



From: Priority Dispatch Corp UK - LTD

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The Forgotten Omega Code and the Missed Alternate Response in the UK.

One of the myths that we constantly battle surrounding the Medical Priority Dispatch System (MPDS) is that it dictates a response or level of response. The confusion comes from the MPDS' grouping of similar patient acuity levels and scene activities into Echo, Delta, Charlie, Bravo, Alpha and Omega tiers. If the ambulance agency wants to group their responses to these tiers, that is fine. If they want to attach specific responses to the actual code and even the sub code suffix, better yet – but use of the MPDS requires neither. Nowhere is this confusion more prevalent than in the UK with their national Category C response.

In an effort to clarify the MPDS usage and position, we will attempt to outline a brief history of the Omega protocol and what happened in the UK with Cat C in 2003 and 2004. There is no doubt that some of the specifics surrounding Cat C will not be completely accurate nor as referenced in NHS documents; our access is limited and we can only work with what the Trusts have relayed or asked of us. Where the mistake is not material, please accept any subtle differences and keep the overall objective in mind.

OMEGA Protocol:

The Omega tier within the MPDS was sought and developed over 15 years ago. It was originally trialed and ultimately deployed in Montreal, Canada in 1993. It has since been deployed in various agencies throughout the world, including in the USA, Canada, Australia, Europe and Africa. The intent of the Omega grouping of codes was to allow referral to these very low acuity incidents out of the EMS system to an alternate response; not, a non-response, but to another, better, avenue of care. These could include information or advice lines (poison control, “ask a nurse”, rape crisis lines, mental health help lines, etc.), doctors, clinics, community services that assist immobilized or elderly patients and so on. This could effectively allow the EMD to refer a caller directly to a Walk-in Centre, a GP, an Out of Hours line, or other resource depending on what is available.

As with all codes that the MPDS produces, exactly what the better avenue of care is, is dependent on what the agency, government, and/or community have available. Priority Dispatch (PDC) and the International Academy of Emergency Dispatch (IAED), can assist and bring its experience in an effort to help the agency determine what is best used within their system – but, ultimately, it is up to the agency.

Because of the nature of the responses associated with Omega – delayed, even non-hands on evaluation – the MPDS user deploying the Omega protocol must be operating at an IAED Accredited performance level.

(http://www.emergencydispatch.org/acc_home.php). Any system that would implement

this type of response and not have a high level of Quality Assurance and external validation is extremely risky and has proven liability.

With proven compliance to the proper usage of the MPDS, the Omega protocol has proven safe for alternate response. Worldwide, the MPDS has over 3,000 control rooms, 75,000 users and 18,000 seats of software in use. This generates, on average, over 40 million calls run through the MPDS per year. This level of data helps to continue to improve the total of the MPDS, but also prove the accuracy of its acuity grouping and tiers, including Omega. These hundreds of millions of calls and the history of the MPDS, 30 years in total, with over 15 for Omega, have validated the MPDS as the standard of care in Emergency Medical Dispatch (EMD).

Category C:

PDC first became aware of Cat C in 2003. PDC's understanding was that the NHS was allowing Ambulance Trusts to seek alternate responses for 999 calls – not always send an ambulance. There did not appear to be a lot of information or guidance surrounding what type of calls or how to determine those calls or what was an acceptable alternate response. In July of 2003 PDC sent information on the Omega protocol to all the Ambulance Trusts. The response was large and immediate this was a perfect fit for what the Trusts were trying to do. In late 2003, PDC started negotiating the NEMA agreement with the NHS. PDC was asked by the NHS to make Omega available to all the Ambulance Trusts as part of this agreement. Further, they asked that PDC make it available during the negotiations as the need was immediate. PDC agreed and the Omega protocol was made available to all Ambulance Trusts using the MPDS with no cost in early 2004.

Some of the first Trusts to deploy Omega were East Anglia and Oxfordshire, followed shortly by several others. While testing the deployment, East Anglia expressed frustration in the fact that the Omega tier was only about 8% of their total call volume. As other Trusts implemented Omega, they expressed similar concerns – the overall intent of the Trusts was to reduce the number of calls that required an ambulance response, thus increase their performance to those patients that needed an ambulance. PDC and the IAED started working with various Trusts to study and determine other codes that could safely receive alternate responses. There were various “obvious” ones such as most codes in the 26 Alpha group. During the studies, there were various problems within the Alpha group, even some fatalities, that prohibited IAED from moving them safely to the Omega tier.

East Anglia and Staffordshire were willing to further vet these additional codes, now being referred to as Omega “Plus”, through a Nurse Triage system to ensure an additional safety net. PDC and the IAED agreed and the nurse system, PSIAM was implemented. With PSIAM further vetting these calls and sending any at risk ones back to 999 for an ambulance response, the total of the system (MPDS & PSIAM) and codes were being proven safe. Further, this combination was achieving 15-19% Cat C responses. This model was quickly adopted in most of the other Trusts and is the primary model operating today in the UK.

True OMEGA and the Missed Alternate Response:

In a rush to achieve high levels of Cat C grouping, the UK Trusts wholeheartedly adopted the earlier described model. What was missed was the core group of Omega codes, those that have been proven safe for out of EMS referral for over 15 years. The deployed model leads to most, if not all of the Cat C calls being referred to PSIAM, another nurse triage system, or NHSD. This is excessive, about 6-8% of the total calls, or about half of

the Cat C calls, can be safely routed directly to a better care system. Obviously, the additional triage by a nurse does add an additional level of safety to all the Cat C calls, but is, in effect, a waste of that resource for those true Omega calls.

As the demand for services on the Ambulance Trusts continue to increase on all resources, there is a continued effort to investigate more efficient means to handle 999 calls and responses. One of the latest investigations has led Ambulance Trusts to try and determine if there is a system that can allow the EMD to safely refer calls out of the EMS system. A lot of time, effort and money has been spent by the NHS and Ambulance Trusts to try and find out if this can be achieved. The MPDS, which is used by every Trust in the UK except one, already provides for this in the “true Omega” codes. There is no reason for additional product development, additional training or the implementation of an unproven, risky code set. There simply needs to be an assessment of what each Trust has available as a better care system for referral and which MPDS Omega codes those are best suited for.

The ProQA software has the capability, and the NEMA contract covers any of the costs of third party integration. We can immediately interface with the necessary PCT systems, Walk-in Centres, etc. We already have basic interfaces with NHSD and Adastra. The only thing remaining is for your Trust to determine what is the best use of your resources and with who, and to what extent, this integration may be useful. PDC and the IAED have offered to help with this assessment at the Trust level, PCT level, ECPAG level, and DoH level. PDC’s offer to assist with this assessment is still open. If you are a member of a group that is interested in investigating this safe, proven, referral system for an Ambulance Trust, please contact us and we can start to achieve the best way forward.

Possible Response Distribution for the UK:

With millions of calls worth of MPDS data available from just within the UK, we can look at how the codes break down for a Trust and for the UK as a whole. There is obviously some difference based on demographics (urban, rural, age, etc.). To account for the possible differences, we have listed them here as ranges – exactly which percentage may be achievable by a specific Ambulance Trust will be dependent on their MPDS code set and the available resources for them to refer calls to.

Current Category Distribution of MPDS Codes throughout the UK:

Category A	30.7 – 32.3%
Category B	46.2 – 48.3%
Category C	18.1 – 23.2%

Possible Category Distribution if “True” Omega is Implemented:

Category A	30.7 – 32.3%
Category B	46.2 – 48.3%
Category Cn	10.2 – 16.3% (Nurse Triage)
Category Ce	6.9 – 7.9% (EMD Referral)

Again, exactly which percentage may be achievable by a specific Ambulance Trust will be dependent on their MPDS code data set and available resources for them to refer calls to.