

Preventing Repeat Alcohol Admissions

a. Strap line

Preventing repeat alcohol admissions using a trigger score to capture the point where protective lifestyle mechanisms reduce, and risks increase.

b. Summary

To identify a trigger point, based on Alcohol Attributable Fraction (AAF) score, to capture people at the point where their protective lifestyle mechanisms (e.g. job, marriage) reduce, and risks increase. Then manage these patients within an assertive outreach model using an holistic approach, larger than the current medical model, to manage lifestyle factors (e.g. housing) in partnership with other agencies to ensure acute care pathways integrate services beyond health.

c. What is the issue?

Salford is ranked 15th most deprived local authority area in England, and is one of the 10 local authorities with the highest levels of alcohol related harm and alcohol related admissions rate in England. In the Healthier Horizons Vision, lifestyle issues such as alcohol contribute to 21 of the 31 elements of the health profile of the North West, and also impact on worklessness levels, and hence the local economy. Salford is also one of the worst performing areas in the country for alcohol, with the 6th highest rate of alcohol-related hospital admissions. It is estimated that for every £1 spent reducing alcohol related harm, the local health economy has a £5 return. With links to many illnesses, diseases and social need, the impact on the health service and other public sector agencies is considerable. Not to mention the impact on quality of life. Other organisations may have similar issues; however the size and nature of the problem in Salford is more pervasive than other areas of the country. Reducing alcohol related harm and admission rates is a national priority area, and also part of the Staying Healthy Clinical Pathway set out in the Healthier Horizons Vision.

d. The Innovation Solution

To identify a trigger point, based on Alcohol Attributable Fraction (AAF) score, to capture people at the point where their protective lifestyle mechanisms (e.g. job, marriage) reduce, and risks increase. Then manage these patients within an assertive outreach model using an holistic approach, larger than the current medical model, to manage lifestyle factors (e.g. housing) in partnership with other agencies to ensure acute care pathways integrate services beyond health. No other model seeks to identify patients at this critical stage using an holistic approach to support people to manage their own lives effectively, and take responsibility for their own health and wellbeing, without using the health service as a crisis point. A database has been developed to monitor patients based on AAF score, bed days etc, and the top 20 patients profiled in detail. A review of community alcohol services has highlighted the gap in service provision for patients who are currently drinking but ready to stop, but for whom the wet houses are unsuitable. Early work has identified that the biggest return is gained from working with these complex patients, with the intention of supporting patients with necessary services prior to destabilisation of all key factors.

e. Partnerships and Delivery Team

This model is being developed with support from Salford Royal NHS Foundation Trust, Salford DAAT, NHS Salford, Mental Health, Housing and Probation Services, and community alcohol projects.

f. Key Benefits

Success will be measured by identifying the numbers of repeat attenders triggering the pathway. Currently this stands at 8-10 patients per month, but further analysis is required to determine a baseline figure. A database has already been developed to capture these patients, and the trigger will be incorporated into this. The database ranks patients by cumulative AAF score over a 6 month period, and compares this score with the previous 6 month period, thus highlighting any increase in activity. Other factors identified include number of bed days, Number of A&E attendances, and cumulative HRG tariff. Once the trigger is identified, the assertive outreach team will review and monitor the client, and identify their service need at that point, supporting them in accessing help and support as necessary. It is envisaged that this will prevent the client from 'rising through the ranks' and hopefully result in a reduction of their overall AAF score.

g. Funding/Return on Investment/Savings

The project received £25,000 to cover part of the costs of the co-ordinator post. Savings are expected to be achieved through deflection of A&E attendances and hospital admissions for this patient group.

h. Potential to Scale and Strategy for Sustainability

Once the trigger functionality and outreach model have been fully developed with the support of the co-ordinator, it is envisaged that this will be a self-supporting model, embedded in the practices of the multiagency team. Communication and information sharing will be paramount.

i. Name and Contact Details

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