



# Frequent Caller Procedure

## Contents

<b>1</b>	<b>Scope.....</b>	<b>2</b>
<b>2</b>	<b>Identification of Frequent Callers.....</b>	<b>3</b>
<b>3</b>	<b>Initial screening and management.....</b>	<b>4</b>
<b>4</b>	<b>Interventions .....</b>	<b>6</b>
<b>5</b>	<b>Specific management by colleagues .....</b>	<b>13</b>
<b>6</b>	<b>Information Governance .....</b>	<b>16</b>
<b>7</b>	<b>Responsibilities .....</b>	<b>18</b>
<b>8</b>	<b>Audit and Review (evaluating effectiveness) .....</b>	<b>18</b>
<b>9</b>	<b>Financial Checkpoint .....</b>	<b>19</b>
<b>10</b>	<b>Equality Analysis.....</b>	<b>19</b>



# 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 (FC) 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 centres and in field operations.
- 1.4. The identification and management of FC to the urgent and emergency care 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, there is a BI dashboard highlighting <18 FC that meet the national definition. Should the frequent caller team (FCT) identify a frequent caller <18 they will immediately notify the safeguarding team via e-mail appending the relevant patient demographics and call history for the safeguarding team to investigate further.
- 1.9. The FCT can with the agreement of safeguarding and consultant paramedic manage an under 18 FC by exception, this may be due to significant impact on call handling and operational functions requiring clinical oversight and specific case management.

- 1.10. The FC Toolkit is a standalone document containing specific flowcharts detailing the processes that should be followed for routine and urgent FC management, interventions and colleague specific actions. This specific document will be updated more frequently when minor/major changes are needed to specific interventions or colleague actions.
- 1.11. The FC Toolkit will be the go-to document for staff to refer to for specific actions, this document is supplemented by this procedure. The FC Toolkit will go through Trust approved governance processes when changes/updates are required.
- 1.12. The FCT has the final decision on which patients are to be managed under this procedure. The team will consider current capacity and ability to safely review, manage and coordinate care prior to formally accepting a patient for management.

## **2 Identification of Frequent Callers**

### **2.1. Identification using automated reporting**

- 2.1.1. Identification of a 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 management system (FCMS).
- 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.", This definition is subject to change and the Trust will ensure it follows the most up to date national 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 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 colleagues have designated levels of access to the information provided and that colleagues 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 FC by operational colleagues independent from the automated reports, in this instance, colleagues should e-mail the FCT outlining their concerns.
- 2.2.2. This will be particularly useful for FC presenting from public places and multiple locations.
- 2.2.3. Identification of FC via the Trust's safeguarding reporting procedure will also provide an opportunity to identify FC that patient facing colleagues deem particularly vulnerable or are noted to be potentially presenting inappropriately to the Trust with unmet needs as a priority.
- 2.2.4. Colleagues should refer to the Trust's safeguarding referrals procedure for the reporting of vulnerable individuals and note the specific subcategories relating to FC when completing the referral.
- 2.2.5. The Safeguarding team will notify the FCT of any referrals they receive which may highlight a FC or a known FC where a specific concern has been noted.

## **2.3. Identification by operations centre colleagues**

- 2.3.1. FC are likely to be identified by 999 and 111 operations centre colleagues
- 2.3.2. Colleagues should be mindful of repeat callers vs frequent callers definition. Patients presenting with 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. New or escalating FC can be highlighted to the FCT by e-mail: [frequent.caller@secamb.nhs.uk](mailto:frequent.caller@secamb.nhs.uk).

# **3 Initial screening and management**

- 3.1.1. Management of FC 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 the FC Toolkit for further information.
  - 3.1.3. New FC to the Trust (where the team are considering management) will be screened on a monthly basis using the team's clinical screening tool. This tool is linked to clinical presentation and 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 FCMS.
- 3.2.4. For 999 FC send a Stage 1 letter and e-mail GP/lead HCP for awareness. For 111 FC, consider a telephone call to discuss concerns in the first instance.
- 3.2.5. 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.
- 3.2.6. Consider implementing a Patient Response Plan (PRP) if clinically appropriate.
- 3.2.7. Monitor call volume for up to 8-weeks, if no acceptable reduction in call volume then progress to stage 2.
- 3.2.8. Review call status, removing the patient from the FC process if the reduction in call volume meets the required standard.
- 3.2.9. **Stage 2**
  - 3.2.9.1. Consider a pre-arranged home visit where clinically appropriate, where not possible, consider a telephone call to the patient to discuss concerns and how the Trust can support.
  - 3.2.9.2. Where a home visit is completed, any areas of concern must be documented and referred to an appropriate agency, completing a safeguarding referral where necessary. All actions must be fully documented on the corresponding ePCR/FCMS, patient consent should be gained unless acting in best interests.
  - 3.2.9.3. Request a professionals meeting and/or refer to a place based multi-disciplinary meeting (MDT).
  - 3.2.9.4. Consider implementing a PRP/ABA where necessary and the patients meets the inclusion criteria.
  - 3.2.9.5. Monitor call volume until an acceptable reduction is seen, with a formal review of a PRP required at 6-month intervals. If no acceptable reduction in call volume is seen, progress to stage 3.
  - 3.2.9.6. 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. Contribute to further MDT, review any existing PRP/ABA to ensure this remains clinically safe & effective for the Trust and patient, make changes accordingly where required.
- 3.2.10.2. Monitor call volume until an acceptable reduction is seen, a formal review of a PRP is required at 6-month intervals.
- 3.2.10.3. 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.
- 3.2.10.4. If no acceptable reduction in call volume, then progress to stage 4.

### **3.2.11. Stage 4**

- 3.2.11.1. FCL becomes overall case manager to facilitate further management.
- 3.2.11.2. Implement a revised PRP where beneficial.
- 3.2.11.3. There may be occasions where a patients call volume continues despite the best efforts of the Trust and system partners. Further management and escalation will be required and the patients case should be presented to the Frequent Caller Sub-Group (FCSG).
- 3.2.11.4. Continue to monitor call volume and information sharing with system partners. A formal review of the PRP is required at 6-month intervals.
- 3.2.11.5. Present case to FreCaNN for support and to share lessons learnt.

## **4 Interventions**

### **4.1. Patient Response Plans (PRP)**

- 4.1.1. Within the Trust, the implementation of a PRP relates to how incoming 999 and NHS 111 calls are handled differently from that of standard call handling procedures.
- 4.1.2. A PRP allows for call handlers to triage calls via the frequent caller pathway in module 0 and not complete a full triage as per NHS Pathways which is the Trust's call handling triage tool used across 999 and NHS 111.
- 4.1.3. PRP are created where evidence suggests FC have not required immediate care or treatment from SECamb, and that calls can be safely managed by the Clinical Support Desk (CSD). The patient may have multiple ambulance attendances but very low conveyance rate to hospital.
- 4.1.4. PRP are tailored to each FC, the FCT will complete a PRP application form for consideration and approval.
- 4.1.5. All FC subject to PRP will have an associated at-risk marker on the CAD, the PRP and associated at-risk marker will have exception criteria, where

it would not be appropriate to follow the FC pathway in module 0 and where call handlers should triage the call in full as per normal procedures.

- 4.1.6. All FC subject to PRP will receive a standard letter informing them of this plan, the GP/lead HCP will also receive a copy.
- 4.1.7. All PRP applications (except 7-day timed triage) can be authorised by the FCL with input from Trust subject matter experts. At any time, any application can be approved in the interim by the FCL and ratified at the next scheduled FCSG for formal approval, amendment or be revoked.
- 4.1.8. All 7-day applications must be authorised by the FCSG and cannot be implemented as an interim measure. FC should already be subject to a timed triage plan before an application is made for extending this to a 7-day timed triage.
- 4.1.9. All FC with a PRP will have an associated frequent caller marker on the Trust's CAD system. These markers are split into three categories:
- 4.1.10. **Frequent Caller** – Patients on these plans will receive a clinical call back for each 999/111 call made (known as a clinical triage every call plan).
- 4.1.11. **Frequent Caller – Timed Triage** – FC are restricted to one contact (ambulance response or clinical triage) within a defined period of time: 4/8/12/24-hours or 7-days. These plans are linked to the patients 'usual presentation'. This type of plan is designed to assist the Clinical Support Desk (CSD) in managing FC who present multiple times a day.
  - 4.1.11.1. Each CAD received will be transferred to CSD for clinical review (unless any exception criteria met in which case the call will be triaged in full by the call handler).
  - 4.1.11.2. Where a patient is within their timed triage window, the duty clinician will review the corresponding FC record, where the CAD relates to the patients 'usual presentation' the CAD may be closed. Where there is a new presentation not listed on the FC record or any clinical concerns, the duty clinician can mark the CAD for another clinical triage to be completed or send to dispatch for an operational response.
  - 4.1.11.3. Timed Triage plans operate across 999 and NHS 111, therefore, a patient subject to a 12-hr timed triage plan who receives 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.
- 4.1.12. **Frequent Caller – NHS 111** – These plans are only applicable to managed FC to NHS 111 only and should only be accepted and followed by NHS 111 call handlers. Where a FC with this type of marker presents to 999, the call handler should not accept this marker and should triage the 999 call in full as per normal call handling procedures.
- 4.1.13. Timed Triage plans can be implemented as an 'On Day Escalation' measure by the Duty Clinical Safety Navigator/CAS Clinical Navigator.

Colleagues should refer to the FC Toolkit for this specific flowchart and implementation process.

- 4.1.14. All response plans will be reviewed fortnightly for the first 4-weeks to review their effectiveness and highlight any potential patient or Trust safety concerns. After this period all PRP should be reviewed every 6-months as a minimum or sooner if any clinical concerns are identified.
- 4.1.15. The allocated Frequent Caller Practitioner (FCP) is responsible for completing this review, a dip-test of calls, associated outcomes, and ePCRs should be reviewed to determine whether the PRP remains safe and effective with a decision made to either: continue, change or rescind the plan based on the evidence provided. Where interoperability systems are available, the FCP should confirm there have been no significant medical changes by reviewing the patient's secondary care clinical data and Trust interoperability systems.
- 4.1.16. The PRP process will be overseen by the FCL.

#### 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 FC 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. FC 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 colleagues 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. FC 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 ABA 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. Copies of any authorised ABA will be sent to the patients GP/lead HCP.

#### 4.3. **999 Stage 2 Call Block**

4.3.1. Colleagues must refer to the FC Toolkit for the specific flowchart detailing this process to confirm eligibility, authorisation process, inclusion and exclusion criteria and specific actions to follow.

4.3.2. BT 999 Stage 2 Block (available for landline and mobile phones) may be utilised to temporarily block a FC from connecting to SECamb via the 999 service. The maximum timeframe allowed for each request is 8-hours.

4.3.3. This intervention may be utilised when patients are actively calling 999 excessively for non-emergency complaints, significantly impacting on Trust call answer performance or are rude/verbally abusive on the telephone despite warnings to cease this behaviour.

4.3.4. 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.

4.3.5. Prior to implementation, FC must have received either a telephone clinical triage or operational response to confirm there is no immediate medical need or the patient is within their timed triage window.

4.3.6. Authorising colleagues should carefully consider the risks and mitigations prior to requesting a block with BT, particularly if applying a block for a landline.

4.3.7. The timeframe applied to a block should be the least restrictive and proportionate to the impact on the Trust and call handler availability.

4.3.8. Blocks must not be auto-extended, FC must be allowed to reconnect to 999 after the block has expired, another block may be requested where the call volume remains excessive, impact on Trust performance and timely patient care.

#### **4.4. 999 Emergency SMS Call Block**

- 4.4.1. Emergency SMS service allows deaf, hearing impaired and speech-impaired individuals in the UK to send an SMS text message to the UK 999 service where it will be passed to the police, ambulance, fire rescue, or coastguard.
- 4.4.2. A small minority of patients inappropriately use this service in order to gain ambulance attendances these calls (in the absence of any life-threatening symptoms) will always result in a C3 urgent ambulance response.
- 4.4.3. Should the team be made aware of an identified FC inappropriately accessing the service, a member of the team will contact the patient by phone to discuss our concerns, where it is determined that there is no medical need for the FC to use this service then the FC Lead will be notified and charged with contacting the relevant authority to remove the patient's access.
- 4.4.4. This action will remain indefinitely unless a request to un-blacklist is received from the mobile phone user. In this instance, the mobile phone user may request to contact the Trust directly or the voice services team will contact the Trust on their behalf to make a formal request and pursue the Trust's authority to un-blacklist the number.
- 4.4.5. The number will not be un-blacklisted unless confirmation is received from the Trust.
- 4.4.6. The Lead BT 999 contact centre should be contacted to obtain current contact details for the 999 voice services team.

#### **4.5. NHS 111 Call Block**

- 4.5.1. Colleagues must refer to the FC Toolkit for the specific flowchart detailing this process to confirm eligibility, authorisation process, inclusion and exclusion criteria and specific actions to follow.
- 4.5.2. NHS 111 call block is available to use for patients who are inappropriately contacting the Trust's 111 service and impacting on service delivery and/or impacting on colleagues wellbeing. In all circumstances colleagues should complete a datix for investigation.
- 4.5.3. The FCL can authorise these independently or the request discussed with the FCSG or Integrated Care Leadership Team.
- 4.5.4. There is no maximum time limit applied to block an individual from using NHS 111, therefore, the Trust should apply a pragmatic approach when considering the length of block.
- 4.5.5. All patients should be forewarned of a block preferably by phone call, if a block is to last longer than 7-days then a written letter must be posted outlining the rationale with a copy e-mailed to the patients GP/lead HCP.

- 4.5.6. The FCL will contact the NHS 111 call trace team to request a block for the agreed period.
- 4.5.7. The call block will be automatically removed at the end of the requested period.
- 4.5.8. Call routed via NHS 111 Online will still be received but are included in the block period. A CAD marker will be applied by the FCL to highlight these calls to the duty CCN for appropriate closure.
- 4.5.9. A FC cannot be blocked from 999 and NHS 111 simultaneously without prior agreement by the FCL.

#### 4.6. **On Day Escalation**

- 4.6.1. Colleagues must refer to the FC Toolkit for the specific flowchart detailing this process to confirm eligibility, authorisation process, inclusion and exclusion criteria and specific actions to follow.
- 4.6.2. During periods of sustained pressure on the Trust where activity exceeds the number of resources e.g. call handlers, clinicians, operational resources then identified FC 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'.
- 4.6.3. 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.
- 4.6.4. 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.
- 4.6.5. Call handlers 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. **Frequent Caller Sub-Group (FCSG)**

- 4.7.1. The FCSG is established by the Professional Practice Group (PPG).
- 4.7.2. The purpose of the group is to oversee the development and implementation of individual interventions for identified FC who have reached stage 4 of the FC framework or whose complex presentations fall outside the remit of the Trust's policies and procedures.
- 4.7.3. The FCSG is integral in developing and monitoring the effectiveness of interventions such as PRP and ABA.

4.7.4. 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.

4.7.5. The group meets bi-monthly to:

- ✚ Review complex and escalating FC cases. Integral to the group is identifying the known and potential risks to our patients including but not limited to: clinical, social, health and environmental factors. The FCSG must balance these known and potential risks against the operational impact on the Trust and to the wider patient population. The FCSG must recognise and find solutions to safely manage these risks and demand on 999/111 and operations.
- ✚ Review, critique and authorise any interim and outstanding PRP and ABA applications.
- ✚ Review any 999/111 call blocks implemented between meetings
- ✚ Review any FC deaths who were subject to a PRP and contribute to the learning from death (LFD) process.
- ✚ Create, implement and review individual interventions that fall outside of standard Trust policies and procedures. Examples include but are not limited to: unique interventions required to maintain Trust and patient safety e.g. withdrawal of services, prolonged restricted sends and other restrictive measures.

#### 4.8. **Home Visits**

4.8.1. Pre-arranged home visits allow the opportunity for the team to conduct an in-person medical & holistic assessment of the patient, outside of the context of an emergency call. Home visits allow for an informal conversation as to call volume, outcomes, expectations of the service and an opportunity to provide signposting advice and complete necessary referrals to system partners.

4.8.2. The Trust's FCP are integral to this process. Home visits can either be completed face to face, over the telephone or virtually where systems allow.

4.8.3. The team may also utilise the support of the Trust's Advanced Paramedic Practitioners (APP) who have dedicated non-clinical hours to support their Operating Units. The Specialist & Advanced Paramedic OU support toolkit allows APP 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 will manage any home visits which require the support of APP within their area.

4.8.4. Prior to any contact with the patient, 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.

- 4.8.5. Consideration must be given as to the suitability of conducting a home visit, considering patient history, presentation, previous DIF-1 and associated at-risk CAD markers.
- 4.8.6. 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.
- 4.8.7. 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.
- 4.8.8. 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.
- 4.8.9. 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 dedicated FCT voicemail service. This will be the line of established communication if an appointment must be rescheduled, or the patient has any questions regarding the process.
- 4.8.10. Home visits must be completed in Trust uniform, in a Trust issued vehicle with a routine CAD created, the vehicle call-sign must be allocated to the CAD for the duration of the visit, this allows EOC to track the member of staff and summon assistance if required. The attending member of staff must be signed on to the vehicle and have access to an airwave handset and/or NMA mobile device to contact EOC if required. An ePCR with basic details should be submitted at the end of the visit.

## **5 Specific management by colleagues**

### **5.1. Call Handling Functions**

- 5.1.1. Colleagues should refer to the FC Toolkit to review call handling specific flowcharts and supplementary information.
- 5.1.2. Colleagues will be alerted to a PRP by a standardised at-risk CAD marker which will be linked to the patient's demographics (often name, address, postcode and telephone number).
- 5.1.3. Pre-triage sieve questions and selection of the Nature of Call (Noc) will determine if the call requires a Category 1 response.
- 5.1.4. When a third-party call is made, NHSP will always establish if the patient is breathing, conscious, fitting or choking at the time of call prior to reaching the FC answer stem in module 0.

- 5.1.5. Call handlers should confirm the at-risk prompt in CAD matches the FC, if so, the marker should be accepted. Once an immediate life-threatening emergency has been excluded, call handlers should read each marker in full on each encounter to ensure they are familiar with the exception criteria and at what point to follow the FC pathway.
- 5.1.6. Call handlers should routinely use the FC answer stem in module 0 to pass the CAD to CSD. A clinical reason for the call must be entered into the specify box that populates after selecting the FC answer stem.
- 5.1.7. As no triage has been conducted, the call handler should enter sufficient call notes to assist CSD colleagues in risk assessing the call, examples of notes can be found in the FC Toolkit.
- 5.1.8. If the call handler is unsure as to what disposition may be reached based on the caller's declared symptoms, a full triage should be completed until a final disposition is reached. If no exception criteria are met, then the call can be early exited and transferred to CSD.
- 5.1.9. There are occasions where CSD have organised an ambulance response, please check any live CADs and the map to confirm if an ambulance response has been arranged, in these cases the FC closing script is not required and call handlers can adapt the closing advice to suit the current call.
- 5.1.10. All FC with a PRP should be given the FC closing advice which can be found in the FC toolkit. Standard NHSP closing advice should not be given to the FC or any 3<sup>rd</sup> party calling about them, unless an ambulance response has been arranged.
- 5.1.11. Where an identified FC with a corresponding at-risk marker prematurely terminates the call, no call back is required. However, where the call handler has any specific concerns a call back should be attempted in-line with normal call handling procedures.
- 5.1.12. At all times, non-clinical and clinical in-line support can be contacted for queries and advice.
- 5.1.13. Clinical in-line support should be contacted in all cases where a HCP is on-scene with the patient and requesting an ambulance response as these cases will need to be prioritised.
- 5.1.14. CADs should not be closed by call handlers unless the at-risk marker specifically states otherwise.
- 5.2. **Resource Dispatch Functions (RD)**
- 5.2.1. FC with a PRP presenting to SECamb via an out of area 999 and NHS 111 provider will not have been clinically validated by SECamb. These calls will automatically present on the dispatcher's screen.

- 5.2.2. The RD is responsible for accepting any applicable at-risk markers where there is a confirmed patient match and/or force-checking the CAD to look for any at-risk markers.
- 5.2.3. RD who notice a FC at-risk marker should highlight the call to the allocated dispatch clinician or the duty CSN so the call can be transferred to CSD.
- 5.3. **999 and NHS 111 Operations Centre Management Functions**
  - 5.3.1. Dispatch Team Leaders (DTL), Emergency Operations Centre Managers (EOCM) and Duty Contact Centre Managers (DCCM) should consider referring all urgent, time-critical and complex live FC-related CAD incidents to the FCT (during working hours) for specialist advice, support and guidance before escalating to an Operational or Tactical commander. During the out of hours period, colleagues should e-mail: [frequent.caller@secamb.nhs.uk](mailto:frequent.caller@secamb.nhs.uk) for the team to review at the earliest opportunity.
- 5.4. **Clinical Functions**
  - 5.4.1. Colleagues must refer to the FC Toolkit to review clinician specific flowcharts and supplementary information.
  - 5.4.2. Prior to any contact with a FC the clinician must familiarise themselves with the patient's FC record and any clinical information held on IBIS or other nominated interoperability system. The clinician should also review the FC call history/outcomes and ePCR's to familiarise themselves with what action has been taken so far and what the patients 'usual presentation' is.
  - 5.4.3. The duty clinician that completes the initial risk assessment of CSD cases should refer to the FCMS, reviewing the FC current clinical presentation and CAD call notes against the 'usual presentation' documented on the FC record to risk assess the CAD and prioritise accordingly.
  - 5.4.4. Where there is a new clinical presentation or notes suggestive of any potential clinical concerns, the CAD should be risk assessed accordingly and marked for an early clinical call back and triage. This is particularly important when the Trust is in Clinical Safety Plan (CSP) escalation.
  - 5.4.5. Clinicians should check who the origin caller is for each CAD received, especially for FC where the Trust cannot accept remote third-party calls. There may be occasions where the patient is the 1<sup>st</sup> party caller or the original 3<sup>rd</sup> party caller is now on scene and therefore a clinical call back is required.
  - 5.4.6. Clinicians should instigate the call back as soon as possible considering the presenting complaint and the wider CSD workload and Trust pressures.
  - 5.4.7. Clinicians can complete a full clinical triage using an approved Clinical Decision Support Software (CDSS) or utilise the FC functionality within NHSP where the end disposition is already known. All available clinical history and associated risks should be considered and documented if using the FC pathway.

- 5.4.8. Appropriate signposting advice should be given to FC, this can be adjusted to any format to reflect the nature of the presentation, demand on the Trust and community services available. Worsening care advice should not ordinarily be given unless an ambulance response has been arranged.
- 5.4.9. Clinicians must document the triage and agreed outcomes in the CAD notes.
- 5.4.10. Where a FC is subject to a Timed Triage plan, the clinician should document within the CAD notes and timed triage log on the FCMS when the next clinical call back is due.
- 5.4.11. The duty clinician should review each new CAD presented during the timed triage window, refer to previous calls and completed ePCR's, as well as the FC record to satisfy themselves whether the current call is the FC usual presentation. If so, the call may be closed. If the clinician notes a new presentation or has any other clinical concerns, then another clinical call back should be completed.
- 5.4.12. The same timed triage log will be used across 999 and NHS 111.
- 5.4.13. Where a FC does not answer the telephone after the agreed number of call back attempts (depending on CSP), the clinician should risk assess the call based on all available clinical information and either close the CAD or arrange an ambulance response.
- 5.4.14. FC subject to a Timed Triage plan who fail to answer return calls, clinicians may use their discretion and update the Timed Triage Log based on repeated failed call back attempts.
- 5.4.15. Quick SMS may be used (for mobile phones and where voicemail is unavailable) to notify patients of any CAD being closed and signposting advice provided.
- 5.4.16. FC subject to a Timed Triage Plan who persist in calling, it is acceptable for the clinician to send a Quick SMS reminding the FC of their PRP and provide signposting advice.
- 5.4.17. Calls received from HCP for FC subject to a PRP can still receive a clinical triage, however, colleagues should maintain a low threshold for allocation. Where the HCP is on scene, these CAD should be prioritised for the next clinical call back.

## **6 Information Governance**

### **6.1. Record Keeping, Confidentiality and Information Sharing**

- 6.1.1. All Trust employees involved in the management of frequent callers will be responsible for the maintenance of confidential records.
- 6.1.2. The Trust's FCMS 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.



- 6.1.3. 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.
- 6.1.4. 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.
- 6.1.5. 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.

## 6.2. **Record Retirement**

- 6.2.1. 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 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.
- 6.2.2. During the 6-month period, should the patient's address reappear on the report then their record will be made 'live', their case reviewed, and the patient will resume on the last stage of the process they were at.
- 6.2.3. Should 6-months pass with call activity remaining below the national threshold, then the patient's FC 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 as standard, they will start back at the beginning of the frequent caller framework, unless agreed by the FC Lead that the case (and associated PRP) may be reopened and continue from the previous case stage.
- 6.2.4. All patients will have one record. Cases marked as 'closed' who then require monitoring at a later clinical stage will have their original record reopened, there will be no duplicate records created.
- 6.2.5. SECAMB procedures for information sharing and maintaining confidentiality must be adhered to at all times during the management of frequent callers.

## 6.3. **Patient Address Changes**

- 6.3.1. In many 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 colleagues e-mailing the FCT.

- 6.3.2. 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.

## 7 Responsibilities

- 7.1. The **Chief Executive Officer** is the overarching executive lead for the Trust.
- 7.2. The **Chief Medical Officer** and **Chief Paramedic Officer** are responsible for clinical governance within the Trust.
- 7.3. The **Frequent Caller Sub-Group** is responsible for the ongoing effectiveness of this procedure.
- 7.4. The **Frequent Caller Lead** is responsible for managing, reviewing and updating this procedure in line with local and national recommendations.
- 7.5. The **Frequent Caller Practitioners** are responsible for assisting the Frequent Caller Lead with identifying, coordinating and managing FC within their designated operating units.
- 7.6. The **Frequent Caller Practitioners** are also responsible for providing expert advice, support, guidance and training to colleagues in relation to FC.
- 7.7. **Emergency Operations Centre Managers, Duty Contact Centre Managers** and **Clinical Operations Manager for Integrated Urgent Care** are responsible for local implementation of this procedure and FC Toolkit within 999 and NHS 111 contact centres and dissemination to colleagues.
- 7.8. **Clinical Safety Navigators** and **CAS Clinical Navigators** are responsible for the adherence of this procedure within the respective clinical contact centre settings.
- 7.9. **Safeguarding** colleagues are responsible for the identification and management of <18 FC, unless the FCT have agreed to manage a particular case by exception.
- 7.10. **All employees** particularly those referenced within this procedure are responsible for adhering to this procedure.

## 8 Audit and Review (evaluating effectiveness)

- 8.1.1. 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.
- 8.1.2. 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).

- 8.1.3. 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.
- 8.1.4. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.

## **9 Financial Checkpoint**

- 9.1. This document has been confirmed by Finance to have no unbudgeted financial implications.

## **10 Equality Analysis**

- 10.1. 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.
- 10.2. 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.