London Ambulance Service NHS
NHS Trust

Policy & Procedure for the Management of Frequent Callers

DOCUMENT PROFILE and CONTROL.

Purpose of the document: is to ensure that an appropriate care strategy is adopted by the Trust when responding to frequent caller service users.

Sponsor Department: Patient Experiences

Author/Reviewer: Head of Patient Experiences. To be reviewed by Nov 2009.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
03/11/08	0.1	Head of Patient Experiences	Major – first draft
04/11/08	0.2	Records Manager	Minor- reformatted
04/11/08	0.3	Head of Records Management and BC	Minor
20/11/08	1.1	Head of RM & BC	Minor – incorporating CGC amendment to introduction.
27/11/08	1.2	Head of Patient Experiences	Minor – training & monitoring added incl. ref to ADO/AOM PIs removed from S.3
06/02/09	1.3	Records Manager	Minor – added ratification date

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	**Date Approved**	**Version**
CGC	12/11/08	1.0
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Trust Board	27/01/09	1.2

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The Pulse	03/12/08	Records Manager	GDU

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP /012	Data Protection Policy	
HS/011	Incident Reporting Procedure	
	Data Protection Act 1998	
	MPS/LAS Protocols (Updated Sept 2004)	
OP/10	Procedure for the Maintenance of the High Risk Address Register and Notification of High Risk Addresses	
TP/018	Suspected Cases of Child Abuse Procedure and Recognition of Abuse notes	
TP/019	Suspected Abuse of Vulnerable Adults Procedure and Recognition of Abuse Notes:	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

Introduction

A relatively small minority of patients throughout London repeatedly access 999 services, often when an alternative care pathway would be more appropriate. This situation is a serious drain on London Ambulance Service Trust (LAS) resources, as well as effectively putting other lives at risk as a consequence of an opportunity cost effect, in that resources are in essence diverted from other emergency calls to attend these patients. In busy times, this has the effect of creating a stacking system where the LAS cannot respond to other emergency calls as quickly as we would wish. Persistent calls have the effect of clogging the call lines.

Unnecessary conveyance to hospital exacerbates the pressure on A&E departments. It should also be noted that Primary Care Trusts (PCT) effectively fund this emergency care activity via the general LAS funding arrangements.

The patients concerned often have complex health and social care needs. This policy and procedure sets out guidelines for practice in creating a management strategy and seeks to adopt a patient-centred approach by working across health and social care organisational boundaries. Positive outcomes should also impact on Trust-wide and local performance by freeing up resources.

Objectives

1 To achieve an appropriate care pathway for frequent service users, where the deployment of an emergency ambulance may not be the most appropriate response.

2. To create local multi-disciplinary network forums in partnership with local authority Social Services departments, Primary Care, Mental Health and Acute Trusts and other agencies towards resolving the issues presented by this patient community.

Policy / Procedure

1.0 Definition

1.1 For the purpose of this policy, a patient may be defined as a ‘frequent caller ‘ where 10 or more emergency calls have been placed within a period of a calendar month. This is not however a fixed rule and discretion should be exercised according to the circumstances of the particular patient.

2.0 Patient Identification Process

Each complex will work with and have responsibility for a designated local authority and PCT area.

It is anticipated that following the upgrade of EOC systems, Management Information will routinely provide AOMs with data identifying patients in the local area who may be deemed to be potential frequent callers.

In the interim, AOMs should nominate a lead officer to liaise with PALS Frequent Caller Unit to identify patients within their catchment area. These local representatives will be afforded dedicated time to undertake the activity required and the role should be included within the portfolio of the AOM and nominated officer.

3.0 Internal relationships

A PALS Frequent Caller Unit Officer will be allocated responsibility to liaise with each station complex. The PALS Frequent Caller Unit Officer will work with a designated officer who will be afforded lead responsibility for this area of work. Further local delegation may be made accordingly. PALS Frequent Caller Unit will assist local staff to enable the development of skills and processes involved in building local contact networks, so that future cases can be undertaken locally with PALS Frequent caller Unit playing a supporting rather than a lead role. All resulting care plans in relation to individual patients will be agreed with the Medical Directorate prior to implementation. PALS Frequent Caller unit will however maintain management responsibility for the most complex cases. Where available, Community Involvement Officers may also be involved.

Clinical Support Desk will facilitate any action deemed appropriate to initiate a care plan approach, where a referral is made at the time of an emergency call, and will liaise with PALS Frequent Caller Unit to manage the case from that point.

4.0 Creation and Maintenance of Local Liaison Forums

Following an introductory approach from the Medical Director, each complex will create a local multi-disciplinary partnership liaison forum, consisting of representatives of the Social Services departments, Primary Care, Mental Health and Acute Trusts and other relevant agencies. It is envisaged that regular meetings will enable the devising of care plans to address the needs of specific patients via case conference mechanisms.

The local liaison forums will also allow health and social care colleagues to advise the LAS of any patients that may similarly be posing problems to the respective agencies where the LAS may be able to play a role in achieving an appropriate care pathway. An additional benefit is that this mechanism should enable issues to be raised beyond the confines of this specific project. There

will also be close correlation with Procedure for the Maintenance of the High Risk Address Register and Notification of High Risk Addresses.

5.0 Information Sharing

Wherever possible, consent should be obtained from the patient before passing on their personal information to other agencies. Due regard should be given to involving the patient's relatives, carer or advocate, where the patient consents to that. Naturally circumstances should dictate how contact is made, and consideration should be given so that matters may be approached with sensitivity and with regard to personal safety.

However, Paragraph 8 of Schedule 2 of the Data Protection Act (1998) enables the sharing of information where that is necessary for medical purposes and is carried out by medical professionals or others owing an obligation of confidence to the data subject. Personal data consisting of information as to the physical or mental health or condition of the patient is also covered in 30 (3) (b) DPA (1998) in relation to the purposes of carrying out social work. The Trust takes the view that this area of work falls under these provisions, towards the establishment of an emergency care component of a community care plan.

See also
http://www.foi.gov.uk/sharing/faqs.htm
http://www.ico.gov.uk/upload/documents/pressreleases/2007/information_sharing.pdf
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_401039
www.ecm.gov.uk/informationsharing

A pan-London information sharing protocol is being devised, led by the Head of Records Management. However, as an interim measure, the Head of Records Management will work with the Head of Patient Experiences or PALS delegate in devising a protocol to be used at local forums, where this may be at issue.

6.0 Evidence Gathering

It is important to gather evidence of the number of 999 calls that have been made and to identify if there is a pattern that emerges. Data may be obtained from Management Information. This will require completion of Disclosure of Information form (LA413) and a subsequent analysis of the information made available.

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Basic information should be gathered to include the patient's name, address, telephone number, information about any physical/mental health issues, domestic circumstances, details of any relevant contacts (soc wkr/GP/other health & social care professionals). Contextual information from visiting crews or EOC staff handling the calls may also be helpful. Carefully note who the information came from, in view of Data Protection considerations which may be raised at a later date.

7.0 Contacting other Agencies

Complex representatives should ascertain the NHS organisations involved – see http://www.nhs.uk/
Sometimes it may be helpful to ask the Acute Trust PALS to become involved, particularly where the patient is conveyed to hospital with any regularity. The PCT PALS may also be a source of assistance in obtaining more information, or passing information to the patient's GP. There may also be an established relationship between the PCT and acute or mental health trust PALS teams.

8.0 Making a Referral

It is anticipated that each complex will establish a local liaison forum as set out in paragraph 4, and that this will serve as the principle mechanism to facilitate this area of work. However, there will be occasions when a direct referral is appropriate outside this pathway.

Many care services are now provided by PCTs – see http://www.nhs.uk/England/AboutTheNhs/Default.cmsx
Local complex representatives should become familiar with the local social care arrangements via web searches.

Immediate referrals are usually made via a Duty System, unless details of an allocated social worker are available. Many hospitals and PCTs have a Fast Response Team or similar, who may be able to liaise with colleagues in community social work teams. Once again, the respective PALS should be able to assist.

Consideration should also be given at the time of an incident as to whether it is appropriate to submit a 'vulnerable adult' referral (LA280), including where the patient concerned may have mental health problems (see TP/019).

After reporting the situation to Social Services/PCT, any relevant action should be agreed. It is often useful to meet with the patient or the patient's advocate, usually in a joint meeting with any health or social care workers involved. It is good practice to check with the relevant health professionals who are working with a patient if a visit would be appropriate, and/or any information that may be relevant to that. Usually, there may be a need to request a Case Conference as a mechanism to involve all interested parties.

There may be a need to contact other agencies, e.g. Home Care, Housing, voluntary agencies etc – much will depend on individual case and agreed action with Social Services/PCT.

9.0 Care Plan Action

Where appropriate, patient specific protocols will be achieved and placed on EOC software so that any call received may be actioned accordingly. It remains a possibility that this may involve the Trust accepting in some extreme cases that there will be a need to override the MPDS triage system to enable the adoption of an Alternative Response strategy where we are unable to achieve any alternative care pathway following close liaison with other care providers. Whilst the Trust will accept the clinical risk involved, any such individual case **must** be agreed with the Medical Director.

10.0 Legal Action

The Trust supports the pursuance of Acceptable Behaviour Contracts or Anti-Social Behaviour Orders as a last resort and it is envisaged that this will only be undertaken in partnership with the other care providers involved. Any such case **must** be discussed and agreed with the Head of Patient Experiences and the Medical Director. Advice will be sought from Legal Services and NHS Security Management Service.

11.0 Post Referral Liaison

Complex representatives should ensure that they receive feedback to make sure that action is being taken. Where the referral originates from a member of crew staff, similar feedback should be made. The PALS Frequent Caller Unit must also be notified of the case and outcome.

12.0 Records Management

A local referencing system should be completed and close liaison affected with PALS Frequent Caller Unit, to ensure evidence recording. PALS Frequent Caller Unit will devise a means of recording, utilising the Datix case management system, so that the Trust can evidence the resources and financial savings involved as developments occur.

13.0 Hoax and Nuisance Calls

Calls suspected of being a hoax or nuisance will be initially managed by the Call Taking Manager or Operational Centre Manager. In all cases other than where the call is an obvious hoax, the matter will be referred to Clinical Support Desk to contact the caller and attempt to obtain additional information. At the discretion of Clinical Support Desk and the Call Taking Manager or Operational Centre Manager, an operational manager/team leader will be requested to attend the location to attempt to clarify the situation.

Where there are grounds to suggest that the behaviour of the caller may be as a consequence of a learning disability, personality disorder, mental health condition or other condition (for example autism), a referral should be made to the PALS Frequent Caller Unit who will manage the case in accordance with the processes and practices outlined in this policy and procedure.

The Trust is obliged to observe the Code of Practice for the Public Emergency Call Service (PECS) Between Communications Providers and the Emergency Services - see http://www.northumberland.gov.uk/%5Cdrftp%5C12407.pdf
This gives specific guidance in relation to nuisance calls. The process outlined therein will be undertaken by the Call Taking Manager or Operational Centre Manager following liaison with PALS Frequent Caller Unit where any case has been so referred. Any relevant case will also be duly referred to the police by the relevant Call Taking Manager or Operational Centre Manager. Assistance may be sought from those Control Services staff who are designated as approved Single Points of Contact (SPOC) for the purposes of the Regulation of Investigatory Powers Act (2000) (RIPA) – (see http://security.homeoffice.gov.uk/ripa/about-ripa/) who are able to formally request subscriber details from communications providers in the accepted format. If a SPOC is not available, then the matter may need to be routed via the Metropolitan Police service.

IF YOU REQUIRE ASSISTANCE WITH ANY OF THE ABOVE – contact PALS Frequent Caller Unit - Telephone 020-7887-6659 or 6688 – Fax 020-7887-6670 – Email Frequentcaller@lond-amb.nhs.uk

IMPLEMENTATION PLAN	
Intended Audience	All staff
Dissemination	Available to all staff on the Pulse
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	PALS Frequent Caller Unit will assist and support the development of local liaison forums on approach by complex managers; Education & Development will embed the practice within existing training programmes, particularly in relation to New Ways of Working initiatives.
Monitoring	Head of Patient Experiences; ADOs; AOMs From April 2009, it is the Trust's intention to monitor local complex progress as part of the Performance Indicators for ADOs and AOMs. Good practice will be disseminated via familiar Trust mechanisms. Regular reporting will be made to Clinical Governance Committee.