South East Coast Ambulance Service NHS
NHS Foundation Trust

Emergency Operations Centre
Call Handling Procedure

Contents

1 Scope

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) is required to receive and manage requests for urgent or emergency assistance from a variety of sources, including 999 calls from members of the public, Health Care Professionals (HCP), other emergency services and partner agencies.

1.2. This procedure describes how the Trust will deal with all aspects relating to call handling in the Emergency Operations Centre (EOC), including local procedures to be used in specific situations.

1.3. The procedure details how all calls received will be managed throughout all stages of the call handling process, ensuring that each call is of a high quality, handled safely and appropriately, and reflective of the needs of the patients and communities we serve.

1.4. Calls that require triage will be processed through NHS Pathways (NHSP), a clinical decision support system (CDSS) which supports the remote assessment of callers to urgent and emergency services. It is used in a variety of settings, including NHS 111, 999 emergency operations centres, integrated urgent care clinical assessment services, NHS 111 online and to assist in the management of patients presenting to urgent care or emergency departments, through a product called Reception Point.

1.5. The NHS Pathways End User Licence sets out the responsibilities of the organisation in relation to the deployment and ongoing use of the NHS Pathways system. Please refer to the appropriate schedules as required.

1.6. Any elements of EOC call handling that relate to one of the NHS Pathways End User Licence schedules are out of scope and therefore not covered within this procedure.

1.7. This procedure will ensure all calls handled by the EOC are matched to a ‘disposition’ which will provide recommendation for the most appropriate clinical care, dependant on the needs of the individual patient in line with national and local performance standards.

1.8. The needs of patients will be considered at all times through this process, in the context of risk and patient safety issues, by providing a robust clinical, safeguarding and patient safety environment through a ‘continuous improvement’ approach.

1.9. This procedure does not include issues and activities relating to the dispatch of ambulance resources.

1.10. This procedure promotes safe delivery of ‘Hear and Treat’ dispositions, where patients are supported without the requirement for a face-to-face

'See and Treat' ambulance response. This ensures efficient use of ambulance resources to meet individual patient needs.

1.11. This procedure promotes consistent and standardised call handling processes across all Trust EOC sites.

1.12. For the purposes of this document, any reference to 'Call Handlers' is any non-clinical member of staff qualified to handle a call using NHSP, with the necessary competencies.

2 Procedure

3 Answering an Emergency Call and Initial Triage

3.1. Emergency calls routed from the BT operator will be answered by the next available Call Handler within EOC.

3.2. Enhanced Information Service for Emergency Calls (EISEC) or Caller Line Identification (CLI) enables emergency services to identify a caller's location swiftly. This is a critical first step of the call taking process, since the line could be dropped, leaving the location unknown. EISEC technology provided by call handling agencies allows the billing address of the landline phone from which the emergency call is being made, to be displayed to the Call Handler, speeding up the information process. This technology can also be used to establish the location of mobile phone calls, identifying the cell network from which they are calling.

3.3. CLI improves efficiency and accuracy to help minimise dialogue between the Call Handler and the caller.

3.4. When a 999 call is received into EOC, if the address is auto populated by EISEC, the Call Handler must ensure it is verified at this point by asking the caller to repeat it back in full. Particular focus must be given to verifying a district if missed by the caller.

3.5. If the address is not auto by EISEC/CLI the Call Hander must search for the address appropriately. Searching by the postcode, if known, is recognised as being an effective method.

3.6. If any changes are made to the auto-populated address, or the Call Handler must manually search for the address, the address must be reconfirmed by the caller in full.

3.7. Advance Mobile Location (AML) will automatically send accurate location information from a caller's phone directly to the emergency services using the mobile phone's built-in Global Positioning System (GPS). AML is not a phone application and does not require any action from the caller as it is

built into modern smartphones. The location provided to the emergency services will be as accurate as the GPS on the caller's phone. The accuracy is generally between 5 and 30 metres.

3.8. When a 999 call is made, the caller's mobile phone will automatically enable location services (using GPS or Wi-Fi) and will send this information to BT. This information is delivered to SECAmb within around 25 seconds of the call being delivered. The result will be an approximate radius of 3000 metres, which can close to an approximate radius of 5 metres in around 25 seconds.

3.9. As the return delay can take up to 25 seconds, Call Handers are likely to have answered the call before AML is available. The CLI/EISEC detail section on the call screen will start with limited details, then once AML has been delivered, it will present with a road name, town and postcode, as well as Eastings and Northings.

3.10. What3Words (W3W) provides a precise location based on a grid of 3m x 3m squares, each area assigned with three unique words. Call Handlers can send a 'Quick SMS' link to the W3W website from the call handling screen if required. Call Handlers must take the three word location from the caller and confirm the three words carefully.

3.11. Call Handlers should then click the 'W3W' button above the Incident Location field on the emergency call screen. This will open a CAD pop up to enter the three words. By clicking 'Find W3W Suggestions' this will return five suggestions. Double clicking on the result that seems to be the correct location will return a map of the area and, in a green bar, the nearest gazetteer (geographical index) entry will be presented. Clicking the 'Use Co-Ordinates and Nearest Address' button will move the marker to the actual What3Words location.

3.12. In the event of any potential unconfirmed or 'rough' location, the Call Handler must request a secondary address or landmark to verify the location as best as possible from the caller.

3.13. The Ambulance Response Programme (ARP) was introduced nationally to ensure that all patients receive the most appropriate response for their presenting condition. Under the ARP model, the use of 'Nature of Call' (NoC) at the beginning of a 999 call aims to achieve early recognition of potentially life-threatening conditions.

3.14. NoC achieves faster dispatch to the most critical patients using 'pre-triage' questions, prior to opening NHS Pathways. Call Handlers must select the most appropriate NoC 'condition' to allow other CAD users to easily identify what the call is relating to. Each NoC has its own predetermined priority based on the likelihood of the final (NHS Pathways) disposition.

3.15. There are four categories of ambulance response:

3.16. **Category 1** (C1) – Life-threatening event with a mean response time of seven minutes and 90th centile target of 15 minutes.

3.17. **Category 2** (C2) – Emergency, potentially serious incident with a mean response time of 18 minutes and 90th centile target of 40 minutes.

3.18. **Category 3** (C3) – Urgent problem with a 90th centile target of 120 minutes.

3.19. **Category 4** (C4) – Less urgent problem with a 90th centile target of 180 minutes.

3.20. For patients who are determined (by NHS Pathways) to require an outcome that is not an ambulance, this is referred to as a 'non-ambulance' disposition or Category 5 (C5).

4 Attend Incident

4.1. Attend Incident must be utilised for calls taken by a Call Handler from the following:

- Police service
- Fire service
- Coastguard
- Other Ambulance services who have triaged and reached a dispatch disposition.
- An NHS 111 service who have triaged and reached a dispatch disposition.
- An ambulance crew that has come across an incident (running call)
- Prisons (including immigration detention centres)
- Airports
- A member of the public calling regarding 'the scene' of an incident rather than situations in which a sole patient requires triage for a medical or trauma incident.

4.2. Calls from telecare providers such as careline / lifeline alarm activations are not covered within the Attend Incident function and must continue to be handled by utilising the NHSP, early exit, remote observer process.

4.3. If a Call Handler reaches Category 3 dispositions Dx01213 (Emergency Ambulance Response for Accidental Poisoning) or Dx0124 (Emergency Ambulance Response for Risk of Suicide) there is no need to contact clinical in line support. If, however, any other Category 3 disposition is reached where there is a risk of suicide or overdose, the Call Handler must continue to highlight the incident through clinical inline support.

4.4. In certain situations, Attend Incident requires the Call Handler to choose a level of response, either category 2 or category 3. For these calls, the Call Handler must select emergency ambulance response (Category 3) for incidents in which there are no reported casualties, or an ambulance is being requested to 'stand by'. All other incidents are to be selected as emergency ambulance response (Category 2).

4.5. All third and fourth party calls must, where appropriate, be asked for a contact number to attempt two callbacks, to undertake a first or second party triage. This is regardless of the initial category of disposition reached through Attend Incident.

4.6. Calls from another Ambulance service that have reached a Category 5 (C5) non ambulance disposition will not be handled within Attend Incident and must continue to be processed utilising Early Exit – transfer to a clinician and select the relevant answer stem as to why the call required further clinical assessment.

5 Healthcare Professional and Inter-Facility Transfer calls.

5.1. Calls from a Healthcare Professional (HCP), including Inter-Facility Transfer (IFT) requests, may be received into the EOC via a dedicated HCP line or via 999. They are managed through the NHS England HCP and IFT frameworks embedded within NHS Pathways. The HCP framework is intended for patients who require an ambulance response in a community setting following clinical assessment by a healthcare professional. The IFT framework is intended for patients who require transfer by ambulance between facilities due to an increase in either their medical or nursing care need.

5.2. There are four levels of HCP/IFT response:

5.3. **Level 1** (Category 1) 7 minute mean response time - This level of response is reserved for those exceptional circumstances when a facility is unable to provide immediate life-saving clinical intervention such as resuscitation or in the case of a declared obstetric emergency and requires the clinical assistance of the ambulance trust in addition to a transporting resource. These requests are processed through NHSP and only those that are deemed a Category 1 under that assessment receive a Category 1 response. Examples would include cardiac arrest, anaphylaxis, birth units

requiring immediate assistance or acute life-threatening asthma in an urgent care facility.

5.4. **Level 2** (Category 2) 18 minute mean response time - This level of response is based on the clinical condition of the patient and the need, or a high likelihood of the need, for further treatment and management at the destination facility rather than the patient's diagnosis. Immediate life, limb, or sight (globe trauma) threatening situations that require immediate management in another healthcare facility receive this level of response. Other examples include patients going directly to theatre for immediate neurosurgery, primary percutaneous coronary intervention, stroke thrombolysis, mechanical thrombectomy, surgery for ruptured aortic aneurysm, laparotomy, surgery for ectopic pregnancy, and limb or sight saving surgery. These Level 2 patients are mapped to a Category 2 response.

5.5. **Level 3** (within 1 hour or 2 hours) locally commissioned response - This level is locally commissioned for patients who do not require immediate life or limb saving interventions but require an increase in their level of clinical care as an emergency. The Trust provides a Level 3 (within 2 hours) for physical health needs that are more urgent than a Level 4 response. A Level 3 (within 1 hour) is offered only for patients with mental health needs. Level 3 (1 hour) patients are mapped to a Category 3 response on the CAD, however, aim to be responded to within 1 hour. A Level 3 (within 3 hours) is not offered by the Trust.

5.6. **Level 4** (within 4 hours) locally commissioned response - This is for all other patients who do not fit the above definitions and require urgent transport for ongoing care but do not need to be managed as an emergency transfer. Patients being transferred to inpatient wards for ongoing management or for elective and semi elective procedures or investigations are included in this group.

5.7. Repatriations, step-down transfers, discharges to non-hospital facilities, outpatient appointment transport and patient movements for the purpose of bed management are not included in the HCP/IFT framework and must not be accepted.

5.8. For all types of HCP/IFT call, the Call Handler must, where available, add the following information to the incident after triage has been completed:

- A callback number for the patient
- The destination hospital, receiving unit/department and their contact number. NB: For many patients with urgent or emergency care needs, they will not be 'booked' to go to a specific hospital or department, therefore this information will not need to be

documented as the attending ambulance clinicians will transport accordingly.

- Name of referring HCP and their contact details
- The number of escorts travelling with the patient (e.g., relative/professional)
- Any other relevant information provided by the HCP

5.9. Care must be taken to accurately document all information provided by the HCP. The Call Handler must clarify any information as required for accuracy. If the Call Handler feels that all information has been entered correctly, there is no requirement to routinely read all details back to the caller.

5.10. For any HCP call, the Call Handler must ask if the patient is ready to travel. If they are not, the Call Handler must advise the HCP that we are unable to accept the call until the patient is ready to travel.

5.11. Patients must be transferred, where necessary, with an appropriate hospital escort to meet their clinical needs.

5.12. The Trust is not commissioned for the return of personnel or equipment to facilities.

6 Answering Non-Emergency Calls

6.1 The Call Handler must answer any non-emergency call with an appropriate professional greeting.

7 Personal Demographics Service

7.1. The Personal Demographics Service (PDS) is the national electronic database of NHS patient details such as name, address, date of birth and NHS Number (known as demographic information). PDS is used by NHS healthcare professionals to identify patients that use their service.

7.2. Call Handlers must attempt to use PDS on all C2, C3 and C4 ambulance dispositions once full triage has been completed and all care advice has been given.

7.3. For calls that reach a non-ambulance (i.e. C5) disposition, best practice is for the Call Handler to attempt a PDS lookup prior to connecting to the Directory of Services (DoS), as obtaining the patient demographics can assist in the DoS populating appropriate services.

7.4. For any call in which continual care advice or instructions are being given, including C1 dispositions, the Call Handler does not need to use PDS.

7.5. Call Handlers must ask for the patient's full name and date of birth and enter the information into the patient demographics field. The patient's gender should have been populated automatically from NHS Pathways, however this must be amended or changed where necessary. The gender selected needs to match how the patient is registered with the NHS. All information must be entered correctly (e.g. accurate spelling) so the PDS can find the patient on the NHS Spine database.

8 Calls From NHS 111

8.1. The majority of referrals from NHS 111 will be received directly into the CAD for dispatch via the Interoperability Toolkit (ITK) link.

8.2. There are occasions where an NHS 111 provider will need to pass a case manually to EOC. In these instances, the Call Handler will use NHSP Attend Incident module to enter the case onto the CAD and generate the appropriate disposition, as specified by the NHS 111 provider. The Call Handler will also receive and document any other pertinent information, which must include the following as a minimum:

- Patient and/or informant's name and contact number
- Name of NHS 111 provider
- NHS 111 case reference number
- Any other relevant information regarding the patient's condition

9 Mental Health Transport Requests

9.1. Where a booking is made by an Approved Mental Health Practitioner (AMHP) in the community, or an AMHP's representative, the Call Handler can offer an HCP Level 3 (1 hour) response. The AMHP must have assessed the patient before the booking is made and the patient must be ready to travel at the time of the call.

9.2. It is considered best practice for the AMHP to remain with the patient until transport arrives. This must be the case if the patient presents with any risks that need to be discussed with the crew. If the AMHP is not going to stay with the patient, ensure contact details for the patient are entered into the CAD so that welfare callbacks can be completed, as necessary.

9.3. Acute Behavioural Disturbance (ABD) describes the sudden onset of aggression, agitation and/or violent behaviour. This is typically caused by

drug use or mental illness. A very common presentation in individuals with this condition is a tendency to remove clothing. This is due to the increase in body temperature, which is a common feature of the condition.

9.4. Patients experiencing ABD are likely to present with multiple symptoms, therefore they may be difficult to triage effectively through NHSP. Call Handlers may receive three 'not sure' answers, which will signpost the call for a clinical callback. Call Handlers must triage following standard processes, however if during the call it becomes apparent that the patient has experienced sudden onset of aggression, agitation, or violent behaviour and/or the specific term "acute behavioural disturbance" is used, the Call Handler must highlight the case to clinical inline support.

9.5. If the patient is being restrained by more than one police officer, the Call Handler must urgently flag the incident to a Clinical Supervisor who will then prioritise accordingly and may consider upgrading to a C1.

10.6 Requests for transport (from the community to a place of safety) following the application of a Section 136 are normally made from the police, these will therefore be handled through Attend Incident.

10.7 It should be uncommon for the police to request section 136 transport from a healthcare facility as the patient is within a place of safety. This request can only be made if the Section 136 has been applied at the facility. If this is not the case and the patient is within an Emergency Department (A&E), the usual appropriate course of action is that the hospital's psychiatric liaison team will assess the patient and, if required, apply an appropriate Mental Health Act section. The mental health professional can then call into the EOC if they require ambulance transfer and will be offered an HCP/IFT Level 3 (within 1 hour) as above. If there is any confusion, the Call Handler can access clinical in line support for guidance.

10 Automated External Defibrillators (AED) and Public Access Defibrillators (PAD)

10.1. The Call Handler must follow CAD specific training for the identification of an AED/PAD. Once a location has been identified, CAD will present a 'Possible AED location' box informing the Call Handler of its location, distance, codes and any additional information that is relevant.

10.2. AED/PAD usage will be completed in line with NHSP. An AED/PAD needs to be requested only where NHSP deems it appropriate.

10.3. The Call Handler must not send a 2nd party caller who is alone to get an AED/PAD.

10.4. If there are multiple rescuers on scene who are willing and capable of retrieving an AED/PAD, the Call Handler must instruct them to do so, providing them with the location, distance and code, along with a reminder to return with it promptly.

10.5. Call Handlers are only to accept an AED/PAD site when instructed to do so during the NHSP triage.

10.6. When AED/PAD sites are accepted, the defibrillator will be taken out of service on “The Circuit” until the device’s guardian checks that it is emergency ready. This can take up to 24 hours, meaning the defibrillator will be unavailable until reviewed. The Circuit is a national database of defibrillators managed by the British Heart Foundation.

10.7. If there is no intention of using the AED/PAD site, the Call Handler must select ‘cancel’ in the CAD prompt. This will prevent the defibrillator from being taken offline.

10.8. If a bystander becomes available later into the call, or the patient's condition deteriorates, the Call Handler, can access the ‘Possible CPAD Locations’ search again by pressing the ‘force another AED/CPAD check’ button.

11 GoodSAM

11.1. GoodSAM is a network of volunteer responders who provide basic life support to nearby patients in cardiac arrest.

11.2. A GoodSAM ‘alert’ will populate within NHSP when it is confirmed that the patient is not breathing adequately. This will then activate the two closest GoodSAM responders within 1,000 meters. If the Call Handler feels the scene is not safe, then the button labelled "NOT suitable for CFR" must be selected. The Call Handler will then enter a reason why e.g. violent attacker on scene or unsafe conditions such as an RTC.

11.3. When a GoodSAM responder arrives on scene, the Call Handler must allow them to conduct an assessment of the patient and then ask for an update. Due to a GoodSAM responder potentially being a lay member of public, the Call Handler must stay on the line until a crew arrive on scene.

12 Patients Reported as Dying or Deceased

12.1. When a caller reports that someone has “died” or is “dying”, the Call Handler must seek to establish why that is suspected, the history and circumstances.

12.2. The terms “dead” or “passed away” commonly suggest the presence of a dead body that is beyond help – i.e. does not require resuscitation.

12.3. The term “dying” suggests that the patient is expected to die and is within the final stages of passing away.

12.4. In these cases, it may be appropriate to follow the ‘Early Exit – triage not possible – contact is about a dead or dying person’ route within NHS Pathways.

12.5. If the call is coming from a third party who are not with the patient, the Call Handler must treat the call as a cardiac arrest unless the information provided is without doubt, e.g., the body is decomposing. The Call Handler must attempt callbacks to scene to carry out a second party triage.

12.6. If the patient has passed away, the death is unexpected and the Call Handler is presented with the following words “From what you have told me, the death is unexpected”, the Call Handler must treat this as a “Contact Police” disposition. The Call Handler must, where possible, take the patient’s name, date of birth, current location and name of the informant and pass this information to police force that cover that area for them to attend.

12.7. If the patient has passed away and the death is expected, depending on time of day, NHS Pathways/Directory of Services may support the Call Handler to signpost the caller to a local service – for example, the patient’s home GP. The Call Handler must take into consideration that the caller may be upset or distressed, and therefore may feel it is appropriate to offer they contact the service on the caller’s behalf.

12.8. If there is any doubt as to whether a death is expected, the Call Handler must treat the patient as ‘Unconscious, not breathing normally’ within NHSP and aim to reduce delays in offering CPR instructions.

12.9. If the caller does not want to start CPR, follow the advice and instructions provided in Pathways which include advice for rolling the patient on their side.

13 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

13.1. DNACPR stands for ‘do not attempt cardiopulmonary resuscitation (CPR)’. It means that if a person has a cardiac arrest or dies suddenly, there will be guidance on what actions are advocated (i.e. should or shouldn’t be taken) by a healthcare professional, including not performing CPR on the patient.

13.2. There are many reasons why a person might have a recorded DNACPR decision. Some people choose to have one simply because they do not want to be resuscitated in an emergency. They might have a personal reason to make this decision, but this varies depending on the individual.

13.3. Others make the decision along with their health care provider after experiencing health issues that might inform their decision.

13.4. There are also occasions when healthcare teams may have to make decisions on behalf of patients. In this case, they would try to involve patients or their loved ones wherever possible. This might happen because a patient is so unwell from an underlying illness that CPR will not prevent their death. By making the decision on behalf of the patient, there is an opportunity for the patient to have a peaceful, dignified death.

13.5. DNACPR only specifies whether CPR would be of likely benefit (or not) to the patient in the event of cardiac arrest. Patients will still receive appropriate treatment for their health issues and all personal care needs will be attended to.

14 Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

14.1. ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Such emergencies may include death or cardiac arrest but are not limited to those events.

14.2. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether CPR should be attempted if the person's heart and breathing stop.

14.3. These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.

14.4. What is important to a person and clinical recommendations are recorded on a non-legally binding form, which can be reviewed and adapted if circumstances change.

15 Advance Decision to Refuse Treatment (ADRT)

15.1. An ADRT enables someone aged 18 or over, while still capable, to refuse specified medical treatment for a time in the future when they may not be able to do so.

15.2. It is a legally binding document that allows the individual to express their wishes while they are able to make decisions and communicate them in advance of a possible emergency.

16 Consideration of Advance Care Plans within the EOC

16.1. Call Handlers may become aware that a patient has a form of Advanced Care Plan (e.g. DNACPR, ReSPECT or ADRT) during a call. This could be due to the caller declaring information, and/or due to a notification within the CAD, such as an At-Risk Marker.

16.2. Where appropriate and required, Call Handlers must seek to support callers with accessing and utilising any relevant Advance Care Plans. If a Call Handler feels out of their depth during the call, they must access clinical assistance (either clinical inline or side-by-side) to guide them.

16.3. To ensure a document is valid, there are two main criteria that must be met:

- It must be clearly identified that the document pertains to the patient – for example, includes the patient's name, date of birth and/or NHS number.

- It must be signed by an appropriate registered healthcare professional. A written ink signature or typed or electronic signatures (paired with the HCP's registration number) are all acceptable.

16.4. A caller may alert the Call Handler to the presence of a paper copy of an ACP on scene. In this circumstance, the Call Handler must seek to ascertain any specific information regarding resuscitation (such as DNACPR) and be confident that it contains the validity criteria mentioned above. The confirmation of an ACP for the patient will often support the Call Handler to follow the 'expected death' route within NHSP.

16.5. If the Call Handler has any doubts, or they are not satisfied about the existence, validity, or applicability of the resuscitation decision or ADRT, Basic Life Support (CPR) advice must be provided without delay.

16.6. If CPR is commenced, and it subsequently becomes evident that there is a DNACPR directive in place, resuscitation can be ceased. Clinical Supervisors can be sought for further advice and support if needed.

16.7. Historically, DNACPRs used to contain a review date. This is no longer standard practice and DNACPR decisions are lasting. If the DNACPR decision no longer stands, the documentation should have been destroyed.

16.8. Advance Care Plans are increasingly available in electronic form through shared patient records and often vary in terminology. Some examples

include DNACPR, ReSPECT, ADRT, Treatment Escalation Plan (TEP) and Future Wishes Plan.

16.9. There are some circumstances when a DNACPR decision is not applicable (in the context of telephone triage) and must not be followed, namely:

- In cases of apparent asphyxia (lack of oxygen) – such as choking, hanging or a blocked tracheostomy tube
- In cases of suicide

16.10. If the caller refuses CPR instruction, follow the advice and instructions provided in Pathways which include advice for rolling the patient on their side.

17 No, No, Go

17.1. Within the context of 999 call handing, it must be assumed that every call is a cardiac arrest until proven otherwise. Research has shown that use of two key questions is the most effective way to exclude cardiac arrest during telephone triage:

- Is the patient conscious?
- Are they breathing in and out normally?

17.2. If the answer to both questions is “no”, cardiac arrest cannot be excluded therefore the Call Handler must ‘go’ with starting CPR instructions. Call Handlers are advocated to remember “No, no, go!”.

17.3. CPR instructions must not be withheld or delayed due to the Call Handler feeling worried about resuscitating a patient who is not in cardiac arrest. Several studies have shown that performing CPR on a patient who is not in cardiac arrest is unlikely to cause harm, however delaying CPR or not doing it at all is likely to result in a poor outcome. If the Call Handler is in any doubt as to whether a patient’s breathing is normal, they must select the ‘no’ answer stem and provide CPR instructions.

17.4. Chances of surviving a cardiac arrest drop by approximately 10% for every minute that CPR is delayed. It is therefore essential that the need for CPR is recognised quickly, and that clear and assertive instructions are provided to the caller.

17.5. Every time there are pauses in chest compressions, the patient’s chances of survival reduce, therefore focus must be made to avoid interrupting the caller and encourage them to re-start compressions quickly if there are any pauses.

17.6. Once established that the patient is likely to be in cardiac arrest and requires CPR, the Call Handler must not subsequently ask whether the patient has got a DNACPR, ReSPECT or ADRT, unless it has been prompted by CAD or NHSP. If mentioned by the caller, the Call Handler can then attempt to confirm that the document is for the patient and that it is valid. Where there is any uncertainty, a Clinical Supervisor must provide side-by-side support.

17.7. The Call Handler must attempt to continue providing CPR instructions whilst accessing clinical support until such time that they are advised (by a clinical supervisor) to stop.

18 Sepsis

18.1. Within NHS Pathways, the majority of patients experiencing 'severe sepsis' (a.k.a. septic shock) will be quickly identified within Module 0 where there are specific questions regarding unconsciousness, severe respiratory distress, neurological impairment and hypoperfusion (failure in circulation) - triggering either a Category 1 or Category 2 ambulance disposition.

18.2. Within Module 1 there are several questions across multiple pathways that identify abnormal breathlessness, tachypnoea (rapid breathing), severe illness, purpuric (purple) rashes, current/persistent/reoccurring fever, altered mental state, symptoms indicative of infection, and specific risk factors such as impairment of the immune system. For individual patients who are not showing signs of septic shock, but have a high suspicion of sepsis, NHSP will recommend a safe and appropriate disposition.

18.3. For other patients who present with potential signs or symptoms of an infection, NHSP may recommend a range of urgent non-ambulance dispositions, ranging across community, primary and urgent care services depending on the level of suspicion and risk.

19 Sickle Cell Disease

19.1. Patients with sickle cell disease produce red blood cells that are unusually shaped. These cells can cause problems because they do not live as long as healthy blood cells and can block blood vessels. Sickle cell disease is a serious and lifelong health condition, although treatment can help manage many of the symptoms.

19.2. Patients who declare they are having a sickle cell 'crisis' must be managed through the 'individual has been told to follow a particular course of action' pathway. The question "Is there an immediate threat to life?" must be answered as yes, generating a C2 response.

19.3. Patients who do not declare they are in sickle cell crisis however mention they have sickle cell disease must, as per standard call handling for NHSP, be transferred to the CSD as “declared medical history”. This must be undertaken after clearing Module 0.

20 Addison’s Disease / Adrenal Insufficiency / Adrenal Crisis

20.1. Addison’s disease, also known as adrenal insufficiency or hypoadrenalism, is a rare disorder of the adrenal glands. The adrenal glands are two small glands that sit on top of the kidneys. They produce two essential hormones: cortisol and aldosterone. The adrenal gland is damaged in Addison's disease, so it does not produce enough cortisol or aldosterone.

20.2. Patients who have declared they are having an adrenal ‘crisis’ must be managed through the ‘individual has been told to follow a particular course of action’ pathway. The question “Is there an immediate threat to life?” must be answered as yes, generating a C2 response.

20.3. Patients who do not declare they are in adrenal crisis however mention they have Addison’s disease or adrenal insufficiency must, as per standard call handling for NHSP, be transferred to the CSD as “declared medical history”. This must be undertaken after clearing Module 0.

21 ‘Contact Police’ Dispositions

21.1. Certain triages through NHSP will generate a ‘contact Police’ disposition. The rationale behind this is due to the requirement for police to manage the scene and then undertake an assessment as to whether there is a medical need.

21.2. In most cases, the Call Handler must follow the recommended disposition and contact the police on behalf of the caller. If the police feel that an ambulance is required, they will re-contact the Trust as necessary.

21.3. Call Handlers must however note that there may be individual cases where is it may not be appropriate to contact the police, or there may be a requirement for a joint response from both police and ambulance at the same time. If the Call Handler feels this may be the case, they can contact clinical inline support for further guidance.

21.4. If a clinician feels that an ambulance response may be required, they can request that the Call Handler transfers the case to CSD for a further assessment, ideally via ‘warm transfer’ if available.

22 Automatic Notifications

22.1. Several applications (apps) are available which will automatically call the emergency services in the event of an incident. The apps have built-in technology that detects physical changes that occur, followed by no movement.

22.2. If an app detects this, it activates an alarm. If the user is unharmed or does not want assistance from the emergency services, they can deactivate the alarm and the app takes no further action.

22.3. When the Call Handler is informed of a crash notification that has not been deactivated, they must utilise the early exit function within NHSP, “remote observer” and answer ‘yes’ to ‘major trauma has occurred’, specifying ‘no contact possible’.

23 Calls from Airports

Gatwick Airport:

23.1. Calls from Gatwick Airport will generally come via the Gatwick Control Centre (GCC). They must be handled through Attend Incident for singular patients, multiple patients, those who are airside, landside, or on an inbound flight.

23.2. The Call Handler must document all information provided by GCC, including any rendezvous point (RVP), if applicable, and nature of incident.

23.3. 999 calls made directly from members of the public who are within the airport must be triaged as normal through Modules 0-1, with the appropriate disposition given to the caller.

23.4. The Dispatch function is then responsible for alerting the relevant Airport Control room of an ongoing 999 call.

Local airports/aerodromes

23.5. Any calls received from other local aerodromes must be dealt with via Attend Incident provided the call is made by the airport authority.

23.6. 999 calls made directly from members of the public who are within the airport must be triaged as normal through Modules 0-1, with the appropriate disposition given to the caller.

23.7. The Dispatch function is then responsible for alerting the relevant Airport Control room of an ongoing 999 call.

24 Calls from His Majesty's Prison (HMP) Sites

24.1. When calling 999, HMP sites may declare that the call relates to a particular code:

- Code Blue = MEDICAL
- Code Red = TRAUMA

24.2. When a HMP site declares a 'Code Blue' or 'Code Red' incident internally, their Control Room will contact EOC. The Call Handler must use Attend Incident via NHSP and appropriately reach a C1 or C2 disposition. There is a national agreement with NHS Ambulance Services and HMP sites that no disposition lower than a C2 will be arranged via their control room.

24.3. If the call comes directly from an HCP within the prison, the Call Handler must complete a full triage via the HCP route in NHSP to reach the most appropriate disposition.

25 Calls from HM Coastguard

25.1. The nature of calls from HM Coastguard will vary but all calls must be answered in line with NHSP training and triaged through Attend Incident.

26 Coastal Incidents (Beach, Coast or Sea)

26.1. For any calls around the coast where the Call Handler can obtain a fixed location from the informant, and the call has not come in via the Coastguard, the Call Handler must carry out a full NHSP triage as normal.

26.2. Calls from Coastguard, where the patient is at sea, will be accepted when there is an estimated time of arrival (ETA) to shore, and an appropriate RVP location has been provided. Any call where the Coastguard does not have an ETA and/or RVP must be escalated to the EMATL/EOCM.

26.3. For any calls for an incident around the coast where the Call Handler cannot obtain a location, the Call Handler must obtain as much information as possible and advise the caller that they will warm transfer them through to the Coastguard after confirming the caller's contact number. The Call Handler must 'Early Exit, wrong service called' and then pass the information to the Coastguard, remembering to document their reference in CAD appropriately.

27 Requests for SECAmb Cross-Border Assistance

27.1. These are generally referred to as a 'request for assistance' within the EOC environment and relate to situations where a neighbouring ambulance

service ask for assistance with responding to an incident that is on the border of Trust boundaries.

27.2. Once advised the call is a request for assistance from another ambulance service, the Call Handler must follow the normal Nature of Call (NoC) process. The Call Handler must then triage through Attend Incident to generate the category of response to match that of the requesting Trust. The Call Handler must input “Amb service req assistance” into the instructions box.

27.3. The Call Handler must ask the other Trust where they are ‘running from’ (i.e. the current location of their responding vehicle), the type and skillset of that vehicle and the type and skillset of the vehicle being requested. The Call Handler must record all of this information in the incident. This allows Resource Dispatchers (RD) to make an informed decision before allocating to a SECAmb resource.

27.4. The Call Handler, after entering the incident onto CAD, must monitor for a response from the dispatch team and update the other Trust’s Call Handler accordingly.

27.5. If there is a delay in receiving a response from dispatch, the Call Handler must escalate this to an EMATL so that verbal contact can be made with the relevant RD/Dispatch Team Leader/EOCM.

27.6. If SECAmb are unable to assist or do not have a closer response to send, the Call Handler must exchange reference numbers with the requesting ambulance service, as any request for assistance must be recorded on the CAD. The Call Handler must triage through NHSP and select ‘Early Exit, cancelled by caller’ and close the incident appropriately.

27.7. If SECAmb can assist, the Call Handler must document the following minimum information:

- Patient telephone number
- The name and reference number of the referring ambulance service
- Any other relevant information, including access information if required.

27.8. There is no need to call the patient back, as the referring ambulance service maintain responsibility for telephone management of the patient’s care until help arrives on scene.

28 Passing and Receiving Out of Area 999 Calls

28.1. Passing an out-of-area 999 call

28.2. Most out-of-area 999 calls will be handled by the ITK link, however the Response Desk Co-Ordinator is accountable for ensuring any ITK failures are passed manually.

28.3. Category 5 non-ambulance dispositions that are reached for those who are out of area will fall into the clinical support desk to pass across to the relevant ambulance trust. The Clinical Safety Navigator (CSN) may ask the response desk to pass the call if they do not have capacity.

28.4. If the out-of-area call to SECAmb is being made by an HCP or an NHS 111 provider, the Call Handler must offer to transfer them through to the correct service provider and clear the line once it has started to ring.

28.5. Receiving out-of-area ETA calls from another agency

28.6. Where the caller is requesting an ETA for a patient located in another ambulance service's area, the Call Handler must triage as normal through NHSP if there has been any change or worsening in the patient's condition. This information will then be transferred to the corresponding ambulance service via the ITK.

28.7. If there has been no change or worsening, it is acceptable for the Call Handler to advise that SECAmb is unable to view the status of calls in other areas so would be unable to give any information.

28.8. In this circumstance, there is no need to contact the other ambulance service to advise them of an ETA call with no change or worsening of the patient's condition.

28.9. Receiving a call from another ambulance service

28.10. All calls (already triaged) manually passed from other ambulance services must be triaged through NHSP Attend Incident.

28.11. If the service passing the call is not in England (e.g. Scotland, Wales or Ireland), the Call Handler must input the priority closest to the timeframe provided by the other service. For example, a service passing a call with a 30 minute response time must be recorded as a C2 in CAD. The Call Handler must only call back to re-triage if there are any concerns or further information required, in which case the Call Handler must approach an EMATL to authorise a callback.

29 Calls from Short Message Service (SMS) Emergency Notification System

29.1. Callers accessing ambulance assistance via the SMS text relay service will do so via the BT emergency operator. The SMS text relay service allows those who are deaf or hard of hearing to communicate via SMS messages rather than voice.

29.2. In these situations, it is not appropriate to undertake a full NHSP assessment; however the Call Handler must make every effort to triage through Module 0 before using the 'Early Exit – Remote observer' pathway and follow NHSP as appropriate with the information available.

30 Calls from Emergency Video Relay Service

30.1. BT will receive a voice call from the third party British Sign Language (BSL) Video Relay Service, who will obtain an approximate location so that the call can be routed and connected to the correct emergency service.

30.2. The BT emergency operator will use the following handover when connecting a BSL 999 call to an ambulance service:

"[Centre name] connecting a Video Relay call at an unconfirmed location."

30.3. BT operators will relinquish a BSL call once two-way conversation has been established with the ambulance service. The BSL interpreter will remain on the line to relay the conversation between the caller and the Call Handler. Should there be any difficulties and the BSL call is not straightforward, then the BT operator will continue to monitor as with other non-standard call types.

30.4. In these situations, it is not appropriate to undertake a full NHSP assessment, however the Call Handler must make every effort to triage through Module 0 before using the 'Early exit – Remote observer' pathway and follow NHSP as appropriate with the information available.

31 Remote Observers

31.1. All third and fourth party callers must, where appropriate, be asked for a patient contact number in order to attempt two callbacks, to undertake a first or second party triage, and where there is a need to provide a welfare call. This is regardless of the category of disposition reached through NHSP. It would be considered reasonable to leave between 30 to 60 seconds between the call back attempts.

31.2. If a Call Handler manages to contact the patient (or someone with the patient) and assistance is required, they must ensure they complete a first

or second party triage utilising NHSP to reach an appropriate disposition and provide relevant interim care advice.

31.3. Where a call back is required, the Call Handler must not close NHSP until the callback attempts have been completed.

32 NHS Pathways Closed in Error

32.1. Call Handlers must only close NHSP once the call has been completed. Should NHSP be closed in error, the Call Handler must tick the 'NHSP Closed in Error' box under the Keyword – Other tab on the call taking screen.

33 Duplicate Calls

33.1. A 'duplicate call' is defined as any call where the Trust have already received a call for the same patient, which is currently active/live within the CAD. Examples may include:

- An incident that has been witnessed by numerous informants
- A person placing a subsequent call to request an ETA
- A call for perceived worsening or changed symptoms
- A person wishing to cancel an ambulance

33.2. Call Handlers must attempt to triage all duplicate calls fully following standard 999 Call Handling processes, adding 'DUPE' within the instructions field where required.

33.3. The subsequent management of duplicate calls (e.g. matching together, closing where relevant and resource allocation to the appropriate incident) is handled by the Dispatch and Clinical teams in EOC.

33.4. For any duplicate call, including ETA calls, the Call Handler must ask whether the patient's condition has changed – i.e. improved or has worsened. In order to establish if there has been an apparent change in the patient's condition, the Call Handler must always locate and open the original call, check the disposition and validate the original triage. They must also check whether the reported symptoms (on the original call) match the symptoms reported on the duplicate call. If the description of the patient's symptoms has changed or worsened, then a re-triage must take place.

33.5. Any ETA calls received from 'on scene' where the original call has not been fully triaged must be triaged in full through NHS Pathways.

33.6. Where there is no apparent change indicated in the patient's condition, an ETA incident can be generated without an assessment through NHSP. The Call Handler must enter a summary of what information has been provided to the caller regarding the ETA.

33.7. If there are reported changes or the caller is unsure about any change, a reassessment must be carried out to ensure that the appropriate level of response is confirmed.

33.8. Where new or worsening symptoms are described, a new triage must be carried out as if it is a new call.

33.9. In circumstances where a patient's symptoms have improved and the caller still requests an ambulance response, a full re-triage must be carried out and if a lower disposition is reached this must be checked by a CS to confirm which response is most appropriate.

33.10. Any type of duplicate call which does not generate a new incident automatically must have one manually generated so that the appropriate notes can be added. This must be mapped to the same address as the original.

34 Providing an Estimated Time of Arrival (ETA) for Ambulance Response

34.1. All calls received into the EOC (including 999 calls, HCP calls and calls from other agencies) will be provided with an ETA for the ambulance response unless the incident is triaged to a Category 1.

34.2. The Call Handler must provide the predicted ETA upon reaching the disposition. The ETA will be displayed within NHSP.

34.3. For most category 1 calls, it will not be appropriate to give an ETA however, if the Call Handler is struggling to control the call, they can reassure the caller that a category 1 response is the highest priority, that the ambulance will be travelling to them using blue lights and that answering questions will not cause any delay.

34.4. When providing an ETA, the Call Handler must ensure that the following points are clearly articulated to the caller:

- The ETA provided is only an estimate and reflects a predicted time of arrival based upon current demand and activity.
- It is not a disposition timeframe
- The ETA is not a promised time of arrival

34.5. Below provides some suggested wording that could be used when providing an ETA:

"Based on how busy it currently is in your area and the resources we have; we are estimating that an ambulance is likely to take [INSERT TIME] to arrive at your location."

34.6. Following the provision of an ETA, a caller may wish to cancel the ambulance response, for example because they choose to access an alternative care option. In this case, the Call Handler would use 'Early Exit, Cancelled by Caller' and provide appropriate worsening care advice.

34.7. Should a Call Handler receive a subsequent call where there is no worsening or change in the patient's condition, an ETA will not be available to the Call Handler as NHSP has not been utilised. In this instance, some suggested worsening that could be used could be:

34.8. "We apologise for the delay; we will be with you as soon as we can" followed by worsening care advice.

35 Requests to Cancel Incidents

35.1. If a caller requests to cancel an active incident, the Call Handler must seek to confirm directly with the patient themselves that they do not require/want an ambulance response. If this is not possible, confirmation must be sought from the original caller or agency.

35.2. Once it is confirmed that a cancellation is appropriate, the Call Handler must open a second 999 incident and utilise NHSP to 'Early Exit, Cancelled by Caller'.

35.3. The Call Handler must then select 'Caller Cancelling Ambulance' in the instructions box drop down for both incidents.

35.4. For any requests to cancel an ambulance where the call relates to a mental health issue, suicide or an overdose, the Call Handler must transfer the subsequent call to the CSD for a clinical callback and further assessment where required.

35.5. An exception to the above would be any mental health related cancellation that is received from either a healthcare professional (HCP), Approved Mental Health Professional (AMHP) or the police (e.g. regarding a Section 136). In this instance, the call can be cancelled without clinical input.

35.6. Clear documentation must always be added to both the original and any duplicate incident(s) to explain the reason for the caller cancelling the ambulance, including if they have indicated that they will be accessing alternative healthcare.

36 Change of Address

36.1. Where a subsequent call is received with a change of address due to the patient being moved, the Call Handler must create a new incident on CAD with the new location and fully re-triage regardless of the distance the patient has moved or the timeframe between calls.

36.2. If the address has changed due to inaccuracies during the initial 999 call, no re-triage is required unless the patient's condition has changed. The address must be changed in the original incident.

37 Abandoned Calls

37.1. Where a Call Handler receives a call, but the caller has disconnected, they must enter "Abandoned Call" in the instructions box and attempt two callbacks from the number provided by the BT Operator in an attempt to establish the need for an ambulance response.

37.2. If the caller answers and confirms that they have a medical need, the Call Handler must follow the standard primary call handling processes.

37.3. If there is no answer on the second callback attempt, the Call Handler must leave an appropriate voicemail message if possible.

37.4. If the abandoned call has an address populated, the call must be triaged appropriately through NHS Pathways. If no address has been generated, then NHS Pathways does not need to be opened.

37.5. Abandoned call with no address:

37.6. There is no expectation for police to be contacted or a subscriber check to be completed in the event of an abandoned call, unless it is thought that the caller or patient is in a dangerous or life-threatening situation based on what was said to the BT operator. The Call Handler must attempt 2 call backs and leave appropriate worsening care advice on a voicemail where available, before using non-clinical inline to inform a Senior Call Handler or EMATL of the abandoned call.

37.7. The Senior Call Handler or EMATL can search the CAD to ascertain if there has been any other call placed from the telephone number within the past two months. This will determine whether the incident is a duplicate call or may help provide a location or useful information about the caller. If the location is obtained, the call must be triaged appropriately through NHS Pathways.

37.8. The EMATL is responsible for oversight in ensuring that reasonable attempts are made to find an address and establish if there is a need for an ambulance response to any abandoned calls. If there is no history on the

CAD and an appropriate voicemail left where possible, the EMATL must then close the incident off as abandoned.

38 Handling Situations Where The Phone Line Goes Dead

38.1. There are several reasons as to why the Call Handler may not get any further response from the caller, for example:

- Caller loses consciousness
- Lost signal
- Caller clears the line (hangs up)
- Battery issues

38.2. In line with NHSP training, there are various routes through the early exit pathway to cater for these scenarios, including:

- EMERGENCY: unconscious, fitting or choking
- The phone line went dead
- I terminated the call OR the caller terminated the call

38.3. The Call Handler must select the answer stem that they feel is most appropriate with the information they have available to them.

38.4. If the phone line goes dead and the patient or caller re-dials 999, the subsequent (second) Call Handler must complete a full NHSP assessment on their incident.

39 Language Interpretation Services

39.1. To make sure the safety of all calls is managed when the patient does not speak English, the Call Handler can contact Language Line (the Trust's approved provider for interpreting services) to request an interpreter's assistance over the telephone. The details for interpretation services are stored within General Information on the CAD system.

39.2. Before calling Language Line, the Call Handler must Early Exit on NHSP using "triage not possible", selecting the appropriate answer stem to reach the safest possible disposition based on the information available.

39.3. When the Call Handler connects to the interpreter, they must explain to them that they are going to conference them through to the patient/caller. The Call Handler must then restart triage, progressing through NHSP as normal.

39.4. There will be times when Language Line has no interpreter available to support the triage. The Call Handler must gather as much information as possible and attempt to complete as much triage as is safely possible. If the Call Handler is unable to triage the call due to the language barrier, they must follow the 'Early Exit, triage not possible' route within NHSP, then notify the next available Clinical Supervisor through the inline support function.

39.5. Due to a lack of availability, it is not always possible for Language Line to provide an interpreter. Any inability to provide the language requested or the standard of service expected must be reported via a Datix Incident Form (DIF-1).

40 Requests for Information

40.1. Where a Call Handler receives a call requesting information (e.g. a relative wishing to know which hospital the patient has been taken to, or an ambulance has been sent to someone they know), they must be mindful of Information Governance principles.

40.2. While patient confidentiality cannot be breached, it is important to always try to be helpful, as many of these types of calls will be from distressed or worried loved ones of the patient. The Call Handler must never release patient sensitive information or patient identifiable data (PID).

40.3. Where a Call Handler receives a call from the police requesting information, the Call Handler must hot transfer the call to the duty EOCM.

40.4. If a careline/lifeline provider enquires whether we have attended a patient, they can be told if the response has attended or if we are still holding the call. If they request an update on the outcome of the patient, they must be advised that the attending crew must provide an update from scene.

40.5. If the careline request for an additional response to be put on the CAD as they have not been provided with an update for the patient from scene, this must be escalated to an EMATL or EOCM.

41 Frequent Callers

41.1. Every frequent caller, regardless of the origin of the call, must have a full NHSP assessment and appropriate disposition offered to them, unless specified otherwise by an At Risk marker within the CAD.

41.2. Call Handlers will be alerted to an 'identified' frequent caller (i.e. a person being managed within the trust's Frequent Caller Management Procedure) by an At Risk marker, including what actions to take. The At Risk marker

will present once sufficient information has been collected. This is typically based on address, telephone number and patient demographics.

41.3. The frequent caller pathway (within NHSP) can only be used if instructed within an At Risk marker.

41.4. For other patients who are calling frequently but are not an 'identified' frequent caller being managed within the Trust's Frequent Caller Management Procedure, a CS may advise the Call Handler to transfer the incident to the CSD. This must be done via Early Exit, transfer to clinician (i.e. not using the frequent caller route within Module 0).

41.5. Worsening care advice must be given in full, unless identified as a patient under a timed triage plan, in which case they must be read the 'time triage script' contained within the 'Frequent Caller Identification and Management Procedure':

"From the information you have provided and as per your Frequent Caller Response Plan, you will not receive an ambulance attendance at this time. A clinician from our service will review this call and if required they may call you back. Please contact your GP or attend your local Emergency Department should you require further medical assistance."

41.6. If an HCP is calling on behalf of, or on scene with, an identified frequent caller, the Call Handler must take the call as normal through the HCP Pathway.

42 Child Callers

42.1. A child caller is deemed to be any person under the age of 16 years.

42.2. The Call Handler must never assume that a child caller will not be able to answer triage questions, must commence NHSP triage and only utilise 'Early Exit' if the caller is unable to complete a safe triage or if it is unreasonable for them to do so. This will be at the Call Handler's discretion, but clinical or non-clinical advice can be sought if required.

42.3. Where a Hear & Treat (i.e. non-ambulance) disposition is reached for a child that is calling about themselves and is not accompanied by a responsible adult, the Call Handler must seek advice via clinical inline support.

42.4. If the Call Handler believes the child to be under 16 years old, the 'Child Caller' instruction must be selected within CAD.

43 Hoax Calls

43.1. A hoax call is one in which an ambulance response is requested deliberately when it is not required.

43.2. If the Call Handler believes the call to be a hoax, the 'Hoax Call Possible' instruction must be selected within CAD to highlight the incident to the duty EOCM.

43.3. Call Handler must triage appropriately via NHSP regardless of their suspicions, unless told otherwise by an EMA Team Leader or EOCM.

43.4. Only the EOCM may decide not to respond to a potential hoax call and their rationale must be documented in the CAD notes.

43.5. Hoax calls must be reported to the police service that covers the location the call is made from, with their reference being documented in the CAD incident.

44 BT Critical Line

44.1. BT will contact the EOC directly in the event a 'critical call' being held in the 999 queue waiting to be answered.

44.2. The BT critical line must be answered by an appropriate staff member by saying "South East Coast Ambulance Service East/West EOC" and BT will then provide the relevant information.

44.3. The EMATL or other appropriate staff member must advise the BT operator to redirect the call through to the 'secondary 999 line' if not done so already, which will bypass any other 999 calls waiting to be answered.

44.4. If there is nobody available for the secondary line, the EMATL may consider taking the call via their Avaya phone. This must not be taken on the critical line as it is not recorded.

44.5. It is important to remember that BT operators are not medically trained, so will highlight a call as critical if the caller is in distress.

45 Requesting Support During a Call

45.1. If a Call Handler requires support on any element of a call, they can access inline support. There are two options, clinical and non-clinical.

45.2. Clinical inline support must be reserved for when a Call Handler requires quick and simple advice, e.g. regarding interim care instructions. The clinician will not have spoken to the patient during triage, so it is not safe,

appropriate or possible for them to provide in-depth clinical advice, e.g., whether a disposition is 'correct' or 'appropriate'.

45.3. For patients that require significant clinical input, the safest and most preferred option is to transfer the call to the CSD (via NHSP) so that a clinician can call the patient back and undertake their own assessment.

45.4. Non-clinical inline support is provided by ~~a~~ Senior Call Handlers, who are expert users of NHS Pathways and have experience in telephone triage. They are therefore able to provide NHSP advice and support, e.g. guidance as to which pathway to utilise or answer stems to select. They can subsequently signpost to further support from a clinician if they feel it is required.

45.5. Call Handlers must attempt to contact inline support on the phone, as this is the safest and most efficient method due to the conversation being recorded. It is discouraged that Call Handlers approach clinicians directly within the EOC (i.e. speak to them at the clinical desk) as they may be busy undertaking alternative duties. Furthermore, face-to-face conversations may not be accurately recorded within the patient call documents.

45.6. When utilising inline support, the following 'DCRASH' method must be utilised:

D – If a disposition has already been reached

C – If a clinician has already been consulted on this incident

R – The reason for calling inline support

A – The age of the patient

S – The sex of the patient

H – The history of the patient's complaint

45.7. Immediate 'side-by-side' support must be accessed for circumstances where the patient is in an apparent or potential life-threatening situation. Side-by-side support will be provided by the nearest/available Senior Call Handler or clinician in EOC. All clinical advice and support to Call Handlers should ideally be provided in the first instance by a clinician trained in NHS Pathways Module 2.

45.8. If no NHSP clinician is available, any other registered clinician in EOC can support a Call Handler, as a last resort, if the patient's condition is time critical or potentially life threatening (in partnership with a senior Call Handler or Team Leader).

45.9. The Call Handler must document all side-by-side advice, by acknowledging it in the notes, documenting the initials and role of the member of staff who supported them and what information they have been advised to follow.

46 Emergency Rule

46.1. The Trust is required to achieve a mean call answer time of 5 seconds across a 24 hour period. However, at times, due to short staffing or an unexpected spike in 999 call demand, the Trust will need to implement 'Emergency Rule' processes.

46.2. All EMATLs have the responsibility for instigating emergency rule.

46.3. The trigger for Emergency Rule is:

- Five or more 999 calls waiting to be answered, and
- The longest call waiting to be answered is older than 2 minutes.

46.4. Upon taking their next call after Emergency Rule has been initiated, if the Call Handler clears module 0 without a disposition being reached, they must Early Exit through NHSP, selecting 'triage not possible' > 'other' > then write 'EMERGENCY RULE' in the free text box.

46.5. The Call Handler must enter 'Emergency Rule' into the instructions box.

46.6. The EMATLs are responsible for de-escalating out of Emergency Rule when there are five Call Handlers or more available to take calls.

47 Humanitarian Assistance

47.1. There are occasions where the Trust may be asked to provide humanitarian assistance to a person. The aim of humanitarian assistance is to save lives, alleviate suffering and maintain human dignity.

47.2. The Trust is not commissioned to provide such humanitarian assistance; however, we can be asked to move a patient under end-of-life or palliative care if it is anticipated that they are likely to pass away within the next 48 hours.

47.3. All requests for humanitarian assistance must be triaged through the "social domestic" pathway and ultimately triaged to a "transfer to clinician" disposition.

48 Refused Dispositions

48.1. If a caller refuses an ambulance disposition during triage, the Call Handler must select the ambulance disposition answer stem before early exiting and using the appropriate early exit route. This also applies during all levels of surge and when “no send” has been implemented.

49 Incident Closure

49.1. Call Handlers are permitted to close incidents which reach a non-ambulance disposition (i.e. hear & treat) during mentoring, diamond pod and thereafter once signed off to work solo.

49.2. Upon completion of a call that results in a non-ambulance outcome, the Call Handler must close/cancel the incident with an appropriate reason.

50 Staying on the Line

50.1. The Call Handler must stay on the line for any call in which continual care advice or instructions are being given.

50.2. There is no requirement to stay on the line with callers under the age of 16 who are not accompanied by an adult. There are some circumstances where staying on the line would be appropriate. For example, but not limited to:

- They are at risk of harm
- They are in an unsafe place

50.3. If the Call Handler feels it may be appropriate to remain on the line (in the absence of needing to provide continual care advice or instructions) they must escalate this to the EMATL.

51 Service Observe Function

51.1. Service Observe is the ability for authorised staff to listen into any live call for an appropriate and justifiable reason.

51.2. Every time Service Observe is used, the member of staff monitoring the call must note in the incident that silent monitoring is being used and their reason for doing so.

51.3. Managers, Team Leaders and auditors will normally Service Observe for the purposes of assisting with difficult calls, performance assessment and management or any other reason that may assist in the completion of the call.

52 Directory of Services (DoS)

52.1. The Call Handler must ensure the selected service on the DoS has been passed successfully via ITK. If this fails, the Call Handler must follow the instructions in the DoS. In the event of an ITK failure for DoS returns, the call handler must highlight this to an EMATL or SEMA via inline support for a Digital Admin Slip (DAS) to be completed.

53 Abusive Callers

53.1. Section 127 of the Communications Act 2003 makes it an offence to send a message that is grossly offensive or of an indecent, obscene, or menacing character over a public electronic communications network.

53.2. Abuse can be considered to have taken place in several ways, either by direct or indirect foul language, inappropriate comments, and comments that would be considered as potential harassment as identified within the Equality Act 2010 and relevant Trust policies.

53.3. The Call Handler must remain calm and professional throughout every call, and act in accordance with their training. Often, abuse is not personal and is a result of stress or anxiety experienced by the caller in response to the situation, due to the pain of an injury or feeling unwell.

53.4. Abusive callers must be asked politely not to be abusive. If they continue to be abusive after reasonable attempts to de-escalate the situation, seek advice from an EMATL who may opt to take over the call from the Call Handler.

53.5. Where a Call Handler feels they have been subject to abuse, they must escalate their concerns to an EMATL. The Call Handler must complete a Datix Incident Form (DIF-1).

53.6. If the Call Handler feels they have been subject to abuse, for example: racial, sexual, homophobic, or any other personal comments or threats, the Trust will support the Call Handler should they wish to report this to the Police using the non-emergency contact number, or online.

53.7. Managers and Team Leaders must ensure appropriate welfare is provided following a challenging or abusive caller.

54 Scene Safety

54.1. To ensure responding crews are notified of any scene safety issues without delay, the Call Handler must update the CAD incident with all relevant information. The Call Handler must ensure that all notes are saved and

notified on CAD to inform the RD of any information, as they are responsible for notifying the police.

54.2. The Call Handler must ask for, and gather, any further relevant information such as, but not restricted to, the below:

- Where is the attacker/aggressor?
- Do they have a weapon? If so, what kind of weapon?
- Advise the caller to get to a safe place if possible.
- If known, what is the name of the aggressor?
- Consider asking for a description if the attacker is unknown to the caller.

55 Safeguarding

55.1. Any concerns identified regarding a possible child or adult at risk made during a 999 call must be recorded in the call notes. Call Handler may often be the first point of contact with the patient so the actions taken alongside the accuracy of recording all information provided may be crucial to subsequent referrals or enquires.

55.2. Any member of Trust staff identifying a vulnerable person potentially at risk must follow the Trust's referral procedures by completing a Safeguarding referral via Datix.

55.3. The Call Handler must seek consent to share relevant information unless this will put the patient(s), member of staff or caller at risk.

55.4. The Call Handler must report any safeguarding concerns via the appropriate channels. If there is an immediate risk to a child or adult, the Call Handler must notify the EMATL or EOCM straight away. All other concerns must be documented within the CAD for the RD to escalate to police where appropriate and for the Call Handler to complete a safeguarding referral as soon as the call has ended.

55.5. If the Call Handler requires any additional support or guidance on this, they can find the Safeguarding Policy on the Zone.

56 Public Transport

56.1 When Call Handlers are dealing with an incident whereby the patient is on a mode of public transport, they must select the "public transport" instruction as this will highlight the incident to the EOCM & DTL.

57 Definitions

57.1. A ‘Call Handler” is any non-clinical member of staff qualified to handle a call using NHSP with the necessary competencies, known in the EOCs as an Emergency Medical Advisor (EMA).

57.2. Datix is the Trust’s incident management system.

57.3. Senior Call Handler is used to reference the role of Senior Emergency Medical Advisor (SEMA)

57.4. The Zone is the Trusts intranet site.

58 Responsibilities

58.1. The **Chief Executive Officer** is the overarching Executive Lead for the Trust.

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

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

58.4. All NHS Pathways trained staff are responsible for compliance with the procedure with daily monitoring provided by **their relevant line manager**.

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

58.6. 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.

58.7. The **Associate Director of Quality and Compliance** is responsible for auditing and quality assurance,

58.8. The **Head of Integrated Care Development and Education** is responsible for the provision of training systems to support the safe use of NHSP for new and existing staff. This includes any training required following a new version release of NHSP, and documentation of training delivered to all staff.

59 Audit and Review (evaluating effectiveness)

59.1. Compliance with the procedure is monitored through the NHSP audit process and audit compliance is reported to the 111/999 Quality Governance Group (QGG).

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

59.3. 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.

59.4. 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).

59.5. 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.

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

59.7. Services Locations

59.8. Surge Management Plan

60 References

60.1. Mental Health Act 1983

60.2. Communications Act 2003

60.3. Equality Act 2010

61 Financial Checkpoint

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