East Midlands Ambulance Service NHS Trust

# FREQUENT CALLER PROCEDURE

**Links**

The following documents are closely associated with this procedure:

- Joint Royal College Ambulance Liaison Committees (JRCALC) Guidance
- Nursing And Midwifery Council Code
- Health Care Professionals Code of Conduct
- CAD warning marker Policy and Procedure
- Safeguarding Children & Young People Policy
- Safeguarding Adults Policy
- Domestic Violence & Abuse Policy
- Frequent Caller National Network (FreCaNN) Best Practice Guide
- Clinical Assessment Team Protocols
- Advanced Medical Priority Dispatch System (AMPDS)
- NHS England Security Management Services
- Risk Management policy
- Data Protection policy
- EMAS values
- EMAS Equality Statement

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| Equality Impact Assessment | |

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| 1.0 | 15/07/09 | * | Clinical Governance group | * |
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| 3.0 | 15/05/13 | * | Clinical Governance group | * |
| 4.0 | 16/09/15 | * | Clinical Governance group | This policy has been amended to include the new template Reference to the Public Sector Equality Act and The definitions of a FREQUENT CALLER amended from 6 to 5 per month. PMIT changed from BIU |
| 5.0 | 20/07/2016 | 20 October 2016 | Clinical Governance group | Amended to reflect the name change from High Volume service User to Frequent Caller |
| 6.0 | 16 August 2017 | 30 August 2017 | Clinical Governance group | Amended to reflect changes in line with the Ambulance Response Programme |
| 7.0 | 12 December 2018 | | Clinical Governance group | Full Review with amendments to reflect changes in line with the Ambulance Response Programme |

* Details not recorded in previous versions of document due to change in format

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## 1. Introduction

1.1. East Midlands Ambulance Service NHS Trust is committed to providing the best healthcare to the public it serves.

1.2. A small percentage of patients with long term conditions and complex health and social care needs make High Volume calls to 999 services and their care needs to be managed and in a consistent manner.

1.3. The Trust has a responsibility for the security and safety of staff and patients.

1.4. The Trust is committed to working in partnership with outside agencies whilst adhering to Caldicott guidelines.

1.5. EMAS is committed to promoting equality of opportunity, celebrating and valuing diversity and eliminating unlawful discrimination. We are committed to achieving equality for our patients and staff members by reducing discrimination in employment and service delivery on the grounds of age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation.

## 2. Objectives

2.1. The objectives of this procedure are:

- To develop a structured evidence-based approach in identifying and managing the Frequent Callers across East Midlands Ambulance Service NHS Trust.
- Ensure that Frequent Callers are managed consistently and equitably meeting their unique and complex needs.
- To minimise the risk to the patients

## 3. Scope

3.1. This policy applies to all levels and types of permanent and temporary employees of the Trust (e.g. those staff with a contract of employment with the Trust). This also applies to agency staff and voluntary staff who do not have a contract of employment but who are subject to the management arrangements of the Trust.

## 4. Definitions

### 4.1. Frequent Caller

4.1.1. A Frequent Caller is defined as someone aged 18 or over who makes 5 or more emergency calls related to individual episodes of care in a month,

or 12 or more emergency calls related to individual episodes of care in 3 months from a private dwelling

### 4.2. Advanced Medical Priority Dispatch System (AMPDS)

4.2.1. The Triage system used by East Midlands Ambulance Service NHS Trust to identify and prioritise patients' needs and produce a Dispatch code for hear and treat or see and treat.

### 4.3. CAD

4.3.1. The Computer Aided Dispatch system utilised by EMAS to triage calls via AMPDS and dispatch appropriate resources in line with the national response categories.

### 4.4. Frequent Caller CAD Warning Marker

4.4.1. The individuals home address or personal mobile phone is flagged on the computer aided dispatch system (CAD) and when an individual calls 999 or a call in transferred from 111 the marker flags up a warning which prompts the Emergency Medical Dispatcher to hot transfer to the Clinical Assessment Team if the code is catagory1 or catagory2, and the follow normal protocols for all other codes. This action would be taken following discussion with the patient's own GP or with the Trusts Medical Director or his Deputy.

### 4.5. Multi Agency Case Conference

4.5.1. A meeting involving different agencies involved with the patient. Including Health, Social Care, other emergency services and the Voluntary sector.

### 4.6. Frequent Callers Review Meeting

4.6.1. This is a group responsible for discussing and reviewing those Frequent Callers with a Frequent Caller CAD warning Marker, it includes the Deputy Medical Director, Ambulance Operations Managers (Quality), and the Crime and Security team

### 4.7. Long Term Condition

4.7.1. Chronic illness that can limit lifestyle, such as diabetes, heart disease and chronic obstructive pulmonary disease (COPD)

### 4.8. Clinical Assessment Team (CAT)

4.8.1. The CAT consist of nurses and paramedics trained in telephone triage. Their role is to triage patients and escalate to the appropriate care pathways/outcome based on the patient's condition.

### 4.9. The Crime and Security Management Team

4.9.1. Crime and Security management team consists of two local security management specialists who provides expert advice and guidance on the security of the trust.

### 4.10. Care Plan

4.10.1. Patient specific prescriptive plans written by a Frequent Caller team clinician for use by CAT clinicians or attending clinicians. They are available to CAT on the S:drive.

## 5. Responsibilities

### 5.1. Chief Executive

5.1.1. The Chief Executive is the executive member of the trust board with overall accountability in relation to patient care.

### 5.2. Medical Director

5.2.1. The Medical Director is the nominated director responsible for the management of the care plans relating to Frequent Callers within the Trust and ensuring compliance with governance procedures and patient confidentiality.

### 5.3. Director of Quality and Nursing

5.3.1. Director of Quality and Nursing is the nominated director responsible for coordinating the management of the Frequent Caller agenda and part of this role is ensuring that the board receives sufficient assurance on effective management of Frequent callers.

### 5.4. Head of Safeguarding

5.4.1. The Head of Safeguarding has overall responsibility for the Frequent Caller agenda including development and implementation of systems and processes and compliance with the Quality strategy.

### 5.5. Frequent Caller Lead

5.5.1. The Frequent Caller lead provides expert evidence based clinical leadership on all aspects of the Frequent Caller agenda such as compiling reports, policy and procedure development, audit and communications.

5.5.2. The Frequent Caller lead is responsible for managing the care of a designated caseload of Frequent Callers. They are required to review and manage the care of their patients including creation of care plans and organisation and attendance at Multi agency meetings in accordance with the terms of this procedure.

5.5.3. The Frequent Caller Lead manages the complex case managers within the Frequent Caller team and provides case management supervision.

5.5.4. The Frequent Caller Lead chairs the Frequent Caller Review Meeting.

### 5.6. Complex Case Managers

5.6.1. Complex Case Managers are responsible for managing the care for a designated caseload of Frequent Callers. They are required to review and manage the care of their patients including creation of care plans and organisation and attendance at Multi agency meetings in accordance with the terms of this procedure.

### 5.7. Performance Management Information Team

5.7.1. Responsible for providing monthly statistics detailing all Frequent Callers as per the definition for the calendar month.

5.7.2. Responsible for ensuring the data is provided within the first week of the month to enable timely intervention for EMAS patients.

### 5.8. The Clinical Assessment Team

5.8.1. The CAT should be familiar with and adhere to national, local, and EMAS policies and procedures and work within the NMC (Nursing & Midwifery Council) and HCPC (Health and Care Professions Council) Code of Professional Conduct.

5.8.2. The CAT are responsible for following the Frequent Caller care plans and providing information on Frequent Callers and their care plans to attending clinicians.

5.8.3. They are also responsible for recording and reporting abuse via IR1.

### 5.9. Emergency Operations Centre (EOC) Staff

5.9.1. EOC are responsible for passing calls to the CAT or alerting frontline staff to a care plan as per the Frequent Caller Standard Operating Procedure.

5.9.2. They are also responsible for recording and reporting evidence of abuse via IR1.

### 5.10. Operational Staff

5.10.1. Operational staff are responsible for following frequent caller care plans to ensure patient receive appropriate care and treatment.

5.10.2. They are responsible for reporting concerns regarding Frequent Callers and evidence of abuse via the IR1 reporting system.

### 5.11. Health and Safety Coordinator

5.11.1. The Health and Safety Coordinator is responsible for forwarding IR1's detailing frequent and inappropriate use of service to the Frequent Caller team.

## 6. Procedure

6.1. The Frequent Caller team will identify Frequent Callers utilising:

6.1.1. Monthly Statistics from the Performance Management Intelligence Team.

6.1.2. Operational Crews should be encouraged to inform the Frequent Caller Team via email.

6.1.3. The safeguarding team becoming aware of Frequent Callers through investigations, queries and safeguarding referrals.

6.1.4. Risk and safety issues involving Frequent Caller should be reported via IR1.

6.1.5. Via partnership working with external stakeholders.

6.1.6. Emergency Operations Centre staff should be encouraged to inform the Frequent Caller Team via email.

6.2. The Frequent Caller team will manage Frequent Callers using a four stage approach (Please see Appendix 2) in line with the Frequent Caller National Network staged approach.

6.2.1. Stage 1 A review of call data to establish patient contact history an assessment of needs is made

6.2.2. Stage 2 Intervention can vary in the form it takes. It may mean a simple letter to the patient a letter or email to their GP, a referral to alternative specialist services e.g. Mental Health, Alcohol & Substance misuse team or community matron etc.

6.2.3. Stage 3 If necessary a coordinated full Multi-Disciplinary Team meeting (MDT) is arranged and/or attended to ensure fully collaborated care planning to support the patient.

6.2.4. Stage 4 Evaluation of effectiveness of intervention.

6.3. Frequent Caller Team will investigate the nature of calls using the CAD, patient report forms and summary care records. Findings will be discussed on the telephone with the patients GP or other health and social care professionals who are known to the patient to attempt to identify the underlying reasons for the 999 calls and whether there are possible gaps in the patients primary and social care provision.

6.4. The GP will be requested to provide details of the patients past medical history, drug regime and any other known agencies involved in the patients care.

6.5. A multi-disciplinary case conference will be discussed and may be arranged should this be required to support in developing a system of approach for the patient.

6.6. The Frequent Caller team will review safeguarding and care concern referrals raised by EMAS via SystmOne. The Frequent Caller team will liaise with the Safeguarding Team and working together where adults at risk are identified.

6.7. Referrals will be made to external agencies to support the patient in managing there need to call 999.

6.8. For patient who require a care plan a discussion will be held with the GP or other medical specialist involved regarding the best way to manage the patients care and reduce none essential 999 calls or attendances.

6.9. The Frequent Caller team will discuss whether it would be possible to pass the calls to the EMAS CAT for further assessment before a response is dispatched or whether a on scene care plan for operational staff could be beneficial. In some instances, both may be required. If a care plan is agreed on, then this will be written by the Frequent Caller team. Care plans

withholding treatment e.g. analgesia are authorised by the Medical Director or a member of their team. A marker will be placed on the patient's residence to make EMAS EOC and CAT aware of the care plan.

6.10. The Care Plan will be added to the database which is accessible by the CAT team on the S:drive.

6.11. Care Plans for attending clinicians are also shared in an anonymised form with the locality teams.

6.12. All EMAS care plans are saved and shared in PDF format and are not to be shared outside of EMAS without consultation with EMAS frequent callers team. EMAS care plans should not be altered by none EMAS clinicians. There is a standardised format in place for EMAS frequent caller care plans (Appendix 2).

6.13. If there is no evidence of clinical need for calls to 999 or calls are at a level when they are disrupting the smooth running of EOC the case is discussed with the Crime and Security Team. The Medical Director is also appraised of the case and where proportionate a 4-6 hourly or clinical assessment plan may be adopted.

6.14. Care management plans are reviewed monthly by the Frequent Caller team and discussed at the Frequent Caller Review Meeting to ensure that the patient's needs are being met and responses are reduced. Bimonthly patients with markers are also reviewed at the Frequent Caller Review Meeting.

6.15. If there have been less than 5 calls for 3 calendar months the patient is discharged from Frequent Caller care, CAD markers are removed, and care plans are archived. Where appropriate patients with complex needs are passed to the appropriate Ambulance Operations Manager for review by the Frequent Caller forum as appropriate.

## 7. Consultation

7.1. The updated procedure was shared with the Frequent Caller review Meeting members for comments.

7.2. Consultation on the procedure has been sought through EMAS clinical Governance group.

## 8. Monitoring Compliance and Effectiveness

8.1. The Frequent Callers team procedure will be monitored by the Director of Quality and Nursing through monthly integrated reports to the Quality Governance committee. The report will provide details of activity, trends and analysis.

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# Plan for Dissemination of Procedural Document

| | | | |
|---|---|---|---|
| **Title of document:** | **Frequent Caller Procedure** | | |
| **Version Number:** | **7.0** | **Dissemination lead: Print name, title and contact details** | **Frequent caller Lead** |
| **Previous document already being used?** | **Yes** | | |
| **Who does the document need to be disseminated to?** | **Clinical Governance Group, Safeguarding team, Security Management specialists and Frequent Caller Team PALS Coordinators. EOC, Clinical staff, Commissioners and external Stakeholders** | | |
| **Proposed methods of dissemination:** | **Communication via leads for divisions, and directorates and heads of service including commissioners** | | |

**Patient:** ……. **(Date Of Birth)**
**Address:** ……

**GP:**
**Address:**

**Telephone:**

**Care Needed**

**Care Management Plan**

| Instruction | Rationale | Responsibility |
|---|---|---|
| | | |

Written by:
Approved by:
Date of Agreement

This Care Plan has been developed and is being monitored by East Midlands Ambulance Service for use by EMAS staff. No alterations or adaptation should be made to this care plan by any other agency.
This care plan should not be shared externally without consultation of the Safeguarding team.
This care plan will be removed from access when no longer appropriate and should be used until then.
This care plan is reviewed on a monthly basis.

**Process Map (Four stages of Planned intervention inline with national best practice)**