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RADAR

Rapid Access to (alcohol) Detoxification: Acute hospital Referrals

Dr Chris Daly
Consultant Psychiatrist
Chapman Barker Unit

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The Challenge

Significant Burden of Alcohol on Health System

- Alcohol related diseases = 1 in 8 NHS beds
- 35% of A&E attendees alcohol related (between midnight and 5am – 70%)
- North West highest rates of alcohol related hospital admissions in England and worsening gap c.f. rest of England
- Pattern of recurrent brief admissions to general hospitals for alcohol related problems
- Targets to reduce alcohol related admissions rate (formerly NI39), reduced avoidable admissions and readmissions (within 30 days loss of tariff)
- Targets to reduce drop out between Hospital and Community services

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The Solution: RADAR

Rapid transfer of patients presenting to acute hospital to a specialist facility who :

- Want to stop drinking and require a detoxification **who otherwise would have been admitted to acute bed**
- Close working with Alcohol Nurse Specialist within Acute Hospitals (gate-keeping, referral pathway,)
- Transfer as rapidly as possible
- **Rapid access to medically managed detoxification 24 hour per day**
- Utilising 8 beds at Chapman Barker Unit
- 5-7 day admission multi-disciplinary team, 24 hour hospital at night and medical support specialist individual and group PSI therapies
- Emphasis on engagement in aftercare and recovery communities

£750 k funding secured from SHA from November 2012

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RADAR Inclusion Criteria

- Presenting to A&E requiring detoxification and admission for detoxification.
- Alcohol dependent (AUDIT > 20).
- Alcohol withdrawals (CIWA Ar >10).
- Consenting to pathway want could be managed at RADAR.

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Main Aims and Outcomes:

1. To reduce burden on Acute Trusts in relation to alcohol related admissions

Sub-groups

Frequent fliers **-**highest users of services, repeat short term admissions , complex physical and mental health issues. Improved working with frequent flier teams care planning and follow up *Acute presentation in withdrawal-* potential benefit of earlier specialist intervention, detox completion and engagement with aftercare

2. To improve clinical outcomes for service users

3. To provide improved experience for service users in a therapeutic setting

4. To demonstrate cost effectiveness

Admission by referring hospital

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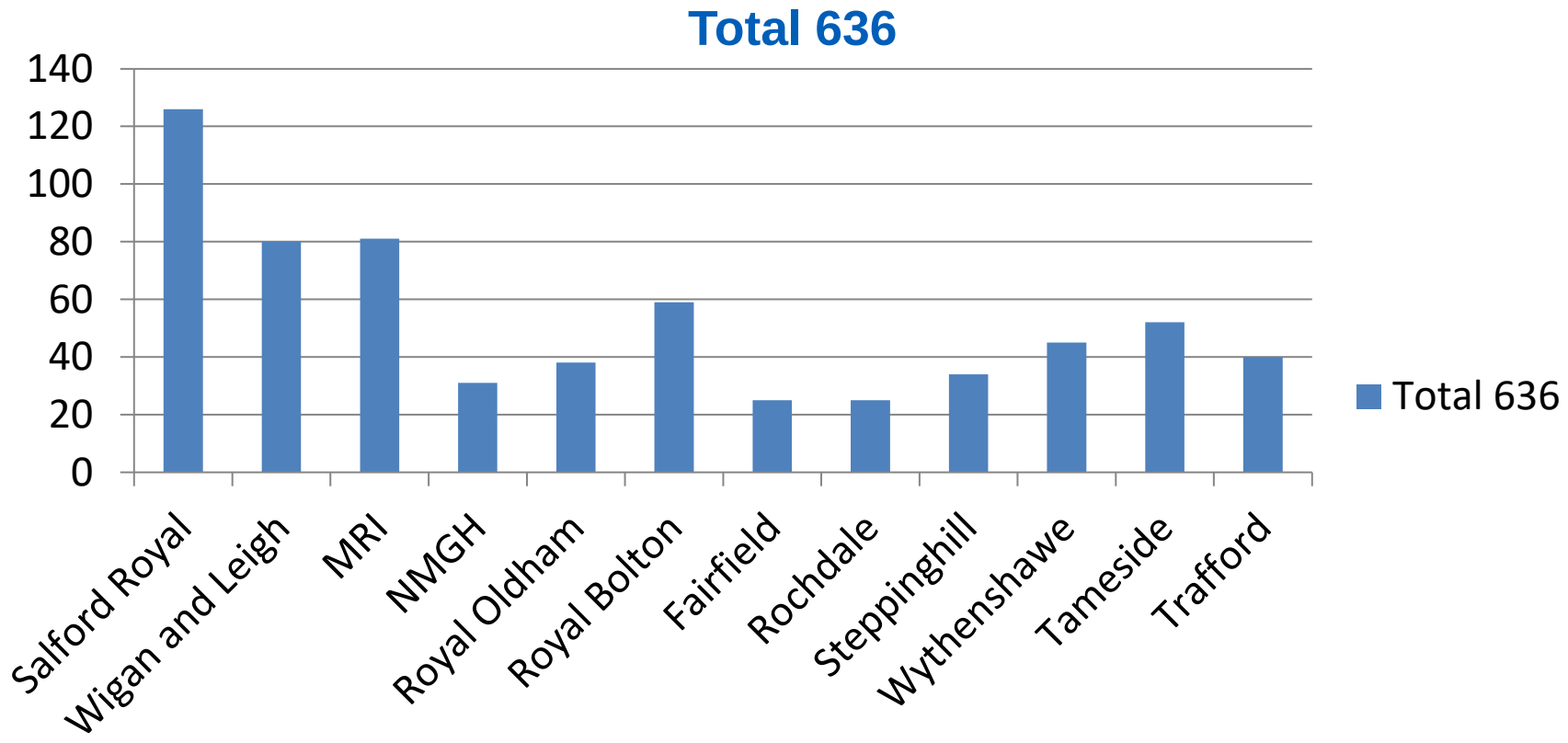

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Patient Profile

- 636 patient episodes in first 2 years
- 67.5% Male
- Mean age 44 range 18-76 (30% < 35 years old, 23% > 50 years old)
- 75.6% Unemployed
- 83% Settled Accommodation
- 20% Married or Cohabiting
- 46% ‘Frequent Flyers’ (3 or more presentations in preceding 6 months)
- 7% Open to Frequent Flyer teams
- 30% Open to Community Alcohol service
- 18% Open to mental health service
- 64% Not open to any services at point of referral
- 11% Never known to any service

Clinical Presentation

Reason for Presentation to Hospital

- 53% Alcohol withdrawal (e.g. seizure)
- 28% Mental health (e.g. suicidal ideation)
- 12% Physical health (e.g. pancreatitis)
- 7% Fall (e.g. head injury)

Clinical Measures

- Mean AUDIT score = 31 / 40

(scores over 20 indicate dependence)

- Mean Units Alcohol in past week = 235

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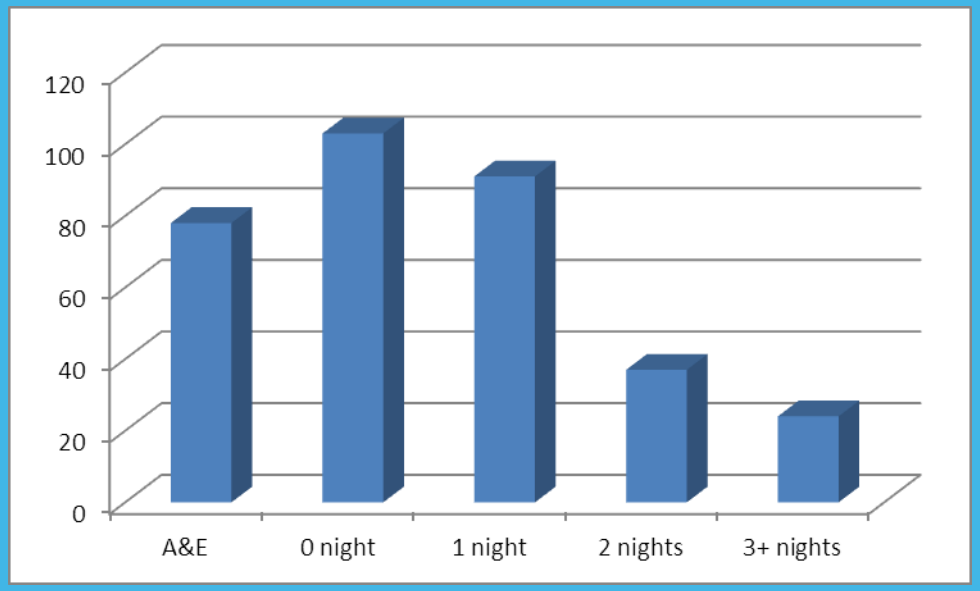
Aim 1: Reduced Burden

Length of Acute Hospital Admission (n=339)



RADAR patients:

- 78 (23%) acute admissions avoided i.e. straight from A&E

Of those admitted to acute:

- 39% no overnight stay
- Only 9% over 2 nights

JMU Telephone Survey Outcomes

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98 patients by JMU Researchers

6/12 pre and post RADAR outcomes

89.6% drinking less/ abstinent

Attending Alcohol services:
47% pre RADAR
69% post RADAR

	Mean	SD	Z score	P value
A&E visits pre RADAR	3.16	9.28		
A&E Visits post RADAR	0.55	1.15	-5.79	<0.001
Overnight hospital stay pre RADAR	2.26	9.31		
Overnight hospital stay post RADAR	0.28	0.65	-5.28	<0.001

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Aim 2:
Improved Clinical Outcomes

Completed Treatment (n=636)

- 604 completed detox (95%)

Planned Stay

- 600 stay 5-7 nights (88%)
- 32 shorter stay (5%)
- 44 extended stay (7%)

Planned Discharge

- 591 - planned discharge (93%)
- 10 - completed detox, but left early (1.5%)
- 32 - unplanned discharges (5%)
- 3 - completed detox, transferred to hospital or CBU (0.5%)

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Aim 2:
Improved Clinical Outcomes

Aftercare Planning

- 96% Appointment with Community Alcohol Service and Recovery Plan
- 48% Arrangement to attend local Mutual Aid
- 25% Appointment for Physical health needs
- 14% Appointment for Mental health needs
- 9% Computerised CBT programme
- 66% Specialist Recovery Prescribing in place
  (62% Acamprosate, 19% Disulfiram)

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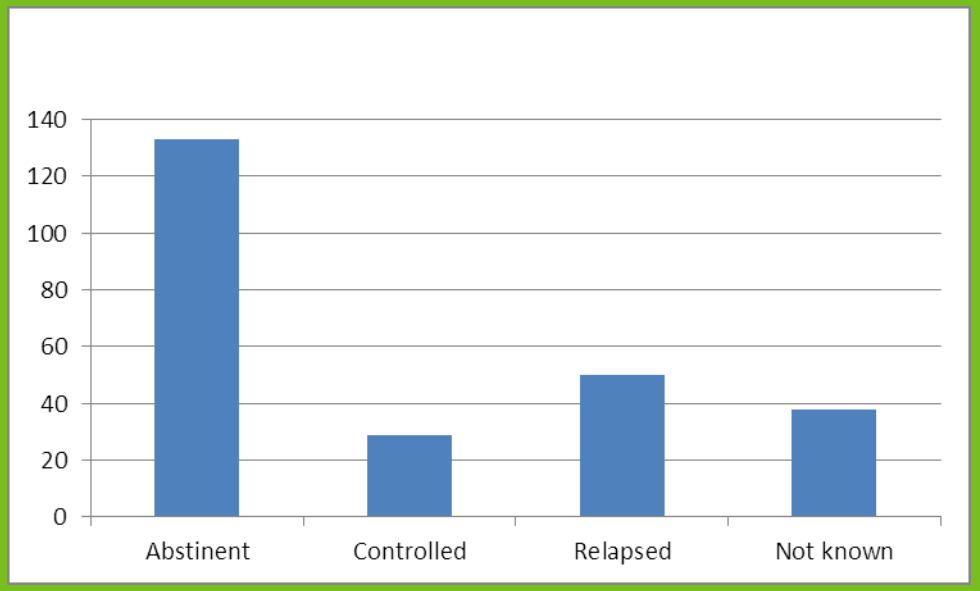
Aim 2:
Improved Clinical Outcomes

Rates of recovery and abstinence



4 week Follow Up of Successful discharges (n=250)

15% outcome not known

Of those known:
74% Abstinent or Controlled

3 month Follow up:
32% outcome not known
Of those known:
59% Abstinent or Controlled

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Aim 2:
Improved Clinical Outcomes

Engagement in the Community

4 week Follow Up

- 71% Engagement with Community Alcohol Team
- 43% Engagement with Mutual Aid

3 month Follow Up

- 51% Engagement with Community Alcohol Team
- 28% Engagement with Mutual Aid

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Aim 3: Patient Experience

What happens….

- Referral – Acute Hospital
- Admission
- CIWAR (Clinical Institute Withdrawal Alcohol Rating)
- Physical / MH assessment
- Medication assessment
- Risk Assessment
- Pabrinex – IM or IV
- Aftercare

- Group Programme
- Carers / family involvement
- Blood tests
- Prescribing for abstinence
- Therapy team
- Treatment physical and mental health

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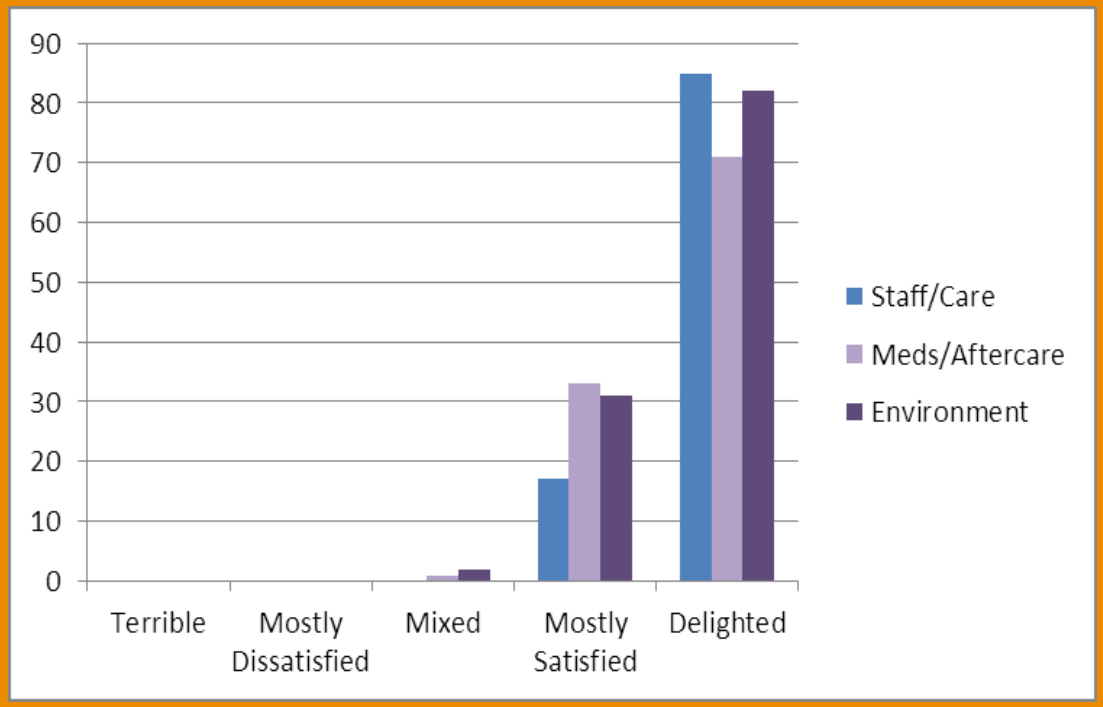
Aim 3 Patient Experience:

Service Satisfaction Scale (Residential)

Total Satisfaction:

80% Delighted
20% Mostly Satisfied



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Aim 3 Patient Experience:

Liked the most:

‘How helpful the staff are’ ‘Feeling safe and looked after’ ‘Meeting people who understand and don’t judge’ ‘Staff giving me strength hope and confidence’ ‘Help with having a plan to cope when I go home’ ‘Mixing with like minded peers’ ‘Coming back to myself again’ ‘Not being looked down to’ ‘From being frightened coming in, to now not wanting to leave!’

Liked the least:

‘Boredom can be a problem’ ‘Smoking in the rain’ ‘No Sky TV’ ‘Realising I must stop drinking’ ‘Being away from friends and family’ ‘Not getting help sooner’ ‘Any chance of a toaster?’ ‘Things to occupy your mind’

Aim 3 Patient Experience:

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Patient with severe alcohol related withdrawal symptoms and poor physical health admitted to RADAR via A&E

Within a few hours showing signs of confusion and disorientation, associated aggression, hostility and agitation. He believed staff were intruders and robbing / trashing his parents' home. He was ataxic.

Duty Dr was required to assess the patient, Followed protocols for management of delirium tremens, IM Lorazepam and Haloperidol required.

Patient placed on section 5/2 MHA . 3:1 observation required initially, reduced to 1:1 observation once he began to settle.

Intermittent confusion continued through the next day however this was managed well, regular Librium commenced plus IV Pabrinex was extended.

4 /7 later improving confusion, motivated and focused to remain alcohol free, and is keen to make positive steps to change. Discharged after 10 days completed detoxification

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Aim 3 Patient Experience:

Retired policeman admitted MAU severe anxiety/ depression and alcohol withdrawals frequent A&E attendance.

Engaged well throughout his admission on RADAR.

Interventions included basic CBT skills [behavioural activation], lifestyle changes, M.I, work around relapse prevention, anxiety, including coping skills and node link mapping. Complementary Therapies, and Breaking Free Online.

AA meetings introduced regular attender

Alcohol free 3/12 no further A&E attendance

Applied to join UACT, Volunteer CBU

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Aim 4: Cost Effectiveness

Cost Modelling

- Based on data from first 6 month evaluation using 2 local authorities (Salford and Wigan)
- Supplemented by date from LJMU telephone survey
- Based on local published data 2011/2012 (AIM):
  - Average length of alcohol related general hospital admission = 2.2 days
  - Average cost per admission = £1667
- Based on 80% occupancy per annum
  - RADAR admissions = 456 patients per year

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Benefits Realisation

80% occupancy

Index Admission	OBN (p.a)	Tariff Liberation
22% transfer from A&E (admission avoided)	221	£161,000
33% transfer same day (bed night avoided)	334	£245,000
24% stay only one night (reduced length of stay)	131	£90,000
Total	**686**	**£496,000**

Benefits Realisation

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Readmission	OBN (if 6 m)	Tariff (if 6 m)	OBN (if12m)	Tariff (if 12m)
75% not readmitted to acute bed in 3 months post RADAR				
Frequent Flyer	1129	£826,443	2257	£1,652,886
Acute presentation	139	£101,928	376	£275,481
Total	**1268**	**£928,371**	**2633**	**£1,928,367**

Summary Total Savings

Index Admission	686	£496,000
Re-admission	2633	£1,928,367
Total	3319	£2,424,367

Estimated Money Savings – Year 2

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Description	6 months	12 month
	£	£
General bed-nights saved due to RADAR admission	517,594	517,594
A&E attendances	104,929	209,858
Hospital admissions	1,008,410	2,016,820
Outpatient attendances	34,305	68,610
GPs	23,085	46,170
Other detox	9,471	18,942
Total	1,180,200	2,360,400
TOTAL BENEFITS	1,697,794	2,877,994
RADAR COST	884,315	884,315
BENEFIT - COST	813,479	1,993,679

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Final Summary

- Pilot Project ended on 31st October 2013
- Agreed Funding from all GM CCGs ongoing for last 8 years annual review and renewal
- Huge benefit for Acute Trusts and Commissioners in managing A&E acute bed pressures. Most important Huge benefit to our patients!
- Royal College of Psychiatrists Team of the Year 2014
- **Recent experience Covid able to flex and increase RADAR beds from 8 to 15 to support acute trusts increased occupancy and diversion away from A&E at crucial time**

RADAR
Rapid Alcohol Detox Acute Hospital Referrals
FINDING A ROUTE INTO RECOVERY

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Thank you

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