South East Coast Ambulance Service NHS
NHS Foundation Trust

Emergency Crew Advice Line (ECAL) Procedure

Contents

1 Scope

1.1. Joint decision-making is the most effective way to reduce clinical risk. It is an essential tool when a clinician is deciding on the appropriate outcome for their patient, supporting care, avoiding unnecessary admissions and promoting appropriate referrals.

1.2. This is an update to the 'Clinical Call Back Procedure' and this procedure is now renamed 'Emergency Crew Advice Line (ECAL) procedure.

1.3. This procedure describes the process for front-line operational ambulance clinicians (when on-scene with a patient) to request and receive a call-back from another clinician via the Emergency Crew Advice Line (ECAL) functionality within the Computer Aided Dispatch (CAD) system.

1.4. This procedure does not relate to any processes surrounding the undertaking of 'clinical call-backs' to patients.

1.5. This procedure does not relate to the process of on-scene ambulance clinicians accessing clinical support or joint decision making from the Critical Care Desk (CCD) in the Emergency Operations Centre (EOC).

1.6. This procedure will ensure that on-scene ambulance clinicians receive a call-back in a timely manner, from multidisciplinary clinicians across the Trust's network of Emergency Operations Centres and Urgent Care Hubs.

1.7. Clinical call-backs may be for joint decision making, assistance with accessing appropriate referral pathways or supported discharge. This procedure should be used in conjunction with the Scope of Practice and Clinical Standards Policy, and the Referral, Discharge and Conveyance Policy.

2 Procedure

Please see Appendix A for Standard Operating Procedure flowchart

2.1. **On-scene clinician – requesting an ECAL call-back**

2.1.1. Ambulance clinician on-scene contacts their Resource Dispatcher (RD) in EOC via airwave radio and asks for a clinician call-back.

2.1.2. Clinician advises RD of the following information:

- Who they would like a call-back from – i.e. what grade/type of clinician
- The urgency of the call-back
- A brief description of the nature/reason for the call-back
- An appropriate phone number for the call-back

2.1.3. The Trust utilise a variety of multidisciplinary clinicians to complete call-backs via ECAL, which may include:

- Paramedic Practitioners
- Clinical Supervisors (Nurses and Paramedics)
- Operational Team Leaders
- Midwives
- Mental Health Practitioners

2.1.4. The above list is not exhaustive and the range of clinicians utilising ECAL is subject to change.

2.1.5. For some grades/types of clinician (e.g. Paramedic Practitioner and Midwife) there will be the option of requesting an 'urgent' call-back, which will present a shorter call-back target timeframe. For other grades/types of clinician, there will be a single 'routine' call-back option.

2.1.6. Urgent call-backs should be requested sparingly and reserved for situations where there is a need to access rapid clinical support for a patient with the potential to deteriorate quickly – for example a dying patient who requires symptom control.

2.1.7. ECAL should not be used to access clinical support or joint decision making for critically unwell patients. For these situations, the Critical Care Desk (CCD) in EOC should be contacted via airwave or contacting directly.

2.2. **EOC Resource Dispatcher (RD) – creating an ECAL request.**

2.2.1. Upon receiving a request from an on-scene ambulance clinician for a call-back, the RD will:

- Locate and open the relevant incident on CAD
- Select the 'ECAL' tab and click the 'ECAL Requested' tick box
- Choose the relevant 'ECAL Response Level' from the drop-down list to identify the appropriate call-back type/urgency
- Enter the call-back number as provided by the on-scene ambulance clinician into the 'Notes' section
- Click 'Save ECAL'

2.2.2. Once saved, the RD should check that the call-back request is showing within the ECAL section of the Clinical Support Desk (CSD) stack.

2.3. **Clinicians undertaking call-backs via ECAL**

2.3.1. Paramedic Practitioners are specialists across urgent and emergency care, therefore will be the primary/default provider of call-back support through ECAL, unless another specific clinical grade/type of clinician (e.g. Midwife or Mental Health Practitioner) has been requested.

2.3.2. Conversely, if a call-back has been requested by a specific clinical grade/type of clinician (e.g. Midwife or Mental Health Practitioner) which cannot be completed within a timely manner (e.g. due to staffing/demands) then a

Paramedic Practitioner or other suitable clinician should undertake the call-back instead.

2.3.3. Clinical Supervisors (Nurses and Paramedics) within the EOC have a primary focus on the calling-back and remote assessment of patients, therefore will only be used for ECAL as a mitigating action, when demand vs. capacity results in severe delays in ambulance clinicians receiving call-backs.

2.3.4. Clinicians undertaking call-backs will:

- Monitor the ECAL section of the Clinical Support Desk (CSD) stack and open the next call-back request, in order of urgency and grade/type

- Review information written within Call Notes, Crew Notes and ECAL Clinical Notes tabs to establish whether they are the most appropriate clinician to undertake the call-back. Where relevant, they may also open the NHS Pathways 'Summary' to review the primary triage assessment and any notes contained within. If the clinician feels that an alternative clinician would be more appropriate to deal with that case, once confirmed that the alternative clinician is available, they must enter notes to explain their rationale and highlight the incident directly to the most appropriate clinician to ensure they take ownership for completing the call-back.

- Undertake a call-back to the on-scene ambulance clinician using the phone number entered by the RD. Call-backs must be completed through Avaya (desk-top phone in EOC/contact centre or cloud-based solution within an Urgent Care Hub) to ensure the conversation is recorded.

2.3.5. The structure of the call-back and clinical support provided should cover the five areas outlined within the Crew Call Back Audit (see Appendix C):

- Information gathering
- Clinical decision making
- Engagement with crew
- Use of system, polices and procedures, to support and meet patient needs
- Supported appropriate patient outcome

2.3.6. During the call-back, relevant notes should be entered under the ECAL tab within the incident to support and reflect the peer-to-peer discussion. Clinical notes may include, where relevant (but not exclusively):

- Presenting complaint

- History of presenting complaint

- Review of systems

- Examination

- Observations
- Past medical history
- Drug history / medications
- Allergies
- Social history
- Treatment provided
- Plan and outcome

2.3.7. The rationale for any joint decisions should be documented.

2.3.8 Worsening care advice and safety netting plans should be documented.

2.3.9. If the clinician utilises any Trust-approved Video Consultation functionality (such as FaceTime or GoodSam), the phone line must remain connected, to ensure that conversations continue to be recorded through Avaya.

2.3.10. At the end of the call-back the clinician should have their notes by clicking 'Save ECAL' and then tick the 'ECAL completed' box. This will remove the incident from the ECAL list.

2.3.11. Clinicians must not use third party applications outside of the Microsoft suite to complete documentation then 'copy and paste' into the incident.

2.3.12. The only apps that can be used for assisting with clinical documentation is Microsoft Notepad or Word. **These must not be saved** in those programmes but should be copied and pasted into the ECAL Clinical Notes section. It is preferable that notes should be typed directly into the ECAL Clinical Notes section.

2.3.13. Paramedic Practitioners may, when undertaking call-backs, generate a 'PP Referral' if an appropriate PP resource is available. This will commonly be for the subsequent attendance of an 'Out Of Plan' PP working on a Single Response Vehicle (SRV), however could be a PP working on a Double Crewed Ambulance (DCA) where there is prior agreement from an RD or Dispatch Team Leader (DTL).

2.3.14. All clinicians are responsible for monitoring the volume of call-back requests within ECAL and escalating any significant delays, if not already identified, to the duty Clinical Safety Navigator (CSN) in EOC. Escalation triggers are as follows:

Parameter	**Actions**

Number of total unallocated ECALs exceeds **double** the number of clinicians undertaking call-backs, irrespective of time outstanding (e.g. 7 unallocated incidents vs. 3 clinicians undertaking call-backs) Or, any single unallocated ECAL breaching its target call-back timeframe by **double** (e.g. an urgent 15-minute call-back outstanding for 30 minutes)	Clinical Safety Navigator to review acuity of patient presentations within ECAL, considering likely impact upon individual and wider patient safety caused by expected delays. CSN to review clinical staffing and allocation of activities. Consideration to request short-term support from alternative clinicians (e.g. a Clinical Supervisor or appropriate on-shift clinical manager) Consideration to request short-term support from a front-line operational PP (i.e. on an SRV/DCA) and/or an Operational Team Leader (OTL)
Number of total unallocated ECALs exceeds **triple** the number of clinicians undertaking call-backs, irrespective of time outstanding (e.g. 10 unallocated incidents vs. 3 clinicians undertaking call-backs) Or, any single unallocated ECAL breaching its target call-back timeframe by **triple** (e.g. an urgent 15-minute call-back outstanding for 45 minutes)	CSN to escalate to on-call Operations Manager Clinical (OMC). OMC and CSN to review clinical staffing and allocation of activities. Consideration to redeploy alternative clinicians (e.g. Clinical Supervisors) to support ECAL, back-filling EOC clinical activities with clinicians from the KMS 111 service. OMC to liaise with relevant on-duty/on-call Tactical Commanders to consider redeployment of front-line operational PPs (i.e. on an SRV/DCA) into an Urgent Care Hub or EOC. Consideration to utilise Operational Team Leaders to support ECAL.
Number of total unallocated ECALs exceeds **quadruple** the number of clinicians undertaking call-backs, irrespective of time outstanding (e.g. 12 unallocated incidents vs. 3 clinicians undertaking call-backs) Or, any single unallocated ECAL breaching its target call-back	On-call OMC escalates to on-call Strategic Commander.

timeframe by **quadruple** (e.g. an urgent 15-minute call-back outstanding for 60 minutes)	

2.4. **Clinical Safety Navigator (CSN)**

2.4.1. The duty Clinical Safety Navigator in EOC will provide oversight and coordination of activities relating to ECAL. They will also be the first point-of-contact for escalation of issues relating to ECAL.

2.4.2. Following the above escalation plan, the CSN can consider requesting assistance from operational Paramedic Practitioners (**PPs or Student PPs in year 2 or 3 trained in CAD**), in the first instance, or Operational Team Leaders (OTLs) to provide support at times when demand upon ECAL exceeds staffing capacity to complete clinical call-backs within a reasonable timeframe.

2.4.3. The decision to consider utilisation of operational PPs and/or OTLs should be made by the duty CSN only, as they have oversight and responsibility for regional EOC/999 clinical activity/operations. If felt required, the CSN should escalate to the on-call Operations Manager Clinical, to support review of clinical activities and consider short-term utilisation of alternative EOC/111 clinicians for support. If the on-call OMC agrees that operational PPs and/or OTLs should be used, they will liaise with relevant on-duty/on-call Tactical Commanders (field operations) to plan redeployment of front-line operational PPs (i.e. on an SRV/DCA) and/or OTLs into an Urgent Care Hub or EOC.

2.4.4. If contingencies are implemented, the CSN will liaise with relevant Dispatch Team Leaders (DTLs) and Resource Dispatchers (RDs) to inform them that their operational PPs/OTLs are to be used for call-backs. The RD will show specific identified PPs/OTLs as 'out of service' (available for C1 calls only) on the CAD. The CSN will review regularly and inform DTLs/RDs when call-back responsibility is returning to standard processes.

2.4.5. In situations where a PP/OTL is being used who is not situated within an Urgent Care Hub (or is not CAD trained to see the ECAL stack), the CSN will be responsible for liaising directly with the PP/OTL and organising a point of contact to take ownership for forwarding the details of call-backs, which require completion, and processing accordingly on CAD/ECAL.

2.5. **Operational PP or Operational Team Leader (OTL) – during times of escalation**

2.5.1. During times of escalation where operational PPs/OTLs are being used for support, they will complete individual call-backs using a Trust phone via the Avaya telephony recording system. See Appendix B**.** The PP/OTL will provide joint

clinical decision making to support the on-scene clinician in the safe referral/discharge/conveyance of the patient, as per the Scope of Practice Policy.

2.5.2. If the PP or OTL is booked onto a vehicle, they should request their status is changed to 'Out of Service – Unavailable' for the duration of the call back, to ensure they do not get allocated to any calls.

2.5.3. Calls should be made via Avaya telephony if available so that the call is recorded.

2.5.4. Should Avaya telephone not be available, crews should utilise the telephony function of Airwaves, as described in Appendix B. This is a recorded line.

2.5.5. In the first instance, if available and trained to do so, the PP/OTL should use live Cleric CAD (within an EOC or UCH) to add clinical notes into the incident, within the 'ECAL' tab.

2.5.6. If live Cleric CAD is not available (or if the PP/OTL is not trained to use), then CAD Online should be used to add clinical notes into the incident, within the 'Call Notes' section.

2.5.7. If neither live Cleric CAD or CAD Online is available/appropriate, the clinical notes should be documented on a paper Patient Clinical Record (PCR) continuation form, using the correct incident/daily ID number and the PP/OTL call sign.

2.5.8. The RD/CSN should be updated by the operational/hub PP or OTL once they have completed the call-back. If required, the CSN (or nominated point of contact) will process the ECAL within CAD on behalf of the PP/OTL.

2.5.9. If an operational/hub PP agrees with the on-scene clinician to generate a PP Referral, they must contact their Resource Dispatcher and request the incident is converted into to a PP Referral, within a 2 hour or 4 hour timeframe In times of Surge Management Plan (SMP) level 3 or 4, PP Referrals may not be routinely booked, however this can be discussed with the duty Clinical Safety Navigator to support a balanced decision of risk.

2.6. **EOC Resource Dispatcher (RD) – allocating an operational PP or OTL**

2.6.1 When the duty Clinical Safety Navigator requests an operational PP/OTL to be assigned to a call-back, the most appropriately located PP/OTL should be allocated, such as from an OU where current demand is lower.

2.6.2 If an operational PP, following a clinical call-back, would like to generate a PP Referral, and there is suitable availability of PPs, the RD must downgrade the incident on CAD to a PP Referral within a 2 hour or 4-hour timeframe.

3. Definitions

3.1. Datix is the Trust's incident management system. There are also modules within Datix for safeguarding, risks and frequent caller management.

4. Responsibilities

4.1. The **Chief Executive Officer** is accountable for patient safety.

4.2. The **Medical Director** has responsibility for clinical practice in the Trust.

4.3. The **Consultant Paramedics** are responsible for managing and developing the procedure, and for the monitoring and auditing process through the Professional Practice and Clinical Pathways Group.

4.4. **All employees** are responsible for adhering to this procedure.

5. Audit and Review (evaluating effectiveness)

5.1. Incidents generating clinical call-backs will be monitored using data collection. This will be collated into a quarterly report by the **Quality Assurance Officer** and presented to the Professional Practice Working Group.

5.2. Calls will be randomly audited using the clinical call-back audit tool (see Appendix C). The audit results will be fed back to the relevant clinicians.

5.3. Any incident requiring investigation should be reported via a Datix Incident Form (DIF-1).

5.4. This procedure's effectiveness will be audited by the Professional Practice Group (PPG).

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

5.6. 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).

5.7. 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.

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

6. Associated Trust Documentation

6.1 Mobile Device Policy.

6.2 Information Governance Policy

6.3 Data Protection Policy

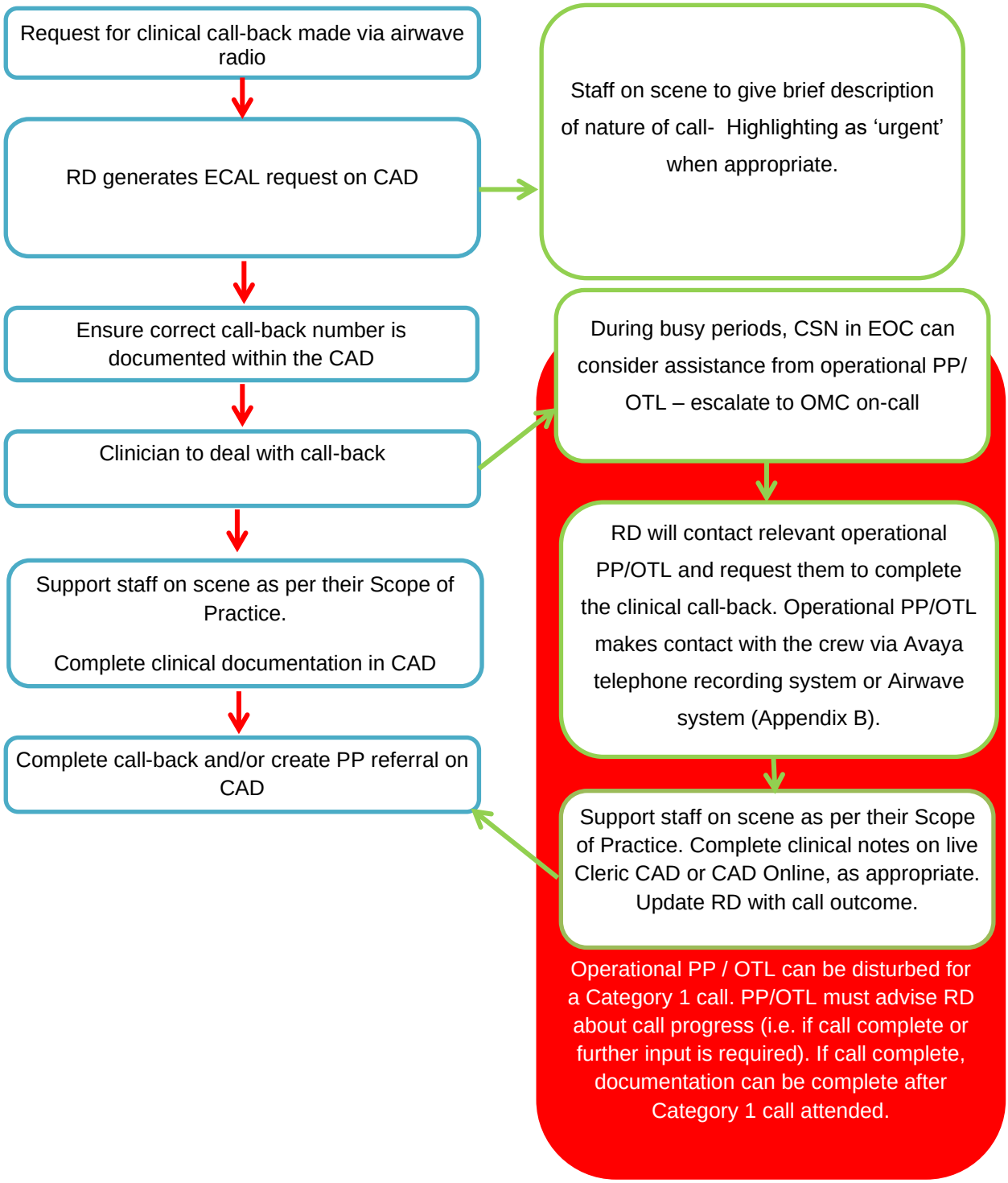
6.4 Scope of Practice and Clinical Standards Policy

6.5 Records Management Policy

6.6	Referral, Discharge and Conveyance Policy
6.7	Referrals Procedure
6.8	Discharge Procedure
6.9	Surge Management Plan
6.10	Urgent Care Hub Toolkit
6.11	PP Deployment Procedure
6.12	Community Falls Team Model of Care

Appendix A

Clinical Advice Queue procedure flow chart



Appendix B - Recorded Phone Calls Via Airwaves

PP hubs and EOCs

To call a crew on their handset, dial 01293 221 019 using AVAYA where possible, then enter just the digits of the crews call sign. If the numbers entered only matches one call sign, it will ring through to the crews handset(s). However, if the number matches multiple call signs, you will be given the option of which one you wish to dial. E.g. if you entered 003, you would be given the options of:

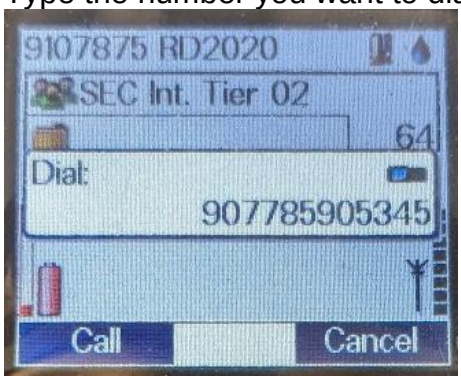
- T003
- TA003
- OC003
- IPC003
- P003
- SC003
- TEC003
- TC003

Once you have chosen your option, please be patient. The system will play hold music whilst it attempts to connect your call. To do this, it will ring a particular handset and if they do not answer, it will ring the next handset associated with the vehicle. This will include base sets in the vehicle if they have them. There is no centrally held information to determine which radios are base sets and which are handsets, however as people answer calls, the system remembers which handsets have been used the most to receive calls and calls those first in future.

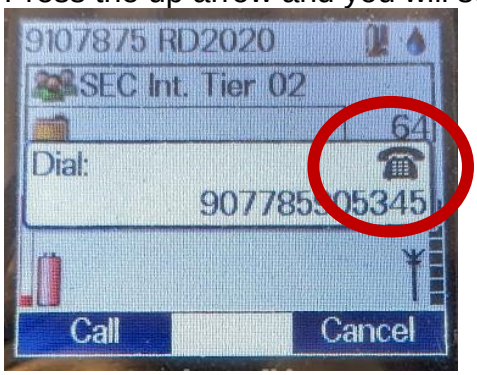
Frontline Crews with Airwaves Handsets
Dialling out

Starting with no menus open.

Type the number you want to dial, prefixed by a 9. E.g. 907785905345



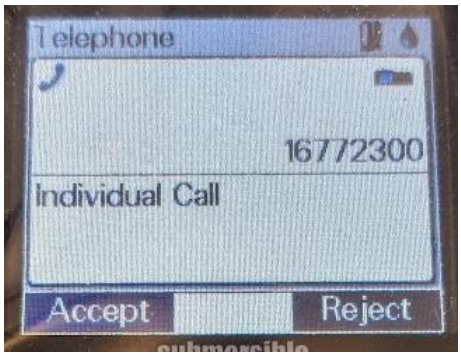
Press the up arrow and you will see a phone icon appear (as circled in red)



Select Call to begin the call, by pressing the top left button on the handset (nearest the Call text).

Receiving a call

The handset will make a ringing noise and vibrate. The display will show “Individual Call”



Press the top left button, nearest to the word “Accept” to answer the call.

The call will not immediately connect. Instead you will hear an option to “press 1 to accept the call”.

Press the 1 button.

The call will now be connected.

Appendix C – Crew Call Back Audit

South East Coast Ambulance Service NHS
NHS Foundation Trust

Crew Call Back Audit

Clinician Name		Dave Jones	FURTHER INFO	
Auditor Name				
Case Reference			Call Date	
Call Reference			SELECT ↓	Notes
Information Gathering	1	Clear Introduction. Introduces themselves in line with NHS ethos of "Hello my name is..." This includes introduction from the refering and the receiving clinicians		
	2	Confirmed patient details and appropriate demographics		
	3	Clearly records reason for call within Consultation screen (have reviewed pc/hpc and o/e here as forms basis of advice for pt outcome questioning here		
	4	Discussed Previous Medical History		
	5	Discussed Current Treatements and Medications & Allergies		
	6	Discussed Crew / On-Scene actions and Treatments. Ensured recommendations were within the SOP of the attending clinician		
	7	Review of advice relating to medication outside of crews scope of practice and ensured they fully understood advice		
Clinical Decision Making	8	Does the Agent utilise additional support for clinical decision making where appropriate (eg medicines complete, BNF etc)		
	9	Clincial Decision to idenify appropriate care utilising patient mangement strategies ie falls referral/diabetic referal informing gp if appropriate		
	10	Did the PP follow a systematic approach? Was there a logical progression throughout the call back? Appropriate follow up questions?		
Engagement with Crew	11	Telephone conversation flowed easily		
	12	The crew was listened to with dignity and respect		
	13	Questions answered appropriately - Did the agent answer questions using language that the on scene clinican understood		
Use of System, policies and procedures to support and meet patient needs	14	Call back completed in a timely manner		
	15	Call Completed appropriatley through system use (ECAL completed or delayed conveyance/pp referral with accurate notes added into CAD Patient Record as appropriate)		
	16	Local policies/guidance, Clinical call back and conveyance/referral, safeguarding procedures followed		
Supported appropriate patient outcome	17	Outcome agreed/negotiated with Patient / Carer / Crew		
	18	Patient/carer happy with outcome		
	19	Consideration to alternate pathways considered here and reasons documented if not appropriate		
		Overall Result	Save For Feedback	
TOTAL		**0%**		**Fail**

To pass the call must achieve a score of 86 or above

Key:

Full achievement: this means the indicator was demonstrated to a good/excellent standard or that the indicator did not apply to the circumstances of the call.

Partial achievement: this means the indicator was adequately demonstrated and that any issues identified in relation to this indicator did not affect the overall safety and/or quality of the call.

Not achieved: this means the indicator was not adequately demonstrated and the issues identified detracted from the overall safety and/or quality of the call.