will advise the RD of the update.

19.6. Only the clinical team leader should be reviewing calls within the dispatch lists and utilising the clinical T-cards to move cases to the clinical team for review.

19.7. When taking a 999 T card from the dispatch board, the clinical team leader must leave the top copy of the clinical and 999 T card and staple together and take the bottom copy of the clinical and 999 T card, again these should be stapled together, to prevent T cards from getting lost or mixed up with other T cards.

19.8. Any concerns must be escalated to the on-site clinical team leader.

20. Category 1 calls

20.1. When taking a Category 1 (C1) call, upon taking the minimum data set, the EMA must hold up the top copy of the T-Card along with the C1 card for a Runner to collect. The bottom copy is not held up until the end of the call. All other category of calls should be triaged fully before the T-Card is held up for collection.

21. Hear and Treat

21.1. Upon reaching a hear and treat disposition, EMAs must give the disposition as presented within NHS Pathways. The disposition must be written in full in the notes Section of the T-Card (not solely DX codes).

21.2. Hear and treat T-cards must be passed to the Clinical Team Leader for review and action as appropriate, including prioritising cases that require passing to an out of hours provider.

If a hear and treat disposition is reached during ‘in-hours’ (08:00-18:30 Monday to Friday), the EMA must advise the caller that they need to contact their own GP or make their own way to hospital. The EMA must document how the caller or patient are meeting the disposition in the notes section of the T-Card.#

21.3. When reaching a hear and treat disposition during the ‘out-of-hours' period (18:30-08:00 Monday to Friday, all day Saturday, Sunday and bank holidays), EMAs must give the disposition as follows:

- Emergency Treatment Centre & Emergency Department dispositions – Deliver as normal
- Speak to clinician (immediate, 60 minutes, 120 minutes and home management advice – Deliver as normal).
- For any speak to or contact GP dispositions – The EMA must advise the patient/caller that a clinician will call them back.

21.4. If a call requires contact with a GP within the out of hours period, the clinician must ensure a Digital Admin Slip (DAS) is raised for the case, and the patient contacted to advise when the GP will be in contact.

22. What 3 Words (W3W)

22.1. During a CAD outage, the ability to send SMS ‘what 3 words’ to callers will not be available. EMAs can ask the EMATL for assistance as they will have access to the W3W app.

23. Operations & Support Services

23.1. All operational resources must refer to the “CAD Outage - Operational Staff” aide memoir when notified of a CAD outage.

23.2. All on duty admin Operational Team Leaders (OTL) and Response Capable Managers (RCMs) must contact EOC via the resource dispatchers.

23.3. The Ops Tactical Commanders must liaise with the 999/111 Operations Tactical Commander to decide on appropriate deployment of roles to support operations during the CAD outage such as hospital ambulance liaison officer (HALO) or clinical response.

23.4. All operational resources must document the information passed to them by their RD. This will include the paper reference which will consist of one letter and five numbers, eg. A12345

23.5. All operational resources must verbally update their status' in real time via Airwave (mobile, arrive scene, left scene, at hospital, handover and clear) including signing on and off. Where possible, crews should still update their status' through the Mobile Data Terminal (MDT) in addition to verbal confirmation.

23.6. All operational resources must continue to use electronic patient clinical record (ePCR) unless directed by the Strategic Commander, under advice from Critical Systems.

23.7. 999/111 Operations Tactical in partnership with the OMC will coordinate the deployment of other support services to assist within EOC.

24. Transitioning back to Live CAD

24.1. Due to complex situations following an outage, the decision and plan to transition back to live CAD will come from critical systems and IT incident manager.

24.2. Resource dispatchers to show resources who are currently assigned to a paper incident as 'OOS – Paperworking'.

25. Inputting Live Retrospective Incidents

25.1. Only those that have been trained to input live retrospective (retro) incidents on CAD will be granted access to do so by Critical Systems. These members of staff will be identified and designated the live retro input role by the EOCM.

25.2. Only incidents that have not had a resource assigned to it at any point can be entered onto the CAD as a live retro. Live Retro's will only be added to the Cad in the EOC environment.

25.3. Once given the go-ahead by Critical Systems, those nominated to input live retros will start to input unassigned Category 2 (C2) calls in time order. Once all C2 calls for all desks have been inputted, Category 3 (C3) calls will then follow the same process, as will Category 4 (C4) and timed Health Care Professional (HCP) calls.

25.4. Once an incident has been created on CAD, the CAD incident number (which is 8 digits long) needs to be documented on the 999 T-Card along with the name and initials of the person entering the incident on CAD.

25.5. Once all live retro calls have been inputted, the T-Cards must be given to the DTL to review Cad/T card to ensure data accuracy and place with the

completed T cards in the relevant envelope. The DTL will then pass the T Cards to the EOCM who will file them away securely.

26. Inputting Retrospective Incidents

26.1. Only those that have been trained to input retrospective (retro) incidents on CAD will be granted access to do so by Critical Systems.

26.2. The inputting of T-Cards will only take place at an EOC location or restricted areas of the HQ. T Cards are not permitted to be taken home and completed off site.

26.3. Those inputting retro incidents on CAD must refer to the “Creating Retrospective Incidents Guide” to ensure they are completing them accurately.

26.4. Once an incident has been created on CAD, the CAD incident number (which is 8 digits long) needs to be documented on the T-Card along with the name and initials of the person entering the incident on CAD.

26.5. After inputting the retro T-cards, the CAD reference number and T-Cards reference must be documented on a copy of the “Master Spreadsheet” located on MS Teams for Health Records.

26.6. The retro CAD reference must be the eight-digit number and the T-Cards reference will be one letter followed by five numbers.

26.7. After each shift of entering retrospective incidents, the spreadsheet mentioned will be managed by the functional EOCM lead for retrospective incidents.

26.8. The Informatics team complete data validation checks and any incident entered with incorrect data retrospectively will be captured and fed back to the individual and recorded either on the T card or Cad incident number.

27. Emergency Crew Advice LIne (ECAL)

27.1. In order to support shared decision making for operational colleagues via the ECAL process, a Paramedic Practitioner (PP) will be required to attend each EOC. The 999/111 Clinical Tactical on call will liaise with the Operational Tactical for East and West and arrange for a PP to relocate to each EOC.

27.2. For any incident where an operational colleague is requesting shared decision making, the RD must ensure a clinical T-card is completed for the incident and given to the clinical team leader for actioning.

27.3. In the event the PP has not yet arrived at the EOC, the clinical team leader must ensure a clinician is assigned to support.

28. Overdose / Suicide Review Process

28.1. During an outage the current overdose / suicide review process will not be operating due to the reliance on the CAD to operate.

28.2. The Clinical Team Leader will ensure they review all cases that may potentially be an overdose or mention suicidal ideation each time they review the dispatch lists.

28.3. Any cases identified must be risk assessed and either prioritised for clinical call back or upgraded as appropriate by the Clinical Team Leader.

29. Category 3 (C3) & Category 4 (C4) Validation Process

29.1. During a CAD outage, the category 3 & 4 validation process will be switched off due to the reduced clinical capacity of the team.

29.2. If an EMA reaches a C3 or C4 disposition during their triage, they must ensure they deliver the disposition as normal.

29.3. All C3 & C4 calls will be passed to the appropriate RD following the gate-keeper review.

29.4. The Clinical Team Leader on site at both EOCs will ensure they review all C3 and C4 calls within all dispatch lists for appropriate calls that would benefit from an enhanced clinical assessment and manage as appropriate.

30. Restocking

30.1. It is the responsibility of the DTLs and EMATLs to ensure that a restock takes place of the dispatch boards and EMA packs after a CAD outage.

30.2. A restock must be completed as soon as practicably possible after the migration back to CAD.

30.3. Those undertaking the restock must use the load lists stored in the EMATL and DTL packs. This will ensure that there is the correct level of stock available should a subsequent CAD outage be experienced.

31. Reordering

31.1. It is the responsibility of the Operating Unit Manager for Dispatch to order products from T-Cards direct & approved suppliers for consumables such as pens and staplers. In the event the OUM is unavailable this task will be delegated to the EOC Administration Team.

31.2. For business continuity purposes, this stock must not drop below 20,000 cards which will allow for approximately 10 outage days. This will be monitored and managed by the OUM.

32. Responsibilities

32.1. The Chief Executive Officer is the overarching Executive Lead for the Trust.

32.2. The Executive Director of Operations is responsible for implementation of the procedure.

32.3. The Operating Unit Manager (OUM) for each EOC is responsible for the day-to-day implementation of the procedure.

32.4. The Executive Medical Director is responsible for Clinical Governance within the Trust.

32.5. All staff are responsible for compliance with the procedure with daily monitoring provided by the Emergency Operations Centre Manager (EOCM), Dispatch Team Leader (DTL), Resource Dispatcher (RD) Emergency Medical Advisor Team Leader (EMATL), Clinical Supervisor (CS), Clinical Safety Navigator (CSN) and the Operations Manager Clinical (OMC).

32.6. Head of Integrated Care Training & Development is responsible for overseeing the governance of clinical components of the NHSP and for the audit and quality assurance of calls.

32.7. The Operations Managers Clinical are responsible for ensuring implementation and adherence to relevant standards and overseeing clinical safety, through devolved responsibilities to the Clinical Supervisors across the Trust.

32.8. All employees are responsible for adhering to this procedure.

33. Education and Training

33.1. All existing staff using the previous version of the paper working process have attended an 8 hour key skills day dedicated to the implementation and training of the new paper working process.

33.2. All new RDs, EMAs and clinicians will be taught how to use the new paper working process during their initial training course.

33.3. NHS 111 – Taking a triaged emergency call on paper

33.4. All HA's will be trained how to receive a 999 call from other Ambulance Trusts and other agencies on a 999 T card. This will enable all EMAs to staff the 999 lines.

33.5. There will be annual refresher training for all EOC staff during key skills.

34. Audit and Review

34.1. Compliance with the procedure is monitored through the 111/999 Quality Governance Group (QGG)

34.2. This procedure will be reviewed every three years or sooner if new legislation, codes of practice or national standards are introduced.

34.3. All procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

34.4. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

34.5. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

34.6. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.

35. Associated Trust Documentation

35.1. This is a new procedure as there was not one in place for paper working.

36. Financial Checkpoint

36.1. This document has been confirmed by Finance to have no unbudgeted financial implications.

37. Equality Analysis

The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.