**In response to the question made around call coding and your response - a suggestion would be having clinically trained people taking the calls and that would make the triage more accurate? A cost of course but the Trust needs to stop reacting and be proactive - spend money to save money?**
Yes, it is really difficult, because we have toyed with this many times. It actually used to be like this. It used to be called Criteria Based Dispatch. So the calls and the responding bit used to be undertaken by a clinician and then assigned a priority element as well and it is always a balance of where do you use that. So, in part, some of it is money, some of it though is actually having people. It is having clinicians as well. Now that poses another debate around MPDS as a triage which is what we use at the moment. NHS  pathways as a triage and subtly, I would probably say triage versus assessment and the work that health advisors can do versus a clinician in the control room and the sensitivity that goes behind it. What is always really difficult is the balance. Some of this is still dependant what the person phoning 999 will actually tell you as well. We are looking and what we have done and what our clinicians in the control room will do cancel the call at a high surge level which we have brought forward so they will intervene on category C2s so if you think about so if you think about two years ago when we brought this in we do a number of no sends everyday and that is call handlers triage and that is also about clinicians in there as well.

The whole thing is about scalability and quick sift and sort and I guess the balance of the first bit is we need to be able to identify those patients who are not breathing and are really unwell and then it is how you build everything on the backend of that initial sift into a full triage assessment which is the nuanced bit of where you want to get to an assessment of what people actually need because we do know that what they may need, based around the urgency of it, is always really difficult because in part you are constrained by time. That is the bit that says you need to make some decisions within time so not something I would dismiss because, in some respect, actually the levels of care are not actually about money at the moment they are about what we can demonstrate and what we can do. Now we have done what we class as tests of change in other words, pilots, we have done some of those where we have looked at whether we can do rapid interventional triage so we have done a small scale pilot and it is only for one day as which is why it was a test for change and that is a dedicated ccord who has been absolutely interrogating calls in one really tight area in an AGM area and the result was we’ve got to follow the patient through now their diversion to other pathways to C2 C3 in the time they did it was 81% and that is without an ambulance. 81% did not get an ambulance they were referred either back to GP or other pathways or told to make their own way to ED. Now actually, that is really good. That is really high. So we have to look at that look it is one day, you have to really test that. We really have to see is it sustainable, does it makes a difference? And all of these are really important when we look at the current pressure but also about future models of care. And I’m really keen that one of our problems with things like advance practice in this Trust and I’m forever chasing my tail for everything or how we put in a break in there. Look actually could we look at a supervision model, could we look at a different support bubble of advanced practice or primary or critical care. Could we look at triage by iPad by the side of the road. It some of these things that we have to be a bit brave about. And now we  have a conversations where we say look we don’t have all the answers but we are going to work out how we facilitate it. Let’s have the conversations to do it.