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South East Alcohol Innovation Programme

Evaluation Report

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1 Introduction

The Department of Health's report '*Safe. Sensible. Social. The next steps in the National Alcohol Strategy*'¹ set out the previous Government administration's agenda on alcohol misuse. This was followed by '*Signs for improvement - commissioning interventions to reduce alcohol-related harm*'² which was guidance designed to direct commissioners in areas where tackling alcohol harm was an identified priority and which would assist them in commissioning interventions to reduce the harm caused by alcohol in their local community.

Excessive drinking is a major cause of disease and injury, accounting worldwide for 9.2% of disability-adjusted life years with only tobacco smoking and high blood pressure as higher risk factors. For the NHS alone, the estimated financial burden of alcohol misuse is around £2.7 billion³ in hospital admissions, attendance at A&E and primary care, etc. The wider costs are vast, in England and Wales alone alcohol misuse is estimated to cost around £20 billion per year. Health inequalities are clearly evident as a result of alcohol-related harm where Department of Health analysis of data indicates that alcohol related deaths are about 45% higher in areas of high deprivation⁴.

The effects of alcohol and excessive drinking can be seen every week on the streets of towns and cities across the country. Anti-Social behaviour and criminality, sickness absence and poor health amongst the drinkers themselves are evident problems resulting from current patterns of drinking.

At this time, the Government administration identified that because alcohol fuels so many of society's problems, concerted action on alcohol was a sound investment for public agencies. In the South East, the Regional Alcohol Manager (RAM) at the Government Office for the South East (GOSE) took the decision to tackle alcohol issues by using a range of different tactics. A different approach was taken to other Regions and a two year programme, The South East Innovation Project, (SEIP) was established from 2010 to 2011, to fund innovation activities in the public and voluntary sectors.

A key objective of this project was to reduce alcohol related harm as measured by the level of hospital related alcohol admissions. Other outcomes were to influence the adverse impact on population health and criminal justice challenges associated with violence and anti-social behaviour. The RAM's initiative was responsible for stimulating and developing new and different ways to reduce alcohol related admissions, through an innovation fund. PCTs and their partners were encouraged to bid for funds (£300,000 for the duration of the investment plan) to test out innovative approaches to reducing alcohol related hospital admissions. The pilot projects were run for between 6 and 8 weeks and successful bidders were encouraged to report on the outcomes in an established framework.

The RAM was supported in the delivery of the programme by the Centre for Public Innovation (CPI). CPI is a social enterprise organisation that provides research, consultancy and training for the public and third sectors and specialises in stimulating and supporting innovation solutions to some of society's most intractable problems.

¹ *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*, Department of Health, Home Office, Department for Education and Skills, Department of Culture, Media and Sport, 2007 Gateway 8079.

² *Signs for improvement - commissioning interventions to reduce alcohol-related harm - commissioning interventions to reduce alcohol-related harm*

³ *The cost of alcohol-related harm to the NHS in England*, Department of Health. 2008

⁴ *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*, Department of Health, Home Office, Department for Education and Skills, Department of Culture, Media and Sport, 2007 Gateway 8079.

2 Objectives of the Evaluation Report

The objective of the evaluation report is to make a judgement on the outcomes of the second year projects and identify:

- their impact with regard to alcohol admissions, demonstrable outcomes for clients, financial gain, sustainability and diffusion;
- recommendations on mainstreaming these projects; and
- recommendations on lessons learnt and future learning.

Although a full health economic evaluation/cost benefit analysis would be a desired outcome across the year 2 programme **this was not possible** as each of the 10 projects were set up in fundamentally different ways and the availability of financial reporting, its accuracy and financial assumptions made, differed across each project.

It should also be noted that each project had a duration of just three months. Although there are indications across projects that the innovation worked these remain an indication and there would need to be more longitudinal studies undertaken to provide more long term concrete evidence.

Lundbeck has provided written and editorial support to this evaluation.

Background: Year 1

In Year 1 of the Programme the aim was to fund as many innovative ideas as possible to tackle alcohol related hospital admissions. The process effectively allowed funds to be allocated to a broad range of pilots across the region and informed the process for year two. Using 'innovation funnelling' these projects were then scored against a range of domains to agree which projects would be funded in the second year and allow bids for these to be brought forward.

£145,895.30 of grant money was spent or earmarked against specific projects. The money funded a total of 26 projects across three thematic grant rounds:

- Seasonal Alcohol Campaigns
- High Impact Grant Programmes
- Joint Commissioner-Provider Pilots

3 Year 1 - Seasonal Alcohol Campaigns

This component of the programme focused on stimulating and enhancing existing packages of work that were aimed at dealing with alcohol consumption over the 2009/2010 festive period.

In total, seven projects were funded to a total value of £21,547.80 with an average per project expenditure of £3,078.

Seasonal projects were funded in:

- Eastbourne
- Fareham and Gosport
- Gravesham
- Milton Keynes
- Portsmouth (x2)
- Windsor and Maidenhead.

The following initiatives were funded:

- Extension of alcohol arrest referral service
- Extension of taxi marshal scheme
- SOS Safe Space serving night-time economy (x2)
- Social marketing campaigns (x2)
- Activities for an alcohol support group over Christmas.

From these projects it was decided that Social Marketing campaigns would not be considered for year two as the impact of these projects was too difficult to measure against the set domains.

4 Year 1 - High Impact Grant Programmes

This component of the programme sought to encourage innovative local solutions based around the seven High Impact Changes. (see Appendix 2)

In total 16 bids were funded to a total value of £110,278.50 with an average allocation of £6,892.

Projects were funded in the following areas:

- Brighton
- Buckinghamshire
- Canterbury
- East Kent
- East Sussex (x2)
- Gravesham
- Hampshire
- Medway
- Portsmouth (x2)
- Southampton
- Surrey (x2)
- West Sussex
- Windsor and Maidenhead.

The following pilots were funded:

- Social marketing campaign aimed at increasing risk drinkers in the professional classes
- Supporting a self-help group for homeless drinkers
- A course exploring links between alcohol consumption and sex aimed at young people
- IBA training for hospital healthcare workers
- Intensive support service for a group of “frequent flyers” - the 10 people in the area who have the highest level of alcohol hospital admissions
- Outreach to vulnerable young people to engage them in a short training programme
- Clinical support to hostels with alcohol dependent clients
- Delivery of BI from a pharmacy setting (x4)
- Establishing a self-help group in a supported housing setting
- Distribution of a self-screening scratch card
- Programme aimed at male perpetrators of domestic violence looking to address underlying alcohol issues
- Peer delivery of BI in a prison setting
- Investigation of drinking behaviours of 6th formers.

Again it was decided that social marketing projects would not be considered for year two as the impact of these projects was too difficult to measure against the set domains.

5 Year 1 - Joint Commissioner-Provider Pilots

This component of the programme followed on from training that brought alcohol commissioners and their providers together and encouraged them to jointly develop innovative ideas to implement locally.

In total three projects were funded to a total value of £14,069 with an average per project expenditure £4,689.

Projects were funded in the following areas:

- Brighton
- East Sussex
- Worthing

The successful bids were looking to do the following range of activities:

- Promoting nutrition and healthy eating among those recovering from alcohol dependency;
- Gender specific service for women who are dependent drinkers, looking at their wider needs
- An initiative aimed at reducing alcohol related disorder during the World Cup period.

Moving to year 2

Following the first year projects the RAM and CPI undertook an assessment of each completed project against a set of key domains to score. Using the data gathered at Stage 1 (above) the second phase of the programme involved sifting out those pilots which had demonstrated increased levels of performance, from those pilots which had replicated existing levels of performance, and those which had little or no impact. The top ten projects were then agreed and scored again through the funnelling process with 5 projects being finally agreed. The Scoring system is shown in Appendix 3.

6 Year 2 Evaluation

For the year 2 programme the RAM and the CPI selected the top 5 pilots that had the greatest impact and a service specification was set out against each of these pilots. The five areas which were agreed for the second year pilots were:

- Frequent Flyers (FF)
- Pharmacy Brief Advice (PBA)
- Hostel Clinical Nurse (HCN)
- Supported Housing Self-Help Group (SHG)
- Hospital Healthcare Workers - IBA Delivery (HHW)

Bids were reviewed for each of the projects via a grant application form and had to be based clearly on the five high impact innovation models. 10 projects were funded and run between December 2010 and April 2011. The evaluation was undertaken between May and August 2011. Details of project outcomes are in Appendix 1.

Brief description for each project area:

A description of the five areas was issued for the bidders to design their proposed projects against. Bids that didn't follow the outline of the descriptions were rejected:

Frequent flyers

The project provided a specialist community based worker to work intensively with a small cohort (n=10) of patients with the highest level of alcohol related repeat hospital admissions, to coordinate their care, reduce the impact on other services and ultimately reduce the likelihood of further admissions. Individuals were identified by Medical Assessment Unit (MAU) records and referred to the community based specialist worker. The worker proactively contacted the individuals and sought to engage them in a full assessment of their needs, linking with, and coordinating the care and treatment from, other specialist services. By offering dedicated care management of these individuals the specialist worker aimed to achieve a more effective and coordinated approach to their treatment, freeing up resources of those currently working with them in a more sporadic, unplanned way. The model drew on learning from a drugs approach which suggested that this dedicated, intensive approach yields better results in terms of effectively engaging patients and improving their motivation to remain in treatment and make positive health and lifestyle changes.

Pharmacy Brief Advice

The project engaged with community pharmacies to provide pro-active alcohol brief advice offering health awareness, understanding units, early identification of possible excess, data capture on awareness and units consumed and signposting/referral for additional support where required. This project sought to raise awareness of safe alcohol consumption amongst those who are not aware of how much alcohol they are consuming. The project specifically sought to target low and increasing risk drinkers.

Hostel Clinical Nurse

The project provided increased opportunities for alcohol dependent clients living in a hostel environment to address their substance misuse as well as improve their mental and physical health. Due to being heavily alcohol dependent and chaotic, the target group does not currently tend to access existing services. The project funded a clinician to provide clinical support and training for hostel staff to support previous rough sleepers with alcohol dependency to reduce their drinking and address attendant health problems, within a 24 hour supported environment. The project specifically targeted a group for whom inpatient detox does not work - usually ending with a return to the hostel environment and resumed drinking. The project aimed to replace this cycle with personalised, gradual detox within the hostel environment.

Supported Housing self help group

The project raised awareness of alcohol use amongst clients and established a client self-help group within a supported housing setting. It used the vehicle of alcohol workshops to encourage the formation of a group. The project addressed some of the issues which made these clients reluctant to access specialist services whilst providing awareness of the levels of alcohol consumption and ways to reduce this to safer levels. The self-help format enabled clients to support one another, drawing on their own skills and experiences, to participate in group discussions. The discussions drew out and identified their reasons for non-engagement with treatment services, and therefore put in place mechanisms to manage these reasons for non-engagement.

Hospital Healthcare Workers - IBA Delivery

The project trained healthcare support workers in Accident & Emergency, Medical Assessment Unit and gastroenterology wards in simple IBA techniques. Healthcare support workers come into contact with all patients admitted and usually have more time available to deal with patients than nursing and medical staff. The project trained these workers to screen patients to identify problematic alcohol use and deliver brief advice to these patients whilst performing basic care tasks thereby effectively delivering information at a point of crisis for individuals, to impact on their alcohol use and reduce repeat admissions for alcohol related conditions.

7 Key findings for year 2 projects

The 2 year project and the identification of high impact projects through incubating, prototyping and funnelling is a positive and successful approach. Objectives to reduce alcohol harm and support the reduction of alcohol related admissions are apparent across the projects.

The implementation of the projects show that alcohol issues act as an impetus for innovation projects through the process of designing, developing and growing new ideas that work to meet unmet need. Each project has been evaluated at a moment in time. The range of innovation projects undertaken was particularly varied in their delivery, taking into account local need, and therefore, apart from following the framework, there was minimal commonality in approach. However, projects showed that a reduction in alcohol harm will only be achieved through understanding and responding to local needs and circumstances.

Reasons for success or lack of success were multi-faceted but the innovation approach has allowed for a wide range of approaches to be carried forward into the future. All of the High Impact Projects in Year 2 have the potential to be replicated elsewhere. Projects showed outcomes relating to a reduction of alcohol consumption, reduction in dependence,

potential amelioration of alcohol-related health problems, such as liver disease, malnutrition or psychological problems, potential amelioration of alcohol related social problems and general improvement in health and social functioning. Projects undertaken demonstrated that there are a range of effective treatments to suit the variety of service users. In line with findings by the National Treatment Agency⁵ projects indicated that whilst increasing risk and higher risk drinkers are likely to benefit from Identification and Brief Advice (IBA) given by generic workers in almost any setting, such as community pharmacies, dependent and more chaotic drinkers may require more intensive treatment given by specialist workers. Innovation projects indicate that a robust, flexible and diverse market serving people at risk of alcohol-related harm in all areas of provision (health, housing, social care and community settings) are most likely to support effective outcomes. However, there are some key lessons that have been learnt through the process which should influence any future decision making on project implementation.

Projects to tackle frequent flyers have been successful and there is evidence across the projects that there are clear benefits in this approach in terms of client outcomes, financial gains, potential for replicating and scaling up and for diffusion to other services. Across the projects it has been shown that a dedicated, intensive approach yields better results in terms of effectively engaging patients and improving their motivation to remain in treatment and make positive health and lifestyle changes. This may be undertaken using different models dependent on local circumstances. Some projects took a more intensive approach whereas others accepted referrals from a wider range of professionals. However, particular attention needs to be given to the setting up of these projects ensuring that they have clear terms of reference, referral guidelines and buy in from all agencies involved. Aspects of geographical location were also important and availability of the team/member of staff implementing the project. All projects which had been completed could identify a reduction in hospital related admissions and assumptions on significant financial savings could be made.

At the other end of the spectrum of need the IBA project undertaken by pharmacies showed that IBAs are effective interventions directed at patients drinking at increasing or higher-risk levels who are not typically complaining about or seeking help for an alcohol problem. Although the project had issues in showing outcomes in the three months the project has moved forward and gained momentum locally.

Supported Housing self help group projects faced the biggest challenges for success. Barriers appear to have been engagement and training issues with appropriate workers and clients in this arena. However, other key projects have shown significant success, in particular the hostel clinical nurse project which supported alcohol clients to reduce alcohol use, significantly reduced hospital admissions and improved access to primary care health services including dentistry. Further to this the project found that hostel staff attitudes were challenged and changed as a result of participating in the pilot. For many of the clients in the pilot, staff had come to believe that they were pre-contemplative. By being part of the pilot staff were able to see the results obtainable by working in a different way. This increased staff skill and knowledge and made a significant difference in staff levels of aspiration about the client's ability to change.

A testimony to the range of innovation projects has been that four of them have been taken up as a QIPP (Quality, Innovation, Productivity and Prevention) initiative where they have been generated through the NHS and others have been given extended funding and future planned funding on the basis of the initial outcomes.

The role of CPI has been integral to the identification and support of the projects. There was positive feedback for the CPI from the majority of project coordinators.

⁵ National Treatment Agency (2006). *Review of the effectiveness of treatment for alcohol problems*. London: NTA

8 Evaluation Recommendations based on key lessons learnt

Recommendations are made based on the outcomes of the projects, the barriers faced and the lessons learnt.

1. Commissioners of alcohol projects should consider using the methodology of 'innovation funnelling' as an approach to identifying local initiatives;
2. Commissioners should have a full understanding of the alcohol misuse make-up of the community for whom they are commissioning, i.e approximate numbers of lower risk, increasing risk and high risk drinkers, to support the understanding of which initiatives to invest in locally
3. Providers and commissioners of alcohol interventions should ensure that there is significant buy-in across statutory and voluntary organisations to ensure key aims of projects are explicit in service specifications and supported to reduce and avoid duplication of service delivery;
4. Providers should ensure that there are clear terms of reference for the initiative, effective project planning and identification of resources are in place;
5. Commissioners of alcohol initiatives should hold service providers to account for delivery. There should be a commitment by senior management and commissioners, particularly in the statutory sector, on staff resources for the duration of a project to avoid projects failing when staff are given alternative tasks;
6. Commissioners should consider the use of third sector providers when delivering services to specific communities;
7. Confidentiality and data protection issues should be addressed prior to commencing projects so that data to monitor progress can be accessed;
8. Changes to the political landscape and funding in the statutory sector should be taken into account when first implementing projects;
9. Clarity on the potential financial efficiencies expected from the interventions and how these will be defined and performance measured should be agreed at set up;
10. Interventions need to take into account the geographical locations and facilities available to provide effective services to clients with alcohol issues;
11. Consideration needs to be given to using the most appropriate staff, with ring fenced allocated time, to deliver interventions;
12. Twenty four hour services, if judged cost effective, should be provided to enhance impact;
13. Providers and commissioners need to recognise that this is a difficult client group (who may have a dual-diagnosis) and therefore alcohol innovations should not be seen as an answer to issues in isolation of other projects; Local population needs will most effectively be understood across partnerships;
14. Providers and commissioners implementing alcohol innovation projects should understand that alcohol intervention can have impact even when abstinence is not the end goal and a moderation goal should be considered; and
15. Projects receiving ongoing funded should be subject to regular review to ensure continual effective performance.

Project Details

Project		Title	
1	PBA	Alcohol identification and Brief Advice Training for Pharmacists	Royal Borough of Windsor and Maidenheads Community Safety Partnership
2	FF	Brighton and Hove Frequent Flyers	Brighton and Hove Drug and Alcohol Team
3	HCN	Brighton and Hove Hostels Clinical Nurse	BHT
4	FF	Dartford and Gravesend and Swanley Assertive Alcohol Outreach Project	Kent and Medway NHS and Social Care Partnership Trust
5	FF	Frequent Flyers at St Richards Hospital, Chichester, West Sussex	West Sussex PCT
6	FF	Hasting Frequent Flyers	Action for Change
7	HHW	Identification and Brief advice training for Medway Maritime hospital healthcare support workers	Medway Council
8	SHG	Peer Recovery Facilitators	Portsmouth Council
9	SHG	Self Help Alcohol Awareness Groups in Supported Housing settings	Surrey PCT
10	FF	Southampton Alcohol Intensive Case Management Project	Southampton County Council

Project outcomes against overall aims

Project	Reduction in Hospital admissions	Demonstrable outcomes	Demonstrable Financial gain	Sustainability	Diffusion
1	x	✓	✓	✓	✓
2	✓	✓	✓	✓	✓
3	✓	✓	✓	✓	✓
4*	x	x	x	✓	✓
5	✓	✓	✓	✓	✓
6	✓	✓	✓	✓	✓
7**	x	✓	x	✓	✓
8	✓	✓	x	✓	✓
9***	x	x	x	x	x
10	✓	✓	x	✓	✓

* Project 4 was not completed at the time of the evaluation

** Project 7 was delayed.

*** Project 9 could not produce any evaluation due to barriers in establishing the project, therefore a judgement could not be made at the time of evaluation.

9 Appendix 1- Projects in detail

Year 2 project evaluation:

1. Alcohol identification and Brief Advice Training for Pharmacists - Royal Borough of Windsor Community Safety Partnership

Background:

This project involved the development of skills and training of community pharmacists to deliver IBA face to face to people attending community pharmacies. The cost of the project was £10,250.

Outcome

This project has the potential to be successful. However, there is a need for substantial buy in from the local pharmacists. Although evidence indicates that all those who receive IBAs will benefit from increased awareness of the risks of drinking above 'safe' levels it was not possible to judge whether the IBAs resulted in a decrease in harmful drinking and reduced alcohol related admissions as there was insufficient follow up of the IBAs undertaken.

Evidence:

Did the project meet its planned outcomes including reducing alcohol related admissions?

The project was self assessed on being successful in meeting its three outcomes (1: extremely successful, 5: extremely unsuccessful) :

- Increasing awareness of units and the risk of drinking above the recommended units per day. (2)
- Helping residents assess their drinking habits and see a reduction in harmful drinking. (3)
- Ensuring those assessed as drinking above 'safe' levels feel encouraged and supported and take necessary steps to alter their drinking. (3)

Did the project meet its target?

The project was self assessed as being relatively successful in meeting its original targets (2).

Target	Actual Performance
25 pharmacists and their support staff will have identification and brief advice training	22 pharmacists were trained from 19 pharmacies. 1 locum pharmacist was trained.
1,250 identification and brief advice to be delivered within the medicine use reviews (MURs) (50 IBAs per pharmacist)	62 IBAs were delivered within MURs.
40 identification and brief advice to be delivered opportunistically (to those coming in for medicine supplies, morning after pill and hang-over-cures)	24 opportunistic IBAs were delivered.
75% of those assessed as increasing risk will be given a follow up IBA	6 follow up IBAs were undertaken but these were on clients categorised as low risk.

Were cost savings identified?

The project organisers could identify potential cost savings made on a range of assumptions.

85 people were interviewed by the pharmacists with 40% having an audit score >5. Therefore 34 people with a risk had an intervention. Research⁶ has shown that 1 in 8 people who are at risk will reduce their alcohol intake i.e. 4 (34/8) will reduce their alcohol intake.

Therefore of the 85 people given an alcohol IBA, 4 will reduce their alcohol intake. For each at risk person reducing their alcohol intake there is a potential saving of £126 in primary care treatment (GP usually) or £300 in secondary care (hospital)

Project organisers worked on the assumption that the primary care route will be followed giving a saving of 4x £126 = £504.

The Project will be taken forward as a QIPP initiative locally. The project organisers could also identify cost savings for the lifespan of the project of £14,000. Again this was based on a range of assumptions as part of the local QIPP programme. The project aims to deliver 2000 IBAs with 40% of people having an audit score of >5. Therefore 800 people with a risk will have an intervention 1 in 8 of these people will reduce their alcohol intake. From these figures an assumption can be made that 100 people will reduce their alcohol intake. Savings for this per person will be £126 in primary care treatment (GP usually) or £300 in secondary care (hospital). Project savings are based on 100 x £126 = £12,600 primary care or 100 x £300 secondary care = £30,000. There will probably be mostly primary care savings but with higher numbers there may also be secondary care savings.

⁶ Moyer, A., Finney, J., Swearingham, C and Vergun, P. (2002) Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment seeking populations, *Addiction*, 97, 279-292

What were the key barriers to the project?

Key barriers were identified:

- Only 6 of the trained pharmacists carried out the IBAs
- The project was introduced in December which was an extremely busy time for the Pharmacists
- Although an enhanced payment of £7 was paid this proved to be a small draw
- Pharmacists had reached their limit of 400 MURs at this time of the year (Quarter 4 NHS Financial year) so therefore they were reluctant to undertake further interventions; and Pharmacists felt uncomfortable in delivering IBAs to certain ethnic groups.

What were the lessons learnt?

Key lessons learnt

- The project showed that there is an extensive amount of work to be undertaken to persuade pharmacists of the value of engaging with their customers about lifestyle factors;
- There is a need to ensure that paper-work is straight forward and, following the pilot, the IBA recording form is being refined;
- Healthcare assistants are being trained to carry out opportunistic IBAs; and
- The project should not just focus of MURs but should encourage staff to take any opportunity to carry out IBAs.

Impact

The project has had an impact on mainstream delivery and how local services will be delivered in the future.

Recommendations Project 1

For any future projects being delivered:

- Ensure that pharmacy staff are motivated and have the support mechanisms / adequate training to deliver interventions.
- Ensure sustainability through simple paperwork, training in communication skills, publicity materials and motivational support.
- Consideration is given to training a wider group of staff in interventions such as Healthcare assistants in the community pharmacy arena.

2. Brighton and Hove Frequent Flyers Project - Alcohol Assertive Outreach Service

Background

This project was delivered by the local Alcohol Assertive Outreach Service and involved the appointment of an Alcohol Assertive Outreach worker (AOW) to work with clients defined as frequent flyers in the local health economy. The cost of the project was £15,000.

Outcome:

This project showed success with regard to patient outcomes and potential efficiencies to the health economy. However, effective referral criteria need to be in place to control the caseload and ensure that there is no creep outside the criteria for the project, ensuring the identification and provision of interventions to the right client group.

Evidence

The project was self assessed on being successful in meeting its three outcomes (**1: extremely successful, 5: extremely unsuccessful**):

- An overall reduction in hospital admissions for alcohol related admissions and a measurable reduction in the number of admissions for the identified cohort of patients. **(3)**
- An increase in the number of referrals received by the Community Alcohol Team from the acute sector and an increase in engagement with the Community Alcohol Team and other support services including primary care, mental health services, welfare and housing.**(3)**

The reason for these scores was that the team felt that it was too early to identify/ assess success at the time of evaluation.

Did the project meet its target?

The project was self assessed as being extremely successful in meeting its original target **(1)**.

Target	Actual Performance
Contact made with a maximum of 20 'frequent flyer' clients who had previously been identified and flagged within the local hospitals administration system	23 referrals were made to the service, and, following assessment 11 were accepted onto the caseload meeting the target during the three month period.
Intensive support and engagement achieved and sustained with a maximum caseload of 15 'frequent flyer' patients.	The caseload for the three months reached 11. The project coordinators agreed that the worker did not have the capacity to support further. This led to the acknowledgement that the intensity of support required to deliver real change within this community of clients.
Accompanying of fifteen patients to the first appointment with the Community Alcohol Team.	7 clients were referred to the Community Alcohol Team - 50% achievement rate.

Were cost savings identified?

The Alcohol Assertive Outreach Service used a cost assumption model based on the data from the 3 month review and rounding this up to one year. The admissions potentially avoided per patient per year were 5.5. It was recognised that this work would need to be reviewed as a longitudinal study to identify the true savings. Two models were then used to identify the potential savings. This was based on the annual management of 20-24 clients if the service were retained. Table 1 and 2 (below) detail the potential savings.

Table 1: Cost Savings of the AOW, Based on Existing Reduction in Admissions for Two Clients Modelled over a 12 month Period with the AOW Working with 24 clients. 24 clients saving 5.5 admissions each = saving of 132 admissions.

From Portsmouth DAAT

	Estimated Cost per Episode	Annual Admissions Averted	Cost
Cost of an Alcohol Related Admission	£1,502	132	£198,264
A&E attendance	£86.83	132	£11,462
		Total Saving	£209,726

From Families Cost Saving Calculator

	Estimated Cost per Episode	Admissions Averted	Cost
A&E	£105	132	£13,860
Emergency ambulance	£246	132	£32,472
Inpatient treatment for drugs/alcohol misuse	£615	132	£81,180
		Total Saving	£127,512

Table 2: Cost Savings of the AOW, Based on Existing Reduction in Admissions for Two Clients Modelled over a 12 month Period with the AOW Working with 20 clients. Each client achieves a reduction of 5.5 admissions over a 12 month period. 20 clients saving 5.5 admissions each = saving of 110 admissions.

From Portsmouth DAAT

	Estimated Cost per Episode	Annual Admissions Averted	Cost
Cost of an Alcohol Related Admission	£1,502	110	£165,220
A&E attendance	£86.83	110	£9,551
		Total Saving	£174,771

From Families Cost Saving Calculator

	Estimated Cost per Episode	Admissions Averted	Cost
A&E	£105	110	£11,550
Emergency ambulance	£246	110	£27,060
Inpatient treatment for drugs/alcohol misuse	£615	110	£67,650
		Total Saving	£106,260

What were the barriers to the project?

- Ensuring that patients changed their habits. It was felt that some patients will continue to access A&E, in particular those who felt socially isolated. It was felt that it was quite hard to divert this type of behaviour away from the hospital; and
- Patients were referred to the service who had not had a high number of previous admissions and therefore did not meet the set criteria.

What were the lessons learnt?

- The project highlighted issues relating to unplanned alcohol detoxes within the acute hospital setting. This information will be shared across the health economy and subsequently inform future planning;
- Using hospital intelligence to segment and prioritise a population of vulnerable, high risk clients and then deliver intensive support has not been used before locally. Local services need to understand how an AOW can support them with their dependent drinkers; and
- The client population treated have multiple issues and support will be needed on an ongoing basis across a range of services. This project can not be used as a solution in isolation.

Impact

The project has had an impact on mainstream delivery and how local services will be delivered in the future. Considerable savings can be realised.

Recommendations Project 2

For any future projects being delivered:

- Ensure that the referral criteria for the project are clear and that there is no creep.
- Ensure that criteria to undertake a cost benefit analysis are set at the beginning of the project to support any assumptions that are made.
- Frequent flyer projects need to be delivered in partnership with other initiatives and not seen as a solution in isolation.

3. Brighton and Hove Hostels' Clinical Nurse project

Background

The project aimed to provide nurse support in a hostel setting to promote reduction in alcohol consumption and access to appropriate services. The cost of the project was £10,000.

Outcome

The outcome of this project was particularly successful and has gained future funding. Joint working between treatment and housing has enabled effective interventions for the client group. The project identified that one of its key successes was the employing of a nurse within the hostel setting therefore not pressurising hostel workers to extend their roles. This also gave clients a specific professional to access whose role had been made explicit.

Evidence

The project was self assessed on being successful in meeting its three outcomes (**1: extremely successful, 5: extremely unsuccessful**):

- Reduced Hospital admissions - the project aimed to address that inpatient detox does not work for this client group. Inpatient detox is usually followed by returning to the hostel environment and resumed drinking. Working in a different, constructive way the project aimed to increase the numbers addressing dependency, through longer term, personalised and tailored care packages in the community. **(1)**
- Personalised detox programmes - the project aimed to provide a personalised detox programme, within the hostel environment, for 10 people.**(1)**
- Improved health - to address the overall health issues for individual clients - addressing nutrition, GP registration, compliance with medication and health assessments. **(1)**

Did the project meet its target?

The project was self assessed as being extremely successful in meeting its original target (1).

Target	Actual Performance
Alcohol related hospital admissions amongst this group will reduce by 50%.	<p>During engagement with the project, all clients saw a significant reduction in hospital admissions.</p> <p>Emergency call-outs: 6 clients combined had a total of 45 emergency call outs in the 6 months before engagement with the project. 0 call-outs since engagement.</p> <p>Admissions: 2 clients combined had 36 admissions (from ambulance - A&E callouts) in 6 months prior to the start date of the project. Since engagement, 1 admission overall. One of these clients had 90 admissions in the past year.</p>
10 hostel residents who have experienced inpatient detox 2 times in the past 5 years, yet are still heavily alcohol dependent, who are currently not engaged in primary or secondary healthcare and who have had numerous hospital admissions for alcohol related issues will be undergoing a personalised detox programme within a hostel environment	Hostel residents were identified according to the criteria. 11 (out of 14) clients have a treatment plan and were on the waiting list for either detox and / or rehab. All of these clients reduced alcohol consumption and are attending regular GP appointments for physical health and other specialised appointments (eg. Diabetes nurse, family planning etc). All are engaging in preparation for treatment.
Improved health for 100% of service users - 100% will be registered with a GP. 100% will have improved their nutrition. 100% will be complying with medication. 80% will have a full health assessment by their GP.	<p>Significant health improvements were identified.</p> <p>100% are registered with a GP. 100% have improved nutrition. 100% have had a health check. 50% are regularly seeing a GP (were not seeing a GP at all previously) 100% linked in with specialists and attending appointments: Breast Cancer Screening, Family Panning, SMS, St John Ambulance outreach, dentist, audiology, hepatology, haematology, phlebotomy, ulcer clinics, Diabetic clinics, optical specialists and cardiac care.</p>

Were cost savings identified?

The following assumptions on cost savings were identified by the project. The project worked intensively with ten clients. These were alcohol dependent clients living in hostels, heavily dependent and chaotic where inpatient detox had failed multiple times.

1. Emergency Call Outs and A&E Attendance: All clients had histories of disengagement and about 60% had histories of having multiple emergency service call-outs and attendance at A&E.

No clients had emergency service call-outs during the pilot; this includes clients with a history of significant dependence on emergency services.

Client No	Previous Emergency Ambulance Call outs	Emergency Ambulance Call-outs during pilot	Potential call-outs avoided	Potential A&E attendance avoided.
1	2 per week	0	32 (2x16=32)	32
2	2 per week	0	32	16
3	0	0	0	0
4	0	0	0	0
5	0	0	0	0
6	1 per month	0	4	4
7	2 per week	0	32	32
8	3 per week	0	48	16
9	1 per month	0	4	4
10	0	0	0	0
			TOTAL: 152	TOTAL: 104

A conservative estimate of the number of call-outs prevented, based on hostel records of each client, indicated that 152 call-outs were prevented during the pilot.

- Indicative Emergency call-out cost saving: $152 \times \text{£}263 = \text{£}39,976$ (Cost source: Curtis 2009)

Similarly, a conservative estimate of the number of call-outs that would have resulted in attendance at A&E, based on hostel records of each client, indicates that 104 attendances at A&E were prevented during the pilot.

- Indicative A&E cost saving: $104 \times \text{£}109 = \text{£}11,336$ (Cost source: Curtis 2009 - obtained from the SIPS project)

2. Hospital admissions: Some clients will either leave or be asked to leave A&E. If a conservative estimate is made that only 15% of call-outs would have resulted in admission then the pilot will have prevented 23 hospital admissions during the period.

- Indicative cost saving: $23 \times \text{£}1,600 = \text{£}36,800$ (Cost source: DoH)

3. In-patient Detox: 5 of the pilot group had a supervised community detox in the hostel rather than an in-patient detox.

- Indicative cost saving: $5 \times 14 \text{ days} @ \text{£}300 \text{ per day} = \text{£}21,000$ (Cost source Sussex Partnership Trust)

4. Total cost savings: The cost of the pilot was £10,000 with indicative total cost savings: £109,112.

What were the key barriers to the project?

- The project had some initial issues with regard to expectations, communications and recruitment.

What were the lessons learnt?

- Levels of motivation and contemplation towards change amongst the client participants was much higher than anticipated, clients engaged readily and were keen to take up the support offered. Many of the clients had been perceived as being pre-contemplative or unwilling to change, the project showed that this was not the case;
- Staff attitudes were challenged and changed as a result of participating in the pilot. For many of the clients in the pilot staff had come to believe that they were pre-contemplative. By being part of the pilot, staff were able to see the results obtainable by working in a different way. This increased staff skill and knowledge and made a significant difference in staff levels of aspiration about the client's ability to change. Joint working and 3-way meetings have enabled hostel workers to be involved and to work positively with the client; and
- It was particularly important for the post holder to be a nurse as:
 - The nurse was able access and obtain information quickly (e.g. from GP's who were willing to give information to a nurse that they wouldn't give to unqualified workers)
 - Local knowledge of services and processes
 - The nurse could make decisions about treatment plans and what was required - clinical decisions (eg. that a client was not fit for the Day Programme etc)
 - Profile and expectations of a nurse enables client engagement - seen as helpful. It was seen that clients would engage with a nurse on physical health issues / concerns and this then moves to alcohol

Impact

- The project has resulted in reduced evictions and less chaotic behaviour in the hostels. This has also led to less street drinking and anti social behaviour. It has led to improved use of primary care, particularly an increase in dental care.
- The project had an impact on the Community Alcohol Team as the nurse was working with those who have DNA'd for years. The nurse completed the Comprehensive Assessment with clients whilst in hostels and presented back to the Community Alcohol Team at weekly team meetings. Previously these clients would not have been Comprehensively Assessed and would have missed numerous appointments
- Impact on clients attending mainstream GP surgeries - appointments are now not being missed.
- Impact on other statutory services. Multi-agency meetings and formulating treatment plans together. This led to a "united front" with managing chaotic clients. It also led to the allocation of tasks and roles to avoid duplication and confusion.
- Specialist NHS Services, such as breast cancer, diabetes, are now able to reach these clients and clients are not missing appointments.
- A&E - Impact for the Alcohol Liaison Team - the nurse intervention has significantly reduced attendance at A&E where the Alcohol Liaison Team didn't think this was possible with certain clients.

Recommendations for Project 3

For any future projects being delivered:

- When addressing the needs of alcohol dependent clients in the hostel setting support should be given by a qualified nurse who can support clients and hostel workers to meet their goals and aspirations.
- The innovation in hostels should be monitored on a regular basis, if ongoing, to ensure that momentum is not lost due to complacency by clients and hostel workers.

4. Dartford and Gravesend and Swanley Assertive Alcohol Outreach Project

Overview

This Frequent Flyer pilot was part of a larger pilot in which those requiring admission for detoxification within a general hospital setting may be transferred to a specialist residential unit to complete their treatment whilst receiving appropriate psychological input which is not available within acute hospitals. The current treatment system focuses on engagement into tiers 2 and 3 before service users can access tier 4. (for definition see Appendix 2). However, there are some service users whose lifestyle and alcohol consumption is so chaotic that engagement in this way is simply unrealistic and these people become frequent fliers. The Assertive Alcohol Outreach project offers this group of individuals the opportunity to get some clarity through crisis detoxification combined with an assertive plan to engage them into a variety of community services. The cost of the project was £15,000.

Judgement:

This project could not be fully assessed at the time of evaluation due to late starting.

Evidence

The project set three objectives but could not be self assessed at time of the evaluation due to time constraints and a lack of referrals to the service. The reason for the lack of referrals was not clear at the time of the evaluation.

- Lower rates of readmission to the local acute hospital amongst the selected group of service users.
- Increased engagement within community alcohol services.
- Reduced alcohol consumption and/or maintaining abstinence from detoxification.

Did the Project meet its target?

The project could not be self assessed against meeting its targets due to the slow uptake.

Target	Actual Performance
Identify the top 20 attendees at Darent Valley Hospital (DVH). Contact and assess these 20 with a view to engaging 10 of these and have commenced them on the assertive outreach programme by March 31 st 2010	The team identified the top 20 admissions at DVH. The frequent fliers scheme was designed to work alongside another pilot scheme whereby those attending general hospitals for alcohol detox were to be transferred into a specialist unit to allow appropriate psychological work to be undertaken whilst the physical component of the detox was completed. The team expected that the nature of the 'frequent flyers' attendance would mean it would inevitably have contact with them when they were admitted to one of the medical/surgical wards but this didn't happen to the extent expected. After 3 months, 3 of the referrals the team had received had been related to 'frequent flyers', 2 of the referrals being the same person.
Engage each client into the intensive community support programme from the time of consenting to be on the programme until the end of the programme at the end of the June.	The 1 client that was engaged within the 'frequent flyers' scheme has been assessed by the community alcohol services with a view to entering their treatment programme.
Document the number of admissions/A&E attendances during the period of engagement and demonstrate a reduction.	This information was being analysed at the time of evaluation,

Were cost savings identified?

At the time of the evaluation it was not possible to identify any cost savings from the project.

What were the barriers to the project?

- Anecdotally, those delivering the project understood that many regular Frequent Flyer A&E attendees tend not to be admitted and are perhaps repeatedly directed to the community services with whom they may not be engaging. As the project was only able to accept those who had been admitted to DVH and not those who have just attended A&E, it is possible that a number of frequent flyers were not reaching the point at which they could be referred;
- It was possible that this group, once they are admitted, are deemed too unwell by the treating team for transfer to a unit of the type provided by the project (community detox). (Amongst the 12 non-FF referrals received, 3 were not medically fit for transfer at the time of referral to a unit with a stepped down level of medical support);
- The location of the unit is some 20 miles away from the acute hospital causing issues for timely and safe intervention; and
- Changes at PCT level during the project and bureaucratic delays from other organisations due to lack of strategic buy-in to the project meant that there had been a lack of time to implement the project as wished.

What were the lessons learnt:

The project can identify some key lessons/outcomes that will improve services in the future. These include:

- Improved links with Hepatology and Physician colleagues;
- Interest in this scheme at another general hospital in Kent;
- The provision of a viable and visible treatment modality that starts within the general hospital setting has potentially reduced the stigmatisation of these service users; and
- Presenting the service at a medical Continuing Professional Development meeting provided helpful insight into local alcohol services, clarified pathways and elaborated on psychological ways of working with this group of service users such as motivational enhancement work.

Impact

At the time of the review it was undecided whether the project would be mainstreamed. However, the project was being monitored by the local DAAT for a 6 month period with a view to evaluation of the longer term viability of this scheme.

Recommendations for project 4

For any future projects being delivered:

- When implementing projects in a similar geographical area professionals should accept that a wider range of organisations will be involved and need to be involved early in the planning stages;
- Consideration needs to be given to having an official, visible launch, for example, present the service at a medical CPD meeting at the beginning of the programme to have more control over the planning stages.

5. Frequent Flyers at St Richards Hospital, Chichester, West Sussex

Background:

This project involved the appointment of an Alcohol Liaison Nurse (ALN) within the Acute Hospital Setting to engage frequent flyers. The cost of the project was £15,000.

Outcome

This project moved away from its original target, changing the remit of the nurse allowing a wider range of referrals to the service. However, in doing this it has been successful in diffusion with a QIPP initiative being identified for Alcohol Liaison Nurses being appointed across 4 local hospitals. This is a recommended approach by the Royal College of Physicians⁷ which recommends that every acute hospital has an Alcohol Health Worker or an Alcohol Liaison Nurse to manage patients with alcohol problems within the hospital and liaise with community services.

Evidence

Did the project meet its planned outcomes?

The project was self assessed on successfully meeting its three outcomes (1: **extremely successful**, 5: **extremely unsuccessful**)::

- Increased number of successful alcohol detoxifications for patients admitted via MAU (5)
- Better coordination of treatment and care between acute and community services (1)
- Reduced rate of re-admission to hospital in the target group of patients (5)

The reasons for the self assessment were that the remit of the Alcohol Liaison Nurse changed following recruitment and the outcomes were less about supporting detox in hospital and more emphasis put onto links with community services. It was felt that a three month period was too short to determine impact on hospital admissions. However data collection includes NHS numbers so that they can be tracked at a later date using HES data and hospital attendances.

A fourth outcome became:

- To increase awareness of impact of alcohol on admissions across the acute trust (1).

Over the period this post has been in place there has been an increased number of referrals from a wider range of wards and specialties.

⁷ *Alcohol - can the NHS afford it?* London: Royal College of Physicians (2001)

Did the project meet its target?

The project was self assessed as 3 for meeting its targets

Target	Actual Performance
Identify and assess 20 most prolific patients from gastric, MAU and A and E over the past 12 months.	116 referrals were made to the ALN in a three month period. This is a change to the original target as it was not possible to identify and assess the top 20 patients in the time scale. Those that were contacted were unreceptive to the intervention
Demonstrate reduction in month on month admissions to hospital for patients engaged in the programme December 2010- February 2011	This was not possible in the timescale but appropriate information is being collected to enable HES Data to be used to determine annual hospital attendances
Engage 15 of this cohort in specialist treatment	56 of the 116 referrals made to the ALN were referred onto community treatment services, with 40 of these engaging with the community services

The cohort was changed from the original target as a number of frequent flyers were resource intensive. Rather than focussing on the top 20 it was decided to provide an intervention to anyone admitted with an alcohol related problem to provide the opportunity for engagement for all who may be interested and who were more ready to change.

Were cost savings identified?

Although detailed cost savings could not be made for the project the work to date has led to a QIPP initiative being initiated across the area and the appointment of four full time alcohol liaison nurses.

Cost assumptions for this project area as follows and are supplied by West Sussex PCT:

If the following assumptions regarding the effectiveness of alcohol liaison workers are used the appointment of 4 alcohol liaison workers could potentially lead to the reduction of 5 admissions or readmissions per month -total of 60 admissions per worker annually (240 total approximately 15% of current admissions (1600))

There is also evidence that a specialist alcohol worker has an impact on length of stay for patients with alcohol related admissions particularly around detox. This information was yet to be analysed at the time of the evaluation.

Using data for West Sussex, the total percentage of avoided admissions and attendances are potentially 22%. Potential savings are as follows across the four hospitals where West Sussex commissions services

Hospital	Emergency Admissions	Cost	A&E Attendance	Cost	Total Savings
1	93	102,883	93	8280	£111,163
2	61	63,192	61	5405	£68,598
3*	45	42,967	45	4322	£47,298
4	34	22,412	34	3019	£25,431
Total					£252,490

*The innovation fund post was in St Richards Hospital.

What were the key barriers to the project?

- The post holder felt she needed clearer objectives. Commissioners of the service hoped to replicate models that run elsewhere, but this didn't fit with local needs and so initial focus outlined in application was amended to stay within best practice but was made more locally relevant;
- Public health at NHS West Sussex had to work with acute clinicians who had been very resistant to these posts in the past, subsequently the project has very much been a learning experience and a fluid role with regular development and review; and
- Three months was too short a timeline to show true impact.

What were the lessons learnt?

As a result of this post

- The local specialist community treatment (ALN) is doing in reach sessions to the acute sector for assessments and improving referral mechanisms to community services;
- The project acted as a catalyst to AA members visiting in-patients in the acute sector to support their motivation;
- The pathway for referral of alcohol using patients to mental health services improved; and
- Improved training has been given on the impact of alcohol to A&E Staff nurses, Occupational Therapists and Physiotherapists, junior doctors and GPs.

Impact

The project had mainstream potential -

- This post is integral to the West Sussex alcohol care pathway that has been developed over the last 12 months. This is a multi agency care pathway that has recently launched, with additional sessions planned for GPs. The focus of the care pathway is to increase use of AUDIT C and brief interventions, and better flow to community services
- AUDIT C and brief interventions are being recorded on the nursing assessment documentation in AMU at the acute trust.

Recommendations Project 5

For any future projects being delivered:

- Managers of staff providing interventions need to ensure adequate supervision is available throughout the duration of the project to avoid professional isolation - nursing and medical, including mental health.
- Consideration should be given to providing a 24 /7 service to support impact.
- Adequate funding and support from clinicians for supervision and to follow the care pathway need to be in place to support success.
- Support from managers/ directors within the trusts to push through this agenda and recognise it as a priority.
- Staff appointed should be at level Band 7 or above.

6. Hastings Frequent Flyers

Background

This project was delivered by Action for Change (AfC), a third sector company specialising in the delivery of health and wellbeing services particularly in alcohol misuse. It delivers Tier 2 and 3 services in East Sussex and carries out assessments for Tier 4 in-patient detoxifications. The project aimed to reduce the number of attendances at A&E by Frequent Flyers through alcohol key workers proactively engaging Frequent Flyers and motivating them to enter a Tier 3 intervention and if appropriate commence an alcohol detoxification managed by AfC nurses. The intended result was that the Frequent Flyers would reduce the frequency of their attendance at A&E and any unplanned hospital admissions e.g. to Medical Assessment Units. The cost of the project was £12,750.

Outcome

This project showed considerable success in managing frequent flyers. There was clear evidence that the level of hospital admissions reduced over this quarter by over 25% and this is likely to continue into the future. This will be maintained as additional service users are being referred to Action for Change.

Evidence

Did the project meet its planned outcomes?

The project was self assessed on successfully meeting its three outcomes: **(1: extremely successful, 5: extremely unsuccessful)**:

- Reduced rate of re-admission to hospital in the target group of patients. **(1)**
- Increased number of successful alcohol detoxifications. **(5)**
- Improved care co-ordination between hospital and community services. **(1)**

During the time of the project the service users who were engaged did not have, unexpectedly, a need or they did not want to have a detox during the period of the project. The support was available if it had been needed. It is possible the service user may have a detox later in the year if needed.

Outcome 3 was achieved and was above the original expectations in many ways. Regular links with the hospital's various departments were established and are planned to be maintained into the future.

Did the project meet its target?

The project was self assessed as (1) for meeting its targets:

Target	Actual Performance
Identify and assess the 10 most prolific clients admitted through A&E attendance over the last 12 months due to alcohol at Hastings Conquest Hospital A & E, by 30 November 2010.	This was achieved albeit a month later as there was the delay in starting the project and the decision was taken to start after the festive holidays.
Engage 8 of this cohort in specialist community alcohol services by 31 st January 2011	Target 2 was not achieved in the original cohort as they were not able to be contacted directly from the information that was given. No one refused the service offered and they were positive about the prospect of having support around their drinking. The additional service users who engaged on a fast track service more than made up for those who were not able to be found. As part of the project there were improved links with the acute trust and this meant that an additional 21 service users did engage with the service, and this number continues to grow after the completion of the project. Many of these were regular attendees at A&E though not part of the original 10.
Successfully complete 6 outpatient or inpatient alcohol detox by 31 st . March 2011	Target 3 was not met in specific numbers as those who engaged with Action for Change did not have a need for a detox. There were however positive changes to their drinking pattern after engaging with the workers due to the use of psychological interventions. During the time of the project and after, the option of having a detox was always there if that was the treatment they required.

Were cost savings identified?

AfC made the following cost saving assumptions. The estimated annual cost of the cohort of individuals (n=6) helped by this project to local PCTs was £173,030. Additional savings will come from the additional 31 fast track referrals received as a result of improved liaison between the A&E department and the community alcohol team. AfC felt that it can be reasonably concluded that the project has saved the local PCTs money through averted use of A&E, hospital stays and ambulance call outs.

Assumptions on cost savings were made by AfC for the period of the project. AfC recognised that establishing an accurate picture of cost savings relies on a detailed cost picture for previous attendance or admission for this cohort of individuals as the unit price for the range of interventions they would receive will vary considerably.

Costs were taken from NHS Hastings and Rother (source: Programme Lead, Urgent Care) which reports the following costs that may apply to these individuals.

- Average cost of an A&E attendance - £110

- Average cost of an A&E stay - £274
- Average cost of hospital night bed - £443

In addition, some clients will have been admitted into specialist beds. Here the costs increase considerably - Gastroenterology £2711 average for 2 days stay, £4097 for 5 days; ENT between £1400 and £1900 depending on the length of stay; General Medicine between £2200 and £2700. NHS Hastings and Rother apply an average cost of £2500 per admission in preventative schemes. In addition ambulance callouts are £237 per incident.

AfC felt that it was impossible to give an accurate cost comparison as the detailed treatment journey of each of the cohort of Frequent Flyers was not known. However, it was known that this group of 6 individuals attended A&E 122 times in 2010. If assumptions are made that:

- All had a visit (122x £110 = £13,420)
- 50% also included a stay (61x £2500 = £152,500)
- 25% also included an ambulance call out (30x £237=£7,110)
- The total cost would have been £173,030.

What were the key barriers to the project?

- Confidentiality issues - Data protection issues can be a barrier for those outside of the NHS

What were the lessons learnt?

- There is a need for ongoing contact with clients. Clients post crisis may consider that they no longer have a problem and slip backwards
- There is a need for lead up time for staff to identify and contact frequent flyers in the community
- Increased liaison and care coordination between the hospital and AfC. By week 12 of the project, an additional 21 'fast track' referrals of patients presenting with alcohol related problems were received from the local acute hospital. Of these, 13 were then engaged in treatment.

Impact

There were many positive changes to the service users who engaged with Action for Change during the period of the project. Numbers of admissions reduced, levels of drinking were reduced, clients had an improving outlook on their lives with an overall improvement to their psychological outlook.

Recommendations project 6

For any future projects:

- Ensure that data protection and agreement to share data is managed at the time of setting up the project

7. Identification and Brief advice training for Medway Maritime hospital healthcare support workers

Background

This project was aimed at training 30 hospital staff in relevant areas (Accident and Emergency and Medical Assessment Unit) in brief advice training (IBA) on alcohol intervention.

Outcome

This project was a potential success but was hindered by a lack of staff attending training and lack of buy in by the acute provider. The approach can be seen as an effective way of tackling hospital related admissions and is sustainable but needs true buy in from all staff.

Evidence

The project was self assessed on being relatively successful in meeting its three outcomes (1: extremely successful, 5: extremely unsuccessful):

- Improved standards of healthcare delivery through early identification of those patients not only dependent on alcohol but those who may be drinking at increasing and higher risk levels (1).
- Improved understanding of healthcare staff around the evidence of effectiveness of an IBA as well as knowledge of high risk drinking levels (1)
- Reduction in hospital admissions due to alcohol related conditions (3).

The project was hindered in its early stages. Although training was arranged and agreed for 30 staff, only 12 attended the training when it was delivered. Whilst the organisers of the project felt that there was buy-in and support from the hospital management, and agreed to run the training on site, paying staff to attend, attendance was poor.

Did the project meet its targets?

The project was self assessed as being in meeting its original target (3).

Target	Actual Performance
Training to be provided for thirty healthcare workers who work in emergency medicine, medical assessment unit and the gastroenterology ward at Medway Maritime hospital	Only 12 staff trained
All patients being admitted onto these departments will undergo an alcohol screening and receive brief interventions if appropriate.	The project was delayed due to lack of staff attending training
A reduction in the amount of alcohol consumed by those patients whom are identified as drinking at Increasing and higher risk levels. All patients found to be alcohol dependant will be referred to a specialist treatment service.	Not able to measure this target, but based on the research for one in eight that are screened it can be expected that there will be a reduction in their alcohol consumption. If staff trained identify patients early and refer those appropriate for treatment to the relevant services then it may be assumed that this will have a positive impact on alcohol admissions.

Were savings identified?

The project could not identify substantial savings at the time of evaluation.

What were the key barriers to the project?

- There was lack of support/ sponsorship from the hospital management team and thus staff were not motivated to attend training;
- Lack of time - project organisers felt that the three month window to deliver the project was too short to deliver its objectives; and
- Bureaucratic delays from between organisations (public health and the acute trust).

What were the lessons learnt?

- The project established a good communication channel and working relationship between public health and hospital management staff;
- Identification of potential alcohol champions was an unexpected outcome and the team is now working to further develop this area; and
- It is hoped that staff who undertook the training will deliver IBA as part of every patient's admission procedure. During the training, participants were looking at ways to design the AUDIT C into their admission forms.

Impact

Although not successful against its original objectives the project has generated improved working relationships and a new scheme to develop alcohol champions across the Trust rather than just A&E and MAU. The potential impact for the project may therefore be wider than originally planned.

Recommendations from project 7

For any future projects being delivered:

- Ensure that there is a member of staff within the acute trust to champion the project and deliver the training
- Consider changing approach and appointing alcohol champions across the Trust who have reputable high quality training, in line with the Royal College of GPs and with the knowledge to manage alcohol use disorders in addition to delivering IBA.

8. Portsmouth Peer Recovery Facilitators

Background

Portsmouth City Council employed a Peer Recovery Facilitator for the South East Alcohol Programme and gained match funding by Portsmouth PCT to employ a second worker. The aim of the innovation project was to develop self-help groups which provided residents in supported housing with an opportunity to explore their drinking, the reasons for it and opportunities to cut down/stop drinking. It was also hoped that the employment of 2 ex-service users would support their personal development, providing them with a part time job. They received line management and support from the Service User Involvement Co-ordinator, who had significant experience of developing service user's skills. The project cost £8250

Outcome

This project encountered problems with recruitment of peer recovery facilitators. However, the facilitator who was recruited had demonstrable success. The project has also been seen as a catalyst to raising the priority of managing clients with alcohol problems across the local area.

Evidence

The project was self assessed in successfully meeting its three outcomes (1: extremely successful, 5: extremely unsuccessful):

- Groups will be successfully established in supported housing locations .(3)
- Group attendees will reduce the amount of alcohol they consume. (3)
- Group attendees will be referred and engage with other treatment services. (3)

Overall the project was not as successful as hoped locally. Whilst two peer recovery facilitators were recruited, post recruitment it became apparent that one recruit was struggling with the SMART Recovery model and also struggled to show the level of personal development needed. Despite considerable investment of time and support this worker did not develop sufficiently to contribute effectively to the project. However, the other worker showed considerable personal development, facilitating groups weekly.

Did the project meet its target?

The project was not self assessed against its targets.

Target	Actual Performance
4 groups successfully established in supported housing venues	Due to staffing issues the project did not establish the number of groups aimed for.
40 people attending at least 3 sessions during the three month project	The project struggled to engage effectively with the range of housing providers hoped for and thus the amount of clients accessing the service. 21 people attended a group at one homeless hostel.
10 people will have attended a first appointment at a treatment service	5 people went on to access services
5 people will have accessed a detoxification service	1 client successfully went on to detox.

Were cost savings identified?

The project was not able to identify cost savings however interviews indicate that there are potential savings but these are not tangible at the moment.

What were the key barriers to the project

- Issues with recruiting peer recovery facilitators;
- Cultural issues within supported housing - there appeared to be a co-dependency between supported housing workers and the clients which led to a reluctance to actively support the project;
- There was a need for further identifiable funding to imbed the project on a long term basis;
- Difficulty with working with some clients as they had issues with drugs alongside alcohol and therefore did not meet the criteria for the project.

What were the lessons learnt?

- The project has been a catalyst to raise alcohol awareness across the area;
- The project used the SMART (see Appendix 2) methodology and showed that this worked with this client group with regard to the process of rationalisation working on reducing need; and
- Service users who have used the service are encouraging other service users to engage in the process as they can see the benefits.

Impact

Despite the project not being as successful as had been initially hoped, the project is going to continue for a further 6-11 months. A new peer recovery facilitator was appointed. This post however will not focus on supported housing, as this avenue has not proved fruitful. The new post will instead focus on work in the local acute hospital and other established community venues.

Recommendations from project 8

For any future projects being delivered:

- Consideration should be given to employing an alcohol nurse to work alongside facilitators
- Selection process for facilitators needs to be very clear to ensure that those potentially recruited are at a time in their recovery where they can undertake the role
- Ensure that targets and plans are realistic and that there is buy-in from other workers in the field.

9. Self Help Alcohol Awareness Groups in Supported Housing settings

Background

The project was aimed at males and females over the age of 16, often vulnerable with complex alcohol needs. The plan was to deliver training to staff in two supported housing settings (one male and one female) to support clients' understanding of the underlying causes behind their drinking habits. The aim was to help service users in understanding alcohol harm and enabling them to work on personal goals which would enable them to gain the motivation and self esteem needed to engage in specialist services for alcohol dependency when and if required. Personal client outcomes were set out in tailor made personal improvement plans measured using the Alcohol Star model for Alcohol Recovery. This model enables workers and clients to measure progress with 'softer' outcomes, both holistic and subtle changes. It is designed to complement measurement of change in consumption and other hard outcomes. The cost of the project was £7,500.

Outcomes and Targets

The outcomes detailed for the project could have potential to improve outcomes for clients and could be potentially considered by other commissioners and providers. However, due to technical, resource and partnership issues this project did not succeed.

This project did not succeed and targets were not met.

Outcomes for the project were set but not self evaluated:

- All clients to have an improved understanding of alcohol harm
- All clients to have a set of goals towards reducing their drinking habits and to have signed-up to a personal health and well being improvement plan
- Two self-help groups embedded in providers' core business and all clients to agree to engaging and running alcohol self-help groups
- Willing clients to agree to engaging with specialist services on a case by case basis
- For each group, two individuals to agree to act as peer supporters in the running of the self help groups (specific training around the skills and dynamic of running group work will be provided).
- All clients to have improved self esteem and understand how to improve their personal circumstances.

Although both providers understood the constant difficulties in addressing the needs of homeless individuals with an alcohol problem and the barrier that alcohol is in preventing them engaging with specialist services the project faced a range of barriers which prevented its self evaluation.

Were cost savings identified?

The project was not able to identify cost savings.

What were the key barriers to the project?

- The training of the staff was delayed and the staff at one facility did not feel that they were adequately equipped to deliver the work with difficult clients
- Better sponsorship was needed by the commissioners of the service to support its intervention.
- Time constraints and changes to responsibilities and capacity of commissioners to support implementation.

Impact

The coordinator of the project felt that there was potential for this project to be revived and, if outcomes detailed were met there would be potential impact for local clients.

Recommendation Project 9

For future projects being delivered

- Ensure that there is ongoing, identified sponsorship at commissioning level throughout the duration of projects

10. Southampton Alcohol Intensive Case Management Project

Background

This project involved the intensive case management team working with over 20 clients, with a dedicated intensive support worker assisting across a number of cases. This involved one directly funded post and one indirectly at the cost of £15,000.

Outcome

This project was successful. The interventions set up, including referral pathways, enabled access (and earlier intervention) to intensive support at key periods in an individual's life. This led to a reduction in the number of hospital admissions, by way of increased community support, or in some cases, improved hospital discharge arrangements to better accommodation services, thus reducing re-admission rates.

Did the project meet its outcomes including reducing alcohol related admissions?

Evidence

The project was self assessed on meeting its three outcomes (1: extremely successful, 5: extremely unsuccessful):

- Reduced impact on other high-end services and de-escalation of the need for crisis interventions (2)
- Reduced re-admissions to hospital (and presentations to high-end children's services) (2)
- Earlier intervention through coordinated support which is needs-led (2)

Did the project meet its targets?

The project was self assessed as being successful in meeting its original targets (2).

Target	Actual Performance
Reduced impact on other high-end services and de-escalation of the need for crisis interventions.	Securing actual metrics to evidence a reduced impact on other high-end services has proved problematic, although case information shows significant changes in each case. Case reviews have shown an increased level of engagement with appropriate support services, thereby reducing the impact on high-end and crisis intervention services.
Reduced re-admissions to hospital (and presentations to high-end children's services)	Increased and intensive support to the individuals led to an improved level of engagement with a range of different services [accommodation, health, support services], leading to increased health and/or stability in their lives, and resulting in reduced or no contact with acute services.
Earlier intervention through coordinated support which is needs- led.	The key contributor to the success of the work was the intensive and often earlier intervention, coordinated across a range of services. The intensive level of input available significantly increased the opportunities to support these hard to reach clients to engage better with available services.

Were cost savings identified?

At the time of the evaluation cost savings could not be accurately identified.

However, The work will be captured in the QIPP Alcohol initiative, initially through an invest to save approach during a period of remodelling and review, leading to increased capacity within Tier 3 services, alongside improved or newly developed alcohol treatment pathways across the City partners.

What were the key barriers to the project?

- The depth and breadth of the problem was hard to tackle sufficiently in the small timescale available. The link to a longer project working with this client group enabled relatively quick identification of individuals and prompt engagement; and
- The ability to develop new providers and to better understand the possibility of building long term success through intensive support will need to be explored as the project becomes mainstream.

What were the lessons learnt?

- Improved the confidence of a wider range of professionals working with long term entrenched drinkers, particularly as the intensive support worker role enabled a new and additional service to be available to a very hard to reach and hard to engage client group;

- Through intensive support it was possible to identify and address a far wider range of general health needs. In one case, addressing general health needs enabled the individual to continue to care for their partner;
- The approach has identified a number of areas where services were not working in a coordinated way, often reflecting the need for a high level of intensive support, which has not been readily available or flexible enough to support this client group; and
- The intensive support work identified a number of individuals who are using crisis services on a regular basis. Importantly, they were able to afford the time to address a range of issues, often unique to the individual, to either reduce or negate the impact on the emergency or crisis services.

Impact

This project showed considerable success and this could be replicated and expanded. The service has informed future service provision and the need to establish ongoing intensive support for this client group. Analysis of the cases receiving intensive support showed:

- A reduction in health crisis situations;
- Faster implementation of crisis plan when needed;
- Admission avoidance achieved;
- A reduced impact on out of hours service;
- Improved health and well being outcomes;
- Ability to maintain their own tenancy with intensive support.

The team also established the importance of anticipatory care planning, which needs give consideration to issues of the client having mental capacity, and choice.

Recommendations for project 10

For future projects being delivered:

- Establish a priority list of clients, with baseline information from emergency services (hospital and ambulance services), and wider professional groups, to enable robust assessment of the impact intensive support work has had on the individual
- Introduce an outcome tool to evidence small, but important changes in a range of domains - currently considering the Alcohol Star Outcome tool
- Review existing workforce, pathways and funding to incorporate an intensive case management approach into mainstream services.

10 Appendix 2 - Definitions

1. Audit C

To evaluate the 3 alcohol consumption questions from the Alcohol Use Disorders Identification Test (AUDIT-C) as a brief screening test for heavy drinking and/or active alcohol abuse or dependence

2. Identification and Brief Advice

Alcohol Identification and Brief Advice (IBA).

- It is a simple means of case finding followed by simple alcohol advice.
- Brief advice within an IBA approach is not effective for dependent drinkers.
- It is effective for increasing risk and higher risk drinkers
- Brief advice interventions are motivational; they involve encouraging people to change behavior
- The aim of the intervention therefore is to encourage the person to recognize that they are drinking at levels that could be harmful to their health and encourage them to reduce consumption to sensible limits in order to reduce the risk of future health problems.
- IBA is usually opportunistic, in that the person has not complained about a problem with alcohol use and is seeking help for reasons other than an alcohol problem.

3. Medicines Use Review (MUR)

The first Advanced service introduced within the NHS community pharmacy contract was the Medicines Use Review (MUR) and Prescription Intervention Service.

The service consists of accredited pharmacists undertaking structured adherence-centred reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions. The MUR process attempts to establish a picture of the patient's use of their medicines - both prescribed and non-prescribed. The review will help patients understand their therapy and it will identify any problems they are experiencing along with possible solutions. A report of the review will be provided to the patient and to their GP where there is an issue for them to consider.

In order to address local priorities, PCTs may recommend that MURs are targeted at certain patient groups.

Tier 1-4 services

The National Treatment Agency refer to the following tiers for alcohol services:

Tier 1	Non-substance misuse specific services providing minimal interventions for alcohol misuse
Tier 2	Open access alcohol treatment services
Tier 3	Structured community-based treatment services
Tier 4a	Residential alcohol misuse specific services
Tier 4b	Highly specialist non-substance misuse specific services

And the type of alcohol services which fit into each Tier are:

Tier 1 interventions	Alcohol awareness and education, screening for alcohol problems, minimal interventions, brief interventions, need assessment, referral to specialist service, harm reduction
Tier 1 Settings	GP/primary care, health promotion, ambulance, A&E, social services, general housing and homelessness services, outreach services, maternity / antenatal services, general psychiatry, CAMHS, probation, police
Tier 2 interventions	Open access services, specialist advice and info, harm reduction, GP advice and info, screening, referral to more specialist services, brief interventions (in generalist and specialist settings), motivational interventions, telephone advice and info, need assessment, counselling and psychotherapy, psycho-educational interventions, group work, relapse prevention, liaison workers working with primary care, liver units, A&E, and psychiatric services, family/carer support services, crisis intervention, preparation for assisted withdrawal, mentoring, befriending, advocacy, diversionary activities
Tier 2 Settings	GP/Primary Care; Open access alcohol services / Drop-in services; specialist alcohol services / community alcohol team; AA/self-help groups; 'wet' and 'dry' houses/hostels, outreach services
Tier 3 interventions	Assisted withdrawal in the community / at home – both supervised and unsupervised, structured community treatment programmes/ day programmes, group therapy / group work programmes, relapse prevention, outreach, (comprehensive) assessment (including MH assessment), motivational interventions, specialist liaison services working with mainstream health services, structured counselling, CBT/psychosocial interventions, controlled drinking interventions, alcohol and offending programmes, family/carer support, structured key-worker support, alternative therapies, links to other services e.g. drug treatment, mental health/dual diagnosis services, alcohol 'shared care' services, community care assessments, structured care planning
Tier 3 Settings	Specialist community alcohol services, structured day programme services, hostels – 'dry' and 'wet'; hospitals, community mental health teams, range of linked services inc mainstream health services, drug treatment services, probation, social services
Tier 4 interventions	Inpatient detox, residential rehab services, specialist assessment and referral, psychiatric input for conditions (such as Korsakoff's), aftercare services – e.g. tenancy support, specialist medical care e.g. for liver problems etc, group therapy, relapse prevention, 12-step programmes
Tier 4 Settings	Hospital inpatient units; residential rehab units, general medical wards, liver units, wet and dry housing/hostels, gastroenterology, hepatology clinics

The 12 Step Programme

A **Twelve-Step Programme** is a set of guiding principles outlining a course of action for recovery from addiction, compulsion, or other behavioral problems. Originally proposed by Alcoholics Anonymous (AA) as a method of recovery from alcoholism, the Twelve Steps were first published in the book, *Alcoholics Anonymous: The Story of How More Than One Hundred Men Have Recovered From Alcoholism* in 1939⁸. The method was then adapted and became the foundation of other twelve-step programmes. As summarized by the American Psychological Association, the process involves the following:

- admitting that one cannot control one's addiction or compulsion;
- recognizing a higher power that can give strength;
- examining past errors with the help of a sponsor (experienced member);
- making amends for these errors;
- learning to live a new life with a new code of behavior;
- helping others who suffer from the same addictions or compulsions.

Seven High Impact Changes

The Department of Health has identified a number of High Impact Changes which are calculated to be the most effective actions for those local areas that have prioritised the reduction in alcohol-related harm. High Impact Changes have been extensively used across the NHS and local government to highlight practical measures that can be implemented at local level.

1. Work in partnership
2. Develop activities to control the impact of alcohol misuse in the community
3. Influence change through advocacy
4. Improve the effectiveness and capacity of specialist treatment
5. Appoint an Alcohol Health Worker
6. IBA - Provide more help to encourage people to drink less
7. Amplify national social marketing priorities

Further information on the High Impact Changes can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_102813

SMART Recovery:

SMART Recovery® (Self Management And Recovery Training) helps individuals gain independence from addiction (substances or activities). Our efforts are based on scientific knowledge and evolve as evidence-based practices of addiction recovery evolve.

The program offers tools and techniques for each program point:

- Point 1: Enhancing and Maintaining Motivation to Abstain
- Point 2: Coping with Urges
- Point 3: Managing Thoughts, Feelings and Behaviour (Problem-Solving)
- Point 4: Balancing Momentary and Enduring Satisfactions (Lifestyle Balance)

⁸ "The Twelve Traditions". *The A.A. Grapevine* (Alcoholics Anonymous) 6 (6). November 1949.

11 Appendix 3 - Scoring system to determine year 2 projects.

Balanced Scorecard

Variable	Score			
	0 - negative impact	5 - neutral	10 - some additional performance	15 - high performing
1. Alcohol related hospital admission	Higher level of hospital admission	Equivalent level of hospital admission	Slightly lower level of hospital admission	Significant client change/impact
2. Outcomes	Poorer client outcomes than mainstream	Equivalent level of impact to mainstream	Some additionality	Significant client change/impact
3. Financial envelope	Exceeded original budget	Stayed within budget	Some additional funding leveraged	Significant additional funding leveraged
4. Sustainability	Unlikely to be commissioned	No more likely to be commissioned than mainstream	Somewhat more likely to be commissioned	Significant chance of being commissioned
5. Diffusion	Not likely to be replicated	Somewhat likely to be replicated	Likely to be piloted elsewhere	Likely to inform mainstream delivery
6. Performance	Under performed against target(s)	Met target(s)	Slightly exceeded target(s)	Significant higher performance

Scoring

Project	1. Alc hosp admissions	2. Outcomes	3. Financial	4. Sustainability	5. Diffusion	6. Performance	Total
Alcohol Speakeasy		5	10	5	10	5	5 40
Frequent Flyer Support		15	15	15	15	15	10 85
Hostel Clinical Nurse Project		10	10	5	10	10	10 55
IBA Hosp Healthcare Workers		10	10	5	5	10	10 50
New Year New You		5	5	5	10	5	0 30
Nutrition in Recovery		5	10	5	10	5	5 40
Pharmacy BI		5	15	15	15	15	5 70
Rethink Your Drinking		5	10	5	10	5	5 40
SAR		5	10	5	5	5	5 35
Self-help groups		5	15	5	10	10	10 55