London Ambulance Service NHS Trust

Overview of Frequent Callers of London Ambulance Services.

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Overview

The London Ambulance Service NHS Trust (the Trust or LAS) is the busiest emergency ambulance service in the UK, providing healthcare that is free to patients at the point of delivery. The Trust is the only NHS organisation which operates across the whole of London and serves the most ethnically diverse population across the United Kingdom.

In 2014/15 over 1.8 million emergency calls were handled across London which resulted in attendance at more than one million incidents. Annual figures suggest the organisation accommodates 1,622 Frequent Callers who generate 49,534 incidents per annum. This activity has been calculated to incur associated costs of approximately £4.4 million to the trust through the annual utilisation of 3,028 twelve hour ambulance shifts.

Frequent Callers are conveyed to the Emergency Department in 80% of recognised incidents, estimated to lead to 7,199 admissions each year (average attendance to admission rate of 18%). Given that the Kings Fund (2012) estimate that an average hospital admission costs £2,000, it could be suggested that LAS Frequent Callers cost the London health care economy £18.8 million annually. This does not take into account other services accessed and provider input into the management of their care.

The predominant chief complaint utilised by Frequent Callers is the unknown category (35.64%) where the caller is unsure or unwilling to describe the problem. This is followed by breathing problems (10.69%), non-traumatic chest pain (9.54%), sick person specific diagnosis (8.62%) and falls (7.89%). It is notable that Psychiatric/ Abnormal Behaviour/ Suicide Attempt is not higher within the predominant chief complaints. This is considered to be due to the patient calling for the outcome of the mental health crisis rather than the crisis itself.

The majority of LAS Frequent Caller identification and management activity is undertaken by the Patient Centred Action Team (PCAT). PCAT was created in 2007 and aims to identify the underlying causes which contribute toward a patients increased call frequency. Following identification of contributory factors, PCAT generates and implements care plans to counteract crisis and improve patient condition. PCAT also undertakes care co-ordination activities to identify alternative health and social care services which may have previously been overlooked.

Community involvement officers (CIO's) contribute toward the management of frequent callers although this is only a facet of their role. LAS currently employ six CIO's which are predominantly located throughout the spine of London.

CIO's utilise an enhanced knowledge of the local care pathways to provide a unique and personalised approach to Frequent Caller management which enhances clinical quality. Established local relationships facilitate the free flow of information between

organisations, improving intelligence and facilitating external escalation when required.

Sector Engagement Managers (SEM) are accountable for the local improvement of Frequent Caller management by actively developing plans with key stakeholders to support the patient through crisis periods.

In a limited number of areas, local champions have also undertaken voluntary Frequent Caller management responsibilities. Usually, this endeavour is completed by local team leaders who aim to provide clinical support, supervision and leadership to staff within a dedicated team in their geographical area of operation.

A specific individual champion was identified during the review period and demonstrated a significant amount of Frequent Caller management activity by using local station and crewmate knowledge to detect Frequent Callers, establish local relationship, identify referral services and generate care plans. This activity is deemed to contribute toward improving local Frequent Caller performance which was demonstrated by comparing the region to those without a local champion.

Significant proportions of Frequent Caller incidents are managed using hear and treat methods, which deliver clinical quality and improve organisational efficiency. A common challenge experienced by clinical advisors is found during the search for appropriate care alternatives which fulfilled clinical and/or social requirements.

Clinical advisors utilise a local database of ACP's in conjunction with the Directory of Service to identify referral pathways. This data is often inaccurate and anecdotally fails to provide the required support or responsiveness to effectively manage Frequent Callers. The absence of an appropriate referral service reduces the likelihood of the patient receiving the most appropriate clinical care.

A significant challenge associated with see and treat methods of Frequent Caller care can be found in ensuring the clinician has sufficient information to support the clinical decision making process. High intensity users demonstrate complex medical and social backgrounds which can be challenging for the pre hospital clinician to acquire within a limited period of time.

London Ambulance Service accommodates this information within Patient Specific Protocols which are stored on a central database. PSP's are most valuable when they provide a suite of escalation care alternatives which take into account the severity of patient crisis. Robust PSP's provide hear and treat, see and treat and see and convey alternatives provided by a group of health and social care providers. However, during the period of review, the quantity of PSP's which demonstrated these attributes were limited and predominantly focussed on the application of a sole ACP. Failure to access alternative pathways reduced confidence in the process and disengaged clinicians and patients. Furthermore, it would appear the majority of

PSP’s did not demonstrate a patient centred approach which could lead the patient to perceive the alternative as a punishment rather than a benefit.

Areas demonstrating comprehensive care plan documents usually accommodate frequent caller management groups which promote the sharing of data to improve collaboration. Frequent caller forums hosted by acute or primary health care providers identify, share and manage the Frequent Caller challenge collaboratively. Key decision makers from commissioning, acute, primary, secondary and charitable care providers meet centrally with social care to share, stratify and manage Frequent Callers in a monthly MDT style environment.

Evidence which supports the application of Frequent Caller Forums is currently limited however accessible data does indicate a reduction in crisis frequency and duration of patients who are managed by the groups. The main challenge associated with the generation and maintenance of forums is the engagement of key decision makers from the breadth of local health and social care organisations. Failure to accomplish full attendance reduces the value of care plans by narrowing the scope of intervention.

A number of forums have mitigated the attendance challenge by virtually hosting forums online or using teleconference facilities. Areas outside of London have mitigated the attendance challenge by ensuring forums are commissioner led. This approach enhances accountability throughout the membership and counteracts the risk of actions remaining uncompleted.

At the time of review, four frequent caller forums were active and eight were being discussed or generated. If all eight potential forums become active, a deficiency would remain within the West sector.

In conclusion, it would appear that the clinical quality delivered to frequent callers aligns with national benchmarks. Staff who endeavour to support patients through periods of crisis are compassionate, caring and regularly surpass expectations.

However, quality and value could be improved by implementing a standardised strategy throughout the organisation to enhance understanding, confidence and accountability.