

Part of Alcohol Concern's Blue Light Project



Alcohol Concern
Promoting health; improving lives

An evaluation of The Nottinghamshire Alcohol Related Long Term Condition Team

An example of good practice with change
resistant drinkers

Mike Ward and Lauren Booker

positive
about integrated healthcare

Nottinghamshire Healthcare
NHS Foundation Trust



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He wrote the Department of Health/NTA guidelines on running drug death review systems and has recently written guidance on minimum standards for alcohol IBA.

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Lauren holds a BSc in Addictions from Leeds and wrote her dissertation on barriers to implementing brief advice for alcohol.

She has delivered over 250 IBA training courses throughout the UK to diverse audiences including hospital staff, probation and prison service, homeless charities and social workers.

Introduction

The Nottinghamshire Alcohol Related Long Term Condition Team

The Nottinghamshire Alcohol Related Long Term Condition Team (LTC) is part of Nottinghamshire Healthcare Trust's Specialist Services Directorate.

They assertively case manage service users who have an alcohol related long term physical health condition and are at high risk of readmission to hospital.

This group of service users place a significant burden on health services: **one patient alone has cost at least £137,000 in a 12 month period.**

The LTC team promotes better coordination of care leading to an appropriate use of services and is one of a small number of services nationally focusing on this client group.

Its work addresses key health and social care priorities. Its impact ranges from the NHS target to reduce liver disease, through the pressure on emergency departments (ED) to public concerns about street drinkers, domestic abuse and alcohol fuelled anti-social behaviour.

However, the team is also working with another dynamic: **people who are treatment or change resistant.** Public Health England has stated that 94% of dependent drinkers are not in treatment at any one time. This is a vast group of people: **over one million.** A small group of these clients place a huge burden on public services and these include the repeated offender, the person committing anti-social behaviour and the frequent hospital attender.



The LTC team is important not only as an example of how to work with repeat hospital users but also as a wider model of working with change resistant individuals.

Aims and objectives of this review

The aim of this project is to evaluate the work of the Nottinghamshire Alcohol Related Long Term Condition Team.

The objectives are to:

- + Describe the team's methodology
- + Capture their outputs
- + Evaluate their impact, and
- + Demonstrate the economic benefit of the team.

In addition the report aims to link with Alcohol Concern's Blue Light project and demonstrate the possibility and benefit of working with change resistant drinkers.

Context – the Blue Light project

In 2014 Alcohol Concern launched the Blue Light project, a national initiative to develop alternative approaches and care pathways for treatment resistant drinkers who place a burden on public services. This group has tended to receive a negative response with services suggesting that if the client is not motivated to change, then nothing can be done. The Blue Light project has challenged this approach by showing that there are positive strategies that can be used with this group.

It has provided:

- + Tools for understanding why clients may not engage
- + Risk assessment tools which are appropriate for drinkers
- + Harm reduction techniques workers can use
- + Advice on crucial nutritional approaches which can reduce alcohol related harm
- + Questions to help non-clinicians identify potential serious health problems and deliver enhanced personalised education
- + Management frameworks
- + Guidance on legal frameworks.

Above all it offers a fundamental positive message that change is possible. We may not always be able to 'treat' someone and make them change completely, but we can help them reduce the harm and manage the risk they pose to themselves and others.

This review is intended both to show the quality of the work offered by the LTC team but also to flag the team's work as a model of working with change resistant drinkers.



Methodology

This was a brief review. The key elements were:

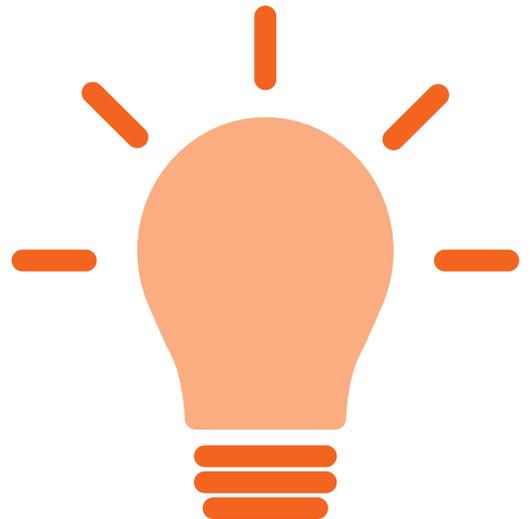
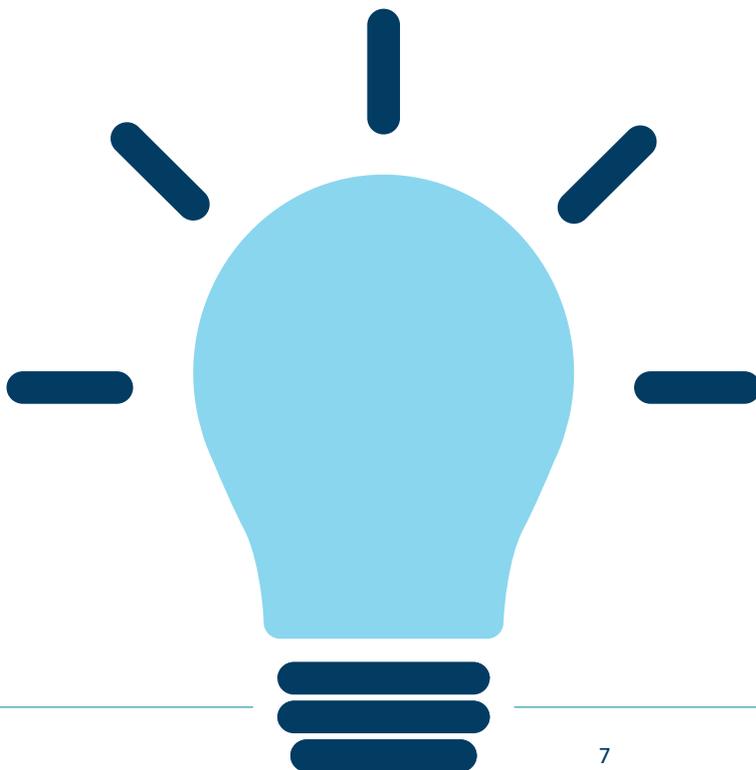
- + Interviews with the staff of the team and managers
- + Interviews with people who worked alongside the team in the local Blue Light meeting including East Midlands Ambulance Service, Nottinghamshire Fire Service, the Police, hepatology and primary care as well as its commissioners
- + Collecting case studies of service clients' journeys
- + Analysing existing output and outcome data on the service
- + Calculating the cost savings achieved.

Acknowledgements

The authors would like to thank all of the interviewees and others who shared their experience. In particular we would thank Mark Holmes the LTC team leader for his help with this project.

Dedication

This report is dedicated to the memory of team member **Lou Mousley** who died on 13th March 2015. Her nursing care was central to the LTC team's success.



How the Alcohol Related LTC Team operates

Overview

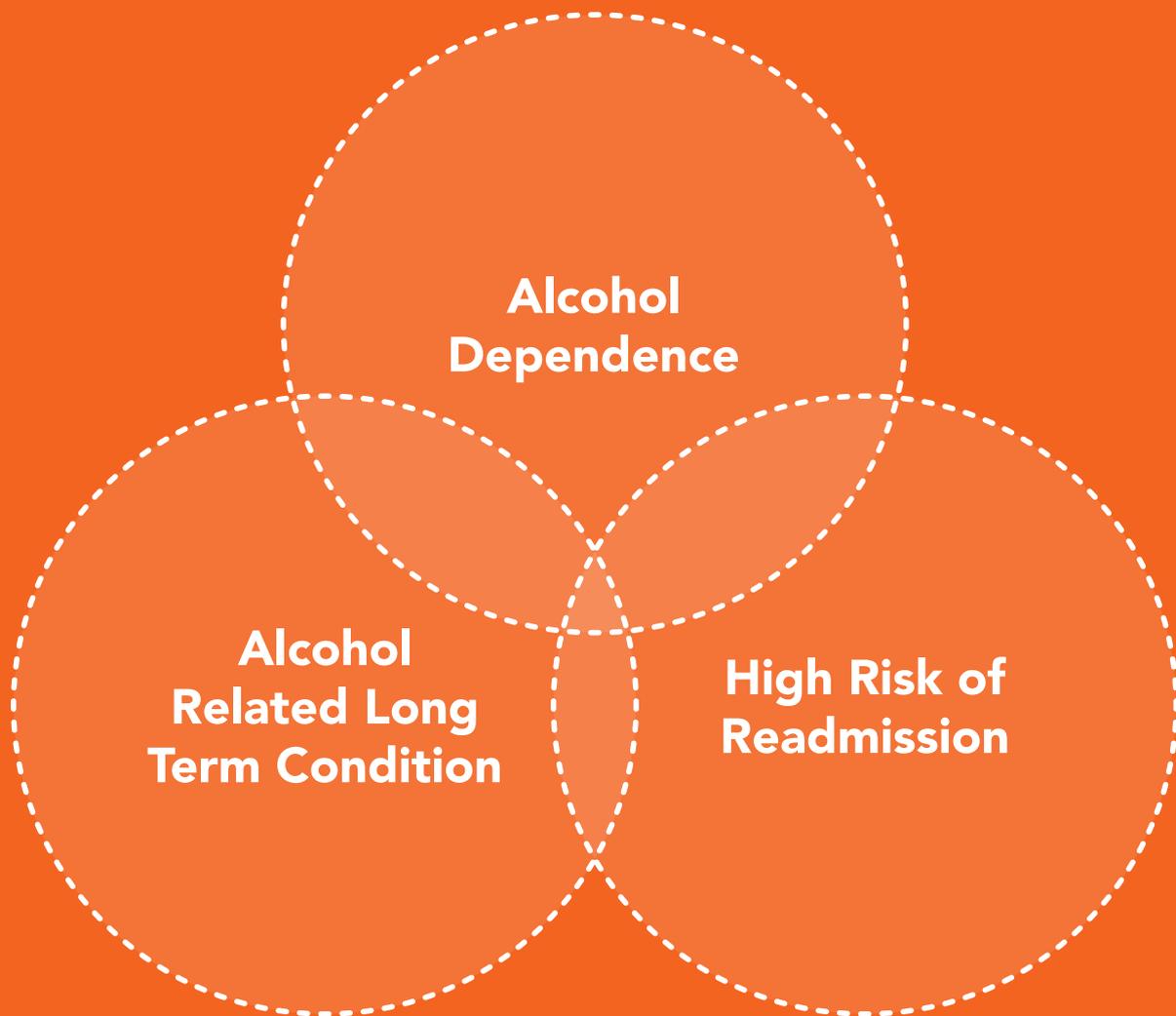
The LTC team works with people who are making excessive use of hospital services due to chronic ill health resulting from their long term use of alcohol. They assertively case manage people with a combination of alcohol dependence, an alcohol related long term physical health condition and a high risk of readmission to hospital.

The aim of the service is to promote better coordination of care leading to appropriate, and hopefully less costly, use of services.

The team is funded by QIPP* monies and started operation in July 2013. It consists of four nurses (mixed RGN and RMN) and an administrator. The administrator is also a recovery support worker and undertakes some client support.¹ They cover the south of the county of Nottinghamshire (but not the city) i.e. Gedling, Rushcliffe, Broxtowe and Newark & Sherwood.



Overview

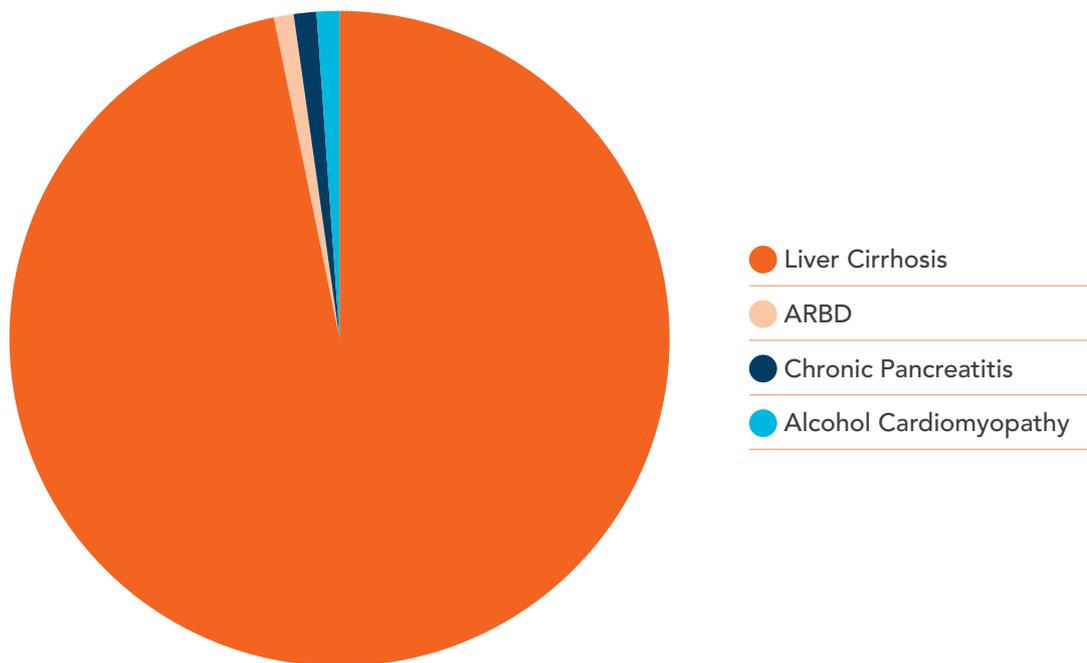


Describing the clients

Since its inception in July 2013 the team has received 84 referrals, of which 47 are still active. 11 of these were not appropriate for the LTC and 26 have been discharged (10 due to death, 6 with interventions completed).

The clients of this service are inevitably people with chronic physical health problems. This is clearly visible in the tables below setting out the diagnoses of the clients: **these are dominated by patients with liver disease.**

Primary diagnosis



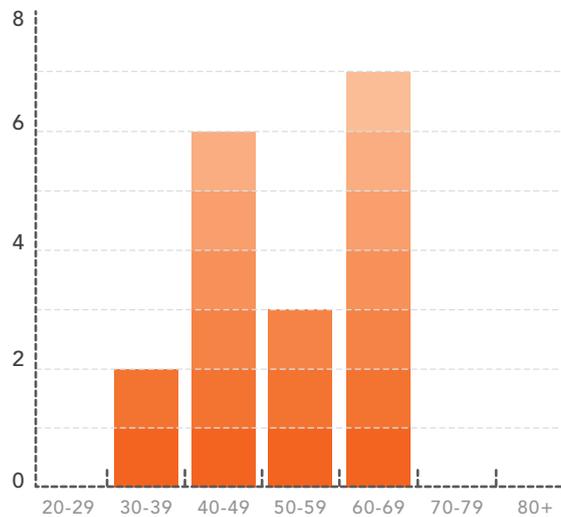
Secondary diagnosis

Epilepsy	2	Acute kidney damage	1
Depression	4	Angioplasty	1
Psoriasis	1	Recurrent variceal bleed	1
Diabetes	5	Chronic hepatitis C	2
Post transplant	1	MRSA	1
COPD	2	Hepatic carcinoma	1
Pulmonary infarction	1	Scoliosis	1

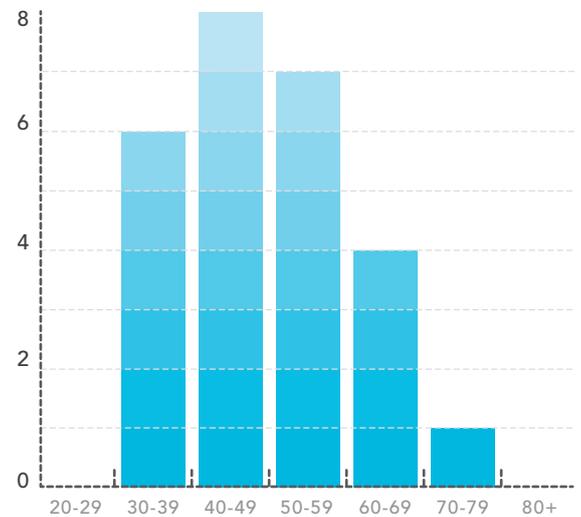
Since it began operation the team has worked with 42 patients who split 26 male to 18 female (57%:43%). Perhaps inevitably, given that the client group is determined by patient ill-health, only 8 clients were under 40 with none under 30. The age breakdown by gender is set out in the table following.

Age and gender breakdown

Females



Males



Interviewees were asked to describe the type of client they refer to the service. This included both health conditions but also risks, vulnerabilities, problems engaging with services, social care, criminal justice and housing problems. These pen portraits give an indication of the range of conditions worked with by the team.

- + Normally people who have alcohol dependency, complex needs and long term health conditions such as liver disease and alcohol related brain injury...some are people who are trying to continue to work, although barely managing by the time they reach us. A lot of people are homeless, using other substances, as well as having mental health concerns or diagnoses. They're often unable to care for themselves properly, unable to engage with services or with their GP. They can be people who are in difficult home circumstances e.g. experiencing domestic abuse or violence²
- + They all have long term alcohol related health problems, especially decompensated liver disease, cirrhosis, pancreatitis, diabetes or ascites. Many are end of life³
- + High volume callers to ambulance services with alcohol problems, usually chaotic, very difficult to manage, not engaging with any sort of services usually, other than the ambulance service and A&E; not even with a GP⁴
- + They can be stuck in environments where alcohol is freely available and encouraged⁵
- + They are isolated or are heavily dependent on one carer who often, with the best will in the world, is part of the problem in terms of enabling continuing consumption. Isolation to some degree. The more complex they become the more skilled they need to be at navigating healthcare and they don't have those skills, through early onset of dementia⁶
- + Most have considerable social challenges including accommodation, lack of social support and other problems with their health⁷
- + These are people who fall between the gaps. We only ever see them when there's a crisis, they don't attend regular appointments, they're difficult to engage with and care for so it's hard to avoid an emergency⁸
- + Regularly attending A&E or not attending outpatient appointments and deemed to have long term alcohol-related conditions: e.g. brain injury, hepatology problems. Sometimes they've got current substance misuse issues and are stuck in those behaviours and don't want to address these...Family problems, quite socially isolated, lots of social problems e.g. maintaining a tenancy, paying the bills and prioritising nutrition over alcohol intake.⁹

This is a classic Blue Light client group: **people who will find it hard to engage with structured interventions and can, therefore, be easily ignored and dismissed by services as unmotivated.**

Referral and assessment

The team receive a referral and aim to contact the person and make an assessment. Key to this phase of the work are:

- + A simple referral methodology: I literally just pick up the phone and discuss it and they would take that as a referral.¹⁰ The team have made their mobile phone numbers readily available¹¹
- + A range of referral methods from "Joe Bloggs on gastro ward B21 can you go in and see him" to a full in depth letter and hand over of care¹²
- + A weekly clinic on the liver ward where they pick up referrals.¹³

The aim is to make access to the service as simple as possible in order to increase the likelihood of engagement.

The elements of the assessment process include:

- + An initial triage of the referral information to ensure the referral is appropriate
- + Gathering information about physical and mental health including blood test results, as well as risk information
- + Making contact with the person by phone or letter to make an initial appointment or a visit in hospital if an inpatient at the time
- + Contact with services working with the person
- + A further comprehensive needs assessment covering physical, mental health and social needs &
- + Contact with, and review of the needs of, family members and other carers.

The LTC attempts to build its interventions on a comprehensive and holistic assessment reflecting the complexity of the client group. Only by understanding the full range of needs and risks can the team formulate an intervention appropriate to that individual.



Care planned interventions

Once the team starts working with the individual the staff will aim to:

- + Build a relationship
- + Stabilise and reduce harm
- + Develop care planned interventions, and
- + Engage in recovery where possible.

All of this operates within a framework of multi-agency working.

Each client will have an individualised care plan which reflects the complex range of services each person requires. The comments on the care planning process were very positive: **Care planning is really effective. I probably hear more about their plans than anyone else and I've not come across a case where I've thought "you don't know what the plan is here".**¹⁴

Other interviewees said:

They always know what the end goal is whether that is abstinence, harm minimisation, or just getting someone stable in their housing and reconnecting with social networks¹⁵

The patients always know what's going on as well¹⁶

The care plans are very in depth...very effective¹⁷

I wouldn't even challenge a care plan that they would do because it's probably higher than a substance misuse service would do¹⁸

They allow you to bring your own agenda and then collectively you come up with a plan. That's what is unique because we don't have that with many agencies¹⁹

It is impossible to say 'what the team do' as this will always be client specific. The LTC nurses provide a package of care and support which is driven by client need rather than a specific service structure or system.

However, the interviewees gave a picture of the range of working methods:

- + They pick up a referral and then they coordinate the care with other agencies and bring other services in. They go out to patients and really get to know them²⁰
- + You name it they do it. Arranging multi-disciplinary team meetings, helping people attend appointments, securing emergency housing, liaising with councils, general health checks and making sure they take their medication²¹
- + They advocate for the patients, attend appointments with them, see patients in their homes. They offer outstanding nursing care²²
- + Patients have a very good relationship with the team. The team anchor them through the different services they need to access²³
- + They take care of everything: getting them into alcohol services and managing them medically, getting medication sorted, getting people registered with a GP, looking into housing services²⁴
- + They have fairly regular contact with the clients from the medical side, they come with them to appointments to make sure they get there²⁵
- + Normally they work one to one, seeing people in their home, or some of the really complex ones they will meet with them wherever they want to meet²⁶
- + They manage all their physical health conditions, they refer people with debts or housing problems, they go the extra mile doing things that are helping the clients, arranging appointments and getting them to the appointments²⁷
- + They'll go out and see the patient and drill down as to what the issues are²⁸
- + They see them at home, taking them to the doctor to get ascites drains and having their gastro reviews, they give good clinical care and support them in reducing isolation²⁹
- + Both regular and ad hoc meetings about patients who need the service.³⁰

The LTC approach is built on flexibility and tailoring services to the patients' needs.³¹



Partners and partnership working

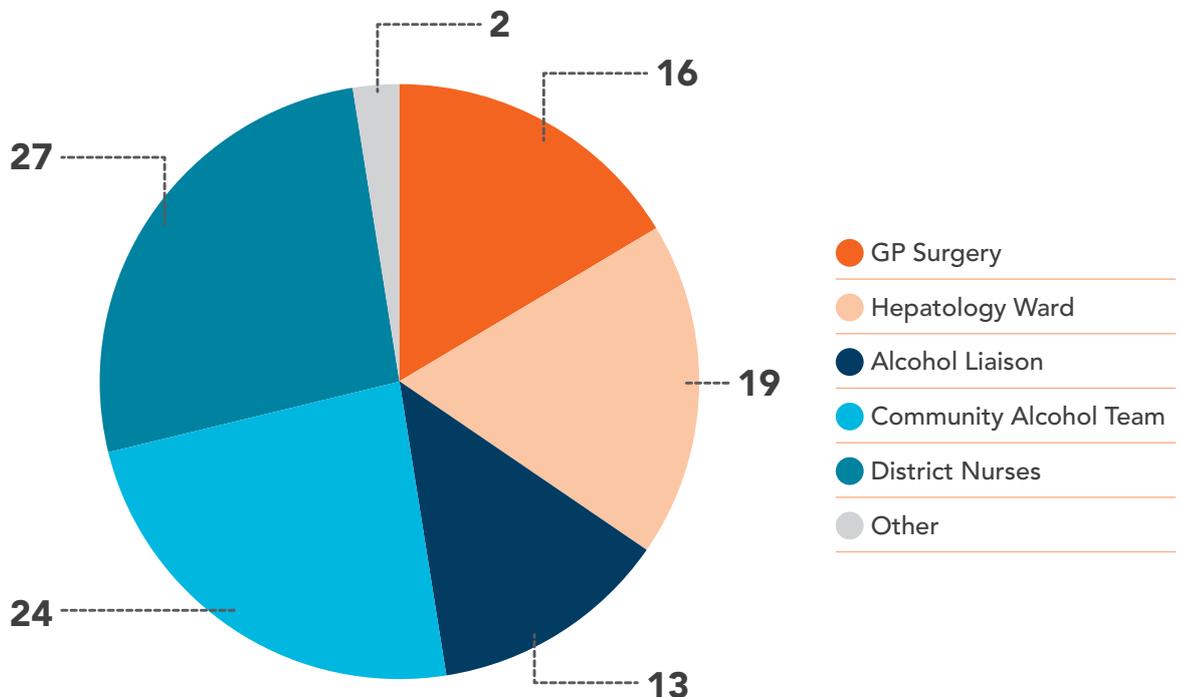
Due to the complexity of the service users the team's approach is built on partnership working. They see the key to their approach as embedding the LTC team within a wider integrated team across a range of community services.

The team is in close liaison with a range of services e.g. the ambulance service, ED, social care and the police. The team have embedded themselves within the district nursing teams, attending multi-disciplinary team meetings including GPs.

They have strong links with the Hepatology team allowing them to, for example, facilitate paracentesis as a day patient rather than a hospital admission (avoiding an ambulance call out and ED visit). The team has established a weekly Hepatology ward round to discuss discharge planning with consultants, wards sisters and alcohol liaison.

The impact of this integrated working is demonstrated by the distribution of referral sources in the table below.

Referrals source



The mainstay of this multi-agency approach has been the establishment of the Blue Light Meeting to discuss high risk clients with alcohol problems.

This meeting is held twice monthly and has been a major help in establishing links between agencies. It is chaired by the LTC team and attended by the East Midlands Ambulance Service (EMAS), Emergency Department's High Volume Service User lead, Hospital Liaison, Fire Service and Police. The process is enhanced by frequent updates outside of meetings.

In the interviews a range of professionals who linked with the team were asked: **Have you had any problems linking with the team?** The answers were uniformly positive about working with the LTC staff.^{32 33 34 35 36 37 38 39}

Beyond these structures which facilitate joint working, the daily coordination of care is central to the team's approach. One of the team's workers commented: **We fight for it. We shout the loudest... We've taken on the role of coordinating. We contact the GPs and district nurses and hepatologists and we ask for things and we're quite passionate about it and we know that the patients we deal with have such complex needs that there will be more issues than one service can deal with. Whether it's housing to social workers, to consultants, to day case units, we make sure everyone's kept in the loop and information gets to wherever it's supposed to.**⁴⁰

Other interviewees described how multi-agency working is facilitated outside the Blue Light meeting itself:

- + They organise multi-agency meetings and getting everyone around the table for this and you're talking about 20 plus people involved in working with one person. They can then discuss what's being done by who and who's said what and how we can best address where we go from here⁴¹
- + They can target patients and integrate their care with allied services: liver, day case, psychiatry, it's not always a formalised MDT discussion but they help get the right people in the room⁴²
- + It's an enhanced level of care coordination. My background is adult mental health and they do much more of that clinical coordination that I'm used to seeing in adult mental health than I've seen in substance misuse.⁴³

Positive comments were also made about communication and information sharing with the team.^{44 45 46} We're all very aware of information sharing legislation and at the end of the day we need to work in patients' best interests. I've had no problems at all at the same time being very aware of the legal side of things.⁴⁷

Interviewees described a system of multi-agency working that was flexible and easy to engage with from the professional standpoint:



If something were to come on to the radar, I would just pick up the phone and have a chat with the team to get advice or see if it is somebody they would be able to work with.⁴⁸



We have regular meetings and if something comes up out of that period we've got a good relationship with them so we can just phone them up and get a response straight away. It's a partnership link that I use on a quite frequent basis.⁴⁹

Palliative/end of life care

A specific element of their work is end of life/palliative care.⁵⁰ They've helped people plan for end of life and die with more dignity than if they'd not met the team.⁵¹

The approach was described thus: **they introduce these concepts to patients as they get near to the end of life. They help with making funeral plans and it's a bit of a reality check for patients. They're able to drip feed information to patients; it's not something that they overlook.**⁵²

One interviewee commented: **it's a much more dignified and wholly more appropriate conclusion for the patient than ending up on an acute ward without support.**⁵³ This view was supported by all the interviewees.^{54 55 56 57 58 59}

Embracing Technology

Flo

Flo is a simple telehealth text messaging service that gives patients personalised health tips, advice about staying on track with treatment and sends medication reminders. More information is available at <http://www.nottinghamnortheastccg.nhs.uk/nhs/florence-the-simple-tele-health-service/#sthash.hz7sUoG1.dpuf>

The LTC team has used Flo as a tool for ascites management. At a cost of £68.86 per patient per year, Flo has been used with 12 patients (20% of caseload) with the aim of:

- + Improving care plan compliance
- + Increasing monitoring information for keyworkers
- + Reducing admissions
- + Delivering effective management and titration in the community setting.

This innovative work has elicited interest from bodies such as Public Health England and Alcohol Concern.

Skype

In partnership with Mansfield CCG, dieticians and the Hepatology team at NUH, the team is examining the use of Skype to conduct outpatient appointments with service users. The aim will be to cut down transport times and reduce the DNA rate.

Case studies of the team in action

The following sections provide six case studies of team clients. These show both:

- + The work undertaken and
- + The complexity of the work.

The potential impact and cost savings are discussed in section 4.

Case study one

A 53 year old man was referred to the LTC Team by his GP. Concerns were being raised by a change and escalation in his behaviour in conjunction with high levels of alcohol consumption.

He had previously been identified as a high volume service user in 2012 and following intensive case management work had become settled in a supported accommodation. The patient was known to have COPD and poor mobility resulting in him using a scooter or wheelchair. He had been brought back by the police on numerous occasions for being intoxicated and unsafe on his scooter. There were also reports that he was aggressive towards staff and other residents. He was also well known to the fire service with high levels of intervention in place to help reduce the risk of fire.

From June 2014 the situation further escalated with numerous calls to the ambulance service and an increasing number of admissions to hospital for confusion, 'acopia' and chest pain. He was increasingly aggressive and in trouble with the police due to shoplifting. He now showed no concern or recognition that his tenancy might be in danger due to his behaviour or that of his friends.

The team visited him at his property and raised concerns with social care regarding his physical appearance. He had:

- + A very unkempt appearance: wearing a hospital gown and cardigan with large holes
- + Set fires, including accidentally setting fire to himself with a cigarette and using vodka to extinguish it
- + No carers supporting him with daily living
- + No means of storing food safely in his flat as he had no fridge
- + No cooker or other means of cooking food due to the high risk of fire
- + Paper all over the living room floor while dropping lit cigarette ends
- + A disposable barbeque to cook with in his living room which on one occasion had filled the house with smoke leading a neighbour to call the fire service.

An urgent MDT was called to discuss ways to reduce the risk of harm to the patient involving:

- + Two hospitals and their Emergency Departments
- + Council and housing association and other housing providers
- + Police, Ambulance and Fire Service
- + GP and community nurses
- + Nurse for alcohol related long term conditions
- + Community mental health services.

A care plan was developed for when he was next admitted to hospital. This covered:

- + Liaison with the mental health and working age dementia teams regarding possible alcohol related brain damage and capacity
- + The very high risk of the patient smoking whilst in the hospital building.

Mental health services were unable to assess due to the high levels of alcohol consumption. Due to the high risk of harm to himself and others the LTC team referred him on two occasions for an assessment under the Mental Health Act; although the risk was high it was not felt that the patient was sectionable.

Following a fall the patient was admitted to hospital with a fractured hip. He underwent surgery, was fully detoxed and referred to social care. The LTC team liaised closely with social care to look at appropriate supported accommodation with the 24 hour a day care and support required.

The LTC nurses and the Blue Light working group developed a coordinated approach and between the end of August and December 2014 he was not in hospital, had only five ambulance call outs and just four clinically appropriate ED attendances.

Case study two

A very different approach was with a 64 year old man who, when intoxicated, was a serial nuisance caller to EMAS making 1,166 999 calls to EMAS between Jan – Sept 2014 (550 in August 2014).

An ambulance attended 40 of these calls, he was taken to ED 6 times. A multi-agency meeting was held and a care plan established. The end result of the partnership working led by EMAS was prosecution under the Telecommunications Act with the support of the Blue Light meeting.



Case study three

A 65 year old man with liver cirrhosis. He was a miner with a history of heavy episodic drinking.

In Jan 2014 he was admitted to hospital with sepsis, encephalopathy, varices banding and ascites. He was placed on the 'End of Life care' pathway by another hospital and had been told "this is going to be your life" with no option for transplant.

He was engaged by the LTC team for symptomatic management of end stage liver disease. Alcohol relapse prevention advice was given and he was taken to hospital appointments for regular ascites drains. The LTC team decided that his care would be better managed by the sister hospital as they had the ability to drain ascites faster, without inpatient stays.

On assessment by that team the revised clinical assessment was he was now suitable for transplantation (abstinent and physically well). He was placed on the transplant list and had a first transplant but unfortunately due to complications had to have a second transplant. The patient is still abstinent and is recovering well.



Case study four

A 65 year old woman initially reported a 5 year history of problematic alcohol use; however reports of her drinking history varied.



Since her retirement she claimed that her alcohol use had increased to around 20 units of whisky a day. She had severe withdrawals from alcohol, cancer of the breast, a fracture to the left elbow requiring surgery and dementia or memory problems. A referral was made by the alcohol team due to concerns regarding her poor memory, increased hospital admissions and poor self-care.

At assessment it became clear that she had difficulty remembering recent events and often confabulated during conversations. She had very little food in her house, was seen wearing the same clothing over a number of weeks and the team suspected that she rarely washed herself. On one occasion she contacted the service because she could not get into her house; however, she had gone to a house she had lived in 15 years previously. She was found and taken home by police and the LTC team. These concerns led the LTC team to make a safeguarding adults referral and referral to the community nursing team for support in wound care management.

On one occasion she was found to have stopped drinking suddenly and had experienced alcohol

withdrawals. Faeces were found in the house. She also had a swollen foot and had no food in the house. To avoid admission on this occasion and ensure she was assessed properly the LTC team supported her in attending the GP surgery, collected some frozen ready meals that she could cook and cleaned up the areas where she had been incontinent.

On another occasion the LTC team helped social services to manage her alcohol withdrawals safely. This helped to resolve the situation and avoided both an ambulance callout and an admission.

A multi-agency meeting was organised which was attended by social care, GP, district nursing, the LTC team and the client's daughters. Other services involved in the patient's care included the police, alcohol services and the Citizen's Advice Bureau. By making appropriate referrals to social care and the district nursing team the LTC team have supported this client in managing her health in the community. Following the multi-agency meeting a comprehensive care package was put in place to support the client and it has now been a year since her last presentation at hospital.

Case study five

The team picked up a patient with liver disease who was living with his partner.



He was living on the sofa because his mobility had gone and he wasn't eating. The team secured him an inpatient detox; however, his health deteriorated rapidly when he went home. The team arranged an ascites drain on a day unit, but then his partner refused to have him home and the team had to sort out housing with the council. They put him in a hostel but his health kept deteriorating and he was in and out of hospital.

The team built contacts with housing to arrange accommodation when he was discharged homeless. The worker could call them up and say, "He's coming out tomorrow, what are we going to do?" The team described a lot of running around and sorting things out and cleaning rooms out and helping him out but eventually he was found a long-term resettlement programme. His health remains poor, but: "he is now doing better than before. He can sort his money out and knows where to go shopping".⁶⁰

Case study six

A man in his mid 30's, who was well known to the system.

He came into hospital after a fall and the concern was that he was suffering from Wernicke's at a very young age and that he would be in a unit for a long time.

There was a possibility to refer him to a rehab unit that were willing to keep him for up to a year and do intensive rehabilitation work with him but a bed was not available for 5 days. Pressure was being exerted to discharge him from hospital before that time: it was the middle of the winter bed rush.

A member of the LTC team went up to the ward every day to argue that if he was discharged to live on the street, he would come back in eventually.

The consultant kept the patient on the ward and he secured his rehab place.

He is still abstinent and this is the longest period of abstinence he has had. He has massive recovery potential and is a very intelligent man.⁶¹



Impact and outcomes

The case studies have demonstrated the positive impact of the LTC. This section attempts to quantify that impact in terms of cost savings and other markers.

Cost savings

The cases above individually demonstrate the remarkable impact of the team. The cost savings are as remarkable. Case study 1 was calculated as having cost public services £137,000 in just one year. Their work resulted in an annualised cost saving of £105,000. Case study 2 cost the NHS £15,436 in nine months and again joint working led to clear cost savings.

A wider dataset demonstrates clear reductions in service use post LTC team intervention. The summary below is based on pre and post-intervention costs of cases currently on the team's caseload in three separate areas.

Savings are based on the following costings:

Ambulance call out	£215
Emergency department attendance	£78
Unplanned admission	£2,344
Bed day	£250 per day

These costs do not include notional savings based on e.g. reduced crisis management, or reduced use of medication. Nor do they include costs to a wider set of stakeholders such as the police. In many cases these savings will be considerable.



Rushcliffe Summary Savings	EMAS calls	ED presentation	Unplanned Admissions	Bed days known
Pre intervention	20	24	25	228
Post intervention	5	4	2	10
Difference	-15	-20	-23	-218
Reduction Impact	-75%	-83%	-92%	-96%
Cost Estimation (£'s)	-3,225	-1,560	-53,912	-54,500
Total Savings (£'s)				-113,197

N. West Summary Savings	EMAS calls	ED presentation	Unplanned Admissions	Bed days known
Pre intervention	84	41	19	201
Post intervention	11	5	1	3
Difference	-73	-36	-18	-198
Reduction Impact	-87%	-88%	-95%	-99%
Cost Estimation (£'s)	-15,695	-2,808	-42,192	-49,500
Total Savings (£'s)				-110,195

NN & East Summary Savings	EMAS calls	ED presentation	Unplanned Admissions	Bed days known
Pre intervention	32	72	46	308
Post intervention	20	27	12	62
Difference	-12	-45	-34	-246
Reduction Impact	-38%	-63%	-74%	-80%
Cost Estimation (£'s)	-2,580	-3,510	-79,696	-61,500
Total Savings (£'s)				-147,286

In just one year the team has saved £360,000 in healthcare costs alone. This far exceeds the cost of providing the service.

Non-costed benefits

The benefits of the improved personal experience of patients, and in particular the reduced burden on informal carers cannot be quantified but should not be overlooked. Three carers commented on their experience of the team:

Carer A

It's great that mum has people working with her who really care about her wellbeing and have been able to drive some change so that she can have support in living safely at home.

Carer B

Previously I have felt alone in managing the care of my father in relation to getting him to see doctors at the hospital, GPs, obtaining blood tests and fortisips. Since the LTC service has come along I no longer feel alone in coping with all these things and a lot of the pressure has been taken off me.

Carer C

Without the support from LTC she would not be where she is now and that is abstinent from alcohol...

The researchers sought the views of stakeholders on the impact of the team; these were very positive.

- + You see a lot of improvement in the way that the patients engage with services. They've made my workload easier to bear⁶²
- + There have been a good number of successes. A lot of work is palliative care and we've had patients die but they've died a lot better than they would have. Others are now abstinent and they keep people under check. There's been a noticeable decrease in A&E admissions for these patients⁶³
- + One of our most chaotic clients is now stable and abstinent⁶⁴
- + Sometimes, even if they've not been able to engage with them, they're able to move it on and maybe go down the enforcement route and solve it that way, with a prosecution⁶⁵
- + Some of our patients have bounced a lot between alcohol services but they seem to engage and stick with the nurses. They continue to let the nurses in, perhaps because it's about their care not about getting them off the alcohol⁶⁶
- + Definitely patients have improved outcomes. It's clear they've been supported through that process⁶⁷
- + They ensure patents coming to clinic actually arrive. This has reduced my DNA rate. They are also bringing people in through the most appropriate and efficient manner, rather than people coming into ED at a point of crisis.⁶⁸

Other indicators of success

The team's work has been subject to a national focus. The team leader has co-authored national guidelines on this area, **Working with change resistant drinkers** for Alcohol Concern and has had another publication: **Technology-enabled care services: a novel method of managing liver disease** published in *Gastrointestinal Nursing* relating to the use of FLO (telehealth) to support ascites management.

The service has been presented at five national conferences including as a Public Health England example of good practice and on the main stages at the British Association of Liver Disease and the National End of Life Care in Liver Disease.

The service has links with the University of Nottingham and is now a confirmed venue for a student nursing 'spoke' placement. Two students start in March 2015.

The LTC team has also conducted training/teaching sessions to 70 delegates including mental health and community nurses and have supported Rushcliffe CCG health events including the **Health Hub** and **Rush for Health**.



What works with Blue Light clients

The previous sections have demonstrated the impact of the team and its approach. However, in the national context, it is important to understand what makes the team effective, so that the approach can be built on and developed in other areas.

The Blue Light project has highlighted a number of characteristics of working with this client group. The six key features are an approach which is:

- + Assertive
- + Focused on building a relationship
- + Flexible
- + Holistic
- + Persistent
- + Consistent.

These were reflected in comments on the LTC team by its staff and partners.

Enhancing service take up

Assertive

It's the assertive approach above all, that is the thing. They will actually go out and hunt down the patient and won't sit back and wait for the patient to attend an appointment but will facilitate that happening and be flexible about that.⁶⁹

Build a relationship

The team is very good at establishing trust with a group that is difficult to engage in both professional and personal interactions.⁷⁰ We are all really good at engagement and by the time we've finished the assessment most patients want to work with us.⁷¹

Flexible

Because of the nature of these patients and the chaos that surrounds them, you have to be flexible and not work the way you've been working for the last 10 years. It's a different approach and a flexible approach, a pro-active approach.⁷²

Flexible contd.

Clients realise that they don't have to travel five miles across town to access the service, because we come to them and see them in their homes.⁷³

Holistic

Working with the patients holistically rather than just focusing on the alcohol.⁷⁴

Persistent

I think the fact that they don't give up. I've been there many times when they've said so and so has discharged the patient and so and so has discharged the patient and they're the only ones still there, still going, championing the underdog.⁷⁵ They go the extra mile.⁷⁶

Consistent

The principles of what they are trying to achieve are consistency and non-judgmental care.⁷⁷

A particular message of the Blue Light project has been that this is a **skilled task**.

Staff need a solid foundation of knowledge about alcohol and its effects and skills in engaging both clients and other potential sources of help. The interviewees commented:

- + They know the physical interaction with alcohol inside out. They are essentially your old style community alcohol matrons, with that level of knowledge about alcohol. They've all got experience of working in the system for a number of years⁷⁸
- + They have exceptionally skilled nurses/healthcare professionals⁷⁹
- + Because they've got NHS badges they don't face as many barriers as some, they've been able to get onto ward rounds, link in to GPs, link with substance misuse, people listen a bit more than they do with a typical drug and alcohol worker.⁸⁰

The team and their colleagues identified other features which have characterised their work and helped tackle this client group.

Passion: We all love what we do and the team leader is very inspirational and enthusiastic and passionate and we all come from the same mould. The passion that we have to be advocates for the people we work with has helped us become a strong team in a short time.⁸¹

A port of call for the patients: The patients have a mobile number they can call. It's someone they can easily contact if they have a problem.⁸²

Being open: They are open to suggestions. They also listen to what each agency needs and then really try to help.⁸³

Multi-agency: Their meetings have the police, ambulance, nurses. I often take the minutes in these meetings so I know that if they've got serious problems they'll arrange multidisciplinary meetings with social workers, GPs and nurses on the ward.⁸⁴

Overcoming barriers: We try to break down the barriers for the patients. They have probably been in treatment services for a long time so we try and look at a different way of working with them: that's what makes it a good team.⁸⁵

Team approach: Although they have their own caseloads they work as a team and they will know what is happening with each other's cases so they can be supported if one is away.⁸⁶

A final point was made about the importance of **technology** in both improving client care but also increasing staff support: **Now that we have laptops and System 1 and BlackBerrys, we've got instant access to any emails we need to read. We can instantly keep in touch with each other and that stops you feeling isolated.**⁸⁷

References

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2. Interviewee 11
3. Interviewee 6
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87. Interviewee 1



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