Brief Evaluation of Frequent Flyers pilot project

Cost of the project: £15,000
Savings generated: estimated £36,000

The project aimed to engage dependant alcohol users, whose alcohol use impacted on their health so significantly that they were the most frequent people admitted to hospital for alcohol related issues. These individuals were identified by the Medical Assessment Unit in Queen Alexandra Hospital and referred to the community based specialist worker.
The Medical Assessment Unit is normally the first department that patients go to when hospitalised and often patients are discharged from there.

The project cost was £15,000; this was funded by the Government Office for the South East, through their alcohol innovation programme. The project ran from mid January to mid April 2010.
The top patients with the highest number of days spent in hospital were selected for the pilot.

The worker's aim was then to proactively contact the individuals and seek to engage them in a full assessment of their needs, linking with and co-ordinating the care and treatment from other specialist services. By offering dedicated care management of these individuals the specialist worker aimed to be able to reduce repeat admissions to hospital. Success of the pilot was measured by reduced hospital admissions. The role of the community based specialist worker was to bridge all the gaps people often fall through in service provision. Hand-holding, support and motivation, ensuring people get to their appointments.

Five individuals were identified as frequent attendees at the hospital and were referred to the community based specialist worker. One of the patients became street homeless and was uncontactable, therefore leaving the pilot. Admission rates for the fourth individual were unavailable.

	Patient 1	Patient 2	Patient 3
Admissions in 2009	56 (4.7 pm)	23 (1.9 pm)	33 (2.75 pm)
Admissions during pilot	0	3	1

We estimate that based on previous attendance rates in 2009 we would have expected the 3 patients to have had 28 admissions during the 3 month pilot. There were actually 4 admissions, 24 less than expected. An average A&E admission costs in the region of £1500, hence the project is likely to have generated considerable savings. This does not include additional savings the Ambulance Service would make in reduced calls.

The community based specialist worker worked intensively with each patient referred to the pilot. Each patient was contacted daily and usually visited at

home every other day. Having this time with each patient permitted the worker to achieve a more effective and co-ordinated approach to their treatment. A more holistic care model was used focusing on offering support in multiple areas. Notable achievements were in accessing support in the following areas: Health, Housing, Mental Health, accessing Welfare Benefits, Debt and other support services.

Whilst the patients were engaged in the project the admission rates reduced, however since the project ended there have been mixed results. Patient 1 has remained sober and has had no further admissions (by now we would have expected 28 admissions, costing up to £42,000?). The other patients have since relapsed and gone back into the cycle of regular admissions, although anecdotally admission stays are shorter than previously. There are no records of length of stays.

This shows that the pilot project was too short and should have run for a longer period. The PCT have since put long term funding in place to fund a Frequent Flyers post, however the post holder will not commence until 12th July. The funding is in place until 2015 if it continues to be successful. The worker will work with no more than 20 patients per year.

Patient 2 case study:
Patient 2 was already in hospital when he was referred and was part of the way through a detox program. When planning discharge the Community Based Specialist Worker liaised with hospital staff to request that he be prescribed the rest of the detox medication to ensure that he could complete his detox at home. Unfortunately, due to complications at discharge Patient 2 was not prescribed the detox medication and was sent home without it. Patient 2 contacted the Community Based Specialist Worker informing them of this, concerned that he would have to start drinking again. The Community Based Specialist Worker contacted his GP to arrange an emergency appointment and recommended that he be prescribed the medication. The GP did prescribe the recommended medication and Patient 2 was able to continue with the detox. Without this first intervention Patient 2 could have started drinking straight out of hospital.
The Alcohol Specialist Nurse Service would provide prescriptions on a daily basis.

Once the detox was finished an assessment and structured plan of care was completed. The care plan formed the basis of the resulting sessions. Actions and results are listed below:

- Visits with Patient 2 to Housing Options due to insufficient housing which, after an investigation due to the complex nature of his situation, resulted in him being added to the Council Housing list.
- More appropriate housing was gained.
- Visits with Patient 2 to Portsmouth Community Legal Advice Centre to support with getting help with debt issues.
- Visits with Patient 2 to GP to ensure health being monitored

- Visits with Patient 2 to structured alcohol support services to bridge the gap of him being willing to access support
- Support with completing Disability claim form which resulted in Patient 2 being awarded Disability benefit
- One to one relapse prevention work

When the pilot finished Patient 2 was regularly accessing structured day support and commented that he felt better and more positive about his future. Since then he has however relapsed and been readmitted to hospital. He is currently in a cycle of admission, detox, attendance at structured day programme and relapse. This patient will be a priority for the new Frequent Flyer worker when in post.

Why was Patient 1 more successful than Patient 2?

What happened to Patient 3?

Do the frequent flyers present the same problems eg housing, debt? Is one circumstance eg poor housing more prevalent than others?

Are there any similar pilots elsewhere in the UK and what were their results?