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Alcohol care in England's hospitals

An opportunity not to be wasted

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Public Health England exists to protect and improve the nation’s health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Introduction

This report is for local authority and NHS commissioners, practitioners in hospital alcohol services and those in associated community services. The document summarises the available evidence for the contribution of specialist alcohol services for patients in secondary care. It takes in recommendations from a range of advisers over the last decade and, based on recent surveys, explores the interventions that these services might provide and describes what is understood about current service provision.

Alcohol specialist services for secondary care patients are set up in order to alleviate the enormous impact of alcohol misuse on secondary care by improving care for alcohol misusing patients who present to hospitals. This document explores the case for these services, identifies a range of service models and, attempts to identify some of the factors that lead to improved patient care and cost effectiveness.

The majority of the current evaluation evidence for hospital alcohol services is for multi-disciplinary alcohol care teams in larger hospitals, but an attempt has been made to describe other models of provision that, according to survey findings, are currently in place in many hospitals.

The document was developed with the active involvement of an advisory group of subject experts, ie, people with expertise in commissioning and delivery of specialist alcohol services.

Project advisory group

Public Health England thanks the advisory group, the consensus of which has informed this document:

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PHE also thanks Professor Sir Ian Gilmore, Dr Lynn Owens and Mr Rod Grant (Peterborough) for their contributions to this document.

Executive summary

In the late 1990s, a few hospitals in England began to implement alcohol liaison nurse services to improve the care and discharge of patients with alcohol problems, which were contributing to their illness or complicating their treatment.

In 2001, the Royal College of Physicians recommended that all major hospitals should adopt alcohol liaison nurse services. In the subsequent 13 years, this recommendation has been reiterated and built upon in recommendations by professional groups, universities, the National Institute for Health and Care Excellence (NICE) and national government.

There is good evidence from the alcohol liaison services or “alcohol care teams” that have been evaluated, that there are significant benefits available from providing specialist care for patients with alcohol problems. Reducing the length of time alcohol dependent patients spend in hospital saves money and addressing their alcohol misuse improves their health by reducing the likelihood of readmission.

Evaluations indicate that return on investment from effective alcohol care teams can be between £3.50 and £3.85 per £1.00 invested. Assertive outreach services that aim to reduce hospital admission and A&E attendance among those who use them frequently can deliver a return of £1.86 per £1.00 invested.

Between 2007 and 2013 it was clear the number of hospitals providing specialist care for alcohol using patients was increasing enormously, but the picture of how many hospitals had services and what they offered was not clear. During 2012 and 2013 a number of surveys explored various aspects of hospital alcohol services in hospitals and one, by PHE, set out to identify which hospitals have alcohol services, how they are funded, staffed and clinically led and what they offer patients.

From the PHE survey of hospitals and subsequent research into non-responding hospitals, information was gathered about the existence or non-existence of alcohol services in 144 of the 191 district general hospitals estimated to be an appropriate size to merit an alcohol service. The service status of the remaining 47 hospitals is currently unknown. From this information, at least 139 (73%) offer some level of specialist alcohol service. Only five hospitals were positively identified as having no alcohol service at all. Of the 40 largest hospitals, which may be best placed to benefit from alcohol care teams, two were positively identified as having no service and a further seven were not known to have services.

Services are diverse, but fall into three broad categories:

- multi-disciplinary alcohol care teams
- in-reach alcohol care teams

- high impact user services

There is a widespread consensus on the need for, and the effectiveness of hospital alcohol services, led by a senior clinician with dedicated time for the team, and providing evidence-based interventions. Teams will facilitate identification of alcohol misusers in hospitals and appropriate packages of care provided by multi-disciplinary teams. Whether teams are large or small, set within the hospital or in-reach, they should be able to provide:

- case identification/identification and brief advice (IBA)
- comprehensive alcohol use assessment
- contribution to nursing and medical care planning
- psychotherapeutic interventions
- medically assisted alcohol withdrawal management
- planning of safe discharge, including referral to community services

The PHE survey of hospital services explored the difference in funding arrangements in the year before and the year after the transition of public health responsibility from the NHS to local authorities. Although NHS England guidance indicates that hospital alcohol services for alcohol users is a clinical commissioning group (CCG) responsibility, the survey showed that, to a large extent, funding responsibility moved with public health departments, from the NHS to local authorities.

The recommendations from this report are that:

- every district general hospital should consider the best way to provide effective specialist alcohol care for its patients in light of the benefit to patient care and the available efficiency savings
- local partners should engage with the health and wellbeing board to ensure existing services for alcohol and other drugs are maintained and developed on the basis of local needs assessment
- hospital alcohol care teams should accelerate identification and brief advice (IBA) delivery throughout the hospital by supporting the training of colleagues in all clinical areas
- local partners should review the response to alcohol-related harm in all district general hospitals, using this document as a guide, and they should ensure that existing services are adequately integrated across primary and secondary care and that new services are implemented where there are none
- local partners should consider employing assertive out-reach or in-reach services for high impact service users in all major hospitals and existing services should be comprehensively evaluated to assess their impact on hospital and community services
- system planning should ensure that community services are accessible and available to ensure continuation of detoxification with psychosocial interventions outside of the hospital

1. The issue: background and context

The World Health Organisation (WHO), states that excess alcohol consumption is a growing public health problem, causing around 5.3% of deaths worldwide in those aged under 60 years.[1] In the UK, alcohol use is the fourth greatest risk factor for years lived with disability (age standardised rate). For men, alcohol use is the second highest and, for women the fourth highest risk factor for years lived with disability.[2] In England, about one in five adults (nine million people) drinks at levels that incur risk to health. An estimated 21,485 deaths are attributable to alcohol consumption in England in 2011-12.[3]

Alcohol is a significant contributor to some 60 health conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression. The increased risk of these conditions is greatest among those 2.2 million people in England drinking at harmful levels (35/50 units per week, female/male) but is significantly increased by even relatively low levels of regular excessive drinking. Binge drinking can lead to injuries, anti-social behaviour and other societal harm.

The risk of common conditions, such as hypertension, increases exponentially as regular daily consumption doubles.

Increase over standard risk of illnesses from alcohol consumption[4]

Regularly consuming	**25g (3 units) p.d.**	**50g (6 units) p.d.**	**100g (12 units) p.d.**
Malignant neoplasm of lip, oral cavity and pharynx	1.96	3.11	6.45
Malignant neoplasm of colon	1.05	1.10	1.21
Malignant neoplasm of oesophagus	1.39	1.93	3.59
Malignant neoplasm of rectum	1.09	1.19	1.21
Malignant neoplasm of liver and intrahepatic bile ducts	1.19	1.40	1.81
Malignant neoplasm of larynx	1.43	2.02	3.86
Malignant neoplasm of breast	1.25(f)	1.55(f)	2.41(f)
Epilepsy and status epilepticus	12.23(m) 1.34(f)	7.52(m) 7.22(f)	6.83 (m) 7.52 (f)
Hypertensive diseases	1.43	2.04	4.15
Ischaemic stroke	0.90	1.17	4.37
Haemorrhagic stroke	1.19	1.82	4.70
Cardiac arrhythmias	1.51	2.23	2.23
Oesophageal varices	1.26	9.54	9.54
Unspecified liver disease	1.26	9.54	9.54
Acute and chronic pancreatitis	1.34	1.74	3.19
Psoriasis	1.58	1.60	2.20

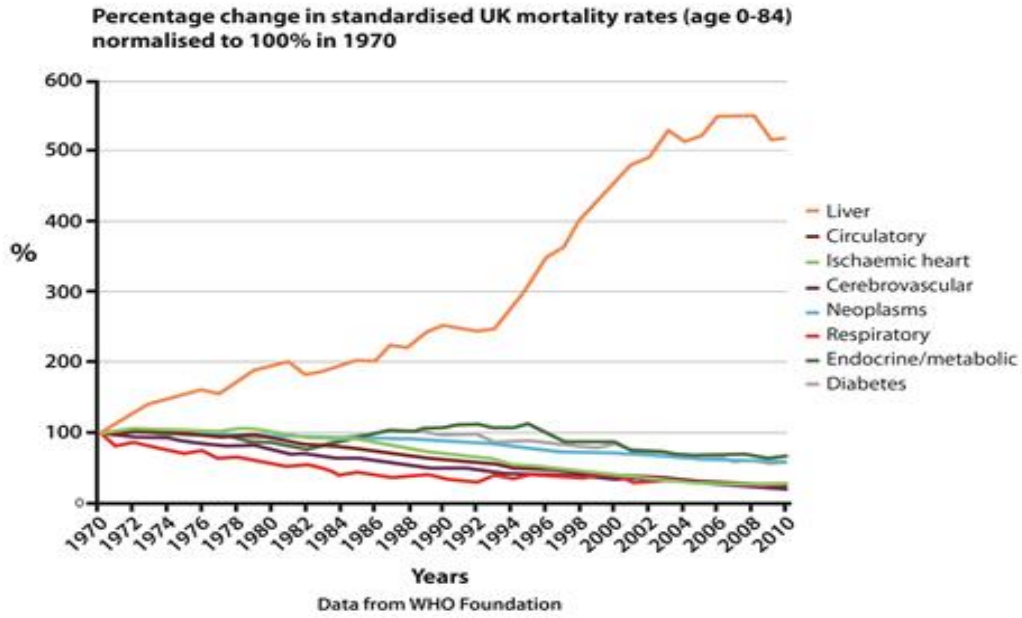
Where alcohol misuse has contributed to a condition for which a patient is admitted to hospital, continued alcohol misuse may contribute to recurrence of the condition, slower recovery or interaction with medication. This continuing harm places a particular burden on hospital resources, in terms of those who are readmitted within 30 days and of those who are frequent users of hospital services.

In England in 2012-13, there were over a million alcohol-related hospital admissions, where an alcohol-related disease, injury or condition was the primary reason for hospital admission, or was a secondary diagnosis.[5]

Of the annual £3.5bn cost from alcohol to the NHS in England, 78% is incurred for hospital-based care.[6] The overall estimated costs of alcohol-related harm include a further £11bn from crime in England and £7bn in lost productivity in the UK.[7]

In England, male and female mortality from alcohol-related liver disease (ARLD) is rising (though rising more quickly among women) and people are dying younger. Liver disease, to which alcohol is a major contributor, is the only one of the major diseases in the UK for which mortality is still increasing. Cirrhosis deaths are rising in England and other UK countries while decreasing in most other EU countries.

Deaths among under 65s in the UK for major conditions, compared with 1970 (WHO)



In her 2011 annual report, the Chief Medical Officer (CMO) for England notes the increasing contribution of alcohol to the rising rate of liver mortality and calls for "improved detection of the early signs of liver disease through appropriate risk assessment strategies in local populations and the use of appropriate tests to identify liver disease." [8]

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) found, in its 2013 review of patients who died with ARLD,[9], that in more than half of the cases reviewed, the care of patients who died with a diagnosis of ARLD was rated as less than good. The majority of patients had been to hospital at least once in the two years before the admission when they died, but not enough was done about their harmful drinking at that time. There was a failure to screen adequately for harmful use of alcohol and even when this was identified, patients were not referred for support.

2. Policy backdrop

The following section demonstrates a widespread recognition of the need for and the effectiveness of hospital alcohol services. What are usually identified as effective are teams led by a senior clinician with dedicated time for the team, providing evidence-based interventions that facilitate identification of alcohol misusers in hospitals and appropriate packages of care provided by multi-disciplinary teams. Whether teams are large or small, set within the hospital or in-reach, they should be able to provide:

- case identification/identification and brief advice (IBA)
- comprehensive alcohol use assessment
- contribution to nursing and medical care planning
- psychotherapeutic interventions
- medically assisted alcohol withdrawal management
- planning of safe discharge, including referral to community services

Multi-disciplinary alcohol care teams aim to reduce acute alcohol-related hospital admissions and readmissions, not only by providing high quality support to those who present with alcohol-related illness, but also by contributing to the development of broad-based strategies to prevent the development of such illness. Alcohol care teams include:

- seven-day hospital-based alcohol specialist nurses
- psychiatry services specialising in alcohol
- multi-agency assertive outreach alcohol services
- integrated alcohol treatment pathways between primary and secondary care
- training in alcohol and addiction for alcohol specialist nurses and trainees in gastroenterology and hepatology, acute medicine, accident and emergency medicine and psychiatry"

In its report in 2001, 'Alcohol – Can the NHS afford it? Recommendations for a coherent alcohol strategy for hospitals,'[10] the Royal College of Physicians (RCP) advocated the appointment of a dedicated alcohol health worker or an alcohol

liaison nurse in each major acute hospital, to work with a named consultant/senior nurse alcohol lead, to provide a focus for:

- medical management of patients with alcohol problems within the hospital
- liaison with community alcohol and other specialist services
- education and support for other healthcare workers in the hospital
- implementation of case-finding strategy and providing brief advice within the hospital

The British Society of Gastroenterology, Alcohol Health Alliance UK and British Association for Study of the Liver produced a joint position paper in 2010, called 'Meeting the challenge of improved quality of care and better use of resources.'[11] The principal recommendation of the paper was for a multi-disciplinary alcohol care team in each district hospital, led by a consultant, with dedicated sessions, who will also collaborate with public health, primary care trusts, patient groups and key stakeholders, to develop and carry out a district alcohol strategy.

The paper also recommended that each health area should establish a hospital-led, multi-agency 'Assertive Outreach Alcohol Service (AOAS)' to move the most frequent attenders and biggest consumers of hospital resources into a more appropriate, supported, community environment.

In 2012 (updated in 2014), the National Institute for Health and Care Excellence (NICE) NHS Evidence website published a proven case study for quality and productivity 'Alcohol care teams: reducing acute hospital admissions and improving quality of care'[12], which reiterated, further developed and provided evidence for these recommendations. The paper adds that this multi-disciplinary alcohol care team would organise systematic interventions and alcohol specialist services to provide a variety of actions, including brief interventions, specialist alcohol nurse care and ways of reaching out to patients. It recommends that hospitals should have coordinated policies of care for patients with alcohol-related problems in A&E and acute medicine departments, including a seven-day alcohol specialist nurse service, a mental health crisis team and alcohol link workers' network.

'The government's alcohol strategy'[13] in 2012, endorsed the recommendations in the above reports, calling for all hospitals to have alcohol provision in place and listing the key functions recommended by the Royal College of Physicians. 'Health First. An evidence-based alcohol strategy for the UK'[14], recommended that "Hospitals need to take a more proactive approach to identifying, addressing and preventing alcohol-related problems" and had among its principal recommendations:

"Every acute hospital should have a specialist, multi -disciplinary alcohol care team tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions."

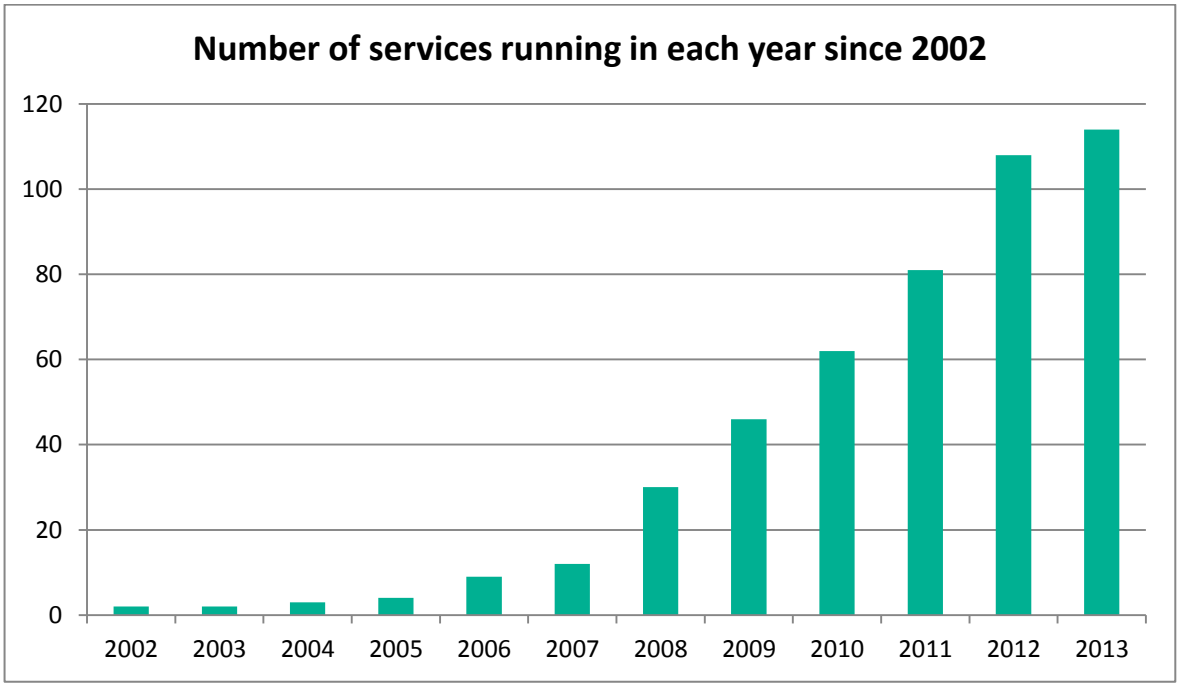
The strategy stresses that this requires leadership, cross-departmental collaboration and partnership with primary care, specialist community alcohol services and patient groups and that there is good evidence that this can be achieved by the establishment of multi-disciplinary alcohol care teams.

The development of alcohol services in hospitals

Specialist alcohol workers in hospitals were first introduced in the mid to late 1990s. In 2001 a RCP working group studied evaluations of these early services and, in its' report,[15] made the first national recommendation for widespread implementation of what was then described as alcohol health workers as part of any hospital strategy to reduce the harm and cost from alcohol-related harm.

The 2007 government alcohol strategy, 'Safe. Sensible. Social'[16] included a case study of the Royal Liverpool Hospital alcohol liaison service as an example of good practice. The adoption, in 2008, of alcohol-related hospital admissions as the standard indicator for alcohol-related harm in both the NHS and local authority indicator frameworks increased NHS focus on alcohol.

In 2009, commissioning guidance from the Department of Health in England 'Signs for Improvement,'[17] focused on a number of high impact changes to address alcohol misuse and reduce the rate of alcohol-related hospital admissions, which included the commissioning of an adequate number of alcohol health workers, or alcohol liaison nurses, to work across the acute hospitals.



PHE's 2013 survey of hospital alcohol services showed a rapid increase in service numbers from 2007-08 (above). Few services have been reported as having been

decommissioned during this time. This means that, of the 114 services that reported when they were set up, nearly three quarters have been set up since 2008 and nearly half have been set up since 2010.

The PHE survey identified the existence or non-existence of services in 133 of the 191 district general hospitals estimated to be of an appropriate size to merit an alcohol service. Subsequent investigation of non-responding hospitals confirmed services, or no services, in a further 11 hospitals. The service status of the remaining 47 hospitals is unknown. From this information, at least 139 (73%) offered some level of specialist alcohol service in 2013-14, which is broadly borne out by other recent surveys. Only five hospitals were positively identified as having no alcohol service at all, however, of the 40 largest hospitals, which may be best placed to benefit from well integrated alcohol care teams, two were positively identified as having no service and a further seven were not known to have services.

3. The evidence and cost effectiveness: what alcohol care teams can do

It is claimed[18] that alcohol care teams can bring qualitative and quantitative improvements such as:

- improving quality and efficiency of care
- reducing admissions, re-admissions and length of stay for patients with alcohol-related problems
- contributing to a potential reduction in alcohol-related A&E attendances
- reducing mortality related to the misuse of alcohol by systematically identifying alcohol-related conditions
- reducing the duration of detoxifications in hospital by working with services in the community to complete detoxification after discharge.

There is growing evidence for the quantitative impacts, such as reduction in re-admissions and the shortening of detox stays in hospitals, but qualitative improvements are mostly inferred from the numerical data. Evidence of improved patient outcomes needs further exploration.

The evidence base and clinical guidelines for the interventions that should be provided by alcohol care teams are described in:

- NICE PH24 for IBA and extended brief interventions
- NICE CG115 for treatment for dependent drinkers

- NICE CG100 for acute alcohol withdrawal, Wernicke's encephalopathy, alcohol-related liver disease and alcohol-related pancreatitis

3.1 Return on investment

A number of sources have calculated the return on investment of different alcohol interventions in hospitals. Although the results vary, there is consistency in the conclusion that hospital alcohol interventions are good value for money.

The NICE endorsed case study, 'Alcohol care teams: reducing acute hospital admissions and improving quality of care'[19] made two key recommendations for hospitals:

1. A seven-day alcohol specialist nurse service to screen, triage and provide brief interventions and provide comprehensive alcohol assessment including physical and mental health:
   - at the Royal Bolton Hospital, the cost of investing in a specialist nurse service is £165,000 annually. As a result of this investment 2,000 bed days are saved, liberating four to six hospital beds. This equates to a financial saving of £636,000, representing a return of £3.85 for every £1.00 invested

2. A hospital-led assertive outreach alcohol service targeting two defined patient groups:

   a) the top-30 patients with frequent alcohol-related admissions
   b) patients, such as those with alcohol-related liver disease, who exceed the threshold of two alcohol-related admissions in a short period, the "fast risers"
   - Salford Royal Hospital has pioneered this service. Work with the first top 30 cohort resulted in a 59% reduction in emergency department attendances in the three-month period post-intervention, when compared with the three-month period before intervention (average monthly attendances were reduced from 120 to 49). There was also a 66% reduction in average monthly hospital admissions (50 to 17)[20]
   - the Salford Royal annual service cost is £300,000, liberating two to three hospital beds and amounting to £556,500 in benefits – this represents a return of £1.86 for every £1.00 invested.

Other wider savings that would come from these alcohol interventions include improving the quality of life of the patients, reducing mortality and clinical accidents, as well as improved outpatient care, teaching and training.

The East of England Regional Alcohol Forum has developed a ready reckoner[21] for calculating return on investment from hospital alcohol specialist services, based on the evidence available in mid-2013. This tool enables planners to model the impact of various service characteristics on hospital admissions.

Comparing the tool's output, based on admissions data for 2012-2013, with actual evaluation data has been fairly reassuring. For instance, for the hospital alcohol liaison project (HALP) in Peterborough City Hospital:

- the ready reckoner estimates that three alcohol liaison specialists employed in Peterborough City Hospital would engage with 774 patients saving 259 admissions.
- the HALP in Peterborough employs three alcohol liaison specialists and in fact engaged 766 patients and, the evaluation calculates, avoided at least 216 admissions

It is believed that the presence of an effective alcohol care team will have a beneficial impact on A&E attendance levels and the consequential costs (average cost £110 per attendance). A study of the alcohol liaison nurse service in St Mary's hospital in Paddington[22] indicated that for every two patients who had an alcohol intervention at hospital, the number of patients attending A&E the following year was reduced by one. If patients are offered an appointment with the alcohol health worker on the same day, almost two-thirds attend. If the appointment is delayed for longer than 48 hours, only 28% attend. Hence, the intervention needs to be immediate.

It is possible to calculate the wider social return on investment (SROI), which will indicate savings from improvements in areas beyond the hospital. New Economy Manchester has developed a unit cost database[23] that brings together more than 600 cost estimates, covering crime, education and skills, employment and economy, fire, health, housing and social services. For more information read the Cabinet Office's 'A guide to social return on investment'.

4. Commissioning

As of 1 April 2013, local authorities took on responsibility for commissioning public health services, including alcohol services and for providing information and expertise to clinical commissioning groups (CCGs) to support them in commissioning health services that improve population health and reduce inequalities.

NHS England's 'Commissioning factsheet for clinical commissioning groups' [24] (Published by the NHS Commissioning Board: October 2012) advises that:

"For health improvement activities transferring to local authorities, such as smoking cessation, sexual health and drug/alcohol services, you may wish to agree joint commissioning arrangements. You should also consider how best to work with local authorities to ensure that health improvement activities are an integral part of the healthcare services that you commission."

A table on page 7 of the document also indicates that CCGs have a responsibility for commissioning alcohol health workers in a variety of healthcare settings.

	Local authority commissioning	**Related CCG commissioning**	**Related NHS CB commissioning**
Alcohol misuse	Alcohol misuse services, prevention and treatment	Alcohol health workers in a variety of healthcare settings	Brief interventions in primary care

Commissioning varies across the country, with alcohol care teams funded by local authorities, clinical commissioning groups and NHS hospital trusts. Investment in such services is viable, due to the savings that can be provided and the value for money that comes from providing a number of public health benefits from one service. Economic motivations are different for each stakeholder: for local authorities, improved treatment of alcohol misusing patients and early intervention with non-dependent patients (IBA and brief treatment) results in improvement in public health and reduced social care costs; for CCGs, the savings are in reduced numbers of hospital admissions; while for provider trusts, the savings will come from reductions in mortality, re-admissions and in length of stay per admission.

The four broad objectives of hospital alcohol services, originally identified by the RCP in 2001, were reiterated by the Department of Health's (DH) commissioning guidance 'Signs for improvement' (2009), High Impact Change 5,[25] and endorsed and built upon in the NICE guidance PH24,[26] in 2011.

These objectives involve interventions ranging from case-finding and providing brief advice for the many risky drinkers in the hospital, to intensive interventions for dependent drinkers, whose alcohol use is already causing significant harm. Successful services are also strong in the strategic and relationship aspects required to become embedded into the working life of the hospital and to forge effective pathways with community services.

As well as providing health benefits to individual patients, alcohol care teams make more efficient use of hospital/community resources, providing evidenced return on investment to NHS services. The impact of alcohol misuse, particularly heavy

drinking, is so prevalent, so far-reaching and so costly that, by reducing long-term ill health, disability and intoxication in the population, these services also reduce impact on a range of public services such as social services, social care, police etc.

Alcohol care teams will be less effective if they are not designed as an integral part of the wider strategic service provision. Health and wellbeing boards will need to ensure that joint health and wellbeing strategies (JHWS) and service planning take meaningful account of this wider strategic framework and may wish to consider co-opting representation from secondary care. Furthermore there will be a need to work with neighboring local authorities, where hospitals serve populations in other local areas, to ensure that the care of alcohol users is not subject to a postcode lottery.

Current commissioning

Four recent surveys give a picture of the current availability and formulation of alcohol services in English hospitals.

In 2013, Patton and O'Hara of the National Addiction Centre published 'Alcohol: signs of improvement. The 2nd national emergency department survey of alcohol identification and intervention activity'[27], which surveyed current alcohol identification and brief advice activity in English emergency departments to compare the results with the previous survey conducted in 2007.

In 2013, PHE conducted a survey, which sought to identify the number of hospitals in England where alcohol teams were operating. Within this, it sought to identify staffing levels, functions, leadership and funding arrangements.

In 2013, The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) published 'Measuring the units: a review of patients who died with alcohol-related liver disease,'[28] a report of a study of NHS hospitals in England, Wales and Northern Ireland as well as hospitals in the independent sector and public hospitals in the Isle of Man, Guernsey and Jersey.

In 2014, 'A national study of acute hospital-based alcohol health workers' by York University,[29] was published in the British Journal of Nursing. The aim of the study was to establish the extent and diversity of alcohol health worker provision at a national level. Hospitals from a proportionally representative study sample of 115 responded to a survey about the numbers employed, who they are, their place of work, their roles, who they see and funding allocation.

Unless otherwise stated, the following section presents findings from the 2013 PHE survey. The questionnaire used for the survey can be found here.

Establishing the availability of alcohol services in hospitals is not straightforward. Alcohol services often operate on a trust-wide basis, so it is not unusual for one service, ie, one commissioned function, to serve multiple hospitals. Some hospitals have multiple alcohol services operating within them, eg, an alcohol specialist nurse service and a high impact user service.

In Patton and O'Hara's study[30] of 189 emergency departments, 71% reported that they had access to an alcohol health worker in 2011 compared with 16.9% in 2006.

The NCEPOD report[31] found that approximately 79% (161/205) of hospitals participating in its survey (not confined to England) reported having an alcohol liaison service.

Because there is no clear consensus on the classification of hospitals, PHE analysed its survey results against general hospitals whose throughput [i] might mean it would be appropriate to provide an alcohol service.

Smaller hospitals of <500 discharges per month were excluded from the list of hospitals most appropriate for alcohol services. Only one such hospital had access to an alcohol service and this was as a result of a service based in another hospital that was available across the trust.

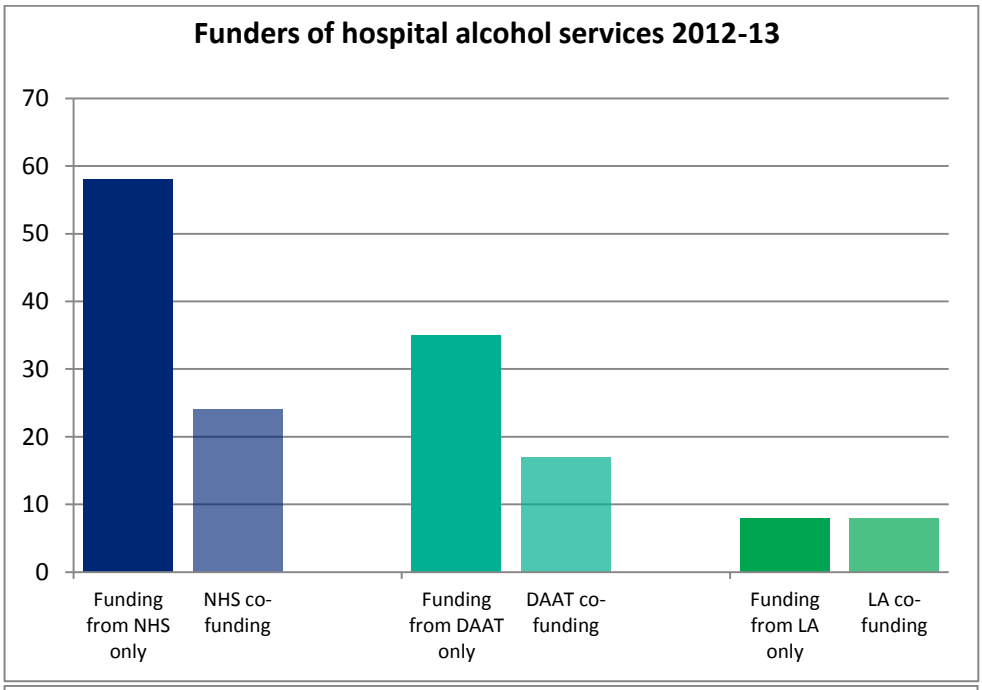
The remaining hospitals were grouped into categories by discharges per month 500-1000, 1000-2000, 2000-3000 and 3000+. Clearly, the larger hospitals would most lend themselves to multi-disciplinary alcohol care teams.

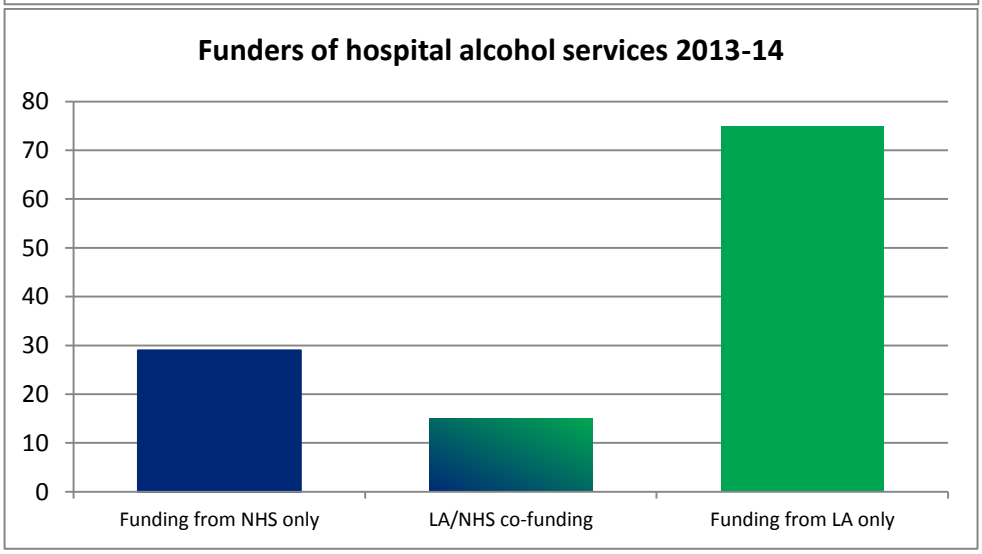
By this method, there are 191 appropriate hospitals in England, 139 (73%) of which are known to have access to some kind of hospital alcohol service. For a breakdown of the number of services by PHE centre area, please see appendix 3.

[i] The notional "size" of hospitals in the PHE report is based on data for the number of discharges in one month (July 2013) from the DH FFT unify2 data team.

How services are funded

NHS/local authority funding comparison 2012-13/2013-14





Reported Funders 2012-13 (n=126)		
	Funder/s	Number of hospitals
Single funder	PCT	48
	acute trust	9
	MHT	1
	DAAT	35
	LA	8
Two funders	PCT/acute trust	2

Reported Funders 2013-14 (n=129)		
	Funder/s	Number of hospitals
Single funder	CCG	20
	acute trust	6
	MHT	1
	LA	75
Two funders	CCG/acute trust	2

	PCT/DAAT	9				
	PCT/LA	5			CCG/LA	10
	PCT/other	1			CCG/other	1
	DAAT/acute trust	2			LA/acute trust	5
	DAAT/LA	1				
Three funders	DAAT/LA/acute trust	1				
	DAAT/PCT/acute trust	1				
	DAAT/LA/PCT	1				
Four funders	DAAT/PCT/acute trust/other	2				
					Not sure	6
					No funder identified at time of survey	3

In 2012-13, the alcohol specialist element was funded or co-funded by NHS bodies (PCTs or NHS trusts) in around two thirds of the hospitals that have services. In 2013-14, this figure was closer to one third, with the majority of the funding responsibility moving with the public health commissioner from PCT to local authority. Drug and alcohol action teams (DAATs) were involved in the funding of services in 52 hospitals in 2012-13. Most of the DAAT funding stream (predominantly the pooled treatment budget for drugs) also moved to local authorities via the public health grant in 2013-14.

The Royal Bolton Hospital alcohol care team has entered into a partnership with public health, council, local authority, GP commissioners, mental health, social services and other key stakeholders. The Bolton Integrated Alcohol Group of key commissioners and providers aims to integrate alcohol and liver disease care and alcohol treatment pathways, while the new national and local commissioning arrangements are established.

5. Service models

Multi-disciplinary alcohol care teams

A multi-disciplinary alcohol care team is, by definition, somewhat complex in its make-up. It may be a comprehensively commissioned entity or a virtual team comprising input from other specialist services within the hospital. Describing commissioning arrangements is therefore not simple. Patients experiencing high levels of alcohol harm will require coordinated packages of care, involving alcohol

specialists and other practitioners from the mainstream hospital and perhaps from other specialist services, such as psychiatric liaison.

The virtual team may also comprise sessional input from an addictions psychiatrist, hepatologist, specialist liver nurse, which may be specifically commissioned as part of the alcohol service, or may simply be a working arrangement, defined by agreed clinical pathways. The alcohol specialist nurse (ASN) will liaise with community alcohol services and the patient's GP for completion of detoxification and structured recovery-oriented treatment in the community. Most of this would take place under the clinical leadership of a senior clinician.

In-reach alcohol care teams

In-reach alcohol teams are based outside the hospital and provide interventions in hospital or clinic settings. They can be delivered by a range of staff including specialist alcohol workers and nurses and may also have medical provision and the range of services they are able to offer varies depending on the staffing mix. This mix may include combinations of specialist alcohol health workers, specialist nurses and doctors. The function of these services is to engage with hospital patients to reduce length of stay in hospital and re-admission. Pathways are set up, whereby nursing and medical staff in the hospital will screen patients using AUDIT,[32] perhaps according to identified inclusion criteria (trigger conditions such as: falls and accidents; assault injuries; gastric, cardiovascular or psychiatric conditions; and repeat attenders). Patients who screen positive will be referred to the in-reach clinic. Services are likely to provide:

- comprehensive alcohol assessment
- evidence-based, structured brief interventions for patients not requiring specialist treatment
- recovery-orientated treatment for dependent drinkers
- prescribing interventions including medically assisted alcohol withdrawal initiated in the hospital setting and prescribing to support sustained abstinence
- follow-up of patients receiving alcohol detoxification in the hospital setting to speed up discharge by completing detoxification after discharge
- a step-up approach for patients requiring in-patient detoxification within a hospital setting.

High impact user services

High impact user (HIU) services identify and assertively engage with a relatively small number (maybe 20-30) of those patients who attend A&E or are admitted most frequently. High impact service user services may be provided as an integral part of

a wider hospital alcohol service e.g. as part of a multidisciplinary alcohol care team, or as a separate but integrated service by an outside agency.

Patients are likely to have complex needs and will often have alcohol and drug use problems, long term physical conditions and/or mental health problems and will make very frequent use of some of the more costly hospital services. They may attend A&E more than once a week and be re-admitted frequently for the same condition. HIU services will closely support patients in accessing healthcare, addictions, social and other services in order that they can stabilise their health conditions and so become less reliant on hospital services.

The RAID model

The Rapid Assessment, Interface and Discharge (RAID) service is a model of liaison psychiatry, developed in Birmingham City Hospital, which is now being adopted across Birmingham and in other areas. In some areas, existing alcohol care teams are being absorbed into RAID teams. The original model provided a rapid response, 24-hour, seven-day, age-inclusive service and a comprehensive range of mental health specialties. Alcohol-related problems comprised 13% of their study population.

Overall, in City Hospital, with 600 beds, the RAID service saved 43–64 beds per day, through linking patients to the right care pathway in the community. The elderly care wards provided most of the bed savings. During the period of the intervention, the City Hospital managed to close 60 beds, without cutting down on services.[33] The internal review estimated the financial savings to be £4–6m per year, based only on saved beds. Using a conservative calculation, the London School of Economics estimated the saving to be around £3.55m per year.[34]

There is a broad consensus from the RCP, NHS Evidence and other cost effectiveness case studies for the consultant-led, multi-disciplinary team including alcohol specialist nurses. This service model may not necessarily be the most appropriate for smaller hospitals and it is difficult to definitively identify this type of service from the staffing and functional data in the PHE survey. However, there is sufficient detail in the survey dataset to identify those hospitals (where they have reported fully) that have access to larger teams and those that are operating with solo staff.

5.1 The picture for current services

From the survey data, at least 30 hospitals appear to have the clinical leadership, capacity and designation of posts to provide consultant-led, multi-disciplinary care teams. In 27 hospitals it is clear that services operate with only one member of staff designated to the service, although almost all report specialist clinical leadership.

For other hospitals, inferences are more difficult to draw from the data alone. In the 2013 NCEPOD study,35 only 23% of hospitals had a multi-disciplinary team.

5.1.1 Scope of services

Scope of services (n 133)

Alcohol targeted services	96
Alcohol & drugs targeted services	37

5.1.2 Service functions

Service functions

Primarily alcohol liaison services	Primarily high impact user services	Wider public health service	not clear	Shared across multiple sites
114	21	7	7	11

Most (77%) of the services reported to the survey were primarily alcohol liaison services, providing prevention, treatment support and referral. A few of these services also provide some level of assertive outreach for high impact users, but this is not seen as their primary function.

21 services primarily provide assertive outreach to high impact users and seven were reported as wider public health services, for which alcohol is an aspect of the team's work, along with, for instance, mental health and caring for older people.

5.1.3 Clinical leadership

Clinical leadership (n 71)

Gastroenterology	26		
Hepatology	7		
ED and gastroenterology consultants	1	34	45.95%
A&E	19	19	25.68%
Substance misuse psychiatrist	10		
Consultant psychiatrist	3		
Consultant liaison psychiatrist	3		
Mental health	2	18	24.32%
Trust medical director	1		
Nursing	1		
Gastro/addictions	1		

Of the services that responded to the clinical leadership question in the survey, nearly half are led from hepatology or gastroenterology. A quarter of services are led by A&E consultants, and another quarter of services are led from psychiatry.

5.1.4 Staffing

Many services are provided on a trust-wide basis and so, cover more than one hospital. In some cases, posts are funded at less than one whole time equivalent, suggesting that duties within the alcohol service are part of a portfolio of roles for the workers. This is also reflective of opportunistic funding from a variety of sources that is reported to be common in hospital alcohol services.

The PHE survey collected information about clinical, management and administrative staffing of services. Some services report having only clinical staff, whereas others include administrators and a few, management staff.

5.1.5 Service base

Where services are based (n 113)

	Based in A&E dept	Based in medical assessment unit	Based in gastroenterology dept	Based in other depts
	57	11	24	21

Departments targeted (n 127)

	Targeting A&E Dept	Targeting Medical Assessment Unit	Targeting Gastroenterology Dept	Targeting many Depts
	100	76	77	58

Where in the hospital services are based is likely to be influenced by the objectives of the service and the motivation for commissioning it, which, in turn, are likely to reflect the senior clinical leadership of the service. The service base does not generally seem to limit their sphere of operation. While only relatively few services seem to operate in all departments, most operate across a number of key departments and no services reported that they operate only in the department in which they are based.

Half of the services that reported are based in A&E, with another 10% in medical assessment units (MAU). Nearly 80% target patients in A&E. Only 24% of services are based in gastroenterology departments. Most significant among the other service bases is liaison psychiatry.

While A&E or MAU provide the base for around 60% of services, nearly half of the hospitals that reported on clinical leadership indicated a gastroenterology or

hepatology lead. The remaining services reported clinical leadership from A&E (26%) and psychiatry (24%).

5.1.6 IBA provision

IBA provision (n 109)

	IBA in A&E dept	IBA in other wards/ depts	IBA in A&E by alcohol staff	IBA in A&E by A&E staff	IBA in other depts by alcohol staff	IBA in other depts by ward staff	Alcohol service but no IBA provision
	95	87	73	45	80	31	9
% of reported	87%	80%	67%	41%	73%	28%	8%

The government's alcohol strategy 2012[36] supports the use of identification and brief advice (IBA) in A&E, as an intervention that has been "proven to reduce drinking, leading to improved health and reduced calls on hospital services", for people who are drinking at levels that put their health at risk, but are not dependent and not necessarily seeking help for alcohol problems.

NICE PH24 recommends that IBA should be routinely provided by all frontline health and social care staff and therefore across the whole hospital.

The focus on A&E as the setting for IBA in hospitals may be linked to the fact that the evidence base for hospital alcohol services has been largely derived from A&E, where many of the early hospital alcohol liaison nurse services were based. Of the 109 hospitals that responded to the IBA section of the survey, 95 provide it in A&E. However, 87 reported that they also provide it in other departments. Only five hospitals reported that they do not have IBA provision in A&E, but all of those provide in other wards.

Many hospitals will undertake a shortened pre-screen, such as AUDIT-C or the Modified Single Alcohol Screening Question (M-SASQ), in A&E to identify alcohol misuse and make referral for a follow up with a member of the alcohol care team at a later time for a full AUDIT and brief advice. As found in the study in Paddington (see page 15), this leads to attrition, as many patients who are not admitted do not re-attend for the follow-up appointment.

5.1.7 IBA training

IBA training (n 109)

	IBA training to hospital staff	IBA training to primary care staff	training in other settings
	75	15	10
% of reported	69%	14%	9%

Seventy-five alcohol care teams reported that they train other hospital staff in inpatient and outpatient departments and 25 provide training beyond the hospital into primary care, social care etc. Use of the expertise of the specialist staff in this way can exponentially expand IBA provision. In some hospitals, IBA is included in making every contact count (MECC) initiatives and/or is incentivised by commissioning for quality and innovation (CQUIN) payments.

The Royal Bolton Hospital recently reported having trained over 600 practitioners in IBA throughout the hospital. All inpatients are routinely screened, using the AUDIT C alcohol questionnaire, facilitating detection of risky drinkers and thus offering opportunities to provide brief health improvement advice and a better chance of early identification of patients with previously undiagnosed liver disease.

5.1.8 Extended brief intervention and brief treatment

Seventy-two per cent of services (n 109) reported that they provide extended brief intervention (EBI). The survey did not differentiate between single and multiple extended brief interventions.

EBI is a 20-30 minute motivational interviewing intervention aimed at reducing alcohol consumption. NICE Public Health Guidance PH24 recommends EBI for those who have not responded to identification and brief advice. A short programme of multiple EBI sessions (also known as brief treatment) is also recommended by NICE as the appropriate intervention for mildly dependent drinkers without complex needs. In order to help clarify the terms, IBA, EBI and brief treatment, in 2013 the Alcohol Academy produced a helpful briefing paper*, '*Clarifying alcohol brief interventions (updated)'.[37]

5.1.9 Detoxification support

78% of services (n 109) reported that they provide support for medically-assisted withdrawal or "detoxification". Only 39% reported that they facilitate detoxification completion in the community. 45 services employ nurse prescribers.

A key role for alcohol specialists in hospitals is to improve care, by supporting colleagues on the wards in detoxifying alcohol dependent patients who require emergency detoxification after they have been admitted. One of the main ways in which alcohol care teams achieves savings is by reducing unnecessary bed days by ensuring that patients can complete detoxification out of the hospital.

5.1.10 High impact user (HIU)/high volume service users (HVSU)

In the PHE survey 21 hospitals reported providing HVSU services. These services are also known as assertive outreach, high impact user or frequent flyer services.

Case study: Sherwood Forest Hospitals NHS Foundation Trust work with HVSU
Sherwood Forest Hospitals NHS Foundation Trust (Sutton in Ashfield, Nottinghamshire) alcohol and drug liaison team had a key role with HVSU. The team defined HVSUs as those with three or more A&E attendances in one calendar month or five or more AE attendances in any six-month period.

Based on these definitions, the 30 most frequent users of services were identified. Data were interrogated further to identify the contributory factors for high volume service use. This included examining electronic and paper healthcare records; looking at past referrals/involvement with hospital liaison and community alcohol and drug services. Looking at reasons for presentation and discharge codes and a patient assessment for HVSU was designed for use by A&E staff.

Alcohol was the largest single contributory factor, but was only a factor in 48% of HVSU presentations. Other contributory causes were: long term physical health conditions; psychiatric disorders (most notably personality disorder); social Issues (such as vulnerable adults with insufficient community care packages, homelessness); and domestic violence.

A cohort of 33 individuals was intensively managed from 1 January 2011 to 30 December 2012. The first 12 months being pre-interventions from the team, the period from December 2012 to June 2012 was the intervention period and the following six months was included as a post-intervention period.

Of the 33 individuals the team started to monitor, only 11 remain HVSU in the post-intervention period; of the 22 that are no longer HVSU, two were deceased. For the 22 that were HVSU but are not now, the combined number of A&E attendances in the 18 months to June 2012 was 265 while in the six months from July 2012 to December 2012 it was 14.

NB. Although this data suggests a positive impact of the interventions it must be stressed that this was not a formal research study but was a service evaluation employed to inform service developments.

6. Discussion

It is encouraging that the number of hospital alcohol services has increased steadily since 2007-08 and that the majority of the largest hospitals are covered by a service. However, nine of the 55 largest (2k+) hospitals are not known to have services. Large hospitals are best placed to carry out and benefit from well integrated alcohol care teams.

There is a strong case to be made that effective alcohol care teams provide, both health improvement activities that are an integral part of CCG commissioned healthcare services and specialist care that improves quality and cost effectiveness in NHS services.

Of the services that responded to the PHE survey, many appeared to have fairly secure funding arrangements in place. However, at the beginning of the 2013-14 financial year ten reported being unclear about future funding and three reported that no funding would be available. There is a danger that hospital services will be lost if lack of clarity about funding responsibilities creates inertia or deadlock between local partners.

The RAID model, first developed in Birmingham is currently being implemented or explored in a number of other areas and there are reports that existing alcohol care teams are being absorbed into new services with wider psychiatric liaison remits. If the evident benefits of addressing alcohol misuse are to be maintained it will be important that an alcohol focus and resource is retained and, within teams, the psychiatric and alcohol specialisms are well integrated.

While the evidence base for alcohol care teams is growing, there is not enough information available with which to compare the respective effectiveness of different models, for example, hospital-based consultant-led teams against community based services that in-reach into the hospital. The advisory group felt that Information on the size of teams may not be as directly meaningful as it might at first seem and that measuring outcomes of services would be much more informative. More evaluative data would assist in comparing the most effective models.

Data on interventions provided was not sought in the PHE survey because there are few published examples of evaluation and it was estimated that many services do not have this information readily to hand. Identifying the level of activity and cross-referencing it against staffing would be an important step in identifying optimum effectiveness and would inform commissioning considerably.

In developing a minimum dataset for measuring the effectiveness of alcohol care teams, a suggestion from the expert group was that it will be most useful to collect data that enables comparison of the number of patients referred to the service with number actually seen, including time and day of week referrals are received, because:

- overall number referred indicates success/progress of IBA training, local guidelines and processes
- it serves to illustrate the number of opportunities missed to provide specialist interventions if sufficient resourcing was in place
- it informs optimum disposition of existing staff resources

7. Recommendations

- every district general hospital should consider the best way to provide effective specialist alcohol care for its patients in light of the benefit to patient care and the available efficiency savings
- local partners, should engage with the health and wellbeing board to ensure that existing services for alcohol and other drugs are maintained and developed, on the basis of local needs assessment
- hospital alcohol care teams should accelerate IBA delivery throughout the hospital, by supporting the training of colleagues in all clinical areas
- local partners should review the response to alcohol-related harm in all district general hospitals, using this document as a guide, and they should ensure that existing services are adequately integrated across primary and secondary care and that new services are implemented where there are none
- local partners should consider employing assertive out-reach or in-reach services for high impact service users in all major hospitals and existing services should be comprehensively evaluated to assess their impact on hospital and community services
- completion of detoxification in the community is a key opportunity for achieving savings by reducing unnecessary bed days. System planning should ensure that community services are accessible and available to ensure continuation of detoxification with psychosocial interventions outside of the hospital

Recommendations for future work

- PHE should work with an expert advisory group to develop pro-forma service specifications for each service model
- PHE should work with an expert advisory group to develop a common minimum dataset by which services can demonstrate effectiveness and plan improvement
- collection and analysis of outcome data to compare the effectiveness of different models of specialist provision
- research to understand how services that include alcohol, but which have a broader focus, in particular RAID services, respond to alcohol misuse, compared with specialist hospital alcohol services would be extremely valuable
- PHE and NHS England should consider undertaking a subsequent survey of hospital alcohol services to compare and report on levels and models of service provision against the current baseline.

Appendix 1. Case studies

Royal Bolton Hospital

The Royal Bolton Hospital has a consultant-led alcohol care team. Since 2009, the five gastroenterology consultants devote two-week periods solely to inpatient care, with daily ward rounds and multi-disciplinary meetings. This has reduced inpatient mortality from 11.2% to 6% and length of stay from 11.5 to 8.9 days, with a 37% increase in discharges.[38] Between 2006-2011, when there were only two alcohol specialist nurses working in partnership, inpatient detoxifications were reduced, saving the trust more than 1,000 bed days annually, equivalent to £250,000 in reduced admissions alone. In 2012, with four nurses providing a seven-day service, a further 1,000 bed days have been saved and readmission rates have been reduced by 3%, compared with an increase across the region.[39]

Alcohol specialist nurse service in Nottingham

Implementation of an alcohol specialist nurse service in Nottingham improved the health outcomes and quality of care of patients admitted to hospital for detoxification, and also of those admitted for the complications of alcohol-related cirrhosis. Hospital admissions were reduced by two-thirds, resulting in a saving of 36.4 bed days per month in patients admitted for detoxification. Clinical incidents were reduced by 75%. Liver enzyme abnormalities were halved and there was also a reduction in bed days used in the cirrhotic group from 6.3 to 3.2 days per month.[40]

Royal Liverpool Hospital

The Royal Liverpool Hospital has alcohol specialist nurses covering A&E and inpatient care and a nurse-led alcohol treatment outpatient service provides daily clinics in different locations across the city. For patients with severe liver disease, a joint treatment plan is developed with community, the alcohol team and the hepatologists. An average of 300 patients per year are helped to complete detoxification as outpatients and the service prevents 200 admissions per year. (For more see: www.alcohollearningcentre.org.uk/LocalInitiatives).

Queen Alexandra Hospital Portsmouth

At Queen Alexandra Hospital in Portsmouth, there are 4.5 whole time equivalent (WTE) alcohol specialist nurses, with one WTE administrator. In 2012-13, this service saved NHS Portsmouth 1071 bed days and NHS Hampshire 952 bed days; 71% of patients now complete detoxification in the community, which saves between two and five bed days per patient

Appendix 2. Benefits across the community

The far-reaching nature of alcohol-related harm means that reducing consumption in increasing and higher risk drinkers and engaging dependent drinkers in effective treatment interventions will have benefits across the local economy and community and the indicator frameworks used to measure improvement in local services.

Public Health Outcomes Framework

The impact of alcohol misuse extends far beyond hospitals and health and is often collateral. Addressing alcohol misuse among non-dependent alcohol misusers and treating dependent drinkers can have an impact on a number of indicators within the Public Health Outcomes Framework.

1. Improving the wider determinants of health

Indicator 1.4: First-time entrants to the youth justice system

In 2003, 16% of offenders aged 11 to 16 in mainstream education reported being under the influence of alcohol when offending. This increases to 26% for those aged 10 to 16 who had been excluded from school.[1] Access to effective alcohol treatment could therefore potentially have a significant impact on this indicator.

Indicator 1.5: 16 to 18-year olds not in education, employment or training

Thirteen per cent of 16 to 18 year old non-participants in education and employment are dependent on alcohol, compared with 5% of participants.[2]

Indicator 1.9: Sickness absence rate

Lost productivity due to alcohol is estimated to be £7.3bn a year.[3] The International Labour Organisation estimates that, globally, 3-5% of the average workforce is alcohol dependent. Up to 17 million working days are lost annually due to alcohol-related absence.[4]

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[1] Youth Justice Board (YJB) (2003). Youth Survey 2003 Research Study conducted for the Youth Justice Board by MORI January – March 2003. http://www.yjb.gov.uk/publications/Scripts/prodView.asp?idproduct=117&eP

[2] Social Exclusion Unit (1999b) Bridging the gap: New opportunities for 16–18 year olds not in education, employment or training, Stationery Office, London.

[3] UK Parliament (2012) Health Committee - Written evidence from the Department of Health (GAS 01) http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm#footnote_25

[4] Institute of Alcohol Studies (IAS) (2011) Alcohol and the Workplace. http://www.ias.org.uk/Alcohol-knowledge-centre/Alcohol-in-the-workplace.aspx

Indicator 1.10: Killed or serious injured casualties on England's roads

430 deaths and 1600 serious injuries every year are attributable to drink driving.[5] Road Traffic Mortality is part of the Local Alcohol Profiles for England.

Indicator 1.11: Domestic abuse

Seventy-three per cent of domestic violence offenders had used alcohol before the offence, 48% are alcohol dependent.[6] According to a Journal of the American Medical Association (JAMA) report,[7] some studies also suggest that people are more likely to be victims of domestic abuse if they use alcohol[8] and that victims of domestic abuse are more likely to misuse substances.[9]

Indicator 1.12: Violent crime (including sexual violence)

A minimum of one in five people arrested by police for violent crime, tests positive for alcohol.[10] An all party group of MPs investigating alcohol and crime[11] was advised by the British Medical Association that alcohol is a factor in: 60-70% of homicides; 75% of stabbings; 70% of beatings; and 50% of fights and domestic assaults.

Indicator 1.15: Statutory homelessness

There is a strong link between alcohol and drugs misuse and homelessness. For example, according to Broadway's CHAIN database, the proportion of people seen rough sleeping with an alcohol support need in 2012-13 was 41%.[12]

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[5] Report of the Review of Drink and Drug Driving Law (2010) http://webarchive.nationalarchives.gov.uk/20100921035225/http://northreview.independent.gov.uk/docs/NorthReview-Report.pdf

[6] Gilchrist, E. et al (2003) Domestic violence offenders: characteristics and offending related needs, Findings, 217, London, Home Office

[7] Brookoff et al (1997) Characteristics of Participants in Domestic Violence Assessment at the Scene of Domestic Assault. Journal of the American Medical Association (JAMA). May 7, 1997, Vol 277, No. 17. http://jama.jamanetwork.com/article.aspx?articleid=415838

[8] 29. Galvani, S. (2010) Grasping the nettle: alcohol and domestic violence. 2nd Edition. London: Alcohol Concern

[9] No Boundaries. The Tayside Domestic Abuse and Substance Misuse Project Final Research Report. (2008) Dolev & Associates

[10] Drugs and Crime: The Results of Research on Drug Testing and Interviewing Arrestees. Home Office Research Study 18, London and Bennett T, Drugs and Crime: the results of the Second Developmental Stage of the New- Adam Programme. Home Office Research Study 205, 2000

[11] 2007, 'Alcohol and Crime: Breaking the Link. All-Party Group on Alcohol Misuse'.

[12] Street to Home Annual Report 2012/2013 http://www.broadwaylondon.org/CHAIN/Reports/S2h2013/Street-to-home-report-2012_13.pdf

2. Health Improvement

Indicator 2.1: Low birth weight of term babies

Ten per cent of children of alcohol-dependent mothers suffer from foetal alcohol effects.[13] Effective alcohol treatment is known to reduce alcohol dependence, which in turn, could prevent low birth weight of term babies.

Indicator 2.10: Hospital admissions as a result of self-harm

The Royal College of Psychiatrists states that the risk of suicide is higher if people are depressed, or have a serious mental illness and use drugs or alcohol when they are upset. Intentional self-harming is recorded as an alcohol-related hospital admission.[14]

Indicator 2.12: Excess weight in adults

Body mass index (BMI) of individuals who drink alcohol may be related to how much, and how often, they drink, according to a study[15] by researchers at the National Institute of Health's National Institute on Alcohol Abuse and Alcoholism (NIAAA). This can contribute to excess weight in adults. Alcohol treatment could therefore be associated with a reduction in excess weight in adults.

Indicator 2.18; Alcohol related admissions to hospital

A dependent drinker costs the NHS twice as much other drinkers and the largest and most immediate reduction in alcohol-related admissions can be achieved by intervening with this group through the provision of specialist treatment.[16]

Indicator 2.22: Take up of the NHS Health Check programme by those eligible

Alcohol identification and any subsequent brief advice needed became a requirement within the NHS Health Check for adults from age 40 to 75 from April 2013. One in eight recipients of IBA will reduce to lower risk drinking.

Indicator 2.24: Falls and injuries in the over 65s

RCPSYCH notes: balance gets worse with age - even a small amount of alcohol can make you more unsteady and more likely to fall. Alcohol misuse appears to be

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[13] HDA's Evidence Briefing Prevention and reduction of alcohol misuse: a review of reviews. 2nd Edition, December 2004. Authors: Caroline Mulvihill, Lorraine Taylor and Seta Waller

[14] Royal College of Psychiatrists College Report CR 158: Self-harm, suicide and risk: helping people who self-harm (2010)

[15] US Department of Health and Human Services (2005) Study Associates Alcohol Use Patterns with Body Mass Index. http://www.nih.gov/news/pr/feb2005/niaaa-15.htm

[16] Department of Health (2009) Signs for Improvement. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104854.pdf

on the increase in older adults and this may be a contributing factor to falls and injuries in this age group.[17]

4. Healthcare public health and preventing premature death.

Indicator 4.1: Infant mortality

Among term infants, intake of at least 4 drinks of alcohol per week or binging on 3 or more occasions during pregnancy are associated with an increased risk of infant mortality, especially during the post neonatal period. Reducing alcohol consumption in pregnancy can reduce infant mortality.[18]

Indicator 4.3: Mortality from causes considered preventable

An estimated 21,485 deaths were attributable to alcohol consumption in England in 2011-12.[19]

Indicator 4.4: Mortality from all cardiovascular diseases (including heart disease and stroke)

The alcohol-attributable fractions include the conditions where there is a significant evidential link with alcohol misuse. The cardiovascular conditions included are: Hypertensive diseases, ischaemic heart disease, cardiac arrhythmias, heart failure, haemorrhagic stroke and ischaemic stroke.[20]

Indicator 4.5: Mortality from cancer

The alcohol-attributable fractions include the conditions where there is a significant evidential link with alcohol misuse. The cancers included, are: lip, oral cavity and pharynx; oesophagus; colon; rectum; liver and intrahepatic bile ducts; larynx; breast.[21]

Indicator 4.6: Mortality from liver disease

In 2012, alcohol accounted for 63% (4,425) of liver disease deaths, 18% higher than the number of deaths in 2002 at 3,629. The majority (31%) of deaths from alcoholic liver disease were among those aged 50-59 years. The number of alcoholic liver

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[17] 68. Blow, F.C. & Barry, K.L. (2012) Alcohol and Substance Misuse in Older Adults. Current Psychiatry Reports, 14(4): 310-319.

[18] Review of the Health Inequalities Infant Mortality PSA Target (DH 2007) See Annex 6 for interventions to reduce infant mortality: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_065545.pdf

[19] Office for National Statistics Public Health Mortality File for 2012 and mid-year population estimates for 2012.

[20] Centre for Public Health. Alcohol-Attributable Fractions Report 2013 http://www.cph.org.uk/wp-content/uploads/2014/03/24892-ALCOHOL-FRACTIONS-REPORT-A4-singles-24.3.14.pdf

[21] Centre for Public Health. Alcohol-Attributable Fractions Report 2013 http://www.cph.org.uk/wp-content/uploads/2014/03/24892-ALCOHOL-FRACTIONS-REPORT-A4-singles-24.3.14.pdf

disease deaths tended to increase for those aged 40 years and over between 2002 and 2012.[22]

Indicator 4.10: Suicide

Forty-one per cent of suicides are associated with alcohol misuse,[23] Accessing drug and alcohol treatment improves access to and effectiveness of mainstream mental health and psychological therapy services.[24]

Indicator 4.11: Emergency readmissions within 30 days of discharge from hospital

Alcohol treatment, especially hospital based services should help reduce rates of readmissions for patients with alcohol related hospital admissions.[25] DH estimates that homeless people are often discharged too early and use four times more acute and eight times more inpatient health services than the general population.[26]

Indicator 4.14: Hip fractures in over 65s

Royal College of Psychiatrists notes: balance gets worse with age – even a small amount of alcohol can make you more unsteady and more likely to fall. Alcohol and substance misuse appears to be on the increase in older adults and this may be a contributing factor to falls and injuries in this age group.

NHS Outcomes Framework

Domain 1. Preventing people from dying prematurely. This domain captures how successful the NHS is in reducing the number of avoidable deaths: Maximising efficacy of alcohol withdrawal management reduces risks, as does reducing number of people returning to problematic drinking. Routine identification and referral of dependent drinkers to specialists for assessment can improve early identification of liver disease and improve survival rates.

Domain 2. Enhancing quality of life for people with long-term conditions. This domain captures how successfully the NHS is supporting people with long-term conditions to live as normal a life as possible In relation to alcoholic liver disease clear pathways are needed from across the hospital, primary care and community

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[22] Alcohol-related deaths in the United Kingdom, registered in 2012, released on 19 February 2014 by the Office for National Statistics. http://www.ons.gov.uk/ons/dcp171778_353201.pdf

[23] National Collaborating Centre for Mental Health (2011). Alcohol Use Disorders. The NICE clinical guideline on diagnosis, assessment and management of harmful drinking and alcohol dependence. National Clinical Practice Guideline 115. http://www.nice.org.uk/guidance/cg115

[24] NTA and DrugScope (2012) IAPT positive practice guide for working with people who use drugs and alcohol - http://www.iapt.nhs.uk/silo/files/iaptdrugandalcoholpositivepracticeguide.pdf

[25] Moriarty, K. et al. (2010) Alcohol Related Disease: Meeting the Challenge of Improved Quality of care and Better Use of Resources http://www.bsg.org.uk/clinical/publications/alcohol-related-disease-2010.html

[26] Office of the Chief Analyst (2010). Healthcare for Single Homeless People. London: Department of Health. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114369.pdf

substance misuse services to liver specialist medical teams improved by alcohol care teams/specialists in substance misuse.

Domain 3. Helping people to recover from episodes of ill health or following injury. This domain captures how people recover from ill health or injury and, wherever possible, how it can be prevented: hospital alcohol services provide interventions to promote recovery and create coherent links between hospital-based interventions and community based recovery-promoting substance misuse services. Alcohol misuse contributes significantly to over 60 conditions. Alcohol care teams can routinely provide, and train others to provide, identification and brief advice to non-dependent alcohol misusers to reduce the risk of prolonged recovery time or recurrence due to continued alcohol misuse.

Domain 4. Ensuring that people have a positive experience of care. This domain looks at the importance of providing a positive experience of care for patients, service users and carers.

Hospital alcohol services improve the treatment of patients who are alcohol dependent as core business.

Domain 5. Treating and caring for people in a safe environment and protecting them from avoidable harm. This domain explores patient safety and its importance in terms of quality of care to deliver better health outcomes.

Significant risks of harm are associated with the alcohol withdrawal period. Interventions, to maximise the care of patients during such periods is a main aim of hospital alcohol services.

NICE Public Health Guideline [PH24], recommends that identification and brief advice should be routinely delivered by professionals who have received the necessary training and work in:

- primary healthcare
- emergency departments
- other healthcare services (hospital wards, outpatient departments, occupational health, sexual health, needle and syringe exchange programmes, pharmacies, dental surgeries, antenatal clinics and those commissioned from the voluntary, community and private sector)

Alcohol care teams can routinely deliver, and train others to deliver, identification and brief advice, which is proven to reduce the risk of over 60 conditions to which alcohol misuse contributes significantly, thus reducing the risk of avoidable ill health.

Appendix 3. Hospitals with alcohol services by PHE centre area

The PHE survey found that, of 191 district general hospitals estimated to be an appropriate size to merit an alcohol service, at least 139 (73%) offer some level of specialist alcohol service. The notional size of hospitals in the PHE report is based on data for the number of discharges in one month (July 2013) from DH unify2 data.

National			
Hospital size	**hospitals**	**covered by service**	**%**
3k+	12	10	83%
2k-3k	43	36	84%
1k-2k	109	78	72%
500-1k	27	15	56%
Total	**191**	**139**	**73%**

South East			
Hospital size	**hospitals**	**covered by service**	**%**
3k+	1	1	100%
2k-3k	7	5	71%
1k-2k	17	11	65%
500-1k	5	2	40%
Total	**30**	**19**	**63%**

Anglia and Essex, South Midlands & Herts			
Hospital size	**hospitals**	**covered by service**	**%**
3k+	1	1	100%
2k-3k	9	9	100%
1k-2k	9	9	100%
500-1k	1	1	100%
Total	**20**	**20**	**100%**

Yorkshire & Humber			
Hospital size	**hospitals**	**covered by service**	**%**
3k+	3	3	100%
2k-3k	2	2	100%
1k-2k	15	12	80%
500-1k	2	0	0%
Total	**22**	**17**	**77%**

Cumbria & Lancashire, Greater Manchester, Cheshire & Merseyside			
Hospital size	**hospitals**	**covered by service**	**%**
3k+	0	0	0%
2k-3k	9	7	78%
1k-2k	14	11	79%
500-1k	5	2	40%
Total	**28**	**20**	**71%**

Devon Cornwall & Somerset, Avon Gloucestershire & Wiltshire			
Hospital size	**hospitals**	**covered by service**	**%**
3k+	1	0	0%
2k-3k	3	2	67%
1k-2k	9	8	89%
500-1k	3	3	100%
Total	**16**	**13**	**81%**

East Midlands			
Hospital size	**hospitals**	**covered by service**	**%**
3k+	3	3	100%
2k-3k	1	1	100%
1k-2k	6	4	67%
500-1k	0	0	0%
Total	**10**	**8**	**80%**

West Midlands			
Hospital size	**hospitals**	**covered by service**	**%**
3k+	2	1	50%
2k-3k	3	2	67%
1k-2k	13	3	23%
500-1k	2	1	50%
Total	**20**	**7**	**35%**

London			
Hospital size	**hospitals**	**covered by service**	**%**
3k+	0	0	0%
2k-3k	6	5	83%
1k-2k	19	13	68%
500-1k	8	5	63%
Total	**33**	**23**	**70%**

North East			
Hospital size	**hospitals**	**covered by service**	**%**
3k+	1	1	100%
2k-3k	3	3	100%
1k-2k	7	7	100%
500-1k	1	1	100%
Total	**12**	**12**	**100%**

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