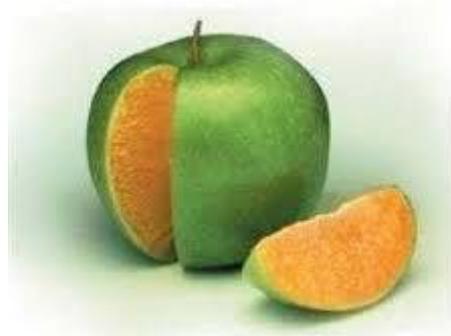


# **FREQUENT CALLERS OF 999**

## **BUILDING STRENGTHS RATHER THAN CORRECTING WEAKNESSES – 12 MONTH REPORT**

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## **FREQUENT CALLERS OF THE AMBULANCE SERVICE**

### **INTRODUCTION**

The paramedic radio alarms. The crew are on their way to a 40 year old male, with 'crushing central chest pain' and a history of stable angina. He greets the paramedic crew by their first names, his bag stands packed ready to go and he looks remarkably well, despite a pain score of 10/10. He is taken at his word and treated unconditionally.

The crew carry him into the awaiting ambulance and he is blue-light transferred to the emergency room where a bed is made available. Blood tests and repeated ECG's are performed as he stays in hospital for 12 hours while conclusive cardiac tests are carried out. Nothing acute is found and the patient is discharged back home.

This is the patient's 4<sup>th</sup> emergency ambulance call out this week and 87<sup>th</sup> call out of the year.

Unfortunately, this scenario is neither rare nor far-fetched in today's society. Whether the presenting complaint is chest pain, abdominal pain, mental health or fitting, the origin is likely be considerably varied with the group of patients who are frequent callers of the ambulance service. The demand that this relatively small group of patients place on today's ambulance and unscheduled care services is immense. It can also be unrelenting and seriously impact upon the availability of emergency ambulances within our communities. Data gathered on the top 100 frequent callers of the local ambulance service revealed they collectively called 1100 times during the three months before being managed. Many exhibited this behaviour for several years, in addition to countless contacts with the police, GP practices and council services.

Two North West CCGs invested in an Advanced Paramedic as a 'Clinical lead for 999 frequent callers', to design and run a project to safely reduce 999 calls of the ambulance service. Between August 2013 and August 2014, 100 of the most chaotic, vulnerable, chronic frequent callers were identified, engaged with and interventions performed. We adopted an approach flexible enough to adapt to the behaviours of the patients and offered the freedom to be innovative and creative with solutions. The result has seen an 89% reduction in 999 calls, 92% reduction in A&E attendances, 82% reduction in hospital admissions and a 98% reduction in self-harm incidences with patients flourishing during the process. Police calls for the same cohort were reduced by 52% as a natural by-product.

As a popular holiday destination and seaside town, Blackpool's dynamic and transient nature of inhabitants adds a pressure to unscheduled care services, arguably unparalleled within the geography of the North West. Evidence from A&E data demonstrates those who regularly present to the ambulance service and A&E often do so following excessive alcohol consumption, displaying injuries of self-harm with suicidal ideation, anxiety or factitious medical symptoms. Each repeated presentation results in another 'brick out of the wall' in the compassion and tolerance levels of the extremely pressurised health, social care and emergency service professionals who are organisationally bound to treat each episode within the same guidelines as if it were the first. Additionally, those who work within the mental health and substance misuse arena become saturated with assessments to discern between a primary diagnosis of alcohol and / or mental health in order to treat appropriately.

### **TIME WASTERS OR ATTENTION SEEKERS ?**

Over time, frequent callers have developed a societal stigma of timewasters and attention seekers who deliberately manipulate the system, who lack the ability to accept recommended support or the resilience to change behaviours. It is believed that frequent callers fundamentally contribute to emergency services and hospitals working at unsustainable levels. There is often a question over whether a frequent caller is telling the truth about how they present. The simple answer is....it doesn't matter either way. When their emotional and social needs were met, any factitious medical presentations disappeared. By addressing individual human need, unscheduled care contacts reduce as a by-product.

### **ENFORCEMENT OR EMPATHY ?**

Addressing frequent callers has almost exclusively been about removing disabling conditions rather than creating the enabling conditions for people to flourish. One approach is to assume the weight of responsibility to change behaviours belongs to the frequent caller and to force the frequent caller to change their behaviour. The majority of frequent callers are offered countless opportunity to change lifestyle and behavioural choices yet fail to move forward - by necessity they need to accept the help available. It may be argued that it has become a societal norm that people expect services to fix them without actually having to make any effort to reconcile their own issues or have their behaviour changed by enforcement. The approach used by the frequent caller project was about using empathy rather than enforcement. No restrictions were imposed, no threats of permanent discharge from services were made and patients were always free to exercise the choice to call 999. This method allows medical emergencies to still be captured, protecting the individual and the organisation from harm.

## **RESULTS**

The table below shows the reduction rates of the Top 50 most frequent callers within the first 3 months of working together. Reductions are separated into 999 calls, A&E attendances, non-elective admissions and self-harm incidences.

Activity	Percent Reduction
999 calls	89%
A&E Attendances	92%
Admissions	82%
Self-Harm Incidences	98%

### **51-100 group– within 3 months post intervention**

Activity	Percent Reduction
999 calls	83%
A&E Attendances	87%
Non – Elective Admissions	87%
Self-Harm Incidences	93%

## **SELF-PRESENTERS TO A&E**

Some patients were managed following referral from the local hospital. This group regularly self-presented to A&E and had an extensive admission and non-elective surgical history over a long period of time despite mainstream interventions; with some individuals accumulating unscheduled health care costs in excess of £50,000. All patients were managed successfully within two weeks of referral and their contacts have ceased for the past six months. Data on this group is still being processed so potential savings or reductions have not been included in this report but the outcomes and processes are the same as those presenting as ambulance service frequent callers. There are 82 patients who are high intensity users of the local hospital (more than 3 admissions in five months) but due to the current capacity of the project, only the top six could be managed.

Analysis of the Top 100 cohort revealed the following information:

- 60% are women
- Average age 35 – 45
- 80% live alone
- Multiple children in care is very common
- There is a 44% overlap with the police frequent callers

An overwhelming majority of calls to 999 stem from individuals living life alone. What often begins as bereavement or loss of a partner leads to consuming alcohol as a way of coping. For many, the ambulance service is the only interaction they have with the outside world and many talk about looking forward to the attention, human interaction and care each visit provides. First thoughts may lead to the view that this group consist of the elderly but this is not the case. Several professional groups, aged 35-45 are among the most prolific callers. Causes of loneliness in this age group stem from family dispersal, insular attitude, accepting loneliness or being afraid to join in. Many lack the capacity to foster, engage and sustain positive social relationships or endure and recover from stressors and isolation.

Learned helplessness and lack of resilience preceded a realisation, both consciously and subconsciously, that a medical complaint attracts a timelier response than a social problem. Patients would call for an objective complaint which, for ambulance crews, would be impossible to discharge at home. Several members of the group acknowledged fabricating medical complaints such as abdominal pain, seizures or chest pain, and even escalation to falsifying a terminal illness in order to receive the connection and help they sought.

A positive outcome of the project was such that patients presenting with anxiety, depression, loneliness or self-harm, no longer felt the obligation to legitimise a 999 call with a simulated medical presentation. In fact, out of 100 patients, only six presented with 'genuine' medical conditions requiring intervention. The speed and intensity of response to a call for anxiety or social issue was brought in line with a physical presentation, in exchange for patients making contact with our service pre crisis point.

## **TECHNIQUES**

The next section describes the techniques and methods used to achieve the results.

### ***IDENTIFYING THE TOP 50***

The Top 100 frequent callers were identified using ambulance service data systems due to the absolute number of calls, with several patients calling between 10-18 times per month. Some patients presenting as vulnerable were also selected to receive support regardless of the absence of chronic ambulance calling. This group may have only called between 8-10 times over the previous three months but presented with episodes of self-harm or homeless patients.

## ***FIRST STEPS - PERSONALISATION***

Each patient is contacted by telephone in order to take a fresh and personalised approach to how they are managed; to detect 'issues' that would then be unpicked and managed. The initial telephone consultation is deliberately performed prior to speaking with professional teams to ensure conversations are not preloaded with opinion. At no point are the reasons for calling 999 mentioned. For example, those presenting with chest pain twelve times a month, the chest pain is not mentioned and instead, open ended questions are asked to consider the root of calling to be something other than a presumed medical, social or mental health complaint. The majority of reasons given as to why they called 999 are nothing related to the presentation to the ambulance service. For example, if the calls were made primarily for abdominal pain, the patient never mentions abdominal pain during the phone call, but rather focuses on a past emotive event that still affects them today. By safely 'de-medicalising' patients to identify the root cause of why they present to 999, successful outcomes can be realised allowing the patient and professional teams to move forward.

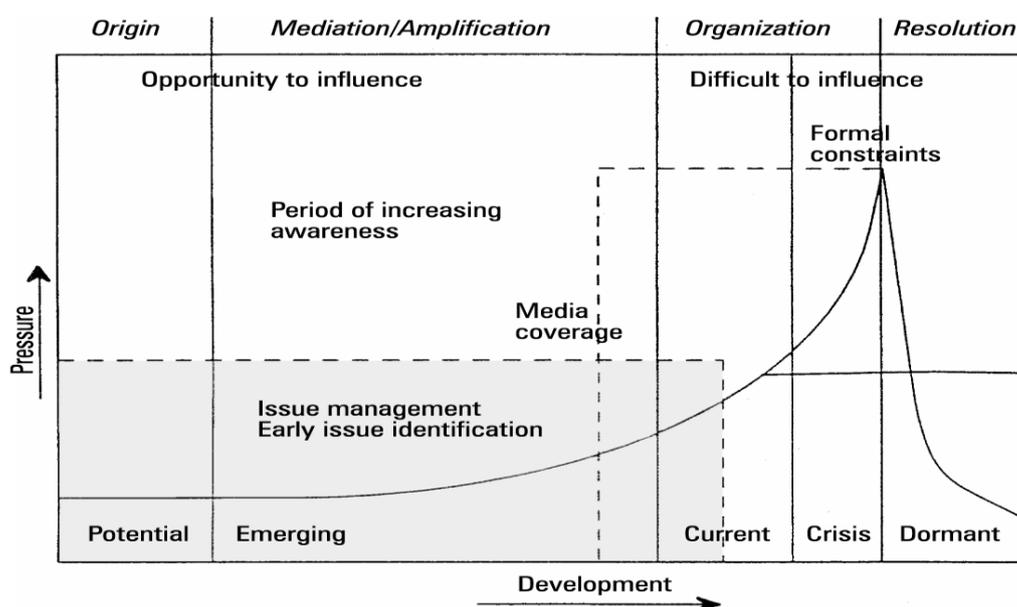
Management of this group focusses solely on the true reason for calling –emotional and social issues, raising emotional support to a position of importance within the Health Service. The most powerful and innovative element of this project is that no restrictions have been placed on any individual. They are never told they cannot call 999 or there is a belief that their presentations are disingenuous. The solution is brought forward through providing one-to-one attention and active listening until the root cause of why their dependence on unscheduled services is established. Approximately 90% of patient contact is performed through telephone consultation with some patients visited on average once, in order to see a change in behaviours and a subsequent reduction in calls. This project has not found success in making endless referrals to already saturated services; the principles are rather to deescalate issues by one-to-one coaching and actually support services stepping down or even stepping out when appropriate.

## DE-ESCALATION BY TELEPHONE

Hainsworth and Meng use an issues management model depicting issues to “evolve in a predictable manner, originating from trends or events and developing through a sequence of identifiable stages”. Issues highlighted through this project appeared to consistently evolve from one stage to another. In understanding the cyclical development of an issue, an organisation can prepare for and be aware of the stages to come and patients in need can be identified prior to them becoming frequent callers.

**Figure 1 – Issue Lifecycle**

The figure below shows the level of pressure exerted on an organisation and patient by a maturing issue against the various stages of development



**Source:** Hainsworth (1990) and Meng (1992)

During the *potential* stage, an issue arises when an individual attaches significance to a perceived problem and gains definition if an organisational response is not forthcoming or does not meet the approval of the individual. During the *emerging* stage, the individual acts to legitimise the issue, gradually increasing pressure on an organisation whilst pushing for *their* interpretation of the issue to be accepted. It is at this stage when an organisation can act to proactively manage such issues and potentially prevent the evolution of the issue. However, it is often difficult to determine the urgency of the issue whilst more pressing and immediate matters are attended to. Once the patient themselves acknowledged and identified their own destructive behaviour patterns, they were encouraged to call the lead or ask for assistance at this early ‘emerging’ stage.

Once a patient entered the *crisis* stage their positions solidify, reaching the height of the pressure that forces organisations to accept it unconditionally. They indulge a habit of having the same ‘mental chatter’ with little real engagement of thoughts or feelings.

The same conversations take place time and time again, often triggering an obligatory crisis response from organisations at the receiving end. And so the cycle continues. The project focussed energy on the *potential* and *emerging* stages and coached individuals to identify and manage issues at this point. A de-escalation service was designed to embed these behaviour changes.

A number of the Top 100 can call our service when they feel social, emotional, financial or family issues are ‘emerging’ rather than historically medicalise issues and call 999. Over a six month period, 293 calls were made from this cohort and conversations centred on housing issues, family concerns, feeling in a low mood and money, rather than conversations around the intention to self-harm or medical complaints. There were two occasions where patients talked about suicidal ideation so an immediate, professional handover to the mental health team took place, where they managed the patient in their expert manner. No phone call ended in a self-harm attempt or escalation to 999 but rather the service acted to correct disabling thoughts midstream, reducing self-harm attempts by 98%. This is not based on replacing every negative thought with a positive one. The process is designed to be a stopgap so the caller is able to focus on right now and to prevent themselves (or others) being at risk due to paralysing thoughts. There is a time and a place to focus on persistent negative thoughts, the role of which is undertaken by professional fields.

Presenting issues are often not resolved during the crisis conversation. Instead contact is made the following day endorsing positive behaviours and teaching patience and trust that they will be called back. Any actions raised from the previous conversation are then relayed to the individual who is encouraged to assume responsibility for them. Empowerment and self-sufficiency is constantly refreshed at a pace suitable for the individual.

### **THE CHALLENGE OF RELAPSE**

Preparing the patient for relapse (defaulting to 999 as within their comfort zone in times of crisis) is important and provides a more realistic platform with which to move forward. There is often a ‘honeymoon’ period with frequent callers who start out extremely positive, decrease their dependency and improve their personal outcomes. This was sometimes followed by a relapse after approximately three months which led to the calls to 999 reappearing. By having a personal connection to this group, being able to identify the same week this occurred, together with preparing the patient for the relapse, the situation was reversed and maintained once more.

## **DISCHARGING FROM THE SERVICE**

Very quickly the phone calls become less often but meaningful using peer support, the recovery community, volunteer groups to embed positive health and social interaction. Encouraging social interaction provides a 'natural' way of discharging individuals from the service – without them knowing it.

It was acknowledged from the outset that this intervention may create an unhealthy dependence upon one person and lacked resilience long term; hence a method of 'discharging' patients from the service was created. One discharge method combined two existing services to operate together and in a different way. *Vitaline*, part of Blackpool Council, offers a range of services designed to support individuals to lead independent lives. Vitaline supplied, installed and maintained 'telephone' units within the homes of patients who regularly contacted our service for ongoing support out of hours. In times of anxiety, depression, feelings of self-harm or loneliness, patients were able to activate the telephone-based units and be connected through to the Mental Health Helpline, anonymously and free of charge from within their home environment. The Mental Health Helpline (MHH) based in Blackpool and commissioned by Lancashire Care NHS Foundation Trust, is staffed by 80 trained volunteers who have embraced this handover and the individuals it serves. Out-of-hours de-escalation phone calls for this patient group is now provided by the MHH which supports the longevity of any intervention provided by the frequent caller project and also helps individuals to flourish using existing services.

## **CASE STUDIES**

### **Gary**

Gary has epilepsy and presented with seizures and regular self-harm attempts, attending A&E, via ambulance, up to four times per week. He has been displaying this pattern of behaviour for the past 18 years. He drank 80 pints of lager each week, failed to maintain any positive relationships and had never been employed. When he wasn't in hospital, he was at his GP surgery making repeated appointments. Gary has been a pleasure to work with and has truly flourished in the process. His drinking has reduced to 10 pints a week, he is in paid employment and has reconnected with his family. He has an extremely supportive new friends base, his self-harm attempts have ceased and his epilepsy is under control. He positively contributes to his community playing an important role in his local football team. Gary recently found a wallet in the street containing £200. When he returned the wallet to the owner he shared his recent journey and felt pride that he is now an honest, confident and sociable person.

### **Leo**

A 45 year old gentleman who, from a successful entrepreneur, millionaire and family man, experienced a downward spiral of events following the suicide of his wife. His business and family were lost and he now resides alone in a bedsit, no contact with family or friends, using all available monies on alcohol. Flagged by the ambulance service as dangerous, he threatens to cut his throat up to five times per week, triggering an additional response from the police. Resolution was found in reaching out to an existing service to work differently. The Mental Health Helpline offered to make phone calls to the Leo each evening when he had no phone credit to make outgoing calls. They acted as a listening service each evening and motivated the patient enough for him to engage with alcohol services. Commitment by all parties has resulted in Leo in substance misuse rehabilitation and recovery with a resulting abstinence in 999 calls. He now has the recovery community to support him going forward rather than dependency on our service.

### **Jasmine**

Jasmine received daily home visits from the high intensity mental health team as well as three phone calls a week from her GP surgery, 20 visits to the walk in centre each month, numerous hospital admissions and required regular general anaesthetics to remove objects inserted following self harm. Resolution was found in rewarding Jasmine with a certificate of achievement every 6 weeks if other coping mechanisms were explored. Overnight, self-harm attempts ceased, a new friends based was formed (supported by a house move) and unscheduled care contacts reduced by 85% leaving only historical wounds to be cared for. Services were able to step down intensity and even discharge Jasmine from their services, having confidence she was managing her own conditions well.

## **DISCUSSION**

The wider economic and financial situation faced by the NHS as well as the focus for addressing the increasing demand for services within tight financial constraints, has been well documented. In order to provide a recovering future for frequent caller patients with complex needs, for provider organisations to increase capacity, a culture change within the Health Service is essential. By flipping the focus of change onto those in a professional role, providers and Clinical Commissioning Groups can continue embracing flexibility, integration, resilience and courage.

Prior to the project starting, the top 100 frequent callers had been offered a myriad of opportunities to affect change in their lives, with some of the essential services working to saturation but in isolation. The success of the project lies in the integration of existing services creating one, consolidated approach, enabling emotional well-being and coaching to have equality of esteem with physical health.

The ultimate outcome would see the health and social care economy anticipate and proactively manage early presentations and support truly personalised patient care. This is entirely possible and does not require copious amounts of funding to do so. The current position for managing frequent callers for any service is anything but early intervention. The top 100 cohort detailed in this paper called 1,100 times every three months – a pattern exhibited for a substantial period of time. Although human nature dictates the likelihood of an ever present, rolling cohort of ‘frequent callers’, individuals can be identified and managed before detrimental behaviours embed. The top 100 currently managed have not merely been replaced with others calling at a similar rate, making early intervention a real possibility.

The majority of patients were already known to many professional groups and, in retrospect, presented with early signs of depression, isolation or learned helplessness. It is at this early stage where health professionals can intervene to play a proactive part in influencing the evolution of the crisis, with often a sixth sense about who will emerge to become a frequent caller. This is difficult to do in isolation so an industrialised approach is recommended going forward to prevent the evidence of repeated calls we have today. The majority of results were achieved by 1:1 coaching rather than through referral to other agencies. The following options enable collaborative working and not merely shunt issues to colleagues within the police, housing or social services.