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**‘Working with ‘Frequent Flyers[[1]](#footnote-1)’**

**Summary report of a workshop held in the North of England**

**Prepared for Alcohol Research UK**

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**Introduction**

Practitioners use various terms to describe those clients who are repeatedly admitted to hospital or attending Accident and Emergency Departments for treatment for alcohol-related conditions e.g. high volume service users, high impact service users, frequent attendees etc. For ease of reference and recall we have adopted ‘Frequent Flyers’ as a working term to identify this client group, although we are aware of pejorative connotations implied by the label. Nationally, 13-20% of all hospital admissions are alcohol-related and this accounts for 35% among A &E attendances (NHS Evidence, 2012). They are known to have some of the highest rates of alcohol-related hospital admissions, thereby placing a considerable burden on NHS resources as well as indicating very poor health outcomes for this client group. Reducing such admissions has become an NHS priority.

Whilst there is a clear need to provide care for this increasingly large group of clients, to-date there has been little evidence of any national quality standards and a lack of policy co-ordination; this has resulted in patchy and poorly targeted ineffective spending on care (Moriarty, 2010). Frequent flyers form a client group of growing concern, but about whom little systematic data has been collected and shared and few services are currently in place to address their needs; yet they are familiar to a wide range of professionals in the health and other sectors.

In the last couple of years a number of innovative approaches have emerged out of the day-to-day practices of healthcare staff (CPI, 2011). Several of these have successfully demonstrated reductions in alcohol related hospital admissions e.g. Portsmouth and Hastings projects (Herring et al, 2011). Some approaches have been identified as having a specific focus on this client group, while other areas of practice are more generic where practitioners are responding to client needs within a more holistic framework, for example, Brighton hostel project (CPI, 2011).

Responding to the need for evidence based policy and practice within this emerging field, an NHS Evidence based QIPP resource recommended that multidisciplinary Alcohol Care Teams (ACT) should be established across primary and secondary care to provide integrated treatment and care pathways for ‘frequent attenders’ (Moriarty, 2010, NHS Evidence, 2011). Establishing multi-agency Assertive Outreach Alcohol Services (AOAS) in order to direct the most frequent attenders into more appropriate and supported community services was a further recommendation (NHS Evidence, 2011). Following this, a number of ACT programmes and AOAS services designed to address local needs have developed across the country e.g. Bolton, Bradford, Newcastle, Salford (see ‘Local Initiatives on www.alcohollearningcentre.org.uk).

Evidence is therefore beginning to accumulate regarding a number of different models of response at the local level, however there is a lack of co-ordination and support in helping practitioners to respond to the needs of this group. There is also evidence of widespread interest in sharing knowledge and developing interventions among this client group. Against this backdrop, the Drug and Alcohol Research Centre at Middlesex University in collaboration with the Centre for Public Innovation and Improving Health & Wellbeing UK delivered a workshop in March 2012 whose overall aim was to explore working with frequent flyers. The event was very well-attended by a diverse range of delegates, among them - practitioners, commissioners, policy representative and ex service users. A brief summary report of the event is available on the Alcohol Research UK website (http://alcoholresearchuk.org/)

Delegates attending the event evaluated it highly for its usefulness for their job role, for its effectiveness and for facilitating shared learning with colleagues. The workshop appeared to have considerable potential as a medium for disseminating knowledge and practice in this emerging field. Those participants attending from areas outside the South East, where the workshop was held, indicated the value of hosting another event in the North of England and this, coupled with a lengthy waiting list of delegates unable to attend the first workshop, prompted the planning of a second event to be held in the North of England. Alcohol Research UK generously provided funding for the North workshop.

**Aims**

The overall aim of the event was to provide a forum for exploring, sharing and disseminating knowledge and learning about frequent flyers to enable practitioners to develop effective interventions. The second workshop was held more than six months after the first event; during this time many new initiatives responding to Frequent Flyers emerged or those more established had been further consolidated or adapted. This time lag provided an opportunity for new knowledge and learning to develop and a further aim of the North event was to integrate new learning into findings from the previous workshop.

More specifically the objectives focused on a number of key areas, some of which had been addressed in the previous workshop. These concerned the following:

* assessing the terminology and criteria used to define the client group;
* exploring communication of issues and needs of frequent flyers;
* examining current approaches/models used in working with this group and their effectiveness;
* investigating workforce issues;
* identifying examples of good practice;
* considering policy implications.

**The workshop**

The event took place in Manchester on 26th October 2012 and was hosted by the Centre for Public Innovation in collaboration with the Drug and Alcohol Research Centre at Middlesex University. As with the previous workshop there was a high demand for places. Organisations where several possible delegates wanted to attend were asked to limit their requests for places. 58 participants took part in the event and again delegates covered a broad spectrum of professions including: alcohol commissioners, alcohol workers - generic and specialist, A&E staff, including consultants, academics and policy makers etc.

**Evaluation**

Delegates attending the workshop were invited to respond to an evaluation questionnaire via an online survey. Their responses across a number of dimensions were sought, including participants’ personal development, usefulness of event and whether learning outcomes were met. (Click [here](http://www.surveymonkey.com/s/frequentflyerworkshopevaluation) for survey.) Compared with the response rate to the first London workshop, which was exceptionally high (64% completed the questionnaire); response rates were lower but still at a favourable level for the North workshop (40% returned the evaluation questionnaire).

While findings from the North evaluation survey mirror those from the London event evaluation, there are some differences. Response is on the whole very favourable, though less intensely so than among Southern participants. This could be a result of the time lag between the two events and that over this time, processes and practices may be better established in some areas and needs better understood. For example in Bolton and Salford, responses are comparatively well developed and this may give rise to the need for coverage of a broader range of issues or more extensive and in-depth discussion than is often possible in any workshop.

Despite this proviso, the North workshop was felt to be useful – 77% highly rated the value of the workshop to their job role and 87% rated it as an effective event. As with the previous workshop, it was very well regarded; with most attendees (85%) suggesting it would have an impact on their working practice. Most (69%) came away with improved understanding of the issues needing to be addressed when delivering services to this client group. Approximately two thirds (65%) welcomed the chance to share learning with colleagues and delegates were particularly keen to hear about the working practices and perspectives from practitioners with more established interventions in place. Most (87%) valued the opportunity for networking and for general discussions with colleagues (73%). These findings confirm the potential of this type of participatory medium for disseminating issues around knowledge and practice in this emerging field.

**Emergent themes**

Findings from both workshops indicate that work with regard to the client group referred to as ‘frequent flyers’ is emerging as a field of great interest and area of practice. Much work still remains to be done though, in terms of clarifying and framing the concepts being used and in developing and delivering services to this client group.

Both workshops were designed to address certain specific topics as outlined above and to follow up others highlighted in the first event, for example, outcomes and challenges. In both workshops, some themes were discussed directly in group work sessions while others emerged or developed in response to topics framed in question and answer sessions with practitioners. The following key themes that need to be explored and better understood emerged from the workshops:

**Defining and identifying the client group**

As already mentioned and observed in both workshops, many terms are in current use to describe what appears to be the same target group of frequent flyers. Examples of names include: High volume service users, ‘our friends’, high impact service users, ‘heart sink patients’. The various names often reveal both underlying value judgements about working with these clients, and attempts to incorporate the idea of intensive use of resources within the term. On the whole, most terms other than ‘high volume service users’ and ‘high attenders’ are felt to be somewhat pejorative.

Delegates volunteered a wide variety of definitions and approaches to defining frequent flyers. Questions of how we should refer to this group are closely linked to defining the parameters that allow individuals to fit within the frequent flyer category. Attempts at creating a common reference for this client group often depend on parameters shaped by local demands on services and conditions. There are quantitative dimensions to consider, such as how many attendances or admissions should be included over a specified time period. More qualitative considerations involve taking into account client characteristics and behaviours other than alcohol use, such as palliative care, complex needs etc. How the client group should be defined also hinges closely on process elements, such as effective information sharing among partners so that clients can be easily identified. Finally, delegates advocate a number of strategies to address some of the challenges affecting the development of effective working definitions and to help reach common understandings of the behaviours and needs of this client group.

*Quantitative measures*

In line with findings from our previous workshop, there are multiple measures and criteria in use to refer to clients. Some of the more quantitative parameters focus simply on frequency and intensity of service use in terms of admissions or attendance e.g. four admissions a month; five admissions over six months, three admissions per year etc. In one area, the top 30 attenders with alcohol related attendances to the Emergency Department are identified for the preceding six months. Monthly updates are provided and there is a separate option at weekly meetings to flag up cases for concern ensuring that new sudden attendance spikes in the data are picked up.

Other more quantitative inclusion and exclusion criteria may be influenced by workload and economic considerations and constraints among other factors; for example, one area takes the 95 top attendees with the greatest cost to services. Some delegates raised the question of whether ambulance call-outs should be factored in to attendance data; others felt that the number of bed days should be included. This highlights the broader concerns not just of which impacts should be incorporated within definitions but whether impacts on *all* services should be identified and included in definitions, and that perhaps definitions should not be limited just to alcohol related admissions.

*Qualitative considerations*

It should be apparent that a single readily available definition of frequent flyers is unlikely to be forthcoming, given that definitions are complicated by the different ways of working with this group at local level. More qualitative aspects mentioned in both workshops include responding to the varying needs of different clients, for example some clients may have chronic conditions; others may be at crisis point. It was felt important to take into account the presence of conditions other than problematic alcohol use e.g. dual diagnosis, long-term health conditions,drug misuse etc. Several delegates working in A & E noted the difficulties in trying to categorically distinguish if some admissions are alcohol related or not. Alcohol attributable fractions were often hard to operationalise, especially in determining the ‘cut-off’ point where particular clients could be filtered out. Although the focus with frequent flyers is on their problematic alcohol use, they are likely to have complex needs affecting their lives and involving other services. There is some recognition that definitions should be adaptable and that they require flexibility to be responsive to varying patient needs.

It was pointed out, and this merits further consideration among policy makers and practitioners, that ‘frequent flyers’ can refer to clients with the highest repeat hospital admissions, irrespective of whether the admission is alcohol related or not. In many cases, alcohol is a contributing factor and decisions need to be reached on a case-by-case basis as to whether the client should progress through an alcohol focussed care pathway. For some clients, following an alcohol care pathway may not be the most appropriate response, for example, for those needing end of life care.

**Identification and information sharing**

A number of structural and process dimensions were particularly evident in the North workshop as presenting challenges to reaching consensus on who should qualify as a frequent flyer. Different trusts have different work protocols in operation. Similarly, different commissioning processes were noted as affecting identification. In one area, difficulties arose in identifying patients partly because of local NHS Trust boundaries not being co-terminous with hospital districts.

Several attendees highlighted the challenges in identifying patients from A & E data arising from the need for patient consent and protection of patient information. A significant barrier appeared to be the mandatory need for NHS organisations to adhere to patient governance guidelines in the form of ‘Caldicott Guardians’. As this is a relatively new field of practice, the need for systems to be developed which can incorporate patient governance, yet provide necessary patient information for practitioners is only just emerging.

Some clients present at different hospitals so that, without adequate information sharing procedures and lack of a name, tracking them across hospitals and PCT boundaries is problematic. In some areas A & E attendance data is not collected because of lack of resources to set up and maintain an effective database; in other areas, admissions data is easier to collect and more reliable than A & E data which can often be poor and of sketchy quality.

There is some evidence in this workshop of co-ordinated approaches between primary and secondary care, but these rely on effective data sharing protocols to be in place; for example, in one area the top ten names were identified via the GP clinical ‘dashboard’ system working in tandem with the local hospital Accident and Emergency Department. It was pointed out that the GP clinical ‘dashboard’ would help overcome many barriers but many delegates were unaware of this initiative and the system does not appear to have been widely implemented among our workshop attendees.

**Overview of current practice and different models in use**

Developing appropriate responses to frequent flyers has been driven through ‘bottom up’ effort deriving from grass roots service developments and approaches appear to have been developed largely through testing out ideas at the local level rather than based on theory or empirical evidence. Areas such as Portsmouth, Bolton and Salford appear to have well developed responses and models in place. Bolton and Salford have established ACT programmes and AOAS services though there are variations in how they have responded to local needs and demands. Some evaluations, often focussing on broader alcohol liaison hospital services, are now available and these indicate that interventions can achieve positive outcomes (see Alcohol Learning Centre ‘Local Initiatives - Outcomes’, for example, East Midlands alcohol liaison hospital evaluation, Royal Bolton hospital, Evaluation of the Effectiveness of the Alcohol Specialist Nurse Service - Portsmouth). Moriarty and colleagues have produced a joint position paper discussing how resources should be developed to improve quality of care with respect to reducing alcohol related disease, in particular outlining alcohol care pathways in secondary care (Moriarty, 2010; NHS Evidence, 2011). Their recommendations are based on empirical evidence and further work could be undertaken to develop more theoretically based models of intervention.

Evident from discussions in both workshops was the need for co-ordinated policies and integrated services between primary and secondary care. A practitioner with well developed care pathways noted that integrating mental health services with other services was vital in achieving better outcomes. Given the complex needs of these clients, care pathways need to be in place to ensure referral into community services and effective care pathways should be established across all aspects of treatment systems. It was suggested that all medical professionals should adhere and comply with the care pathways and this may also apply more broadly to healthcare professionals; however, facilities were currently not always available to make this possible.

Programmes need to be individually tailored and patient-led with flexibility built into current practice so that the care of clients can be adapted to different client needs. It was suggested that a gold standard end of life care pathway was essential. In discussing outcomes, a number of barriers to the desired outcome of community based detox were identified. The length of time between a client

presenting in A & E and their assessment was often too lengthy e.g. four weeks. Clear pathways in A & E for regular attenders should be part of routine practice and effective communication between services would enable users to be promptly targeted. Fast, even instant responses are required and bypassing waiting lists into community services was proposed as a measure to overcome delays. There are barriers in terms of administering assessment tools as nursing workloads mean that there is often lack of time to carry out Audit C. This is further exacerbated by the limited time in teaching hospitals to include Audit C within nursing training. Lack of continuity or availability of support throughout treatment is identified as a barrier in terms of outcomes; many clients are often found to be struggling to find support and this should be provided throughout a care pathway, especially prior to, during and after detox. To prevent relapse, greater investment of resources is needed in order to provide the necessary support in the form of groups, peer-led support, aftercare and outreach.

As already noted, information sharing is a prerequisite for identifying clients, and good intelligence systems, coupled with multi-agency information sharing, lead to better informed care plans. The co-ordination of care depends on effective partnership working which should enable clients to be directed to and involved with other mainstream service providers, such as housing, not just alcohol services and which can effectively provide a wrap-round service.

**Understanding and addressing the needs of frequent flyers**

In both workshops, delegates stressed that engaging with frequent flyers was not always possible because of the chaotic lifestyles and complex needs of many of these hard-to-reach clients. Understanding the client holistically was therefore vital, which means taking time to build trust and engagement so that services could work with them more effectively. There needs to be recognition that for the client, non-alcohol issues e.g. housing, pending court appearance etc may be more pressing and require intervention before alcohol use can be addressed. This suggests that positive attitudes to working intensively with this group and creating good relationships need to be fostered, alongside awareness of their vulnerability and possible lack of life skills. Provision should be made for staff to work flexibly in addressing the needs of clients, e.g. accompanying them to appointments, helping them sort out non-alcohol related issues including debts, housing etc. Key workers could play a critical role in educating and supporting clients in these respects and improving their lives in general.

In the North workshop some clients were reported as having legal and administrative difficulties with their housing assessments because of their classification status as ‘vulnerable’, and there were calls for changes in assessment for access to housing. Many clients are likely to have long term conditions such as diabetes, mental health needs etc which may co-present alongside substance misuse. Alcohol related brain injury and trauma were also mentioned as challenging in the management of care and fluctuating levels of capacity means that clients are not always able to remain autonomous, particularly with respect to making decisions for themselves. Making routine enquiries about domestic violence among all clients presenting was felt to be essential.

In deciding on client outcomes, it was suggested that these should depend on levels of usage and that both short term and long term goals should be worked out. While abstinence may be required for those with cirrhosis and recommended for liver transplant patients, stability or controlled or reduced drinking may be the desired outcome for others. Consultants, for example, could be educated to consider alternatives to implementing drug regimes, such as reductions in alcohol. An important theme evident throughout discussions was the need for client led outcomes. Patient education is likely to play an important role in determining what is possible in terms of symptom management and goals that are realistic. There was some suggestion that clients should be able to set their own goals regarding their drinking.

Communicating the issues and needs associated with this client group was highlighted in discussions in both workshops. Getting the message across is likely to involve developing a common understanding of the problems, the target group and their often complex needs. A range of practitioners and stakeholders may need to be educated, in particular clinicians, A & E consultants and liver specialists, together with service providers and commissioners. Reaching professionals and groups less centrally involved but likely to encounter the target group in the course of their work e.g. fire service and ambulance staff is also necessary. Education may need to focus on processes and outcomes involving both practitioners and clients.

Workforce development

There is a need to consider and plan workforce development so that practitioners have the knowledge and skills required to provide an acceptable, appropriate service for frequent flyers. Delegates at both workshops were invited to discuss the kinds of skills needed in order to provide an effective response and to avoid some of the issues, such as burn-out emerging from findings in earlier studies (see Herring et al, 2011 for example). Discussions during both events highlighted workforce issues such as the highly intensive nature of working directly with frequent flyers both in hospital and community settings.

*Workforce characteristics and training*

Recruiting staff with appropriate personal characteristics and attitudes was a key factor in fostering effective team working. Staff should be approachable and have empathy with clients; resilience is essential in dealing with the day-to-day challenges of working in this field. Collaborative and multi-disciplinary approaches are required and the team should have an appropriate experience and skills mix. Effective team working can be facilitated through fostering respect between consultants and alcohol teams, specialist nurses etc and high motivation within the team needs to be developed and maintained. Training staff to be realistic about their roles and role boundaries should help prevent staff burn-out.

*Support mechanisms/processes needed*

A number of mechanisms and processes to help support staff were highlighted in both workshops. Supervision across the team is felt to be crucial both to help staff to de-stress and to co-ordinate a multi-disciplinary approach. Communication via face-to-face meetings with all staff is vital; delegates advocate regular weekly case conferences with internal teams while multi-disciplinary teams needed to meet less frequently. Underpinning such communication is the need to have in place efficient intelligence systems and information sharing.

To avoid burnout, mechanisms are required to help share burdens and avoid failures to pass clients on to other agencies. Peer group support and volunteers are important as they bring relevant experiences, especially if ex-service-users and, with appropriate training, they can build capacity within the team. Other more general support mechanisms suggested were the development of a regional database of information and regional forums for support.

**Next steps**

As part of the evaluation, delegates were invited to suggest what they would like to happen following on from the workshops. Data from both the London and Manchester event evaluations suggest that most workshop participants would find a toolkit useful. An overwhelming majority, 84% of North workshop delegates indicated that a toolkit would be valuable as did 71% in the South. CPI in collaboration with Middlesex University are currently seeking funding to develop a toolkit which would be piloted, monitored and evaluated before being mainstreamed. Approximately half the delegates in the North workshop asked for formal accredited training, CPD events, an academic publication and a network meeting; interest in these was slightly less intense among London delegates.

**Conclusions and recommendations**

Work with regard to those we are calling frequent flyers is an emerging field and area of practice. There is still much to be done both in terms of framing the concepts, delivering services to this client group and co-ordinating policies. Bringing together practitioners, policy makers and academics has generated greater exploration of knowledge and helped further understanding of this field and so is an important contribution.

In both the South East and North workshops, there were calls for a more standardised approach to enable practitioners to understand who they are working with, to determine the parameters within which work should be delivered and to create a term of reference for policy makers. Developing a national definition needs to be considered or, at minimum, the provision of guidelines on how to define this client group. It seems at the least that all partners within a given area would benefit from a common definition and understanding of these clients.

Practitioners need to access A & E attendance data that is separated from hospital admissions to be able to effectively identify this client group. To facilitate identification, information sharing protocols need to be in place and maintained across relevant local partnerships so that protocols can be adapted to suit local needs and conditions. Lack of patient consent and protecting patient information currently acts as a barrier to effective identification and needs to be addressed as part of any information sharing initiatives.

The results of current service and project interventions for frequent flyers indicate the need to develop a flexible framework of understanding and intervention possibilities. These should allow for some commonality across projects but be able to accommodate local variability and allow for diversity of local needs, infrastructures and traditions of response. Systems for monitoring response rates, in terms of reduced attendance and admissions, and outcomes need to be evaluated in order to identify what is working effectively, gaps in care provision and areas that need further improvement.

Currently there are gaps in our knowledge and understanding with respect to the models and types of responses that already exist for frequent flyers. Both workshops confirm that there is no general approach to these clients but models and responses appear to range from highly focussed services to broader ‘packages of care’. These approaches could be collected and better described, for example through scoping, case study work and talking with professionals, so that we better understand what is currently being done and by whom. Analysis of the core components that are working well and may be similar across programmes is needed with the aim of developing ‘good practice’ or possibly a set of ‘standards’. Lessons learned would enable others to create more effective interventions and care pathways.

The alcohol sector has led the way by identifying this client group and in devising ways of working with them. The needs of this group are complex and require a genuine multi-disciplinary approach within which alcohol is one element and it is a hopeful sign that no particular profession dominates or currently has ownership of this field.

Addressing issues around working with frequent flyers can require intensive and often costly service approaches. Much of the activity around frequent flyers is pilot-based and uses short-term funding to explore new ways of working. Funding needs to be secured from mainstream budgets by commissioners and buy-in elicited across senior level clinicians and policy makers, as well as local ‘champions’. A business case therefore needs to be developed to persuade commissioners and other stakeholders to engage in delivering services to this group.

Finally, both events have underlined the interest and commitment to working with frequent flyers. Efforts should be made to continue the dialogue, to expand opportunities to share knowledge and experiences and to develop intervention models and evaluate their effectiveness in different local contexts.

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1. Those with the highest rates of alcohol-related hospital admissions or highest rates of service use [↑](#footnote-ref-1)