Frequent Caller Identification and Management Procedure

Contents

1 Scope

1.1. This procedure describes the operational systems, patient safety and clinical governance arrangements which will allow for the identification and management of frequent callers to the South East Coast Ambulance Service NHS Foundation Trust (SECAmb, the Trust).

1.2. The overwhelming majority of individuals or organisations who access the Trust via 999 or NHS 111 do so with legitimate healthcare requirements. There are however a group of patients who use the Trust's services more frequently or regularly than others, when they may benefit from alternative pathways of care.

1.3. The identification and management of those who access emergency and urgent healthcare at an abnormally high level, could lead to the identification of individuals who are at risk, vulnerable or have an unmet health and social care need. This can also have a significant impact on SECAmb resources, both within the 999 emergency operations centre (EOC), 111 contact centre and in operations.

1.4. The identification and management of frequent callers to the urgent and emergency service offered by the Trust is essential in order to fulfil its obligation to identify and safeguard vulnerable people and to ensure these patients are appropriately managed.

1.5. Application of this procedure will result in the identification and management of patients at risk, who may not be identified through the routine application of the Trust's safeguarding policy. Where appropriate, existing safeguarding procedures will still be followed.

1.6. The Trust's commitment to delivering mobile healthcare requires the Trust to manage individuals who are accessing the incorrect healthcare for their needs and ensure that unmet health and social care needs are met.

1.7. Efficiency savings will be attained by the Trust as the management of individuals, who are frequently accessing healthcare with unmet needs, will increase resource availability for others in need of care, making best use of Trust resources.

1.8. This procedure will only apply to identified frequent callers who contact the 999 and NHS 111 service who are aged 18 and over. Identified patients under the age of 18 will remain the responsibility of the Trust's safeguarding team. Should the frequent caller team identify a frequent caller <18 they will immediately notify the safeguarding team via e-mail appending the relevant patient demographics and call history and the team will complete a safeguarding referral if appropriate.

2 Identification of Frequent Callers

2.1. Identification using automated reporting

2.1.1. Identification of a Frequent Caller (FC) to the service will primarily be undertaken via automatic data analysis of the Trust's Computer Aided Dispatch System (CAD) and the Trust's frequent caller reports.

2.1.2. Data presented will follow the Frequent Caller National Network (FreCaNN) definition: - "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." This definition is subject to change and the Trust will ensure it follows the most up to date definition.

2.1.3. This definition will also apply to NHS 111 as there is no current nationally agreed definition for 111 services. Given the nature of the service and volume of calls received, the Trust reserves the right to amend this definition and threshold for patient management.

2.1.4. The Frequent Caller Team (FCT) will use its screening tool to determine the priority of patient management, during periods of high demand and/or low team capacity, the team will prioritise the management of frequent callers who place a significant impact on call handling and operational functions and those who score red on the screening tool.

2.1.5. Data capture will originate from mandatory telephone number and address fields within the CAD. Additional demographic fields will be populated in situations when the call also has a Patient Demographic Search (PDS) to match them against the NHS Spine. This will include First Name, Surname, Date of Birth and NHS Number.

2.1.6. The Frequent Caller Lead (FCL) will hold responsibility to ensure that appropriate Trust staff have designated levels of access to the information provided and that Trust staff are reminded of the responsibilities that they hold under the data protection act and General Data Protection Regulations (GDPR).

2.2. Identification by operational staff

2.2.1. Individuals may also be identified as a frequent caller by the Trust's clinical staff independent from the automated FC report, in this instance staff should e-mail the FCT with their concerns.

2.2.2. This will be particularly useful for patients presenting from multiple locations or public places using a mobile phone.

2.2.3. Identification of frequent callers via the Trust's safeguarding reporting procedure will also provide an opportunity to identify frequent callers that patient facing staff feel are particularly vulnerable or are noted to be potentially presenting inappropriately to the Trust with unmet needs as a priority.

2.2.4. Trust staff should refer to the Trust's Safeguarding Referrals Procedure for the reporting of vulnerable people and note specific subcategories relating to frequent callers when completing referrals via the Trust's DATIX system.

2.2.5. The Safeguarding Team will e-mail the FCT any referrals they receive which may highlight a potential frequent caller. This will ensure that information is shared and management of the patient can commence.

2.2.6. The FCL and Frequent Caller Practitioners (FCP) will refer to the automated frequent caller reporting system and the Trust's FC database to ensure that the caller meets the frequent caller definition.

2.3. **Identification by Operations Centre Staff**

2.3.1. FCs are likely to be identified by EOC and NHS 111 staff.

2.3.2. Clinicians must always consider if a new presentation is actually a "repeat caller", as a patient making 3 or more clinically related calls in a single 96-hour period, usually with no history of previously doing so presents high clinical risk that warrants urgent review, repeat callers are not managed by the FCT.

2.3.3. If a safeguarding issue is identified then this should be reported to the Trust's safeguarding team following the Trust's Safeguarding Referrals Procedure for the reporting of vulnerable individuals.

2.3.4. The duty CSN/CCN should e-mail the FCT at frequent.caller@secamb.nhs.uk of any new FCs that are causing an impact on 999/111 call handling/clinical functions.

3 Initial Assessment and Management of Frequent Callers

3.1.1. Management of frequent callers to the Trust will follow national guidance provided by FreCaNN.

3.1.2. This is a 4-stage framework which will be followed by the team – please refer to FC Framework

3.1.3. All new frequent callers are screened on a monthly basis using the FC screening tool. This has been designed based on auditing the Trust's top 50 frequent callers. The tool assists in prioritising which patients should be managed based on qualitative measures such as presenting complaint, age and outcome of calls: this provides assurance that the team is targeting resources effectively.

3.2. **Stage 1**

3.2.1. Review call volume and ensure the definition is met, complete a safeguarding referral if there are any concerns or the patient is less than 18 years of age and note the call time, dates and day of week for general themes. Review case against the screening tool to determine eligibility and order of priority for management.

3.2.2. Consider whether intervention is required. Consideration should be given to calls instigated by health care professionals or if the patient is actually a "repeat caller" (making 3 or more clinically related calls in a single 96-hour period).

3.2.3. Create a file on the FC database and update accordingly.

3.2.4. Liaise with partner agencies such as GP and community teams requesting support to assist the patient and reduce 999/111 calls, gather clinical data

held on Trust interoperability systems to assist in case-gathering.

3.2.5. Send patient a ‘stage 1 letter’ or contact the patient via phone and discuss general themes and provide sign-posting advice to the appropriate community service.

3.2.6. Consider implementing a Patient Response Plan (PRP) where appropriate

3.2.7. Monitor calls volume for up to an 8-week period, if no acceptable reduction in call volume is seen, escalate to stage 2.

3.2.8. Review call status removing the patient from the frequent caller process if the reduction in calls meets the required standard.

3.2.9. **Stage 2**

3.2.9.1. FCP to complete the Frequent Caller Assessment Framework (FCAF) either as a scheduled face-2-face appointment or virtually.

3.2.9.2. Any areas of concern identified during the assessment must be escalated and referred to the appropriate agency, completing another safeguarding referral if deemed necessary. All actions must be fully documented on the FCAF as well as ensuring patient consent is gained.

3.2.9.3. Where the patient’s primary complaint or past medical history would make them unsuitable for a home visit, consideration must be given to completing the FCAF via the telephone or virtually where systems allow.

3.2.9.4. Request a professionals meeting and ensure a referral is completed to any PCN based MDT’s, HIU teams.

3.2.9.5. Consider implementing a Patient Response Plan (if not completed in stage 1) and consider an Acceptable Behaviour Agreement (ABA) should the patient meet the inclusion criteria.

3.2.9.6. Monitor call volume until an acceptable reduction is seen, with a formal review required at 6-months, If no acceptable reduction in call volume is seen, escalate to stage 3.

3.2.9.7. Review call status removing the patient from the frequent caller process and move the case into ‘awaiting closure’ if the reduction in calls meets the required standard and monitor accordingly.

3.2.10. **Stage 3**

3.2.10.1. Facilitate a second professionals meeting (if required) with original agencies and other relevant parties, obtain an update as to the patient's status and ensure any details are current and accurate. Review existing PRP/ABA to ensure the plan is still appropriate, making necessary changes where required.

3.2.10.2. Monitor calls volumes with a formal review every 6-months until an acceptable reduction is seen.

3.2.10.3. Review call status removing the patient from the frequent caller process if the reduction in calls meets required standard. If no acceptable reduction in call volume is seen, escalate to stage 4.

3.2.11. **Stage 4**

3.2.11.1. FCL becomes overall case manager in order to facilitate and monitor further Trust actions, please refer to the FC Routine Escalation flowchart to determine potential next steps.

3.2.11.2. Implement a revised PRP where indicated

3.2.11.3. There may be occasions where a patient's call volume will continue despite the best efforts of the Trust and external agencies. Further management and escalation will be required. In circumstances such as these, the patient's case should be presented to the Frequent Caller Sub-Group.

3.2.11.4. Continuous monitoring of call volume and information sharing.

3.2.11.5. Case presented to FreCaNN to share lessons learnt.

4 Interventions

4.1 Implementation of a Patient Response Plan (PRP)

4.1.1. Within the Trust the implementation of a PRP relates to how an incoming 999 and 111 call is handled differently from that of standard call handling procedures.

4.1.2. A structured process exists to ensure that FCs are correctly identified, engaged and aware of the concerns that the Trust has regarding the call volume being presented within any stage of the frequent caller process,

implementation of a PRP occurs at Stage 1 or 2 of the process unless excluded as a management option for an individual patient by the FCL.

4.1.3. PRPs and associated at-risk markers on the CAD are split into three categories: Triage Every Call, Timed Triage and NHS 111.

4.1.4. All patients subject to a PRP will receive a standard letter template informing them of their plan, the patient's lead healthcare professional (HCP) will also receive a copy of this letter.

4.1.5. **Triage Every Call** plans are invoked at stage 1 or 2 of the Frequent Caller Management Process: the plans are linked to NHSP dispositions with certain exception criteria. Patients on these plans will receive a clinical call back every time they call 999/111. These plans can be authorised by the FCL. These plans will have an associated at-risk marker titled: 'Frequent Caller'

4.1.6. **Timed Triage Plans** can be invoked at any stage of the process authorised by the FCL and Consultant Group (for 24-hr plans). This style of plan can also be implemented for identified FCs as an 'on the day escalatory measure' in EOC/111 contact centre at the duty CSN/CCN discretion along with EOCM/DCCM agreement. These plans will have an associated at-risk marker titled: 'Frequent Caller – Timed Triage' (see FC Urgent Escalation)

4.1.7. Timed triage plans restrict the number of attendances and call-backs the patient receives in a defined time period: 4/8/12/24-hrs, these plans are linked to the patients 'usual presentation'. This type of plan is designed to assist the clinical support desk (CSD) in managing identified FCs who present daily and have regular assessments over the phone or face to face and are deemed to not require medical assistance from the Trust.

4.1.7.1. If this plan is used as an 'on the day escalatory measure' for a FC then the patient's details must e-mailed to the FCT for audit purposes and to review its effectiveness.

4.1.8. **NHS 111** – These plans are only applicable to identified FCs to NHS 111 and should only be followed in this environment, staff operating in the 999 setting should not accept these markers or follow the FC plan. These plans will have an associated at-risk marker titled: 'Frequent Caller – NHS 111'

4.1.8.1. With both 999 and NHS 111 operating on Cleric CAD the timed triage plans operate the same for both services regardless which one completed the clinical triage. Therefore a patient subject to a 12-hr timed triage plan who received a clinical triage from 999 will not receive another clinical call back

from either service until the 12-hrs has elapsed, depending on the patients presentation.

4.1.9. All response plans will be reviewed fortnightly for the first 4-weeks to review their effectiveness and any impact on the patient or the Trust, after this period they will be reviewed every 6-months as a minimum or sooner if any clinical concerns are identified.

4.1.10. The above plans are for identified frequent callers only and must not be used for 'repeat callers.'

4.1.11. The PRP process will be overseen by the Trust's FCL to ensure that appropriate information is made available for all staff involved in the decision and that appropriate at-risk CAD markers and internal FC records adhere to the correct governance required in order to support the alternative call handling requirement.

4.1.12. The Trust utilises NHS Pathways in both its 111 and 999 call handling environments as well as other clinical triage tools, herein referred to as Clinical Decision Support Software (CDSS)

4.1.13. NHS Pathways has a specific built-in functionality regarding the management of identified frequent callers to the service which can be found in module 0 using the answer stem 'The individual is an identified frequent caller.'

4.1.14. This function will be the main method used by call handlers to transfer patients to the clinical queue who have an agreed Frequent Caller at-risk CAD marker. Please refer to the FC Call Handling Flowchart which sets out the call-taking process relating to FCs.

4.1.15. The "Early Exit" function within NHS Pathways can still be utilised to generate a transfer to clinician disposition in situations that include the disposition being refused, the call relates to multiple unrelated symptoms; there is difficulty obtaining sufficient information, the call relates to medication, a medical procedure, a declared medical history or the call is complex for some other reason.

4.1.16. This includes, the caller has difficulty deciding which symptom is troubling them the most or the caller seems very vague, or unable to focus on the questions being asked: this may also mean a caller who is incoherent or extremely difficult to communicate with.

4.1.17. However, this option should not be routinely utilised by a call handler simply because the patient is a known frequent caller to the service unless directed to warm transfer the call by a monitoring clinician.

4.1.18. Call-handling staff will be alerted to a PRP and the requirement to utilise the frequent caller functionality by a standardised CAD at-risk marker based on address, telephone number or patient name.

4.1.19. When the patient is making a first party call the initial Pre-Triage Sieve questions and Nature of Call (NoC) will determine if the call requires a category 1 response.

4.1.20. When a 2nd or 3rd party call is made NHS Pathways will always establish if the patient is breathing, conscious, fitting or choking at the time of call in addition to the options presented for 1st party calls as above prior to reaching the frequent caller answer stem.

4.1.21. In all situations that the above concerns have been immediately excluded the call then reaches a disposition of “Speak to Clinician from our Service immediately – Frequent Caller”.

4.1.22. If the call handler is unsure as to what disposition will be reached based on the callers declared symptoms, they can complete a full triage through pathways until a disposition is reached, they can then determine if the call is suitable for transfer to the clinical desk based on the at-risk CAD marker and exception criteria.

4.1.23. Should the patient be subject to a timed triage PRP, then the call handler will have to read the ‘timed triage script’ detailed within the at-risk marker along with providing any interim and worsening advice as indicated by their triage – please refer to the FC Call Handling Flowchart.

4.1.24. “Clinician Immediate” dispositions have an agreed call-back maximum timeframe instigated within the Trust’s 999 and 111 clinical procedures.

4.1.25. Prior to any contact with the FC the clinician must familiarise themselves with the patient’s FC record and any clinical information held on IBIS or other nominated operability software. The clinician should also review the FCs call history/outcomes and electronic patient care records (ePCR’s) to familiarise themselves with what action has been taken so far and what the patients ‘usual presentation’ is.

4.1.26. The clinician should instigate the call-back as soon as possible considering the presenting complaint and the workload that is being presented by other patients requiring the Trust’s assistance.

4.1.27. The clinician can elect to undertake a full clinical triage of symptoms if felt required.

4.1.28. The clinician can also elect to utilise the NHS Pathways Frequent Caller function or suitable CDSS alternative to arrange a more appropriate disposition. All available clinical history and associated risks would need to have been considered and documented if taking this action.

4.1.29. Appropriate worsening care advice/signposting should be given to frequent callers unless specifically excluded within the PRP. However, this can be adjusted from any standardised format to reflect the nature of the presentation, demand on the Trust and the alternative available resources which the patient may be encouraged to utilise instead.

4.1.30. The clinician must document the discussion and agreed outcomes within the CAD notes. This will influence future management and review of the patients PRP.

4.1.31. Should the patient be subject to a timed triage plan, the clinician should document within the CAD notes and timed triage log held on Microsoft Teams when the next call back is due, should further calls be received then clinicians should refer to this log to see when the next enhanced triage is due.

4.1.32. The clinician should review each new call presented during the timed triage window, refer to previous calls and completed ePCR's (where available) as well as refer to the patients FC record and satisfy themselves whether the call is their usual presentation – if so the call may be closed. If the clinician notes a new presentation or has any other clinical concerns then they can elect to call the patient back sooner and complete another enhanced clinical triage.

4.1.33. The same timed triage log will be utilised by 999 and NHS 111 clinicians. Patients should be informed by the clinician completing the call back that they may not receive a call back from either 999 or NHS 111 until the timeframe (according to their plan) has elapsed.

4.1.34. For patients who usually do not answer return calls and this is part of their 'normal presentation', following 3 x failed call backs the timed triage log can be updated. In all other circumstances the clinician should use their discretion as to what constitutes a clinical contact and then update the timed triage log accordingly.

4.1.35. For persistent FCs their voicemail inbox may be full, in these circumstances it is acceptable to send a 'Quick SMS' where the telephone number is a

mobile and leave appropriate advice and an explanation as to why their call is closed and provide signposting advice.

4.1.36. For FCs who consistently contact the Trust during their timed triage period, it is acceptable for the clinician to send a 'Quick SMS' reminding the patient of their plan and what action to take in the interim period.

4.1.37. There may be occasions where patients contact an out of area NHS 111 service and receive an ambulance disposition. These calls will automatically present on the dispatcher's screen, in this instance the Resource Dispatcher (RD) is charged with accepting any applicable at-risk CAD markers.

4.1.38. RDs who notice a patient has an FC at-risk marker should highlight the call at their earliest convenience to the dispatch clinician or the CSN so they can transfer the call to the clinical queue.

4.1.39. Calls received from HCPs regarding identified FCs can still be enhance triaged by the CSD however, clinical staff should maintain a low threshold for allocation – please refer to the FC Call Handling Flowchart.

4.2 Acceptable Behaviour Agreements (ABA)

4.2.1 An ABA may be used as a non-legal measure to ensure patients access, use, and respond to our services appropriately. Identified FCs who misuse our service, are rude/abusive or step outside the expected norms of patient contact may be issued with one.

4.2.2 It is important to note that an ABA is a local remedy aimed at rectifying particular unwanted patient behaviours: an ABA does not mitigate a patient from further incidences but is a mitigation for their conduct or incident to date.

4.2.3 Patients should also be made aware that matters deemed serious by the Trust may still be escalated through existing security and legal processes in which the staff member/team will receive the Trust's full support.

4.2.4 An ABA is patient specific and is tailored to each patient in order to ensure any behaviours/conduct are document with the expected remedial actions.

4.2.5 Signing an ABA is voluntary, if the patient decides not to wish to sign one they must be made aware that the Trust will continue with its framework for managing frequent callers and that legal action or a referral to the local police force may be made dependent on the circumstances.

4.2.6 Patients deemed suitable for an ABA must have the associated application form completed by the FCT, applications are then reviewed at the Frequent Caller Sub-Group (FCSG) or they can be sent off for individual authorisation by a Trust Consultant/Legal Services outside of this forum.

4.2.7 A member of the FCT must always contact the patient to discuss the Trust's concerns prior to implementing an ABA: where a patient cannot be reached an ABA warning letter can be sent. This letter highlights particular concerns and offers the patients 14-days to respond by post or telephone call to the Patient Experience Team, where no reply is received the Trust assumes consent.

4.2.8 It is advantageous to liaise with health and social care professionals involved in the patient's care prior to issuing an ABA to ensure other services are satisfied this is an appropriate course of action.

4.2.9 It is preferred that ABAs are delivered and discussed in person with the patient, so they have a thorough understanding as to why one is being issued and can sign the associated paperwork, however, due to the size of the Trust these conversations can take place over telephone and a copy posted out to the patient.

4.2.10 A copy of an authorised ABA will be sent to the patient's lead practitioner: in most cases this will be their GP.

4.3 Frequent Caller Sub-Group (FCSG)

4.3.1 The FCSG is established by the Professional Practice, Guidelines and Pathways Sub-Group (PPGPSG).

4.3.2 The purpose of the group is to oversee the development and implementation of individual interventions for identified FCs who have reached stage 4 of the FC framework or whose complex presentations falls outside the remit of the Trust's policies and procedures.

4.3.3 The FCSG is integral is developing and monitoring actions and effectiveness regarding the implementation of tailored PRPs and ABAs.

4.3.4 Fundamental to the group is the review of data, identifying core themes and trends, as well as ensuring areas of learning and necessary changes to practice are shared and embedded.

4.3.5 The group meets bi-monthly to review stage 4 patients, complex and escalating patients where senior oversight is required, to review and authorise complex PRPs and ABAs, and where necessary implement

interventions which may fall outside of this policy and procedure such as withdrawal of services and prolonged restricted sends.

4.4 Pre-planned visiting of Frequent Callers

4.4.1 The Trust's FCPs are integral to the initial contact and assessment of this complex and vulnerable patient group. These can either be completed face to face, over the telephone or virtually where systems allow.

4.4.2 The team may also utilise the support of the Trust's Paramedic Practitioners (PP's) who have dedicated non-clinical hours to support their Operating Units. The Specialist & Advanced Paramedic OU support toolkit allows PP's to support the FCT in completing home visits, allowing them to utilise their links and knowledge of community services and primary care to assess the gaps in provision for this cohort of patients. The FCP's will manage any home visits which require the support of PP's within their area.

4.4.3 Prior to any contact with the frequent caller, general themes and trends regarding their call volume should be noted by interrogating the frequent caller reports which will highlight previous calls, PCR / ePCR records and clinical records if created and matched to previous calls.

4.4.4 Consideration must be given as to the suitability of conducting a home visit, taking into account patient history, presentation, previous DIF 1s and associated at-risk CAD markers.

4.4.5 Initial contact with the patient should be by phone, however judgement can be exercised on a case by case basis. Contact with the patient should explore an empathetic approach and advise that the reason for the visit is to focus on unmet need, ensuring that we as a service are keeping the patient safe due to the high volume of calls that we have received.

4.4.6 At least 7 days' notice should be given to any patient whom an appointment is being made in order to undertake a frequent caller assessment: this is in order to ensure the patient has an appropriate advocate / family support with them.

4.4.7 An appointment should be offered to the patient on the understanding that in exceptional circumstances this may have to be postponed due to the unpredictable nature of the workload the Trust experiences.

4.4.8 This phone call should be undertaken from a withheld number or a Trust phone connected to the main switchboard. During this call the patient should be provided with the contact details of the Trust's Frequent Caller Team voicemail. This will be the line of established communication if an

appointment has to be rescheduled or the patient has any questions regarding the process. The voicemail is checked daily by the Frequent Caller Administrator who will then pass the details to the staff member completing the visit.

4.4.9 On the day of the visit the FCP must contact their relevant dispatch desk and ask for a routine CAD incident to be created prior to any face to face contact.

4.4.10 The created incident must include the patient's demographic details including contact telephone number in order to facilitate an at-risk marker match if applicable, or for the EOC to make contact with the patient and apologise for a delay to the appointment.

4.4.11 Staff must attend the address wearing uniform, in a tracked SECAmb vehicle with the incident assigned and maintain Airwave communication with the EOC. At scene and clear times must be recorded by using the relevant MDT buttons or informing EOC via radio contact.

4.4.12 Staff should complete the Frequent Caller Assessment Framework (FCAF) document on their iPad via Microsoft Forms, completing a full holistic assessment of the patient's needs must be conducted, giving the opportunity for the patient to advise why they feel that they are frequently utilising services provided by the Trust.

4.4.13 Following the visit, the member of staff will need to return to an appropriate Trust facility in order to undertake any agreed actions such as referrals to community services, the document once complete will automatically be sent to the FCT.

4.4.14 Every contact involving a frequent caller to the Trust must be documented within the FC database.

4.4.15 The respective FCP is responsible for sending the patient an outcome letter if appropriate detailing if any referrals have been made and any specific concerns have been noted.

4.5 Restricting Access to 999 – BT Stage 2 Block

4.5.1 BT stage 2 block (available at present for mobile phones only) may be utilised when patients are deemed to pose a significant risk of inappropriately using the 999 service at a high level, and are impacting on

emergency calls that have yet to be answered which poses a significant risk for the Trust and its patients. Until 999 calls are answered, the Trust is unable to determine an appropriate response or provide instructions to help the patient. Utilising a BT block will increase the availability of Emergency Medical Advisors to answer pending 999 calls, thereby improving our call answer time and improving patient care.

4.5.2 If the identified FC is known to the service and they have received an assessment by a clinician and/or received an operational response and there is no medical requirement for further treatment but the patient chooses to continue to dial 999, then a BT stage 2 block can be implemented.

4.5.3 The staff required to implement this procedure are: the CSN, duty EOCM and EOC Tactical or the FCL (during working hours). This is to ensure both clinical risks and service risks are identified and considered prior to implementation.

4.5.4 When a stage 2 block has been implemented, this should not be auto-renewed after the 8-hours. The patients phone must be reinstated and allowed to contact the service to allow for another clinical triage. A decision can then be made based on clinical & service risks whether to request another block.

4.5.5 The FC Urgent Escalation section details how to implement the restriction.

4.6 Restricting Access to 999 – Emergency SMS/Relay UK

4.6.1 Emergency SMS service lets deaf, hard of hearing and speech-impaired people in the UK send an SMS text message to the UK 999 service where it will be passed to the police, ambulance, fire rescue, or coastguard.

4.6.2 A small minority of patients inappropriately use this service in order to gain ambulance attendances as 999 triage in the absence of life threatening symptoms will result in a C3 urgent ambulance response.

4.6.3 Should the team be made aware of an identified frequent caller inappropriately accessing the service, a home visit will be conducted (if not already done so) to determine if there is a medical requirement for the patient using such service. If no credible reason is found, then the patient will be advised that their access to the Emergency SMS service will be withdrawn and should they require an emergency ambulance to contact 999 on the phone. The FC Lead will be notified and charged with contacting the relevant authority to remove the patient's access.

4.7 Frequent Caller – On Day Escalation

4.7.1 During periods of sustained pressure on the Trust where activity exceeds the number of resources e.g. call handlers, clinicians, operational resources then identified FCs can be placed on a temporary on day escalation plan by the implementing an at-risk CAD marker for 12-hrs titled 'Frequent Caller – On Day Escalation'

4.7.2 This marker will mean the patient will not receive a triage after calling 999 or NHS 111 and will not receive an ambulance response or clinical call back, unless they call in for something new, as this will be dependent on the patients 'usual presentation' which can be found on their FC record.

4.7.3 These markers highlight to the call handler that they are not to triage the patient or send an ambulance response, instead, upon confirming patient demographics and the nature of the call they should follow any additional information entered in the at-risk marker which should include the rationale for no triage/no send and provide signposting instructions for the patient to follow.

4.7.4 The call handler should then transfer the call to the clinical desk using the 'identified frequent caller' answer stem so a clinician can review the call and close accordingly.

4.7.5 Please see the FC – Urgent Escalation/On day Escalation for further information.

4.8 Record Keeping, Confidentiality and Information Sharing

4.8.1 All Trust employees involved in the management of frequent callers will be responsible for the maintenance of confidential records.

4.8.2 The Trust's FC database will be maintained for all frequent callers. Appropriate storage of confidential records relating to these callers will be maintained by the FCT in accordance with Information Governance best practice.

4.8.3 The FCT acts in accordance with the Records Management Code of Practice for Health and Social Care 2021 which sets out what NHS organisations need to do to manage records correctly. The detailed retention schedule states that care records should be retained for 8-years from the date of patient was discharged and, at the end of the retention period the records should be reviewed and destroyed if no longer needed.

4.8.4 The FCT has a range of patient and HCP facing correspondence. Any future template letters will continue to undergo scrutiny at various sub-groups and be reviewed by the Trust's Inclusion Hub Advisory Group (IHAG).

4.8.5 Whilst the majority of these are standardised templates with only patient demographics being amended, there are occasions where letters are required to be tailored to individual patients, such as those who have a bespoke response plan. In these circumstances these letters will be authored by the FC Lead and reviewed by other subject matter experts where required such as: legal services and the consultant management group.

4.9 Record Retirement

4.9.1 The FCT adopts the FreCaNN definition that a FC will be discharged from the process after 6-months of their call activity remaining below the national definition. Once a FC's activity falls below the national criteria their case will be moved to 'awaiting closure' and a 6-month review period will then start. All response plans and at-risk CAD markers will remain live during this 6-month period.

4.9.2 During the 6-month period, should the patient's address reappear on the report then their record will be made 'live', their case reviewed to see why their call volume dropped below activity and the patient will resume on the last stage of the process they were at.

4.9.3 Should 6-months pass with no activity noted, then the patient's record will be 'closed', all at-risk CAD markers and response plans will be retired and removed from live systems. Should the patient re-appear on the frequent caller report after this date then they will start back at the beginning of the frequent caller framework.

4.9.4 All patients will have one clinical record. Cases marked as 'closed' who then require monitoring at a later stage will have their original record reopened, there will be no duplicate records created.

4.9.5 SECAmb procedures for information sharing and maintaining confidentiality must be adhered to at all times during the management of frequent callers.

4.10 Patient Address Changes

4.10.1 In the majority of cases the team will be made aware of the patient's new address through the identification of a new address on the frequent caller

reports, or notification from an EOC clinician or operational member of staff e-mailing the team directly.

4.10.2 Once notification has been received of a possible address change, the patient's demographics will be input into the NHS Spine to confirm the NHS number matches. Once this has been verified the team can make the necessary alterations to the patient's clinical record.

5 Responsibilities

5.1 The **Chief Executive Officer** is the overarching Executive Lead for the Trust

5.2 The **Medical Director** is responsible for clinical governance within the Trust

5.3 The **Frequent Caller Sub-Group** is responsible for the ongoing effectiveness of this procedure.

5.4 The **Frequent Caller Lead** is responsible for managing and reviewing this procedure in line with local and national recommendations.

5.5 The Trust's **Frequent Caller Practitioners** are responsible for assisting the Frequent Caller Lead with identifying, coordinating and managing frequent callers within their designated sector.

5.5.1 The FCPs are also responsible for providing advice, support and training (where required) to staff in relation to the identification and management of frequent callers.

5.6 **Emergency Operations Centre Managers, Duty Contact Centre Managers** and **Operations Manager (Clinical)** are responsible for local implementation within the EOC/111 setting to their respective staff groups.

5.7 **Clinical Safety Navigators** and **CAS Clinical Navigators** are responsible for the adherence of this procedure within the EOC/111 clinical settings

5.8 **All employees** particularly those referenced within this procedure such as call handlers and clinicians are responsible for adhering to this procedure.

6 Audit and Review (evaluating effectiveness)

6.1 All procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

6.2 Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

6.3 This document will be reviewed in its entirety every three years or sooner by the Frequent Caller Lead and Frequent Caller Sub-Group if new legislation, codes of practice or national standards are introduced, or in light of any adverse incidents or risks identified.

6.4 All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.

7 References

7.1 Mental Capacity Act 2005.

7.2 Mental Capacity Act: Making Decisions (updated 2014).

7.3 The Care Act 2014.

7.4 Frequent Caller Best Practice Guide v2.0 2021.

7.5 Records Management Code of Practice for Health and Social Care 2021.

8 Equality Analysis

8.1 The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

8.2 Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have

the duty to comply with the equalities duties when carrying out those functions.

Frequent Caller Framework

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Does the patient meet the national frequent caller definition as set by FreCaNN?

Has the patient been flagged by: Frequent Caller Report > DIF-1 > Crew, EOC or 111 Referral?

FCP to extract calls from reports to build up a case file, score using screening tool and identify appropriate/inappropriate calls and general themes to determine suitability for management

Complete a safeguarding referral via the Trusts incident reporting system if there are any concerning factors, a referral must be completed if patient is <18 years of age

STAGE 1

- Liaise with system partners: GP, DN, Social Services, Private Carers
- Upload record on FC database
- Send patient a 'stage 1 letter' or complete telephone call
- Consider implementing a PRP

UP TO 8-WEEK REVIEW
Call volume decreases = remove from process

STAGE 2

- FCP to undertake a home visit either face-to-face or virtual
- Consider implementing a PRP/ABA
- Consider MDT (dependent on presentation) but must liaise with lead HCP's

UP TO 6-MONTH REVIEW
Call volume decreases = awaiting closure and monitor for 6-months

STAGE 3

- Review PRP, see if further interventions or changes are required
- Review if ABA suitable (if not already issued)
- Liaise with system partners to facilitate a 2nd MDT to review current situation, level of risk and outcomes with an aim to safely reduce call volume

ESCALATE IF NO ACCEPTABLE REDUCTION NOTICED
Call volume decreases = awaiting closure and monitor for 6-months

STAGE 4

Should call volume escalate the Trust's Frequent Caller Lead becomes overall case manager in order to facilitate and monitor further Trust actions which may include:

- Case presented to Frequent Caller Sub-Group
- Implement further PRP as specified by Frequent Caller Sub-Group
- Legal action/Police action
- Present Case to CCG/ICS and relevant external organisations
- Case presented to Frequent Caller National Network (FreCaNN) to share lessons learnt

Frequent Caller Routine Escalation

NHS South East Coast Ambulance Service NHS Foundation Trust

Frequent Caller Sub-Group

- For Stage 4 patients or complex cases – Escalate to the FCSG
  Attendees: FC Lead, Consultant Paramedic, Safeguarding, IBIS Lead, Operations Manager Clinical (OMC), Legal Services and Assistant Medical Director (where required)
- The group will review FC background info, work achieved to date, call history, input from services and risk to themselves and potential risk to Trust
- Outcome of FCSG meeting could include:
  - *Changing Response Plan - upgrading to timed triage (if not already done so)*
  - *Issuing an Acceptable Behaviour Agreement (ABA) (if not already done so)*
  - *Implementing a Withdrawal of Service/Restricted Send*

Legal Services

- If patient doesn't meet threshold for Police involvement then Legal Services become involved to remedy at a local level (warning letter sent to patient)
- Should this have no effect and calls continue then the case may be referred to the Trusts external lawyers to review potential options.

Police

- If FC is known to Police or specific offences have been committed then SECAmb reports FC for these offences, Police will then review and collate evidence from SECAmb - decision made whether to prosecute or manage alternatively via:
  - *Community Protection Warning (CPW)*
  - *Community Protection Notice (CPN)*
  - *Fixed Penalty Notice*
  - *Criminal Behaviour Order (CBO) obtained via Magistrates Court*

Communications Act 2003 -
A person is guilty of an offence if, for the purpose of causing annoyance, inconvenience or needless anxiety to another, he— (a) sends by means of a public electronic communications network, a message that he knows to be false. (b) causes such a message to be sent; or (c) persistently makes use of a public electronic communications network.

CCG/ICS

- If calls continue beyond the steps considered above then consideration given to escalate to the Integrated Care Partnership for the locality - the case is then discussed at the ICP Executive Meeting.

Frequent Caller Urgent Escalation

NHS South East Coast Ambulance Service NHS Foundation Trust

Background

There may be occasions when an identified frequent caller to the Trust suddenly and unexpectedly increases their call activity. Whilst the Patient Response Plan (PRP) is structured as a formal process for identifying patients suitable for alternative management, there is a requirement to ensure the effective day to day running of the Trusts Emergency Operations Centres (EOC's) and NHS 111 Contact Centre should a specific patient escalate their call volume, resulting in adverse effects on EOC/111 operations.

This tool is designed to assist 999/111 senior clinicians and EOCM/DCCM's to safely manage unexpected peaks in frequent caller activity to ensure the service continues to deliver its core functions. As a reminder this tool is only to be used for identified frequent callers.

Urgent Escalation Flowchart

Step 1 - Confirmation

- Confirm the patient is an identified frequent caller
  - The patient will have an At-Risk FC marker *and/or*
  - The patient will have a live frequent caller profile on the FC database

- You must ensure the patient has received either an enhanced clinical triage or operational attendance for their presenting complaint and where their medical assessment deems it clear there is no requirement for further input from our service.

Step 2 - Intervention

- **Frequent Caller – On Day Escalation**

1. This escalation route is available for both 999 and NHS 111
2. **For 999** – The FC Lead *and/or* Duty Clinical Safety Navigator (CSN) & Lead Emergency Operations Centre Manager (EOCM) are required to authorise this
3. **For NHS 111** – The FC Lead *and/or* Duty CAS Clinical Navigator (CCN) & Duty Contact Centre Manager (DCCM) are required to authorise this
4. Follow the **Frequent Caller – On Day Escalation** flowchart below

Step 3 – Escalation

- Contact the Trusts Frequent Caller Lead for advice and assistance on potential next steps (Mon-Fri 0900-1700)
- Consider implementing a **BT Stage 2 Block (999 only)** – flowchart below
- Contact the patients local Police Force and request assistance, particularly if the calls are hoax/vexatious in nature
- If the Stage 2 Block is denied then consider escalating to the Strategic Medical Advisor On-Call for further advice and support

Frequent Caller On Day Escalation 999 & NHS 111

NHS South East Coast Ambulance Service NHS Foundation Trust

During periods of sustained pressure on the Trust activity exceeds the number of resources e.g. call handlers, clinicians, operational resources, then identified frequent callers can be placed on a temporary on day escalation plan by implementing an at-risk CAD marker for 12-hrs titled 'Frequent Caller – On Day Escalation'

This marker will mean the patient will not receive a triage after calling 999 or NHS 111 and will not receive an ambulance response or a clinical call back as this will be dependent on the patients 'usual presentation' which found on their FC record and will operate similarly to the current Timed Triage Plans.

ELIGIBILITY AND CONFIRMATION

- Confirm patient is an identified FC – Refer to step 1 confirmation
- The FC must have received either an enhanced clinical triage and/or an operational attendance
- 999 Authorising = FC Lead *and/or* Duty CSN & Lead EOCM
- NHS 111 Authorising = FC Lead *and/or* Duty CCN & DCCM

Review Clinical & Service Risks

Can call handlers absorb the call activity > Surge Management Plan status > Call answer performance > Expected reduction in call handling capacity/Clinical staffing > Time of day > Patient nature of complaint

FC On Day Escalation - APPROVED

- All patients should be forewarned by the Duty CSN/CCN that the Trust will not be triaging or sending an ambulance for the defined period of time, whilst the patient can still contact the Trust, they will be signposted to contact an alternative service.
- A temporary 'Frequent Caller – On Day Escalation' should be added onto the CAD with sufficient patient demographics entered to capture future calls.
- A **'Valid To'** date must be entered to ensure the marker automatically retires off the system
- Enter the name of the staff member adding the marker in the **'Authorised/Supplied by'** section of the at-risk marker
- The following information should be entered into the notes to ensure call handlers are able to provide the patient with sufficient information – the highlighted sections will require personalising.

CAD Marker Template:

At Risk Reason: Frequent Caller – On Day Escalation

Notes: Patient Name – D.O.B – FC Datix reference: XXXX – Implemented by 999/111 - Do not triage this patient, please confirm the patient demographics and note the reason for the call. Please inform the patient that due to their call demand and impact on the service today they will not be receiving an ambulance response or clinical call back at this time. They should contact their GP/Mental Health Team/MOW to the Emergency Department. This will be reviewed on (insert date/time in 12-hrs time) Please open pathways and select 'Identified Frequent Caller' in Module 0, a clinician will then review this call and close accordingly.

Frequent Caller On Day Escalation 999 & NHS 111

NHS South East Coast Ambulance Service NHS Foundation Trust

TO NOTE

- Any calls received during this period will be placed into the clinical queue, the clinician that picks up these calls should check that the presentation aligns with the patients call history and/or is documented as their 'usual presentation' on their FC record.
- Call normal presentation = The incident can be closed off the system with no call back attempted
- Call not normal presentation and/or other concerns= The clinician can elect to call the patient back, triage and choose from any disposition.
- The Lead Duty CSN/CCN must e-mail the Frequent Caller team – frequent.caller@secamb.nhs.uk detailing the
  - FC details
  - Rationale for implementing the on-day escalation, SMP status and any other important information
  - Call volume up to implementation
- This information will be collated centrally for information and audit purposes

Frequent Caller BT Stage 2 Block 999 only

NHS South East Coast Ambulance Service NHS Foundation Trust

Follow Step 1 of the flowchart and confirm eligibility

Lead EOCM as operational commander should raise concerns to EOC Tactical Commander (or the FC Lead during working hours)

CONFERENCE CALL

- Lead EOCM
- EOC Tactical
- Duty Clinical Safety Navigator (CSN) or Operations Manager Clinical (OMC) on call in the absence of a CSN
- Or the FC Lead can authorise these independently during working hours

Review Clinical & Service Risks

Can EMA's absorb the call activity > Surge Management Plan status > Call answer performance > Expected reduction in EOC staffing > Time of day > Patient nature of complaint

BT STAGE 2 BLOCK - APPROVED

- All patients should be forewarned that the Trust will be applying a block which will last a standard 8-hours, the rationale should be explained and inform the patient of what action to take should an ambulance be required during this period of time.
- If the patient doesn't answer their phone then send a Quick SMS detailing this information.
- The Lead EOCM (EOC Operational Commander) should e-mail BT Glasgow requesting a 'Stage 2 Block' confirming:

1. Telephone Number – Taken directly from the CAD, check the number again on the CAD using the 'call search' tool to confirm it is correct.

STAGE 2 DECLINED OR NOT APPROPRIATE

- Continue with 'on day escalation' measures
- If further concerns noted proceed to step 3

TO NOTE

- BT will automatically remove the block after the elapsed timeframe however, the patient will not be informed.
- A stage 2 block must not be renewed/extended, the patient must be allowed to contact the Trust via 999 for a clinical triage, a decision can then be made based on current clinical & service risks whether to request another block.
- After the block has ended the patient will be able to reconnect to the Trust via 999, any emergency calls received after the block has ended should receive an enhanced clinical triage, unless the patient is subject to and within their timed triage period.
- Where a BT block has been implemented the Lead EOCM must e-mail the Frequent Caller team so an audit can be completed – frequent.caller@secamb.nhs.uk

Frequent Caller Call Handling Flowchart 999 & NHS 111

NHS South East Coast Ambulance Service NHS Foundation Trust

Frequent caller with a response plan phones 999/111 or 3rd party calls on their behalf

Call handlers will be alerted to a FC at-risk marker and what action to take once enough patient demographics have been collected, these are based on: address – telephone number – patient name

999 call = Accept FC marker (Except NHS 111 markers)
111 call = Accept all FC markers

EXCEPT C1 MARKER	EXCEPT C1 + C2 MARKER	OTHER EXCEPTIONS	NHS 111 MARKER
• All C1 calls require a full triage + ambulance attendance • All other calls, please select 'Identified Frequent Caller' in Module 0	• All C1 + C2 calls require a full triage + ambulance attendance • All other calls, please select 'Identified Frequent Caller' in Module 0	• Ambulance required if any exception criteria are met • If no exception criteria met, please select 'Identified Frequent Caller' in Module 0	• Applies to 111 calls only • If no exception criteria met, please select 'Identified Frequent Caller' in Module 0

Are they on a timed triage plan?

YES

Call handler to give 'Timed Triage Speech'

"From the information you have provided and as per your Frequent Caller Response Plan, you will not receive an ambulance attendance at this time. A clinician from our service will review this call and if required they may call you back. Please contact your GP or attend your local Emergency Department should you require further medical assistance."

NO

Call handler to give care advice and worsening according to NHSP (unless excluded) and pass call to the clinical desk

Transfer call to the clinical desk

1) If you have stayed within module 0 then select 'Identified Frequent Caller'

2) If you have triaged through NHSP and/or entered notes into the summary box then select:
Early Exit > Transfer to clinician > Local Policy > Other > Enter 'Frequent Caller' in free text box

IF AT ANY POINT YOU ARE UNSURE AS TO THE DISPOSITION YOU MAY REACH THEN TRIAGE THE CALL IN FULL AND THEN SEE IF THE CALL MEETS ANY EXCEPTION CRITERIA

Frequent Caller Call Handling Flowchart 999 & NHS 111

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3RD PARTY / HCP CALLS

- **3rd party/Careline calls** = Accept FC Marker – Transfer call to the clinical desk if no exception criteria met – Inform the call that the patient will receive a call back from a clinician.
- **Remote HCP Calls** = Accept FC Marker – Transfer call to the clinical desk if no exception criteria met – Inform the call that the patient will receive a call back from a clinician
- **HCP on scene** = Accept FC Marker – Speak to 'clinical in-line support' for further assistance, if no answer then transfer call to the clinical desk if no exception criteria met and notify a clinician after the call.

CLINICIANS

- The clinician that picks up these calls should check that the presentation aligns with the patients call history and/or is documented as their 'usual presentation' on their FC record.
- Call normal presentation = The incident can be closed off the system with no call back attempted
- Call not normal presentation and/or other concerns= The clinician can elect to call the patient back, triage and choose from any disposition.
- Ensure you check any interoperability system and previous ePCR's to assist with your decision making
- **3rd party/HCP calls** – Complete clinical triage but maintain a low threshold for allocating on these types of calls, especially if the requesting HCP is on scene with patient.