999 overdose and suicidal ideation calls

Initial assessment of lethality/toxicity principles document

Version 1.1, updated November 2023

Introduction

On 2 April 2019, Professor Jonathan Benger, then National Clinical Director for Urgent and Emergency Care at NHS England, wrote to ambulance trusts and NHS 111 providers to ensure robust clinical oversight was in place in control rooms to monitor self-harm and suicidal patients safely and effectively, particularly those who have been allocated a Category 3 response initially.

The former Healthcare Safety Investigation Branch (HSIB) also investigated the potentially under-recognised risk of harm from the use of propranolol. They made a safety recommendation for NHS England and NHS Improvement to evaluate current approaches to clinical oversight of overdose calls within ambulance control rooms, and to develop a national framework to describe requirements for appropriate clinical oversight of overdose calls.

Through the Ambulance Transformation Forum workstreams, these principles were encompassed in a wider programme of work around clinical validation, enabling quicker decision making and ensuring that patient safety remains at the forefront of delivery for emergency operations centres.

The high-level principles below are set out into five distinct areas of the control room operation:

- Call taking
- Dispatch
- Clinical assessment
- CAD requirements
- Clinical safety and oversight.

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This guidance has been reviewed in October 2023 by the Emergency Call Prioritisation Advisory Group (ECPAG, NHS England) and the National Ambulance Service Medical Director's Group (NASMeD, Association of Ambulance Chief Executives) to ensure it remains fit for purpose. Amendments made following this review are highlighted in yellow.

Principles for validation process: Call taking

- Call takers will answer and assess all 999 calls as per business as usual and in line with their trust's 999 triage tool (advanced medical priority dispatch system [AMPDS] or NHS Pathways).
- There will be no changes made to the 'front end' triage process for call taking, and determinants/dispositions will be reached in the normal way.
- Calls must be handled and coded in the normal manner, except in circumstances where an urgent clinical assessment is requested by a call handler due to a concern that the call may require a higher priority. Processes should be in place to convert third- or fourth-party calls into first- or second-party calls to allow accurate coding and categorisation.
- Where a call completes and the AMPDS/NHS Pathways outcome is a Category 3 overdose/accidental ingestion code or a potential threat of suicide, the control room must have processes in place to flag this to the call taker. This will allow them to give a relevant exit script as they would with Category 5 calls, to ensure the caller keeps the line clear as a clinician 'may' call back.
- Where a call completes and the AMPDS/NHS Pathways outcome is a Category 5 overdose/accidental ingestion code or a potential threat of suicide, the control room must have a similar process to that of the Category 3 requirements to flag this to the call taker as described above.

Principles for validation process: Dispatch

- Dispatchers will continue to monitor the computer-aided dispatch (CAD) and call stacks in the normal way.
- If an incident is dispatched pre AMPDS/NHS Pathways coding (ie due to the Category 1 early predict process), and subsequently the final code/disposition is a Category 3 overdose/accidental ingestion code or a potential threat of suicide, the resource should be left running where possible (subject to other higher acuity incidents waiting).
- Where a Category 3 overdose/accidental ingestion code or a potential threat of suicide incident is unallocated and no resource is available for dispatch, the incident MUST receive a clinical review as per this document. This should be escalated to a dispatch supervisor or supervising clinician to ensure the assessment of lethality is completed

as soon as possible. This includes where the incident was initially subject to a Category 1 early predict, as per the point above, but has been subsequently diverted to a waiting higher acuity incident.

- Incidents must remain visible to dispatchers during the initial clinical review to ensure timely dispatch of an emergency resource where one is available. Should a resource become available during the clinical review, then it must be dispatched and the clinician undertaking the review must be updated accordingly.

Principles initial clinical review: Overdose/accidental ingestion

- Where an incident codes as a Category 3 overdose/accidental ingestion code or a potential threat of suicide, it must be sent to the remote clinical assessment queue for urgent clinical review and be identified as a priority case, while remaining on the dispatch stack.
- Category 5 overdose/accidental ingestion or potential threat of suicide calls should be subject to the same urgent clinical review. Category 3 & 5 overdose/accidental ingestion or potential threat of suicide calls passed to the remote clinical queue must have an initial clinical review as soon as possible, and within a maximum of 30 minutes. This review will determine whether it is appropriate for the incident to remain as a Category 3 or 5 for full clinical review or should be upgraded to a higher response category. Where the incident is upgraded the clinician must inform dispatch immediately. For clarity, the 30 minutes is measured from the incident clock start time as per the ambulance quality indicators (AQIs).
- The choice of Clinical Decision Support System (CDSS) or Triage System to support initial clinical review is for local determination.
- As described above, following initial clinical review, a Category 3 or 5 overdose/accidental ingestion code or a potential threat of suicide incident may require a more urgent response. In such cases, the incident must be upgraded to an appropriate higher response category and identified appropriately within the CAD for dispatch.
- Where Toxbase is consulted as part of the clinical review, the following information is required:
    - Patient age
    - Substance ingested
    - Time of ingestion
    - Route of ingestion
    - Estimated dose/quantity
    - Patient's estimated weight (in some cases).

- It is considered good practice for Toxbase to be viewed for each overdose/accidental ingestion incident, despite the familiarity of the reviewing clinician with that particular toxicity profile.
- The initial clinical review should also take into account any ongoing suicidal ideation with a specific plan/means:
    - Deliberate or accidental self-harm
    - Admission of a specific suicide or self-harm plan
    - Previous suicide attempt(s) and/or mental health history
    - Males are more at risk than females
    - Isolated callers, ie nobody else is with the patient.
- For mixed complex overdoses, the data sheet with the most serious effects should be used, or those whose combination has an interacting toxic effect should be considered for escalation to Category 2.
- For third- and fourth-party calls, efforts must be made to convert this into a first- or second-party call to support a full clinical review and determine patient welfare. This includes consideration of whether the patient has already self-presented at a local Emergency Department, Urgent Treatment Centre or similar healthcare facility.
- Where the information available from the initial call is insufficient for a clinician to complete the clinical review, and the substance could be potentially toxic/lethal, then the caller/patient should be contacted for further information. If immediate contact cannot be made the incident **must** be upgraded. This process also applies in suicidal ideation calls regardless of the original categorisation.
- Where an incident, post clinical review, is upgraded to a higher priority, it must take its place in the appropriate dispatch queue and clock start rules applied as per the AQIs.

Principles for validation process: CAD requirements

- The CAD must be able to flag all Category 3 & 5 overdose/accidental ingestion or potential threat of suicide incidents as requiring urgent clinical review and place them in the clinical assessment queue.
- Where a clinical review of a Category 3 or 5 overdose/accidental ingestion or a potential threat of suicide incident has not taken place within 30 minutes, the CAD must provide a warning.
- Where clinical review of Category 3 or 5 overdose/accidental ingestion or potential threat of suicide incidents has not taken place, for whatever reason, within 40 minutes, and no responding clinician has arrived on scene, the incident **must** automatically receive a non-clinical upgrade to Category 2 and be reported, as per the AQIs.

- The CAD must be able to provide appropriate exit scripts for Category 3 & 5 overdose/accidental ingestion or potential threat of suicide incidents.
- The CAD should be able to alert dispatchers where a call is allocated pre-coding, and then codes as a Category 3 or 5 overdose/accidental ingestion or a potential threat of suicide incident. This will ensure dispatchers are aware a clinical review may be undertaken. However, if a resource has been allocated it should continue unless indicated otherwise, following clinical review.
- The CAD system must be able to stack incidents in the remote clinical queue at differing priority levels where required to flag those requiring more urgent review.

Principles for validation process: Clinical safety/oversight

- Clinical safety is of paramount importance; the introduction of clinical oversight of Category 3 & 5 overdose/accidental ingestion or potential threat of suicide incidents reflects the need for urgent clinical review so that an early assessment can be made of whether a higher priority response is more appropriate.
- Trusts must have a process in place for clinical oversight of patients waiting for clinical assessment and conduct an urgent clinical review as described within these principles. This will involve ensuring any patient who requires escalation to a more rapid clinical assessment or higher category response based on the information available will be managed as per trust procedures for escalation of incidents.
- A registered healthcare professional operating in a clinical oversight role will ensure the timely assessment of patients and be empowered to take the necessary decisions or actions to maintain clinical safety. The Clinical Decision Support Systems/tools used to support clinical review and validation are for local determination.
- The clinical review for assessment of toxicity/lethality or suicidal intent must consider any additional information in the call log, such as care plans, system flags, whether the caller is with the patient or environmental factors. These may influence whether that incident should remain in the clinical assessment queue as well as the dispatch queue or be returned to the dispatch queue for urgent dispatch.
- A suitable audit process for remote clinical assessment must be in place to identify any safety concerns or opportunities for improvement.
- Patient-specific protocols/care records should be accessed where possible to assess for relevance with the current clinical assessment.
- Any adverse incidents/near misses must be reported on Datix and follow the trust's serious incident reporting process.