Frequent Callers
Darzi Fellowship Project
FOR A FAIR SELECTION EVERYBODY HAS TO TAKE THE SAME EXAM: PLEASE CLIMB THAT TREE
Bio

- Paramedic
- HEMS Paramedic
- Advanced Practitioner
- Management Consultant
- Darzi Fellow
- NICE Expert Member
- Clinical Leader
Frequent Caller Darzi Fellowship

“The Darzi programme is designed to meet the organisational needs of the NHS in London and the evolving nature of the healthcare system, focussing on effective partnerships and networks for co-commissioning and integrated delivery that span providers, commissioners and local authorities.”

- Bespoke Leadership Programme
- System Innovation
- Change
- Post Graduate Certificate in Leadership
Darzi Project Overview

Improve the identification and management of complicated frequent callers.

- Multi-agency engagement and participation
- A review of the identification, management and support processes
- Review the effectiveness of current pathways
- Identify the barriers to improvement
- Elements that enable and support success both at a local and a system wide level
CQUIN Overview

Develop and agree a project plan for the identification and management of complicated frequent callers.

• Multi-agency engagement and participation
• A review of the identification, management and support processes
• Review the effectiveness of current pathways
• Identify the barriers to improvement
• Elements that enable and support success both at a local and a system wide level
What is a Frequent Caller?

National definition (FreCaNN):

• “Any one aged 18 or over who calls 5 or more times in 1 month from a private dwelling”
• “Any one aged 18 or over who calls 12 or more times over a 3 month period from a private dwelling”
How many are there?

- 2,000 Patients
- 50,000 incidents
- 31,000 Hear & Treat Incidents
- 9,500 See & Treat Incidents
- 9,500 See & Convey Incidents
- £4.4 million LAS cost
- 3,028 12 Hour Ambulances
- £18.8 cost to the healthcare economy
Who are they?

Nuisance

Drain of resource

Burden

Miscreant

Criminal

Waste
Who are they?

- No single patient profile
- Contributory factors
  - Chronic co-morbidities
  - Mental Health
  - Personality Disorders
  - Learning Disabilities
  - Substance Abuse
  - Frail / Elderly
  - Homeless
  - Hoax Callers
- Care system
Part of the problem?

- Compartmentalised packages of care
- Promotes silo practice
- Inhibits collaboration
- Impedes holistic care
- Reduces Quality of Care
- WHY?
Case Study

- 63 year old female
- Diabetes
- 160 calls in March
  - 112 Chest Pain
  - 43 Unknown
  - 1 Hospital Transfer
  - 4 third part
- Lives in sheltered accommodation.
- GP disengaged
- Care home manager threatening to evict
- Does not see children
- Widowed
- Conveyed once
  - Cancelled by other party 125 times
- 32 hours of ambulances
- £3401
  - Should have been £16,500
Reality

- Abused since the age of six
- Escaped abusive family through marriage
- Became victim of domestic violence
- Had children removed due to risk from abusive father
- Husband died leaving patient isolated

- Children apprehensive to return
- Non stimulating daily routine
- Struggles to engage with fellow patients
- Psych Assessment
  - Seeks safe relationships
  - Controllable
  - Anxiety
  - Lonely
How are we doing?

- Performing in line with national average... just.
- Vanguard leaders of frequent caller management to 4th in the country.
- We aren't sure about the quality we offer to our frequent callers.

- We work well with other people
- We care
- Tremendous skill base
- We are very influential
- We know our stuff
- We would like to do more!
Current Approach Cont.


Source: Hainsworth (1990) and Meng (1992)
Value Production Methodology

Chain (Porter, 2009)
- Processes are largely one way
- Relies on predictability and protocol
- Standardisation is usually the solution
- Scalable

Value Network (Christiensen, 2011)
- No tangible output
- Focus on connection
- Value is aligned to number of connections.
- Expensive to begin with
- Time and growth mitigates cost

Value Shop (Stabell and Fjeldstad, 1998)
- Cyclical
- Problem finding
- Expensive
- Control and Evaluation
PCAT Process
National Approaches

Regional

Individual

Local

Base

Escalating / Deescalating

Prolific
Common Issues

- **Standardisation**
  - Confusion
  - Ambiguity
  - Inefficient

- **Accountability**
  - Support Mechanisms
  - Routes of Escalation
  - Discourages sharing of best practice

- **Quantification**
  - Evidence
  - Quality
  - Value
Proposed Approach

- Manage 425 patients who generate 39,558 Incidents
- Hear & Treat 11% activity
  - 4,351 Incidents
- See & Treat 35% activity
  - 13,845 Incidents
  - 14,953 hrs within the job cycle time
- See & Convey 54% activity
  - 21,361 Incidents
  - 31,615 hrs within job cycle time
- Potential efficiencies of 46,568 (hrs) 3,881 shifts

Patient Centred Action Team
- Prolific frequent callers across London (Top 1% - 5%)
- Maintain current performance output

Stakeholder Engagement Manager
- Adopt the local management of an initial case load of 10 frequent callers
- Total management of 70 frequent callers

CIO / TL / Local Lead
- Continue current endeavours
- Accountable for case load of 15 frequent callers
- Total management of 105 frequent callers
Patient 1

• 55 Years Old Male

• Patient is a rough sleeper who usually calls 999 for central chest pain or mobility problems. Patient was not registered with a GP and had not received a general health assessment other than provided at the Emergency Department for over a decade. Previous medical history of reduced mobility, depression and alcohol dependency.

• In 2015, the patient called 999 on 57 occasions which resulted in conveyance to the Emergency Department in 41 of the incidents. This generated a resource demand of 71.48 hours over the annual period at an estimated cost of £12,843.

• The Frequent caller team worked collaboratively with local services to locate the patient and coordinate services to provide assistance. The Street outreach team used information from the Ambulance service to find the patient and arrange temporary accommodation.

• A collaborative care plan was implemented to support the patient through subsequent episodes of crisis.
Patient 1

Incidents by month for patient 1

Incidents

Month
Patient 2

- 76 Years Old

- Patent is classified as an entrenched frequent caller who usually attends multiple Emergency Departments, and her GP. She is a well dressed and kempt woman with anxiety disorder and breathing problems which is being managed by the local out patients provider. The patient finds it challenging to sleep due to her anxiety and refuses medication to help with this problem.

- Often the patient calls stating she is breathless and sometimes has chest pain. She is known to the mental health teams at both hospitals who in conjunction with her GP review her frequently. Two multi-agency case conferences have taken place to discuss the frequent attendances to all services.

- The patient has been given a care plan, including a diagram (cognitive behavioural therapy method) to help manage periods of crisis. The patient is completely aware that all agencies are working together, including social services, GP, Emergency department and mental health teams.

- Guidance from the care plan indicates that crews should undertake a brief assessment Including oxygen saturations (and 12 lead ECG if patient is complaining of chest pain). If the patient presents with regular symptoms and regular history (as cross referenced by the care plan), the patient should be supported to stay at home without conveyance to the Emergency Department.
Patient 2

- I can't catch my breath
- I am NOT thinking I'm going to die
- I am NOT frightened
- Breathing getting more shallow and fast
- Too much oxygen in blood makes me dizzy and gives me palpitations
- I will use distraction and slow down my breathing
- Breathing gets worse

I heard that I may be frightened but I am not aware of this.
Patient 2

Incidents by month for patient 2

Incidents

Month
How do we do this?

• Identify
• Approach
• Engage
• Investigate
• Support
• Intervene (if required)
• Review
Vehicle to change
Care Planning

- Who can do it?
- Why should we do it?
- What can go wrong
- What happens if it goes wrong?
- What good will it do?
- What should I put in it?
Care Planning

• Lord Darzi’s report, High Quality Care for All, committed the NHS to offering, by 2010, a personalised care plan to all 15.4 million people in England with a long-term condition (Department of Health, 2008b).

• Currently, half of those with long-term conditions are unaware of their treatment options and do not have a plan for managing their condition (Opinion Leader Research, 2006).

• Most people with long-term conditions are keen to take responsibility for their health. Over 90% say they are interested in being more active self carers, and over 75% would feel more confident self caring if they had help from a healthcare professional or peer (DH, 2005b).

• Supporting people to self care through care planning can reduce GP visits by 40% for high-risk groups (Fries and McShane, 1998) and reduce hospital admissions by 50% (Montgomery et al, 1994).
Ethical & Legal Considerations

Risk Management

- Complex patients increase clinical risk
- Management of patient specific clinical risk vs organisational risk is challenging.
Ethical & Legal Considerations

Clinical Management

• High prevalence of mental health which requires skilled navigation of clinical and legal considerations.

• MDT’s
  • Whose accountable?
  • Whose the lead?

• How and when do I escalate?
Ethical & Legal Considerations

Clinical Management

• When all routes have been explored, what do we do?
• Unprecedented solutions.
Ethical & Legal Considerations

Information Governance

- What can I share?
- How can I share it?
- Disparity between health & social care guidance
- Where should this be stored?
Future

• Need for urgent and emergency care redesign.

• Piecemeal developments have created disjointed islands of improvement resulting in complexity.

• Each system is perfectly designed to get the results it gets.

• Pioneers
Frequent Callers

Thank you