East Midlands Ambulance Service NHS Trust

Clinical Assessment Team Protocols

Links

The following documents are closely associated with these protocols:

- Capacity Management Plan
- Dispatcher Protocols
- Safeguarding Triage Team Standard Operating Procedure
- EMD protocols
- Welfare calls prolonged waits

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Equality Impact Assessment	

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Version	Date Approved	Publication Date	Approved By	Summary of Changes
1.0	22 July 2015	23 August 2015	Clinical Governance Group	Replaces the Clinical Assessment Team Governance Framework
2.0	21 June 2017	29 June 2017	Clinical Governance Group	Updated due to the introduction of ARP. Added reference to new welfare call procedure Added reference to EMD protocols. Trauma Desk no longer in operation. Introduction of Card 35 which replaces Urgents. Welfare calls changed to Triage. Calls per hour changed to 6 from 8 Team Leader role added. On scene discharge instruction added Clinicians will be assigned to divisions to triage patients of all Categories. Dispatches do not stand down any crew from a downgrade unless advised by clinician or a CAT 1 comes in. Falls new procedure. Removal of Hot transfers. New instruction for EMD support Role CMP review updated

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1. Introduction

1.1. The Clinical Assessment Team (CAT) protocols are live documents and will be updated with appropriate changes/additions as required to keep them current with the Trusts requirements.

1.2. The CAT protocols have been written in conjunction with service procedures and protocols to ensure that Clinical Advisors within the Emergency Operations Centre (EOC) are clear on what is required of their role. This will ensure consistent working practices in the department. This document will be updated when appropriate and is also available on the Intranet.

2. Objectives

2.1. The objectives of these protocols are to:

- provide a consistent approach to the safe assessment of all patients who are triaged through the CAT team.
- ensure that EMAS achieves its strategic objectives.
- provide care in the right setting, Improving clinical outcomes, safety and governance.

3. Scope

3.1. This following document outlines the structure, role, reporting and responsibilities of the Clinical Assessment Team (CAT) within East Midlands Ambulance Service (EMAS) NHS Trust.

3.2. This document governs the way in which all calls are handled and assessed by the CAT desk during normal working conditions and outlines the response of the CAT clinicians in response to the initiation of the Major Incident Plan or the Capacity Management Plan.

3.3. The overriding consideration of this framework is to promote patient safety and clinical excellence, and to ensure that best practice standards are delivered at all times.

4. Overview

4.1. All 999 and CARD 35 calls are received in the Emergency Operations Centers (EOC) across two sites (Horizon Place, Nottingham and Bracebridge Heath, Lincoln) and are processed by Emergency Medical Dispatchers (EMD) using Advanced Medical Priority Dispatch System (AMPDS). There are six categories of responses allocated by AMPDS, these are:

4.2.

Category 1	Time Critical Life-threatening requiring defibrillator
Category 2	Life-threatening
Category 3	Serious but non-life-threatening
Category 4	Urgent but non-life-threatening
HCP admissions	Urgent request for admission- clinical, social, mental health.

For each priority, there is an agreed point at which the performance clock begins which is referred to as “Clinical Quality Clock Start”

Category 1 Clinical Quality Clock Start is the time the call is received at the telephony switch (Call Connect)

Category 2/3/4- Clinical Quality Clock Start is (whichever time is earliest)

- First Resource allocated
- 240 seconds from Call Connect
- Chief complaint selected

Electronically received 111 calls - Clinical Quality Clock Start will start immediately at the point that the call presents to the Trust’s EOC CAD.

4.3. The CAT Team is responsible for the further clinical assessment of CATEGORY 4 coded calls, clinical assessment and triage of any patient in which there may be delayed response or the patient will benefit from clinical intervention.

4.4. The CAT team is based within the two Emergency Operation Centers. The team provides advanced telephone clinical assessment to patients, ensuring appropriate and timely alternative pathways, including the utilisation of urgent vehicles and other modes of transport.

4.5. The CAT Team consists of Senior Nurses, Paramedics and Emergency Care Practitioners (ECP).

5. Structures and Accountabilities

5.1. The CAT is governed by the Operations Team line management structure with Input from the Clinical Team for clinical governance assurance.

5.2. The General Manager for EOC has overall accountability for the management of the EOC including all the handling of 999 & Card 35 calls, staff and premises.

5.3. The Medical Director is accountable for ensuring adherence to strict clinical governance principles and ensuring patient safety and high quality clinical care.

5.4. The Deputy Director of Operations and the General Manager of EOC are accountable to the Director of Operations to oversee the operational functioning of the EOC.

5.5. The Clinical Service Delivery Manager (CSDM) for CAT is accountable for day to day clinical issues.

5.6. The CSDM is accountable for ensuring day to day provision of CAT clinicians and ensures adherence to procedures and delegating work as appropriate to the CAT Team Leaders.

6. CAT Clinician Development and Monitoring.

6.1. All CAT clinicians will attend the Trust Induction. Training will consist of 2 days training on TAS and. The trainee clinicians will then receive 2 weeks with a named mentor and then will continue in a buddy system arrangement for up to 9 months. A CAT Induction program will be used for all new clinicians using the new CAT starter pack.

6.2. All CAT clinicians will be supported to ensure delivery across the various metrics within their staff group including:

- Monthly performance reviews – Key Performance Indicators (KPI)
- Annual appraisal – Personal Development Review (PDR) Objectives will be set by SDM
- Clinical Supervision session – Quarterly
- Safeguarding supervision - Yearly
- Call Audit – minimum 6 calls per month
- Individual call reflection

6.3. All CAT clinicians will operate in accordance with their respective professional council principles and guidelines. At all times the clinician must ensure the delivery of high quality clinical care and remain professional at all times. They will not act outside their clinical knowledge or competence at any time.

KPI	Description	Objective
Calls per hour	No. of calls each clinician is expected to take per hour	6 calls per hour
Call Duration	The average length of each assessment by the clinician	6.5 minutes per assessment with additional 2.5 minutes to complete notes.
Ambulance stand down	Percentage of ambulances stood down –CATEGORY 4 only	50% ambulance stand down
Refer and Treat	Referral to alternative agency – CATEGORY 4	30% Refer and Treat
Hear and Treat	CATEGORY 4	20% Hear and Treat
AMPDS assessments	Assessment of inappropriately coded CATEGORY 1,2,3	As many as clinically indicated

7. On-going Development

- Essential Education – Non clinical and clinical - Yearly
- Continuing Professional Development
- ECP observer shift –once a year
- Safeguarding training as per Trust requirements
- Working towards Degree or higher level qualifications
- Clinical "Road time" as part of the rota for paramedics.

7.1. All development and education will be recorded in the Organisational Learning management system.

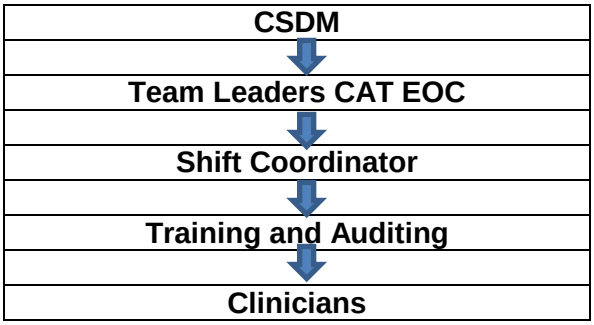
8. Clinical Assessment Team and Clinical Support Desk.

8.1. The Clinical Support Desk (CSD) is responsible for receiving and overseeing all safeguarding referrals in line with the Safeguarding Policy, utilising SystmOne.

8.2. The CAT desk will support the taking of immediate referrals from crews when the CSD is unstaffed or high activity of referrals occurs.

8.3. Any queries on Safeguarding procedures and protocols should be addressed to the main Safeguarding Triage Team based at Beechdale.

9. Clinical Assessment Team Structure



10. Clinical Co-ordination Role and Responsibilities.

10.1. The Team leader will ensure the running sheets are completed for the following day. These will including allocating a clinician per division, to provide a clinician for LINCS CAS and demand allows a EMD support clinician. The Team Leaders will allocate a coordinator per shift to oversee the answering of the crew phone and to be a point of contact for the Duty Manger to ensure prolong waits receive a triage in a timely manner.

10.2. NB. Number of clinical assessors will be determined by capacity of staff numbers per shift vs. EMAS call volume demands.

10.3. The Team leaders will partake in any EOC daily operational meetings, as required. In Capacity Management Plan 3 and above the frequency of meetings may increase. Outside the Team leaders working hours and where demand allows the coordinator will attend in their absence. All discussions must be documented in the Triage Log on CAD.

10.4. The Team Leader & Clinical Coordinator will ensure all calls are revised assessed and processed in a timely and safe manner in accordance with the national standards assessment time

10.5. The Team Leaders will ensure the correct skill mix is achieved to ensure clinicians are allocated appropriately to enhanced clinical assessment, CAT 4 call triage and welfare checks. There is no set number for any of these positions and the Team Leaders & Clinical Coordinator will designate clinicians to their roles, using dynamic assessment through the shift to maintain patient safety at all times..

10.6. The Clinical Coordinator will act as an autonomous decision maker, to make dynamic deployment decisions, to meet the operational demands that may require altering staff allocation to different ARP codes. This may be due to high call demands for different categories or to assist with divisional demands.

10.7. They will liaise with Duty Managers across both EOC's to identify staff allocation per shift and provide clinical support for the operational staff. Allocation will be dynamic and take into account the changing profile of the work during the shift to ensure a balance of patient safety and clinical assessments.

10.8. The Crew advice line will be answered by any available clinician via the dedicated phone number. The details of the patient, advice given and the patient outcome are to be documented. If an unqualified crew is requesting an on scene discharge then a full history must be obtained with 2 sets of observations. The crew must be with the patient. An on scene discharge must only be granted if it is appropriate to do so. All information must be documented in CAD. CAD. The crew referral may result in advice to transport the patient to ED, leave the patient at home,

or identifying alternative arrangements e.g. OOH, GP, District Nurses or Specialist service.

10.9. If a unqualified crew ringing for a on scene discharge after they have referred the patient to another HCP then CAT must treat as above and confirm who the HCP is and what timeframe if any for a triage/home visit. This must be documented in CAD.

10.10. Welfare Calls – Following the attendance of an EMAS resource, the crew may request a welfare call, either if the patient has been assessed as suitable for leaving at home or has been left at home whilst awaiting alternative care pathway and it is deemed safe to do so. The crew should be with the patient when the request for welfare call is made. The welfare call will be made within an agreed time frame after mutual agreement of the CAT clinician and the crew that it is safe and appropriate to do. The patient must have given consent for the welfare call.

10.11. Any patient who refuses hospital transport against the advice of the crew and who has the capacity to make that decision will not normally have a welfare call. This decision will be made by the CAT clinician. All patients must be informed failure to answer the welfare call at the agreed time will result in an ambulance attending the patient as an emergency response.

10.12. The Clinical Coordinator is responsible for ensuring the patient welfare call is performed, or if taken by another Clinician they will be made aware of the requirement by the clinician if they are unable to undertake it themselves. It may not always be in the best interest of the patient and Trust for this to happen, so final decision for the acceptance of the call will rest with the CAT Clinician taking the call. All welfare calls will be documented in the CAD.

10.13. Patients in a nursing or residential care facility and have access to 24 hour care will not normally require a welfare call from a clinician.

10.14. Any clinical concerns/incidents involving triage assessment over the phone are to be reported to the Team Leader or Clinical Coordinator who will escalate to the appropriate managers.

10.15. All clinicians are responsible for the welfare calls of any 111 call which may have a delayed response.

10.16. If the Approved Clinical Triage Software (ACTS) becomes unavailable the Team leaders or Clinical Coordinator is responsible for implementing the No ACTS procedure and escalating to the appropriate managers. Supporting clinicians are to ensure that patient safety is not compromised in this situation.

11. Procedure Overview

11.1. All emergency calls are processed through the AMPDS protocol by the EOC call handlers.

11.2. Predetermined AMPDS codes and other calls will be assessed depending on capacity/demand. The predetermined codes will be passed to the ACTS and the remaining Category codes will be monitored by an identified clinician.

11.3. CATEGORY 1 & 2 calls will be monitored and assessed/triaged if appropriate.

11.4. All calls will be processed utilising the clinical assessment tool unless there is a technical problem and calls are unable to be assessed or at certain action levels of the Capacity Management Plan usually CMP 3 and above have been activated. In this case the No TAS procedure will be activated.

11.5. Clinicians will be assigned to divisional desks to assess all Categories of codes. Once a full triage has taken place a Clinician may stand down any resource travelling to a CATEGORY 1, 2, & 3. The clinician can HAT & RAT any Category of call after a triage.

12. CAT 1 Codes – Specific Procedure For Enhanced Clinical Assessment

12.1. The primary function of CATEGORY 1 enhanced clinical assessment is to provide a timely secondary assessment of the patient whilst waiting for an emergency response. It allows for assessment and ongoing support of the patient and the provision of advanced clinical advice whilst waiting for the resource to arrive. The clinician must wait for the AMPDS code before triaging the call. A clinician should not conduct their triage through the call taker; they should take over the call themselves.

12.2. A clinician may ask the call taker to pass them the call once it has been coded. The clinician then takes all responsibility for that call and patient.

12.3. An assessment can be requested by anyone in EOC regardless of the ETA of crew. Once a crew has arrived on scene the AMPDS code must remain the same.

12.4. Exceptions to CATEGORY 1 enhanced clinical interventions are:

- Active CPR in progress
- 4th Party callers i.e. other control centers unless direct contact to the patient is available.

12.5. This procedure must not interfere or affect the dispatch of an allocated resource as agreed in the National Performance Standards.

12.6. Assessment should take place using ACTS as a support tool unless unavailable or capacity management plan 3 and above has been implemented.

12.7. If the patient deteriorates or becomes critically unwell, the clinician should stay on line until the allocated resource arrives, utilising the emergency

protocols as required/necessary. A copy of these will be found within the CAT room and also via the ACTS, within the program.

12.8. Following assessment, the clinician will override the AMPDS code if suitable prior to arrival on scene of the resource. If the resource arrives whilst assessment is in progress, the AMPDS code will remain the same. The CAT clinician should if possible discuss with the ambulance clinician if any alternative pathway is suitable or if useful information is gathered in the assessment.

12.9. The Clinical Decisions Override (CDO) function is used to downgrade CATEGORY 1 calls to other response levels, i.e. CATEGORY 1, 2, 3, HAT, RAT etc. Call should not be downgraded without an assessment by the clinician.

12.10. The CDO function will also be used to escalate calls as appropriate i.e. CATEGORY 1, when the clinical assessment has determined that the patient is time critical and requires the CATEGORY 1 level response. No call is permitted to be upgraded without a triage by a CAT clinician. Calls should not be escalated without an assessment by a CAT clinician.

12.11. Any responding resource will continue to the scene and should not be stood down from the incident unless a CATEGORY 1 call is received nearby. CAT clinicians may authorise a resource to be stood down following a complete clinical assessment, however no resource will be stood down by dispatch without clinical authorisation from the respective CAT clinician.

12.12. On completing the assessment on ending the call the clinician will advise the caller to re-dial 999 if the patient deteriorates further. Appropriate call back information and safety netting advice should be given.

12.13. All decisions and advice given should be documented in the CAD and ACTS systems. If further information needs to be conveyed to the crew or the dispatch officer this must be done in a timely and relevant manner. The dispatch officer will update the crew via data terminal or radio. Within CAD this should take the form of a brief description of the clinical presentation.

12.14. All clinicians must be up to date with ACTS emergency protocols and confident in giving CPR/Emergency protocols over the phone.

13. Obvious or expected death. Over 18s only

13.1. In the event of obvious or expected death that is not coded as a CATEGORY 4, the call can be transferred to the clinician for enhanced clinical intervention. This should only occur after the EMD has made reasonable requests for CPR to be commenced and all offers of assistance refused by the caller or where the caller states a DNACPR order is in place

13.2. Obvious death as defined by AMPDS is documented Below:

- Cold and stiff in a warm environment
- Decapitation
- Decomposition
- Incineration
- Fetal Maceration
- Severe injuries obviously incompatible with life

13.3. In the event of the patient arresting during the enhanced clinical intervention the clinician is responsible for initiating CPR immediately and utilising TAS emergency protocols.

13.4. Following enhanced clinical intervention calls that are not suitable for a clinical downgrade remain the responsibility of the clinician. The clinician must stay on the line with the caller to ensure continuous care; and monitor the patient's condition until the resource arrives at the patient.

13.5. Patients not demonstrating peri-arrest or immediate life threatening symptoms are suitable for enhanced clinical intervention and appropriate recoding by the clinician.

13.6. After enhanced clinical intervention any call that is deemed not appropriate for a CATEGORY 1 response may be downgraded to a CATEGORY 2, 3, 4, HAT or RAT.

13.7. Obvious Deaths in the community

13.8. All Clinicians should assess each call to ensure the patient is beyond any help or there is a DNACPR in a nursing or care facility.

The clinician must obtain all patient demographics including GP surgery. The clinician will then pass these details to the GP surgery in hours or OOH & Police. The clinician will request a doctor's attendance for certification of death. All communication should be documented in CAD. The CAT for will then be closed as a RAT.

13.9 All under 18s require a DCA response

14. CATOGREY 4 Specific Procedure

14.1. Relates to any call which codes as CAT 4

14.2. Exceptions include
- Dr on scene (Inform CAT)

14.3. All CATEGORY 4 codes will be assessed within 60 minutes

14.4. Following clinical assessment if a response is still required then in line with the HCP protocol the clinician will arrange an appropriate response.

14.5. This response will be via the CDO function to escalate the call to the appropriate level, CATEGORY 1, 2, 3, or CAT HCP response. etc.

14.6. If the patient has been 'referred' on or 'hear and treated' then the CDO function will be used to stop the job using the appropriate stop i.e. HAT, RAT, Leics GP car, LINCS CAS etc.

14.7. All notes should be completed both within the ACTS and a brief summary in CAD for responding crews and dispatchers to be aware of.

14.8. If possible a clinician will be assigned to monitor and triage calls coded as falls still on the floor to maintain patient safety and appropriate referral or upgrade as required.

14.9. ALL calls originating from 111 will be assessed as welfare calls or if there is an identified clinical need based on service levels and resource requirements.

14.10. FALLS on floor

14.11. All falls should be fully assessed and if no injury then the Nursing/care facility should be encouraged to pick patient up using aids available. Carers in patients own home should also be encouraged to help assist the patient. Any refusals should be referred to CSDM with job number. If a resource is required then a clinician will escalate to the appropriate Category. If a resource has not been dispatched within that time frame then a further triage should take place and all falls should be further escalated. Any patient with limited mobility should be given the appropriate pressure area advice and escalated as appropriate.

14.12. A patient who has been on the floor for greater than 4 hours and at risk of pressure sore development should be escalated as a priority. (A maximum to CATEGORY 2 should be considered unless the patient meets CATEGORY 1 criteria).

15. No reply on ring back for CAT 4 Events

For CATEGORY 4 calls the 999 call handler should ensure that they have advised the caller that a clinical advisor will make three attempts to call the patient back over the course of 60 minutes & that the first call will normally be within the hour for Category 4. The caller will be advised that if they do not answer the phone then the call will be closed.

Exceptions:

- Risk of unconsciousness.
- Diabetic Patients.
- Elderly over the age of 69 years.
- Children under 5 who you have clinical concerns.
- Alone.
- A child/young person about whom you have safeguarding concerns.

- Mental health concerns such as expressions of intent to self-harm or attempt suicide.
- You have any other concerns about the safety of the patient.

15.1. The clinician will check to see if the contact details are correct and/or the patient is not in the care of local A&E or OOH provider. The clinician will make three attempts to call the patient back over 20 minutes from the first attempt. On the final occasion the call can be closed using the Clinical Decision's Outcome (CDO) function.

15.2. It is **not** appropriate to close calls if the number is incorrect or unobtainable, rather than: engaged, ringing with no answer or going to voicemail.

15.3. Where ever possible a voicemail must be left to advise the caller that three attempts have been made to call the patient back & their request has now been closed. The clinician should also advise the patient to call again if an ambulance is still required.

15.4. Wherever the clinician is concerned for the patients welfare, or based on the information presented within the event, believes that a physical response is required they should assign the most appropriate response.

16. Category 1, 2, 3, codes

16.1. CAT clinicians will monitor all CATEGORY codes for any patients in whom there may be a delayed response. Clinicians should contact and triage as appropriate the patient to ensure their condition has not altered. This should be done at the earliest opportunity. Patients who have not been contactable for a welfare call, the clinician should phone A&E/OOH to see if patient has self-presented. If the patient has not self-presented then the call should be further upgraded. Where operational demand allows the clinician should continue to try and contact the patient periodically until a resource arrives.

16.2. All calls from Lifeline (LL) where a patient cannot reach the phone a triage should be attempted via LL. If LL is unable to contact the patient then the call should be upgraded accordingly. The clinician where demand allows should continue to try and contact the patient until a resource arrives and if unsuccessful contact LL to ascertain the patient's current medical condition and upgrade accordingly if not able to verify patient medical status.

16.3. The CAT clinician should identify any CATEGORY 1, 2, 3, codes in which an alternative pathway may be suitable, and prevent an unnecessary ambulance response.

16.4. The role of all clinicians is to

- Undertake clinical assessment of appropriate CATEGORY 1, 2, 3, calls

- Identify calls in which an alternative pathway may be suitable and prevent the dispatch of an unnecessary ambulance response.
- Provide clinical assessment, support and welfare checks of all prolong waits of all Categories of calls and assess appropriately as required.

16.5. The CAT clinician will not wait until the patient is at risk of becoming a prolong wait but will initiate a triage to aid the patient with either a RAT & HAT or an upgraded to an appropriate Category.

17. EMD Support

17.1. A clinician where demand allows will be allocated to EMD support. This will aid the EMD to take calls rather than staying on the line with patients. The EMD advice is below.

- ETA is 20 minutes or less there is no point CAT taking over the call (however a clinician may take over the call to review the CATEGORY1, 2, 3, coding)

- Urgent Disconnect should be considered for all cases –

- Breathing Tool - If the caller is not with the patient so you cannot do the breathing tool, then question why we are staying on the line – please do not let the EMD send the caller back to sit with the patient and the EMD stay on the line with a silent phone – as a team leader you can make the decision to tell them to disconnect – the whole purpose of staying on the line is to monitor the patient condition and provide lifesaving instructions if required – if you can't do it – why stay on the line – provide worsening advice and disconnect

- If a patient is a 1st party caller but you are aware there is a responsible adult with the caller then we can disconnect

- If there are more than 5 free EMD then we should not be using the Urgent Disconnect and pass to CAT – unless we think we are going to breach a 20 minute staying on the line time.

- IF there is a HCP that is prepared to care for the patient whilst the ambulance arrives we should not be stopping on the line – remember we are only staying on the line to provide lifesaving instructions to the caller – if the HCP is on scene and they are prepared to look after the patient.

- Maternity – if the head is showing or actively pushing then the EMD needs to stay with that call – regardless of the ETA. There is nothing to stop the help card being raised and the Cat reviewing and possibly upgrading to CATEGORY 1 – but the EMD is the most appropriate person to deliver the baby.

- Where the EMD is stuck on the line and the team leader has reviewed and taken all actions available and you are unable to pass to the EMD

support clinician – then you must speak to a clinician at either site to take the call as priority – the only EMD staying on the line in excess of 20 minute call times are those where the EMD is the most appropriate person to deal with the call e.g. cardiac arrest/delivering a baby.

- A Call delay slip does not require passing to CAT if the coding is CATEGORY 4 unless the EMD is staying on the line as part of the Staying on the line process. Sepsis calls are picked up if CAT 4 we don't need to escalate – CATEGORY 3 and above please complete the call delay slip.

18. Interim assessment Checks

18.1. Following clinical assessment and dependent on the patients presenting clinical condition; if a patient requiring an ambulance response experiences delays in resource being dispatched it is the individual clinicians' responsibility to provide a triage call in order to reassess the patients' condition and upgrade the call if the patients' condition warrants an immediate response.

18.2. Any code that has a delay in resource allocation will receive a triage call from the Clinical Assessment Team in order to provide ongoing care until a resource is dispatched.

18.3. The triage call should where demand and CAT staffing allows take place within 40 minutes of the call going out of time. In most circumstances triage calls should be performed well in advance of this. .

18.4. The CDO function will be used if the clinician believes that the call needs to be escalated due to worsening patient condition.

19. Failed Contact

19.1. The clinician will attempt to make contact with a patient over a 60 minute period starting from the first attempt to contact the patient by the clinician assigned to the incident. If after this timescale no contact has been made with the patient the clinician will contact the nearest A&E/OOH provider to check the patient has not self-presented/referred. If the patient has not self-present/referred the clinician will upgrade the call to the appropriate response. The decision on what Category will be determined form the information provided by in the CAD. The call will be escalated, as per the CDO function if the condition falls outside section 15. The clinician where staffing allows will continue to contact the patient every 20 mins and upgrade accordingly.

20. Major Incident

20.1. In the event of a major incident being declared the clinical assessment desk will continue to prioritise all calls and provide clinical support and assessment for non-major incident related calls.

21. No ACTS Procedure

21.1. In the event of ACTS being unavailable the registered clinicians are able to assess all category calls and patients using their own clinical knowledge and assessment skills. Clinicians will TAG all calls where ACTS is not available. The on call SDM must be notified and an IR1 must be completed.

21.2. Assessment history and clinical outcome of assessment shall be recorded/documented on the computer aided dispatch system.

21.3. Calls assessed using the No ACTS procedure should be subject to the established call review procedure

21.4. In the event of no ACTS being available, ICT must be informed; an Incident form will be completed and raised with the risk and safety department.

21.5. During the activation of Capacity Management Plan action 3 and above TAS may not be utilised for assessment.

22. Insufficient CAT Clinicians Available

22.1. If CAT staffing falls below the core standard patient welfare and safety must be maintained.

22.2. In event of there being insufficient clinicians available the EOC Duty Managers must be informed and the EOC Tactical on call for EOC.

22.3. The clinical advisors priority will be targeted to higher priority calls. CATEGORY 4 calls will be assessed as a priority. Further capacity will be used to maintain patient welfare and safety. This will include the welfare assessing of all category calls

22.4. All children under the age of 2 will require an automatic CATEGORY 3 response if capacity within the team is limited and the child has been given a CATEGORY 4 response.

23. Implementation of Capacity Management Plan (CMP)

23.1. It is the responsibility of the team leader & Clinical Coordinator to liaise with the Duty Managers to identify areas of concern and formulate plans to maintain patient safety.

23.2. During activation of the Capacity Management Plan patient safety will remain the priority. CAT clinicians will prioritise CATEGORY 1, 2, 3, calls where there will be a delayed response.

23.3. During activation of the Capacity Management Plan the EOC DM will assist the CAT with monitoring all CATEGORY 2/3 codes and identify any calls that have either breached response time or where there are no resources available.

23.4. In CMP 1&2 the CAT desk will be made aware of the divisions that are struggling and assist if possible in welfare or clinical assessment calls as appropriate.

23.5. Where codes have been given the no send as per AMPDS the CAT desk will be responsible for removing those appropriate calls, as per CMP guidelines, calls from the ACTS and CAD and cancelling them as Stopped in CMP Procedure using the CDO function. All CMP qualifying codes must be reviewed by the clinician by accessing the note pad and not just relying on the chief complaint. A decision to close a call as CMP lies with the clinician.

23.6. In CMP 3 and above ACTS will not be utilised. Clinicians will use their clinical skills and knowledge to triage patients.

24. No Send Procedure

24.1. Once a call has been passed to the Clinical Assessment Team, the clinician overseeing the call will contact the patient in order to complete a full assessment with the use of ACTS.

24.2. If following a full clinical assessment it is determined that the patient does not require transport, the clinician will advise the patient of the most appropriate referral pathway.

24.3. If the patient has an alternative referral pathway agreed but does not require ambulance transport the clinician is responsible for advising the patient that they should make their own way to the appropriate care provider.

24.4. The clinician is then responsible for updating the call on the CAD system with the appropriate details

24.5. If an alternative pathway is agreed i.e. appointment with a General Practitioner (GP), then this contact must be requested within four hours of the initial call being received by EMAS EOC and documented appropriately.

24.6. If a call coded as CATEGORY 4 falls within the remit of the codes eligible for automatic ‘No send procedure’ then the CAT desk will be responsible for removing the call from the ACTS and CAD and stopping the call as ‘No send Procedure’ using the CDO function. The clinician must review the note pad on CAD before closing any call.

25. Safeguarding Procedure

25.1. It is the responsibility of the Clinical Assessment Team/Advisors to be familiar with and adhere to national/local and EMAS policies and procedures to work within the NMC and HCPC Code of Professional Conduct. Clinicians are required at all times to Safeguard the health and wellbeing of children and vulnerable adults and to use critical thinking

skills to support EOC staff in decision making processes on complex/sensitive scenario's resulting in a safe service user outcome.

25.2. A clinician can escalate a crew referral to an immediate concern if it requires immediate referral to Emergency Social Care Duty Teams and/or the Police.

CLINICIANS may over rule a crew if they believe a referral is not an immediate. The clinician will follow the RAG rating supplied by the safeguarding team.

26. High Volume Service Users (HVSU)

26.1. The clinical assessment team is responsible for following the care management plans in place for identified HVSU. The CAT will assess these patients and ensure that the most appropriate outcome is reached in accordance with the patients presenting clinical needs.

26.2. The CAT clinicians should identify any issues with the HVSU database and escalate these to the CAT HSVU Lead or HVSU lead.

26.3. The CAT clinicians should identify any caller who may benefit from the HVSU input and refer these callers for action to the CAT HSVU Lead or HVSU lead.

26.4. It is the responsibility of the HVSU lead to ensure that all recognised HVSU patients with approved care plans or a local agreement with the GP regarding the management of these individual patients calls have the appropriate CAD warnings/flags and the following notes to be inserted into the CAD.

26.5. Any HVSU that is coded as a CATEGORY 4 call is to be passed to CAT for assessment in the normal way.

27. Clinical Advice Line for EMAS Staff

27.1. The clinical assessment team provides a 24 hour service and can be utilised by all staff within the Organisation in order to be able to assist with patient care ensuring that the most appropriate care/treatment is being provided.

27.2. All advice provided to crews must be documented in CAD in case of issues arising.

27.3. If appropriate external resources such as the DOS system should be utilised to give the most current and clinically relevant advice to a requesting crew

28. Emergency Incidents within EOC

28.1. The clinicians on the CAT desk are responsible for attending medical/trauma emergencies that may occur within the EOC site. Only 1

clinician will attend unless the patient's condition is life-threatening. There should not be a pro longed assessment and a crew should be requested if the colleague is not improving after 15 minutes.

28.2. The Clinical Coordinator and DM on duty should be made aware of the incident and a running call may be entered into CAD.

28.3. The emergency response kit kept at the EOC sites should be used for assessment and treatment of a patient, as per the Emergency Response SOP.

28.4. The CAT desk should not be used for first aid purposes, instead for emergencies only. No Clinician will advise a staff member to go home; this is the decision of the individual.

29. Tagging Levels in CAD

29.1. The 'Tag' function should be used by CAT clinicians when triaging calls as appropriate to the Tag Level. This is accessed via the Inform tab along the row of tabs above the notes window on a job in CAD and then selecting Tag Levels.

29.2. The Welfare Urgent series of Tags should be used as appropriate when the CAT is well faring admission calls.

29.3. Other Tag levels should be used as appropriate.

30. Consultation

30.1. Consultation has been via the Operations SOP Working Group.

- Bob Winter Medical Director.
- Rashid Sohail Deputy Medical Director
- Ian Mursell Consultant Paramedic
- Zoe Rodger-Fox Safeguarding lead. .
- Simon Tomlinson Service Delivery Manager EOC BB
- Clinical Assessment Team

31. Monitoring Compliance and Effectiveness of the protocols.

31.1. Monitoring of the SOP will be undertaken by the Clinical Assessment Team Manager in collaboration with the consultant Paramedic for EOC and through the risk, safety & governance group.

Plan for Dissemination of Procedural Document

Title of document:	**Clinical Assessment Team (CAT) Protocols**		
Version Number:	**V2.0**	**Dissemination lead: Print name, title and contact details**	**Sue Jevons, SDM Clinical Services EOC**
Previous document already being used?	**Yes**		
Who does the document need to be disseminated to?	**Clinical Assessment Team, all EOC staff**		
Proposed methods of dissemination: **Including who will disseminate and when** Some examples of methods of disseminating information on procedural documents include: *Information cascade by managers* *Communication via Management/ Departmental/Team meetings* *Notice board administration* *Articles in bulletins* *Briefing roadshows* *Posting on the Intranet*	**Article in EOC bulletin**		

Note: Following approval of procedural documents it is imperative that all employees or other stakeholders who will be affected by the document are proactively informed and made aware of any changes in practice that will result.