East of England Ambulance Service NHS Trust

Policy for the Management of Patients with Defined Individual Needs

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Dissemination requirements	All managers and staff via email and intranet. To be published on the Trust's public web site
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

Contents

Appendices

1.0 Introduction

East of England Ambulance Service (EEAST) is committed to providing a patient-centred and clinically appropriate service to the patients it serves, ensuring the right response to the right person at the right time.

A wide range of people rely on the 999 service we provide for an emergency response to serious and life-threatening conditions. The majority of patients can be treated with the principles and practices of assessment and care that are laid down in core training.

There are, however, a group of service users who use the 999 emergency service significantly more frequently than others, when they might benefit from an alternative pathway of care and this can have a significant impact on EEAST resources, both within the Ambulance Operations Centre (AOC) and in operations. Some patients will have conditions that require assessment and treatment that is unfamiliar to ambulance personnel.

There may be new guidance on specific treatment for certain conditions that require a specific reminder to crews to ensure that best practice is adhered to.

The patients concerned may:

- Have a long-term condition with an acute exacerbation or require support to manage their condition appropriately at home.
- Be experiencing a specific episode of ill-health or difficulty.
- Have unmet social, physical or mental health care needs.
- Have alcohol and substance misuse-related issues.
- Be unaware of more appropriate entry points into the NHS.

Not all of these callers require an emergency response from an ambulance-based clinician. They may call a substantial number of times per 24-hour period, involving call handlers, the Emergency Clinical Advice and Triage Centre (ECAT) and emergency responders.

This Policy outlines the ways in which EEAST can determine, agree and mobilise appropriate alternative care pathways for people calling 999 regularly, frequently or with very specific and defined needs that may not be covered in core training.

2.0 Purpose

2.1 Strategic aims

The aim of this Policy is to create a consistent and clinically appropriate approach to managing and supporting people who use our service and would benefit from having an individual management plan to identify and meet their unmet specific health and social care needs.

2.2 Objectives

The objectives of the Policy are to:

Achieve an appropriate care pathway for all service users however complex their care needs are, by:

- Defining an agreed process for identifying such callers.
- Developing appropriate alternative pathways of care or care plans for these callers.
- Creating a local multidisciplinary approach to managing identified patients involving local health and social care providers and commissioners.
- Tracking callers and identifying such callers that may be vulnerable or have a safeguarding concern and to inform a multi-agency team regarding alternative support.
- The team will take into account any health inequalities identified during the referral and assessment process.

3.0 Duties

3.1 Director of Nursing, Clinical Quality and Improvement

The Director of Nursing, Clinical Quality and Improvement has delegated responsibility for managing the strategic development and implementation of organisational risk management, clinical effectiveness and clinical governance and is the Board Safeguarding Champion.

3.2 Medical Director

The Medical Director has delegated responsibility for the management of clinical standards. They are also responsible for the national clinical performance indicators, pre-hospital clinical care and research. The Associate Medical Director has overall responsibility for the individual management plans agreed within the scope of this policy.

3.3 Operational and Clinical Staff

Operational and clinical staff have responsibility for identifying and reporting potential patients that would benefit from an individual management plan and fulfilling any care plans developed in respect of individual patients.

3.4 Frequent Caller Lead

The Frequent Caller Lead is responsible for the management of frequent callers within EEAST. They will meet with the Associate Medical Director monthly to review frequent callers and manage frequent callers in line with this policy. They will also be responsible for managing the Frequent Caller Team and delegating roles in line with this policy, attend meetings and manage frequent callers within the scope of this policy.

3.5 Ambulance Operations Centre

The Ambulance Operations Centre (AOC) has responsibility for day-to-day call handling and dispatch for these patients within the scope of this policy.

3.6 Safeguarding Team

The Safeguarding Team is responsible in conjunction with the Clinical Coordinator team for the identification of whether the needs of the child/young person are clinical or safeguarding and identification of an appropriate pathway.

3.7 Clinical Coordinators

The Clinical Coordinator team are responsible for the clinical assessment/management of these patients at the point of call within the scope of this policy and for the implementation of this policy.

3.8 Committee Structure

3.8.1 Compliance and Risk Group (CRG)

The Compliance and Risk Group (CRG) will review the clinical activity provided by the Trust and ensure that all underlying processes fully support staff to provide high quality patient care. This includes clinical effectiveness, safeguarding children and adults, clinical audit and clinical standards. The CRG will monitor and report clinical issues and risks in relation to this Policy to the Patient Safety and Clinical Risk Group. CRG will provide assurance that service provision which impacts on the patient's experience is monitored so action can

be taken as and when necessary to improve the standard of patient care and reduce clinical risk.

4.0 Definitions

For the purposes of this Policy, a person may be defined as using the service regularly or frequently if they call:

- Adults > 18 Years from a private address:
  - 5 or times in a month period
  - 12 or more calls in a 3-month period
  - 15 or more calls in a 1-month period from a communal address

There is an ongoing national review around the management of paediatric Frequent Callers. At present, there is no set criteria or definition for this cohort, however any <18 patients with a high call volume are highlighted to the FC Lead, who then liaises with the Trust Safeguarding team +/- Mental Health as appropriate.

For the purposes of this Policy, a person may be defined as having complex care needs if;

- Their condition is such that the provision of specific information may materially alter the care pathway for that patient.
- The provision of specific care information will ensure that the patient receives treatment in line with the most recent guidance and best practice (that may not have been covered off in training updates).

5.0 Development

5.1 Prioritisation of Work

A wide range of people rely on the 999 service and we provide for an emergency response to serious and life-threatening conditions. The majority of patients can be treated with the principles and practices of assessment and care that are laid down in core training.

There are, however, a group of service users who use the 999 emergency service more frequently or regularly than others, when they might benefit from an

alternative pathway of care and this can have a significant impact on EEAST resources, both within the AOC and in operations.

This policy has been developed to ensure these patients are appropriately managed.

5.2 Identification of Stakeholders

The stakeholders identified as being affected by this policy are as follows;

- Patients
- Trust Staff – AOC & Operational
- Safeguarding Team
- Mental Health Team
- Other Health Care Professionals
- NHS Professionals including Commissioners
- NHS Professionals
- Local Authority
- Police

6.0 Identification of Patients with Individual Needs

6.1 Identification of Frequent callers

Callers can be flagged as frequent callers though:

- A report on PowerBI, identifying frequent callers by Clinical Commissioning Group (CCG) areas
- Individual Name, Date of Birth, Gender and Address identified from PCR (Patient Care Record) or CAD reports.
- Contact with other agencies or providers, from both internal and external incident groups (Datix, operational crews, call handlers, ECAT Clinicians etc.), from other work streams or through the Trust's Patient Advice & Liaison Service (PALS) and safeguarding team.

Frequent Callers >18 years can be identified by the Frequent Caller Lead and the Clinical Coordinator team using the PowerBI reports system, SSRS or from internal and external referrals.

- >18 years, by individual address 5 or more calls (individual episodes of care) in a 1-month period.

- >18 years, by individual address 12 or more calls (individual episodes of care) in a 3-month period
- >18 years, by communal address 15 or more calls in a 1-month period.

6.2 Identification of Patients with Complex Medical Needs

Patients with complex medical needs will primarily be notified to the Trust through contact from the patients GP or specialist on an individual basis.
A small number of patients may communicate directly with the Trust about their clinical condition. The accuracy of the information provided will need to be triangulated with either primary or secondary care professionals.
There are some groups of patients with a specific condition whose care is coordinated through specialist clinics and the Trust may receive information on the whole group of patients.

Additionally, patients with complex clinical needs may be identified through contact with other agencies or providers, from both internal and external incident groups (Datix), from other work streams or through the Trusts Patient Advice & Liaison Service (PALS) plus the safeguarding team.

7.0 Managing Frequent and Complex Callers

7.1 Management of Frequent Callers <18 years:

A national review on the management of paediatric frequent callers is being undertaken by the National Ambulance Safeguarding Advisory Group (NASaG) in conjunction with the Frequent Caller National Network (FreCaNN). Once a consultation and process has been established, an appendix on the management of <18's will be added to this policy in conjunction with the EEAST safeguarding team. It has been agreed between the Frequent Caller Lead and the Head of Safeguarding that until this point, new and existing <18 frequent callers with a high call volume will be managed on a case-by-case basis with direct referral to the safeguarding team and joint case management where required. All patients identified with a clear medical condition or need, will be passed to the Clinical Coordinator Team/Frequent Caller Lead for further review, assessment, and appropriate action as necessary.

7.2 Management of Frequent Callers >18 years:

Individual patients identified by the Frequent Caller Team namely via monthly reports generated by Informatics, operational and AOC staff referrals and external stakeholder referrals.

A GP assistance notification for newly identified patients will be raised via SPOC, however if social or safeguarding issues are identified then appropriate referrals will be made in line with current Safeguarding procedures.

The Frequent Caller Team will coordinate initial registration and review of patients with complex medical needs.

7.3 Safeguarding Team Review Process:

Management of Frequent Callers >18 years:

The Frequent Caller Lead can access social care/safeguarding reports as appropriate via Adastra reporting and can highlight any concerns that require escalation to the Safeguarding Team.

All recommendations from any Serious Adult Reviews (SAR) or Serious Case Reviews (SCR) will be reviewed and taken into consideration.

7.4 Clinical Coordinator Team Process:

The Clinical Coordinator Team/Frequent Caller Lead can liaise with the local named Leading Operations Manager or HALO to review the individual patient.

7.5 Deceased Patients Process:

Where it has been identified that a patient being managed by the Frequent Caller Team has died, the Frequent Caller Lead will review all such cases.
A Datix report will be generated by the Frequent Caller Lead and reviewed by the Patient Safety Team where:

- The patient was on a triage management plan and EEAST has had contact within 7 days prior to their death
- The patient was not on a triage management plan and EEAST has had contact within 24 hours of their death

The Frequent Caller Lead will then support in any subsequent investigation process where required.

8.0 Management Process of Frequent Callers >18 years

All contacts with the patient will be reviewed and an "event history" compiled which will be stored on the Datix system under Progress Notes. This review, where appropriate, can include the Safeguarding Team, local Operational teams and other Health Care Providers.

Following a review of the individual need the Clinical Coordinator Team/Frequent Caller Lead will be responsible for liaising appropriately with Trust teams in line with the process as identified below.

8.1 Stage One (Frequent Caller – Low level activity)

Once identified all frequent callers will be categorised into a coloured, tiered system. The tier will be based on call volume and will be as follows:

Tier	Call volume Over 3 months	
	Min	Max
Green	5	15
Amber	16	24
Red	25	49
Black	50	+

This tiered system will allow the Frequent Caller Team to prioritise workload. For the green tier patient, the Frequent Caller Team will send out a 'Green Tier' advisory letter along with the 'Choose Well' leaflet to the patient. The team will also send a letter to the patient's GP advising of the interaction with the ambulance service. These letters will encourage both the frequent caller and the GP to arrange a face-to-face meeting to assess the patient's current health needs. Green tier frequent callers will then have their activity reviewed three months after this initial letter is sent. If after 3 months the volume of calls has increased, and the criteria is still met for a frequent caller, a management plan will be implemented (as per stage two below). These letters can be found in the Management of Patients with Defined Individual Needs Toolkit.

8.2 Stage Two (Frequent Caller – Inappropriate use of the service)

Trust representative (Clinical Coordinator/Frequent Caller Clinician/Leading Operations Manager) liaises with appropriate Healthcare Professional (GP/Community Service), discussing the patient's activity and health & social needs via email, telephone contact or face to face meeting. A patient can also be referred to the local High Intensity User (HIU) forum if one exists, if there are issues receiving a timely response from primary care or other HCP and internal escalation is required. Acknowledgment is sought on the most appropriate management of the patient, and a Management Plan is formulated (standard plans in Toolkit) with the appropriate Healthcare Professional(s) knowledge.

All plans must have Associate Medical Director sign off before implementation or their nominated deputies, including the Director of Nursing and Clinical Quality or Medical Director.

For all new frequent callers identified, the Frequent Caller Team must contact SPOC to complete a GP Assistance referral as minimum.

These plans will remain in place indefinitely or until the patient is no longer considered a frequent caller of the service or their situation changes. This will be monitored during the 6-month review.

8.3 Frequent Caller Plans

Each time a call is received the Clinical Coordinator or ECAT Team Leader will be notified. The call will be reviewed by the Clinical Coordinator or ECAT Team Leader to ensure we are clinically safe. The demand on the service and the agreed plan will be reviewed every 6 months.

If the call is made by a HCP then the Clinical Coordinator or ECAT Team Leader will have a discussion with the HCP at the time of the call to discuss the patient and any previous call history.

1) Standard Management Plan

1. All emergency calls relating to this address, phone number or when identified as the frequent caller will be triaged in ambulance control as per AOC call handling process.

2. Any call prioritised as a life-threatening emergency (Category 1) will be responded to in line with resource allocation.

3. Following confirmation that there is no immediate threat to life the call will be passed to an ECAT clinician within the control room to triage further (Category 2-4) and the response stood down.
4. The ECAT clinician will contact the patient within the call category timeframe and triage the patient further with a full range of responses and dispositions available – Surge dependent.
5. The patient may be encouraged to access alternative pathways or use home treatments; no ambulance response will be dispatched.
6. If attendance is deemed appropriate the patient will receive a maximum of one face to face assessment per 24-hour period.
7. If the Clinician is satisfied that no response is required, they will inform the patient that they will not receive any further telephone triage for 24 hours.

8. Steps 3-7 of this plan will only occur once every 24-hour period, with all other non-immediate calls being stood down following steps 1 & 2.
9. Any abandoned call from the patient will be deemed a refusal of care – this must be reviewed by the Clinical Coordinator or ECAT Team Leader before the call is closed.

2) Triage Every Time Management Plan

1. All emergency calls relating to this address, phone number or when identified as the frequent caller will be triaged in ambulance control as per AOC call handling process.
2. Any call prioritised as a life-threatening emergency (Category 1) will be responded to in line with resource allocation.
3. Following confirmation that there is no immediate threat to life the call will be passed to an ECAT clinician within the control room to triage further. (Category 2-4) and the response stood down.
4. The ECAT clinician will contact the patient within the call category timeframe and triage the patient further with a full range of responses and dispositions available – Surge dependent.
5. The patient may be encouraged to access alternative pathways or use home treatments; no ambulance response will be dispatched.
6. If attendance is deemed appropriate, then an ambulance will be sent.
7. If the ECAT clinician is satisfied that no response is required, they will inform the patient that they will not receive an ambulance.
8. This process will happen every time the patient calls.
9. Any abandoned call from the patient will be deemed a refusal of care – this

must be reviewed by the Clinical Coordinator or ECAT Team Leader before the call is closed.

3) Time Specific Management Plan

1. All emergency calls relating to this address, phone number or when identified as the frequent caller will be triaged in ambulance control as per AOC call handling process.

2. Any call prioritised as a life-threatening emergency (Category 1) will be responded to in line with resource allocation.

3. Following confirmation that there is no immediate threat to life the call will be passed to an ECAT clinician within the control room to triage further. (Category 2-4) and the response stood down.

4. The ECAT clinician will contact the patient within the call category timeframe and triage the patient further with a full range of responses and dispositions available – Surge dependent.

5. The patient may be encouraged to access alternative pathways or use home treatments; no ambulance response will be dispatched.

6. If attendance is deemed appropriate the patient will receive a maximum of one face to face assessment per 4/8/12/24-hour period (delete as appropriate).

7. If the Clinician is satisfied that no response is required, they will inform the patient that they will not receive any further telephone triage for 4/8/12/24 hours (delete as appropriate).

8. Steps 3- 7 of this plan will only occur once every 4/8/12/24-hour period (delete as appropriate), with all other non-immediate calls being stood down following steps 1 & 2.

9. Any abandoned call from the patient will be deemed a refusal of care – this must be reviewed by the Clinical Coordinator or ECAT Team Leader before the call is closed

Extra steps can be added into the plans to manage individuals more appropriately, including as an example (but not an exhaustive list):

- The Trust will not take calls while the frequent caller is being abusive or using inappropriate language towards our staff on the phone and will terminate these calls after one warning.

- If when the frequent caller calls, if they do not answer return phone calls after 3 attempts, then the event will be closed, and no further contact will be made until the frequent caller rings again.
- If the frequent caller refuses to attend hospital during the telephone triage, then no ambulance will be sent.
- If the frequent callers address is attended and they are abusive, aggressive, or threatening, the crew will take appropriate action and register the incident on Datix for follow up investigation. This will be classed as one ambulance attendance in 24 hours.
- If the frequent caller requests a call back from the psychiatry clinic as their chief complaint, then the call handler or duty clinical coordinator is to ring the psychiatry clinic (01727 ******) between 9am and 5pm or the out of hours helpline number (01438 ******) and request a call back for the frequent caller. If following this call back the frequent caller requires an ambulance, then the psychiatry clinic are to call back and book it as a HCP referral on 01234 716120.
- We can refer the frequent caller to the duty worker at the psychiatry clinic (01727 ******) between 9am and 5pm or the out of hours helpline number (01438 ******)

The 24-hour period starts from when the patient has been last triaged either by a clinician in AOC or on scene, not from the call time.

EEAST will write to the patient advising them that they have been using the service frequently or regularly, including information on when and how to use our emergency service and other options available locally (Choose Well Leaflet). They will also be notified that the East of England Ambulance Service will be holding a record of their interaction with the ambulance service and that we will be reviewing their management plan with their GP and / or other agencies (using the standard letter templates - these letters can be found in the Management of Patients with Defined Individual Needs Toolkit.).

8.3 Stage Three (Frequent Caller - 6 Month Review)

The management plan will be reviewed every 6 months, and the plans will remain in place until it is deemed reasonable for it to be removed.

If there is no improvement at this review, then the Clinical Coordinator Team/Frequent Caller Lead may call a multidisciplinary team meeting (MDT) to discuss an action management plan for the individual patient. This process could

happen before the 6-month review period is due if there is an adverse impact on the Trust. This can be identified by the monthly reports on PowerBI, contact with other agencies or providers, from both internal and external incident groups (Datix), from other work streams or through the Trust's Patient Advice & Liaison Service (PALS). The patient will be notified in writing informing them of this action if anything within the plan type has changed (template letters can be found in the Management of Patients with Defined Individual Needs Toolkit.). The Trust may meet with the patient as part of the MDT or as a separate meeting to discuss their call volume. In the first instance, this would be discussed by the Frequent Caller Lead and local Operational Management.

The Datix record will be updated with any changes and the CAD flag on the patient's address updated if necessary. Calls will be managed in line with the agreed plan.

8.4 Stage Three (Frequent Caller – 1 Year Review)

If no reduction in the frequency of calls is achieved, the case should be reviewed by the Clinical Coordinator, Frequent Caller Lead and Deputy Medical Director and a recommendation made to the Trust to either:

- Have a further urgent case review and multidisciplinary team meeting
- Write to the patient advising them that we will be taking further action – court action / injunction, police involvement, etc.
- Meet with the patient
- Consider court action / injunction

8.5 Temporary Plans

Out of hours it may be appropriate to instigate a Temporary Management Plan due to:

- Excessive 999/111 calls are being received from a caller(s)
- Multiple Ambulance attendances and / or ECAT Triages
- Relevant HCP may not be contactable
- Disruption to EEAST service provision

Two Clinical Coordinators or a Clinical Coordinator and the SOCM Clinical Services/AOC COM/Frequent Caller Lead can put a Temporary Plan in place, but only after an operational crew or RRV has attended and fully assessed the patient and fed back directly to the Clinical Coordinator.

A 1 in 4/8/12/24 plan will be selected and implemented. A SPOC referral for a GP assist must always take place at the time. It is imperative that when the first in hours Clinical Coordinator / Frequent caller Clinician / Lead is on duty they speak to the frequent caller's appropriate HCP and a permanent plan sorted, sent via email using the Temporary Plan letter template.

All Temporary Plans must have a Frequent Caller Risk Assessment completed.

9.0 Management of Patients with Complex Medical Needs

On receipt of patient specific plan/information, the Clinical Coordinator Team/Frequent Caller Lead will coordinate the initial investigation and review the documentation. A CAD marker will be written and actioned in accordance with the CAD Markers Procedure. A Datix will be raised, and the patient specific plan/information will be stored on the shared S Drive (accessible to Clinical Coordinators/Frequent Caller Lead/ECAT staff/AOC Managers/limited approved staff).

HCP's who are responsible for these patients' plans will be accountable for updating EEAST on any changes or alterations required to these plans.

10.0 Multidisciplinary Working

To ensure that appropriate support is available to patients calling the service frequently or regularly, the Trust will:

- Work with local providers of health and social care to identify people using a range of services frequently or regularly and coordinate activity to reduce these calls. This may take the form of case conferences as needed or local forums including representatives from the CCG, mental health providers, out of hour's services and social services.
- Refer to the Home Office Guide to Criminal Behaviour Orders (CBO's) and acceptable behaviour contracts and agreements.
- CBO — issued by the courts after conviction, the order will ban an individual from certain activities or places and require them to address their behaviour, for example attending drug treatment programmes. A breach would see an individual face a maximum five-year prison term.

- Crime Prevention Injunctions - designed to prevent escalation of anti-social behaviour. The injunction would carry a civil burden of proof, making it quicker and easier to obtain than previous tools. For adults, breach of the injunction could see imprisonment or fines being issued. For under-18s, a breach could be dealt with through curfews, supervision, or detention.
- Patients falling into the above categories should have a specific review by the Director of Nursing, Clinical Quality and Improvement or Associate Medical Director before an application is made. This may include the seeking of a legal opinion by the Trust.
- The Frequent Caller Lead may be approached by police colleagues on behalf of other Trusts or organisations pursuing legal action against a HIU patient to provide a statement and data to support this. EEAST has an ISA which covers the sharing of information around frequent callers with police. Any information requests around EEAST contact for non-frequent callers must be referred to the SARS team.

A report of patients who have been placed on a triage management plan should be monitored by the AOC Delivery Group (ADG). This will be provided as part of an update given on a monthly basis by the Frequent Caller Lead at the ADG meeting and should continue until the Trust's legal duty to respond to all 999 calls received is amended.

11.0 Information Sharing

Wherever possible, consent should be obtained from the patient before passing on personal information to other agencies. Due regard should be given to involving the patient's relatives, carer or advocate, where the patient consents to this (with due regard to personal safety).

It is possible to share information directly with other NHS organisations who are also bound by Caldecott principles, namely Principle 7 "The duty to share information for individual care is as important as the duty to protect patient confidentiality".

This states that Health and social care professionals should have the confidence to share confidential information in the best interests of patients and service users within the framework set out by these principles. They should be

supported by the policies of their employers, regulators, and professional bodies.
The Trust takes the view that this area of work falls within these provisions, towards the establishment of an emergency care component of a community care plan.

The Trust holds Information Sharing Agreements (ISA's) with the CCGs for the purposes of this policy (already in place with LSAB and LSCB Board) and other key stakeholders including 111 providers and the police.

12.0 Process for Monitoring Compliance and Effectiveness

IMT teams will be responsible for carrying out audits and monitoring the effectiveness and safety of the Trust's Management of Patients with Defined Individual Needs Policy and will report to the Clinical Review Group on a quarterly basis. This review will include how many patients who meet the definition of being a frequent or regular user are being managed through the AOC and Operations, any care plans in place, reassurance that the care plans are reviewed appropriately, the impact of any care plans (reduction in number of contacts) and any issues arising from the process.

13.0 Standards / Key Performance Indicators

The specific Ambulance Quality Indicator (AQI) related to this area is as follows:

"Calls from frequent callers with a pre-agreed care plan in the CAD can be categorised according to that care plan. Services should be able to identify such calls for audit purposes."

14. Associated Documents

Computer Aided Dispatch (CAD) Markers Policy
Investigations Policy
Patient Confidentiality Policy
Safeguarding Policies
Mental Health Policies
Health, Safety & Security Policies

Appendix A: Frequent Caller Management <18 Years Flow Chart

Table One

A location or individual:

- <18 years by individual name and address.
- who is already classed as a frequent caller where escalation is required.
- identified as part of other workstreams, as part of incident reporting internally/externally or as part of a PALS enquiry.
- where other agencies have contacted EEAST.

Important Notes:

- Document each stage clearly with the themes and issues the facts and associated evidence.
- Ensure that any attendance on multiagency meetings is documented.
- Where contact is made outside of the PALS service ensure this is documented either through PALS, AdAstra or Datix.
- Where any action or management plan exists, this should be available for relevant organisations.
- Any sharing of information needs to follow Caldicott principles and data sharing protocols.
- Consideration should be given to a vulnerability or safeguarding referral.

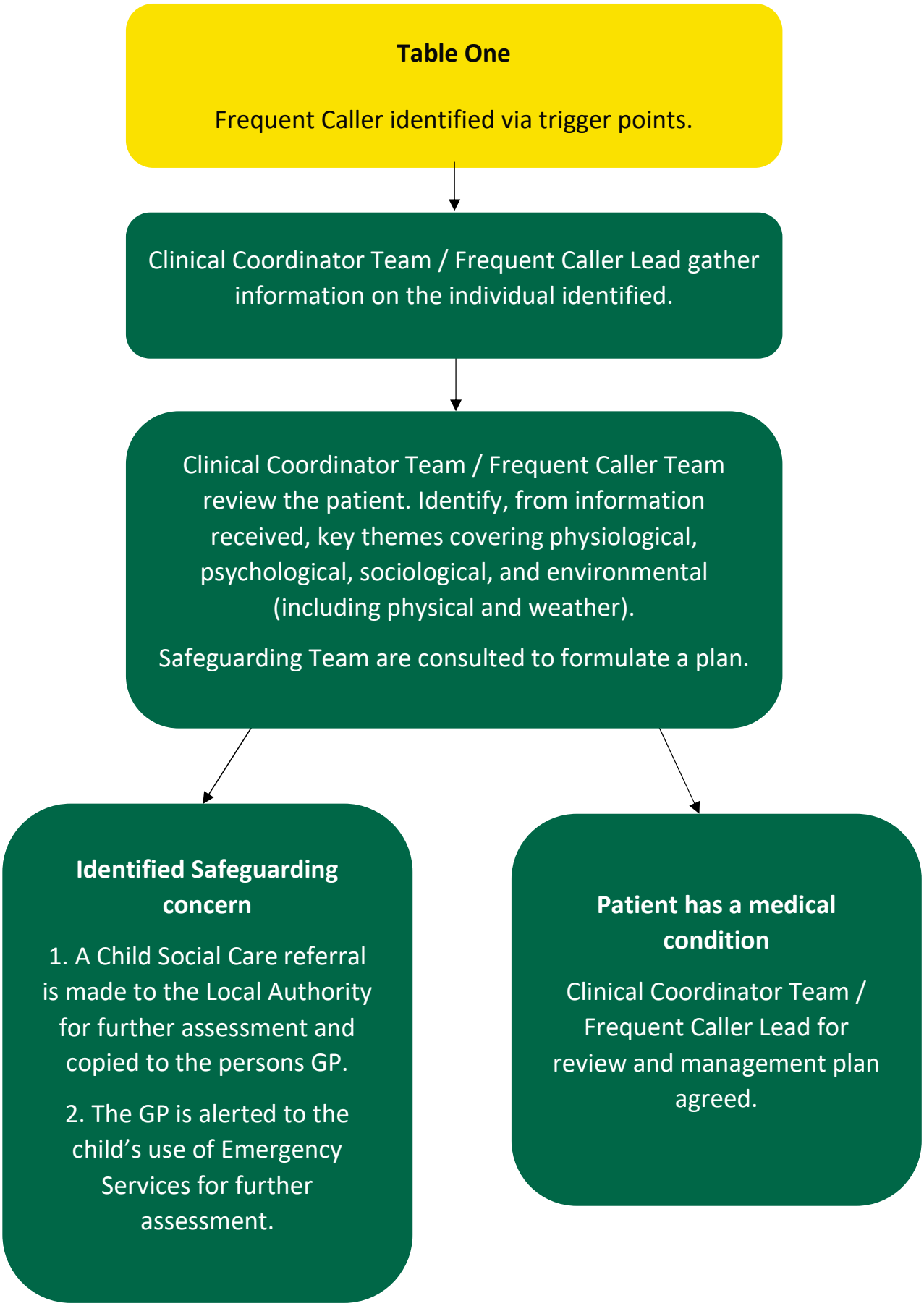


Table One
Frequent Caller identified via trigger points.
Clinical Coordinator Team / Frequent Caller Lead gather information on the individual identified.
Clinical Coordinator Team / Frequent Caller Team review the patient. Identify, from information received, key themes covering physiological, psychological, sociological, and environmental (including physical and weather).
Safeguarding Team are consulted to formulate a plan.
Identified Safeguarding concern
1. A Child Social Care referral is made to the Local Authority for further assessment and copied to the persons GP.
2. The GP is alerted to the child's use of Emergency Services for further assessment.
Patient has a medical condition
Clinical Coordinator Team / Frequent Caller Lead for review and management plan agreed.

Appendix B: Frequent Caller Management >18 Years Flow Chart

Table Two

A location or individual:

- ≥18 years, by individual private address
- ≥5 calls (individual episodes of care) in a 1-month period
- ≥12 calls (individual episodes of care) in a 3-month period
- who is already classed as a frequent caller where escalation is required.
- identified as part of other workstreams, as part of incident reporting internally/externally or as part of a PALS enquiry.
- where other agencies have contacted EEAST.

Important Notes:

- Document each stage clearly with the themes and issues the facts and associated evidence.
- Ensure that any attendance on multiagency meetings is documented.
- Where contact is made outside of the PALS service ensure this is documented either through PALS, AdAstra or Datix.
- Where any action or management plan exists, this should be available for relevant organisations.
- Any sharing of information needs to follow Caldicott principles and data sharing protocols.
- Consideration should be given to a vulnerability or safeguarding referral.

Table Two

Frequent Caller identified via trigger points.

↓

Information gathered on the individual that has triggered – assess clinical records, DATIX, CAD and any existing flag or management plan in place.

↓

GP Assist to be made via SPOC for newly identified frequent callers identified.

Frequent caller is given a tier level based on call volume.

↓

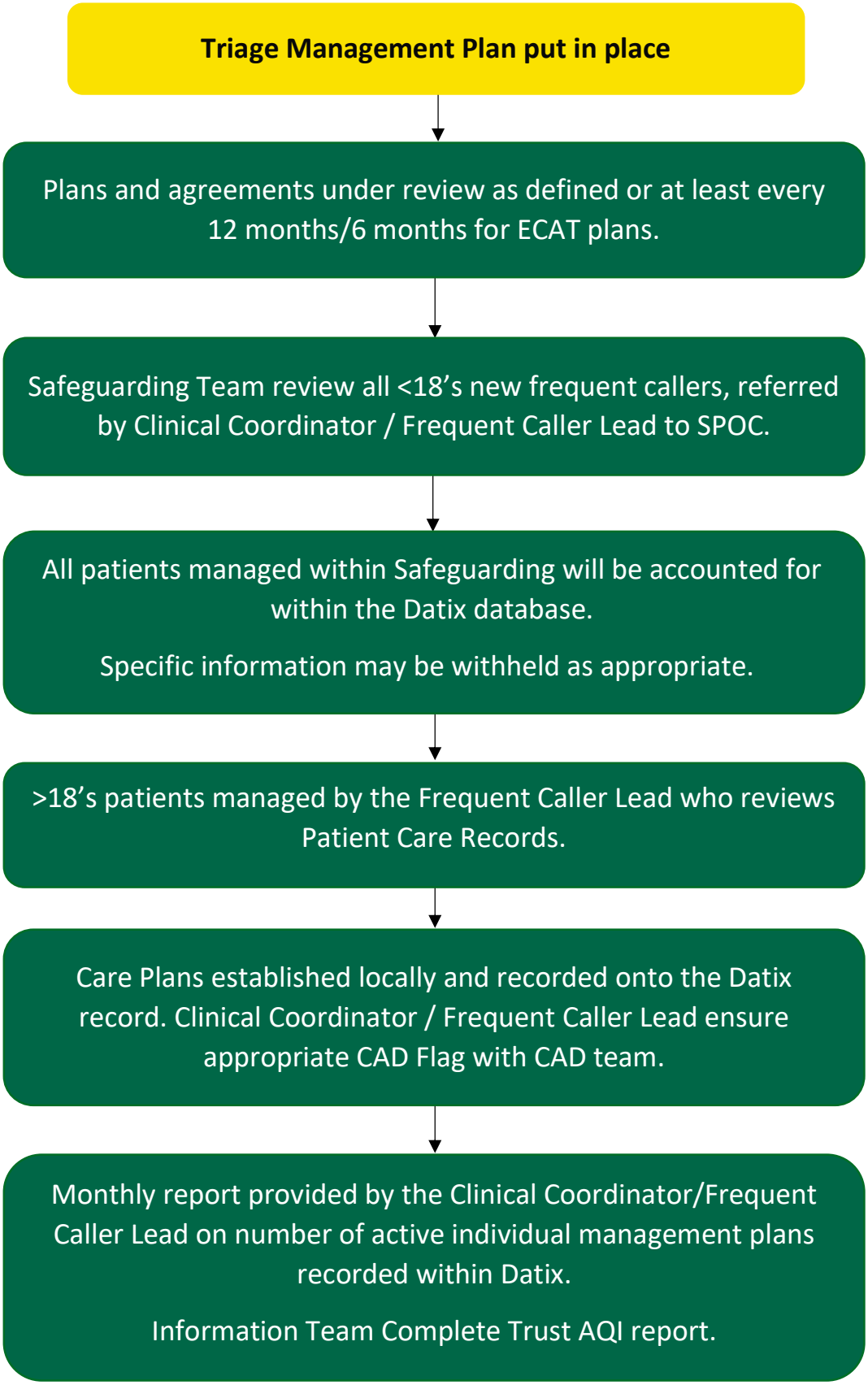
Green tier frequent caller – as per stage one the patient and their GP will be sent a 'green tier advisory' letter by the Frequent Caller Team.

Amber, red, black tier & green tier frequent callers three months since initial letter – as per stage two these patients will be reviewed for a management plan.

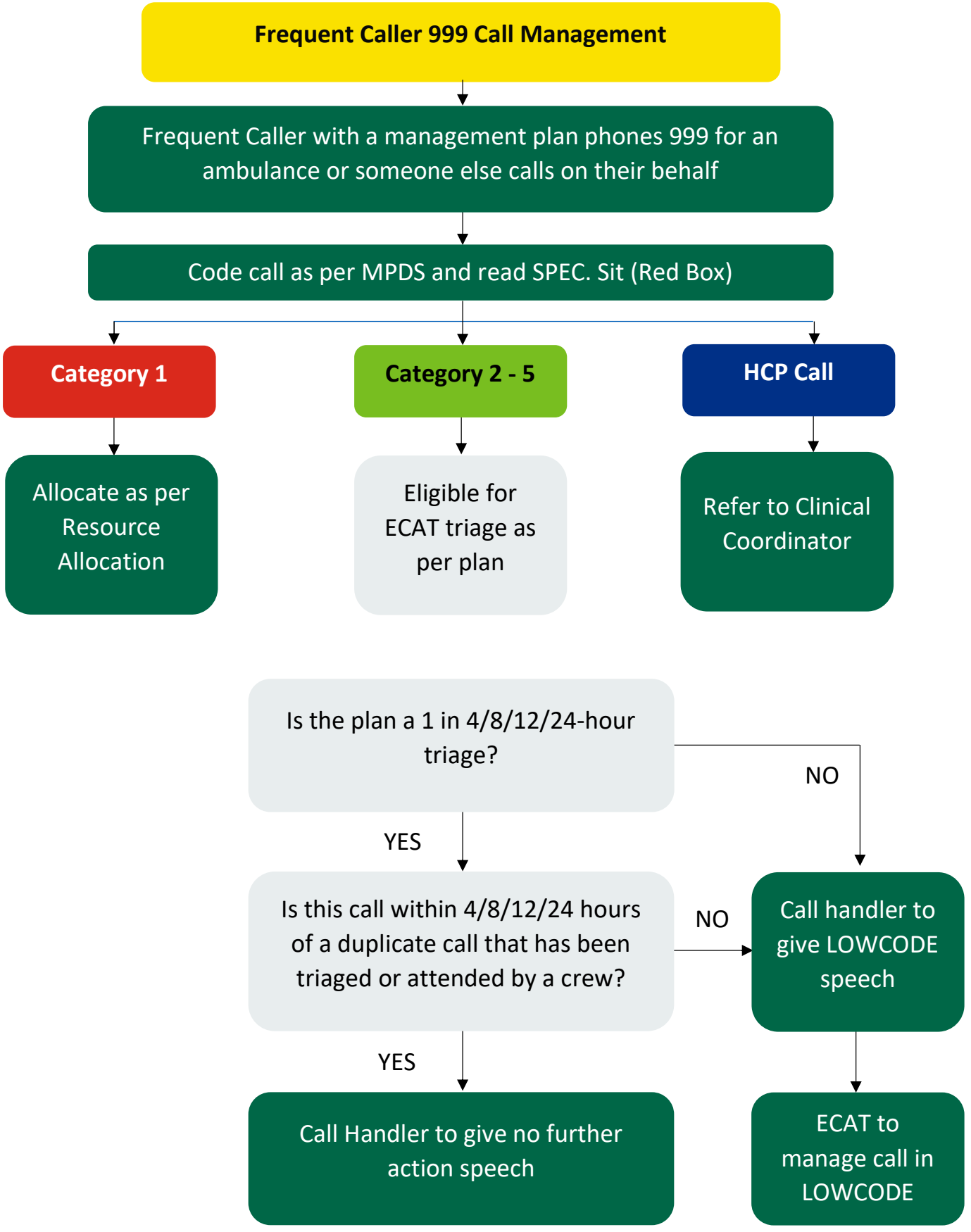
↓

Liaison between the Clinical Coordinator, Frequent Caller Lead and Management Team.

Appendix C: Frequent Caller Information Process



Appendix D: AOC Frequent Caller Process



Pre arrival Speech:

As per ProQA

LowCode / ECAT Speech:

"From the information you have given me your call is appropriate for further clinical assessment and I am going to arrange for one of our clinicians to call you back. Our aim is to do this within ** minutes, if this isn't possible, we will contact you. Is it okay to call you back on this number? May I take your / the patient's name, DOB and GP name please."

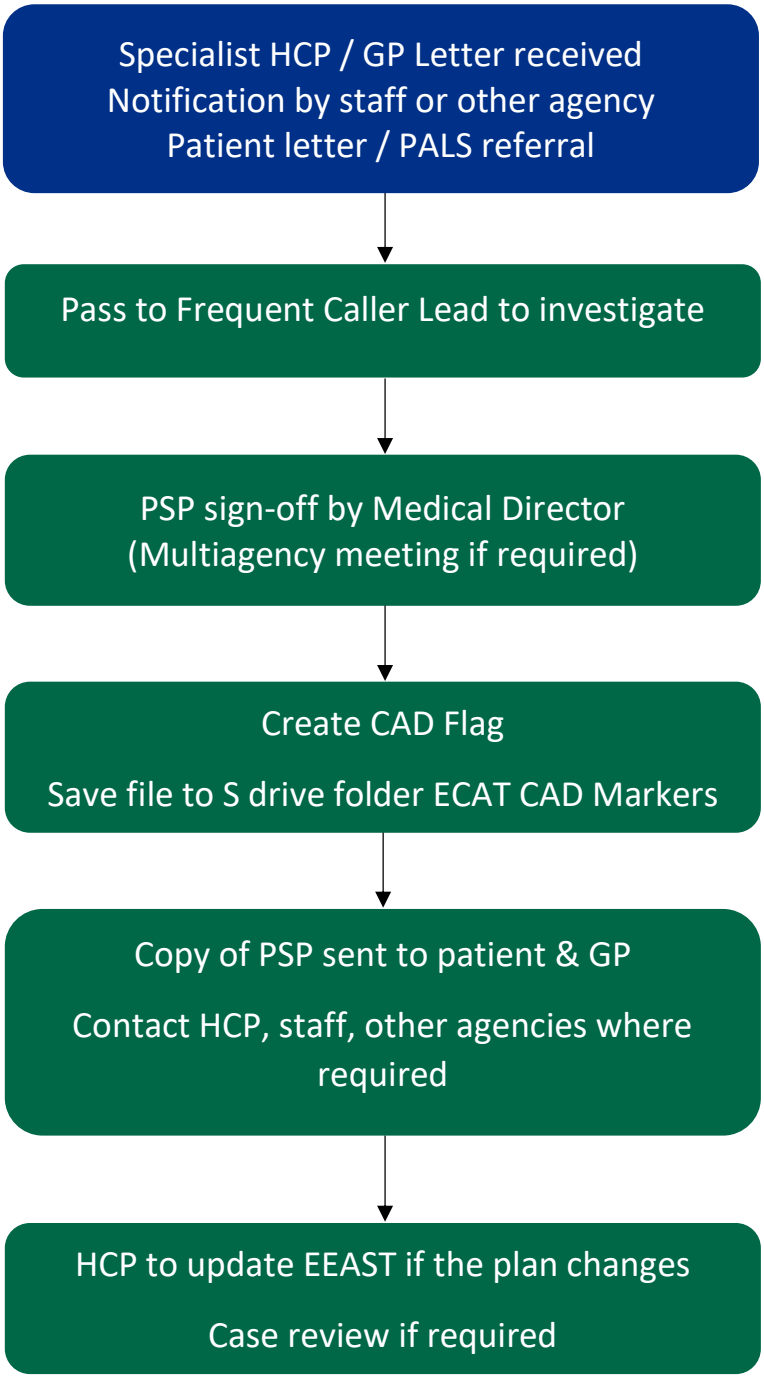
(1st Party Callers) "Do you consent to our clinician viewing your health records to aid assessment?" (2nd, 3rd Party callers) "Please ask the patient if they consent to our clinician viewing their health records to aid assessment?"

"It is important that we are able to contact you, please keep the line clear so we can contact you and if s/he gets worse in any way, call us back immediately for further instructions".

No further action speech:

"From the information you have given me and as per your Ambulance Response Plan, you will not be receiving a call back from a clinician or an ambulance at this time".

Appendix E: Patients with Complex Medical Needs Management Flow Chart



APPENDIX F – Equality Impact Assessment (EIA)

EIA Cover Sheet		
Name of Process/Policy	Policy for the Management of Patients with defined individual needs	
Is the process new or existing? If existing, state policy reference number	Existing (POL038)	
Person Responsible for Process/Policy	Deputy Chief Operating Officer	
Directorate and Department/Section	Ambulance Operations Centre	
Name of Assessment Lead or EIA Assessment Team Members	Head of AOC	
Has Consultation Taken Place? Was consultation internal or external?		
The Assessment is being made on	**Guidelines**	X
	Written Policy Involving Staff and Patients	X
	Strategy	
	Changes in Practice	X
	Department Changes	
	Project Plan	
	Action Plan	X
	Other (Please State)	X - Training Programme

Equality Analysis
What is the aim of the policy/procedure/practice/event?

East of England Ambulance Service (EEAST) is committed to providing a patient-centred and clinically appropriate service to the patients it serves, ensuring the right response to the right person at the right time.

A wide range of people rely on the 999 service we provide for an emergency response to serious and life-threatening conditions. The majority of patients can be treated with the principles and practices of assessment and care that are laid down in core training.

There are, however, a group of service users who use the 999-emergency service significantly more frequently than others, when they might benefit from an alternative pathway of care and this can have a significant impact on EEAST resources, both within the Ambulance Operations Centre (AOC) and in operations.

The team will take into account any health inequalities identified during the referral and assessment process.

Some patients will have conditions that require assessment and treatment that is unfamiliar to ambulance personnel.

There may be new guidance on specific treatment for certain conditions that require a specific reminder to crews to ensure that best practice is adhered to.
The patients concerned may:

- Have a long-term condition with an acute exacerbation or require support to manage their condition appropriately at home.
- Be experiencing a specific episode of ill-health or difficulty.
- Also have unmet social or healthcare needs and alcohol, substance or mental health related healthcare issues.
- Be unaware of more appropriate entry points into the NHS.

Not all of these callers require an emergency response from a qualified clinician. They may call a substantial number of times per 24 hour period, involving call handlers, the Emergency Clinical Advice and Triage Centre (ECAT) and emergency responders.

This Policy outlines the ways in which EEAST can determine, agree and mobilise appropriate alternative care pathways for people calling 999 regularly, frequently or with very specific and defined needs that may not be covered in core training.

Who does the Policy/Procedure/Practice/Event Impact on?					
Race	☒	Religion/Belief	☒	Marriage/Civil Partnership	☒
Gender	☒	Disability	☒	Sexual Orientation	☒

Age	☒	Gender re-assignment	☒	Pregnancy	☒

Who is responsible for monitoring the policy/procedure/practice/event?
Deputy Chief Operating Officer

What information is currently available on the impact of this policy/procedure/practice/event?
User Information & Impact Statements on 999 Service Users

Do you need more guidance before you can make an assessment about this policy/procedure/practice/event? No.

Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? No

Race	☐	Religion/Belief	☐	Marriage/Civil Partnership	☐
Gender	☐	Disability	☐	Sexual Orientation	☐
Age	☐	Gender re-assignment	☐	Pregnancy	☐

If yes, please provide evidence/examples: It is having an impact on patients that require the emergencies in a genuine emergency and we are support those who need us the most, and those who call us inappropriately. We tailor plans to meet patients' needs to ensure we take in to consideration any needs or protected characteristics.

Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics?
If so please provide evidence/examples: No

Race	☐	Religion/Belief	☐	Marriage/Civil Partnership	☐
Gender	☐	Disability	☐	Sexual Orientation	☐
Age	☐	Gender re-assignment	☐	Pregnancy	☐

Action Plan/s – SMART

Specific

- There will be an impact on patients with life threatening emergencies will get a timelier response and patient who are managed under a frequent caller plan will receive care but daily in a reduced amount to support their behaviour.

Measurable

- This is measurable through the statistics provided by the Frequent Caller Team and an improved C1 / C2 response.

Achievable

- We have a dedicated team managing these patients, which fit's their workload.

Relevant

- The policy is evidenced based, and statistics show the success of how we manage these patients, whether they need a response immediately or require us to support them in how they use our service.

Time Limited • Statistics are reviewed monthly
Evaluation Monitoring Plan/How will this be monitored? By the Deputy Chief Operating Officer by receiving feedback from the frequent caller, operational crews and CAD markers team. By: Interim Caller Lead Frequent Caller Lead Reported To: Head of AOC

Appendix G – Monitoring Table

What	Policy for the Management of Patients with Defined Individual Needs
Who	CRG
How	As the CRG we will review any changes needed at each meeting to ensure the document is current, in line with legislation and fit for purpose.
Frequency	We will continually monitor and report any required changed needed every six months. This will be shared with the Deputy COO, AOC & CRG.
Evidence	Factual evidence and any suggestions from improved practice.
Reporting Arrangements	CRG will provide assurance that service provision which impacts on the patient's experience is monitored so action can be taken as and when necessary to improve the standard of patient care and reduce clinical risk.
Acting on Recommendations	Required actions will be identified and completed in a specified timeframe.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.