ROYAL LONDON HOSPITAL HIGH INTENSITY USER TEAM
TOWER HAMLETS FREQUENT CALLER PILOT SCHEME

INTRODUCTION:

The Royal London Hospital High Intensity User Team (HIUT) is an East London Foundation Trust (ELFT) service based in the Royal London Hospital (RLH). The HIUT is a multi-disciplinary team that aims to support patients that regularly attend the RLH A+E department. Patients that regularly attend A+E are identified by means of direct referral (usually from A+E) or by data regularly provided by Barts Health informatics. The RLH HIUT definition of a 'frequent attender is a person who attends the RLH A+E department 10 or more times in the previous 12 months (at point of identification)'.

In addition to the patients who regularly attend A+E, there is another cohort of patients within the London Borough of Tower Hamlets, who are also defined as 'HIU's' and these are classified as 'frequent callers'. Meaning, people who regularly make phone calls to NHS services such as 111/999. Patients within this cohort are identified via data collected by the London Ambulance Service (LAS). The current National Frequent Caller definition is *'callers 18 or over with 5 calls in a month or 12 calls in 3 months from a private residence'* therefore excluding care homes, supported accommodation, hostels and people who are of non fixed abode.

In addition to the current body of work that exists to support the people who regularly attend the RLH A+E department, this pilot scheme provides a basic outline as to how the RLH HIUT will also look to provide support to the Tower Hamlets cohort of people who are defined as 'frequent callers'.

The LAS Frequent Caller Manager for North East London (Chris Williams), regularly provides the RLH HIU with data that identifies the names and details of patients that are noted to be frequent callers (as per above definition). In addition to the patients personal identifiable information, this data also states the frequency of calls to 111/999 (monthly/quarterly and annual data is provided) as well as the relative costing for this calling annually.

The last data that was provided by the LAS, identified that there were 28 individual patients meeting the frequent caller definition for the month of December 2022 in Tower Hamlets, this is the most recent data available at time of writing. The data and information provided by the LAS also details if each patient defined as a frequent caller has an existing 'Urgent Care Plan' (UCP) in operation.

The UCP platform is a relatively new digital care planning system that aims to improve patient care and serve as a platform so share important and personalised information about their care needs. The Urgent Care Plan platform can be accessed via existing NHS electronic records such as the Health Information exchange (HIE) and the East London Patient Record.

As per the UCP One London website:

'The Urgent Care Plan will enable every Londoner to have their care and support wishes digitally shared with healthcare professionals across the capital.'

AIM OF PILOT:

The stated aim of the RLH HIU frequent caller pilot will be to initiate an Urgent Care Plan for each of the people identified in the most recent LAS frequent caller data, December 2022. The aim is with the UCP that the patient will be able access the right care at the right time by sharing relevant health information directly at the point of first contact with emergency responders.

PREDICTED BENEFITS FOR THE PATIENT AND HEALTHCARE PROFESSIONALS IF AN URGENT CARE PLAN IS IMPLEMEMETED:

The predicted benefits and improvements of implementing a UCP for the frequent caller cohort of patients include:

- Providing further information and clarity to emergency professionals regarding the diagnosis and prescribed medications of patients.
- Providing information and contacts of professionals already in a person's care.
- Stating patient's wishes and any do/don'ts when providing them with care
- Completing alerts on UCP, highlighting and flagging essential information regarding risks or disability.
- Emergency contacts of patients (as provided by the person).
- Ensuring patients receive the correct level of emergency response appropriate to their care needs.
- Decreased amounts of emergency calls or crew time spent with a person.

The UCP patient information leaflet states:

- Having a care plan ensures that your wishes and preferences are always considered when healthcare professionals are caring for you or providing you with medical treatment.
- Care planning values you as an expert in the planning and management of your own health and wellbeing.
- A care plan is visible to all health and care services who are involved in your care and will reflect what is important to you.

METHOD:

- HIUT will look to work with the identified patient cases from the last LAS frequent caller spreadsheet, December 2022. There are 28 individual patients on the December 2022 list. Some already have a UCP. Paul F will allocate cases to the HIU team members to share the workload.
- Having allocated patients to HIU team members, a team clinical decision will then be made as to whether it will be appropriate to have direct contact with the patient – if direct contact is appropriate, contact with the person can be through:

    1. A phone call
    2. Direct contact with the person on a ward/in A+E
    3. Arranging a F2F outpatient appointment with the person to discuss the UCP

- Direct contact with the patient may also be deemed to be not appropriate – and this could be due to concerns re the patients capacity to have this discussion, concern that it may not be in the patients best interest to have a further professional involved in their care – or there may be an alternative way of the patient having this discussion e.g. an existing care coordinator or social worker.
- If HIUT determine that there is a professional already involved in the patients care who would be better suited in having the UCP discussion with the patient (for any of the reasons outlined above) HIUT will then look to directly communicate with that professional and request that this

professional have the UCP discussion with the patient. HIUT can provide the UCP patient information leaflet and give clarity as to what is being asked and why.

- CONSENT MUST BE GAINED FROM THE PATIENT before HIUT can initiate a UCP. If they do not consent, we will not be starting up a UCP; will still document this decision and discussion.
- RE – starting a UCP in BI – example - caldicott principle 7
- GUIDANCE RE THE UCP DISCUSSION WITH THE PATIENT IS PROVIDED IN THE NEXT SECTION.
- Once the contact/non-contact with every patient is complete, notes should be documented on RiO (see APPENDIX 1 for example documentation).
- HIUT Team member then completes UCP if patient has consented.
- If there is no consent from the person or issues in terms of making contact – Our approach will be to notify the patients GP to make them aware of this work and our effort to complete the UCP. As part of this notification a request should also be made of the GP to see if they are able to complete the UCP with the patient instead. HIUT can provide the data and collateral re the frequent caller behaviour to provide a rationale for the UCP.
- An email to the patients GP will be completed after every discussion with each patient. This will be to notify the GP of the UCP, make aware of the information not added re CPR/preferred place of care etc and to inform GP that we will not be continuing to monitor the UCP once initially completed – (see APPENDIX 2 for example GP email).
- HIUT will not be completing any CPR/DNAR info on UCP or information relating to 'preferred place of care/death' - this is for the GP only. This is outside the scope of HIUT expertise.
- LAS - will look at each case and provide any relevant info re any challenges or instructions that would be good to discuss with the person from an LAS perspective.
- If the contact with the patient is successful – HIUT will effectively end their relationship with that patient and that will be the sole intervention. If the case is complex and the person brings us further into their care/complexity/vulnerability – it may that there are further actions that need to be completed, likely based around risk or safeguarding. HIUT will then have a discussion re whether that patient needs to be transferred to the main patient list of HIUT for additional support and input.
- The Frequent Caller caseload of patient info is now on the main HIUT caseload spreadsheet under an additional tab – 'FC list'.
- HIUT clinicians will be required to complete all sections of the 'FC list' as the work with the frequent caller client commences – this includes making a note of all interventions and the time spent on each intervention.
- LAS will collect data throughout the year, as they have continued to do so.
- Paul / Chris / others will meet monthly via MST to discuss - first meeting set for: Jan 26th - 13.30hrs.
- Aim to have all the UCPs completed (includes documenting the no consents) by end of January 2023.
- Review LAS data quarterly and aim to contact any newly identified frequent caller cases with a view to completing a UCP.
- End of year – Interpret and analyse available data.

BRIEF GUIDANCE / SCRIPT FOR CONTACT WITH PATIENT:

- Introduce self and explain role.
- Explain that you work alongside the LAS and A+E – that the person has been identified as having high care needs, evidenced by their regular use of emergency services – 111/999/LAS.
- Inform them that there is a new care planning system that emergency services are using (UCP) and that you are assisting the LAS and GP's to complete these plans – give info leaflet (or if it's a T/C use the leaflet to explain to the person what it is and repeat the 'benefits' on the plan).

- If patient consents – see next steps. If no consent – suggest that perhaps it would be something they would prefer to discuss with their GP who will knows them better. Inform them that you will notify their GP of this discussion and their decision today.
- If consents, take info – their contacts and address etc.
- Further explain to the person –you would like to include info re their diagnosis/medications and any specific care needs on the UCP. You will be transferring this info directly from their existing GP records.
- Clarify if they have any allergies – document.
- Do they have a dosset box, or other relevant meds info.
- Do they take: Insulin/steroids/opiates/blood thinners (as per UCP).
- Additionally, tell them you would like NOK or emergency contact info to add to the plan with their consent and ask them for the details.
- Ask for any professional contact info (services, names of professionals, their roles, emails, and contact numbers if available).
- Identify any risk or specific info that could be included on the UCP – Frail/risk of falls/key safe etc etc.
- Anything else relevant to them.
- Once conversation complete – provide leaflet if F2F or if over the phone, ask if they would like a copy sent the them, or give the UCP web page details if they prefer– ucp.onelondon.online
- If contact is over the phone – offer to send a summary letter of discussion today (and include UCP info leaflet).

APPENDIX 1 – Example of RIO entry post UCP review and discussion:

Royal London Hospital - High Intensity User Team:

(Patient name) has been identified as a frequent caller to the London Ambulance service and 111/999:

2022 Data below as per LAS/RLH summary:

X calls in December
X in last quarter
X in last year
X month cost = X

RLH A+E attendances in 2022 - X
RLH Admissions: X
Bed days: X

Discussion with Chris Williams, Frequent Caller Manager NE London from the LAS - re additional support for frequent caller patient group - HIUT to look to call/meet with all of this client group to look to initiate (or update existing) Urgent Care Plans (UCP) as a pilot, to monitor benefits and impact on frequent calls and patient/healthcare worker experience.

(Patient name) currently (does/does not) not have a UCP.

Today – (called / visited / arranged to meet) – (patient name)

Introduced myself - explained what UCP was and provided patient info leaflet re this. Suggested to (patient name) that currently he/she was requiring regular care and support from services such as the LAS/111/999 – he/she agreed/disagreed with this. Discussed the purpose and use of UCP and how it would support him/her in terms of professionals having a better understanding of his/her care needs, illness and people involved in their care - verbal consent gained to update the UCP. Today I was satisfied that (Patient name) understood what was being discussed and that there were no obvious impairments to prevent him from consenting and contributing towards this discussion.

Important info discussed today to add to UCP:

(INSERT Bulleted info re discussion points and info to be entered into UCP)

Look to include and notify info re: Diagnosis / meds / care arrangements / professionals involved in care / any challenges with LAS support – eg. use of hoist, key safe etc.

NOK info:

Insert details of NOK choice including name/relationship and contact info

Other professionals involved:

Include names/service/email/phone – with a view to then including on UCP

PLAN:

- I will update UCP with above info
- Notify GP via email - will send this entry
- GP to continue to monitor and add to UCP
- Update HIUT frequent caller spreadsheet with actions and info today.
- HIUT will not be proactively monitoring (insert names) care - although I have today provided my contact info in case he/she wishes to discuss the UCP further.
- (any other relevant points to plan)

APPENDIX 2 – Example copy of GP email:

Dear (insert GP) - FAO GP to (patient name)

RE: ….. NHS: …..

I work in the Royal London Hospital High Intensity User Team and have been working alongside my colleague Chris Williams (Frequent Caller Manager NE London) to identify and offer support to patients who regularly call 111/999 or attend the Royal London A+E dept. We have recently developed a pilot scheme where we will be aiming to initiate or update 'Urgent Care Plans' for all identified frequent callers.

I met/called (patient name) on the ….. (Patient name) kindly gave their permission for me to initiate an Urgent Care Plan for him and include relevant info re his diagnosis, medicines and NOK contacts, as well as basic info for any professionals who may need to support him in an emergency.

I'd be grateful if the GP practice could also take the time to look at (patient name) Urgent Care Plan (via HIE or ELPR) and make any further amendments or additions as you see fit. My team and I will not be making any entries to UCP regarding DNAR/CPR decisions or preferred place of care/death as this is outside of our pilot and will require a more in-depth conversation with patients best suited to GP's and other more involved professionals. Additionally, we will also not be continuing to monitor and make updates to patients Urgent Care Plans in the event medicines are amended etc.

Below I have copied my documentation regarding the discussion with (patient name) for your records and further info:

INSERT RIO Documentation here)

APPENDIX 3 – Example email to Care Coordinator:

Dear (Name of CC)

RE: (patient name) NHS: ********

(Patient) is on the NE London 'Frequent callers list' to 111/999 and is also a regular attender to the RLH A+E dept (if applicable).

LAS data for calls to 111/999 in 2022 below:

Calls to 999/111, summary for 2022:

Calls in December 2022: **
Calls for last quarter in 2022: **
Call total in 2022: **

Relative costs for calls in 2022: £****
Attendances to the RLH A+E dept 2022: (no of ED)

I'm trying to help the LAS and A+E by completing an 'Urgent Care Plan' (UCP) for all of the frequent caller/attender client group. UCP's are more and more proving to be helpful to assist the LAS and 999/111 call handlers know more about a patients needs in real time, even whilst they are with the patient, and assisting them to make decisions re the most appropriate means of supporting them rather than perhaps an A+E conveyance etc.

I was hoping that when you next see/call (patient name) you may ask her for consent for the Trust (me in this case) to do a UCP for him/her? I could of course arrange to see her myself specifically for this purpose but I'm trying to arrange F2F contact with people who have no support systems and request support from any involved professionals. Once the UCP's are complete I will be liaising with their GP's too for further input and a handover essentially.

I've attached the UCP patient info sheet for reference and perhaps you can show (patient) this when you next have contact if you are happy to do this.

What would I add to the UCP?

Basically all the info that is already out there on his/her GP records - Diagnoses/medicines/any NOK info she/he wants adding / details and contacts of services involved / and a direction to transfer to our MH crisis line number if it's a MH issue..
The plan could also have any info (patient) might want on it such as do/don'ts when interacting with her / any difficulties in communication or disabilities etc, anything really that she feels is important...

Let me know what you think of the above but it would be a great help if you were able to add this discussion to your next point of contact - or if this is not possible for any reason - I can always join you at the CMHT base the next time she is due in.

Let me know what you think and I look forward to hearing back from you.