

EXECUTIVE SUMMARY

Introduction

Alcohol misuse and alcohol-related problems, especially binge drinking and alcohol-related liver disease, are major public health concerns. Recently, much attention has focused on social policy and measures to reduce drinking. There is an additional need to provide care for a large and growing group of patients with alcohol-related problems, where national quality standards are lacking and the absence of coordinated policies means care is imperfect and spending is poorly targeted and ineffective.

In 2006/7, alcohol misuse cost the UK economy £25.1 billion. Of this, the NHS expenditure was £2.7 billion. In 2008, over 78% of the costs were incurred as hospital-based care. This booklet paper is based on the expectation that a substantial proportion of this spending is avoidable and that alcohol services could be significantly more effective, cheaper and person-centred, if each health district had a plan, integrated between primary and secondary care, to deliver evidence-based care in an appropriate setting.

This paper, which focuses particularly, but not exclusively, on secondary care, makes 11 key recommendations relevant to a typical British District General Hospital, serving a population of 250,000. If implemented, they should improve quality and efficiency of care, lower mortality and reduce admissions and readmissions for patients with alcohol-related problems. The paper provides the evidence-base for effective policies and an appropriate workforce required to implement them.

Recommendations

Our principal recommendation is for a multidisciplinary “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 implement a district alcohol strategy.

Hospitals should have coordinated policies of care for patients with alcohol-related problems in Accident and Emergency and Acute Medicine departments, including a 7-day Alcohol Specialist Nurse Service, a Mental Health Crisis Team and an Alcohol Link Workers’ Network. These would provide access to Brief Interventions or advice and appropriate services within 24 hours of detection of an alcohol-related problem. The structured advice lasts 20-40 minutes and involves personalised feedback to individuals about their level of health risk due to alcohol, practical advice about reducing alcohol consumption, with a range of options for change, and written information to support the advice.

Each health district 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. The

AOAS team might include an emergency physician, acute physician, psychiatric crisis team member, alcohol specialist nurse, Drug and Alcohol Action Team member, hospital/community manager and Primary Care Trust Alcohol Commissioner, with links to local authority, social services and third sector agencies and charities.

If each DGH establishes a 7-day Alcohol Specialist Nurse Service to care for patients admitted for 0-1 day, together with an AOAS to care for frequent hospital attenders and long-stay patients, for example those with alcohol-related liver disease, healthcare modelling methodology suggests that this could result in a 5% reduction in alcohol-related hospital admissions, with potential cost-savings to its locality of £1.6 million annually. Since the UK population in 2008 was 61.4 million, this would equate to an annual saving for the overall UK economy of £393 million.

In hospitals, there should be adequate staffing by Consultants in gastroenterology and hepatology. These should be supported by input from liaison and addiction psychiatrists. Collaborative, integrated care between specialists working in gastroenterology and hepatology, psychiatry and in primary care is essential. Care should be person-centred, holistic, timely, non-judgmental and responsive to the needs and views of patients and their families.

Integrated Alcohol Treatment Pathways (ATPs) should be developed between primary and secondary care. This will help drive the shift from secondary care to care within the community and hence reduce costs. Enhanced services must be developed in primary care to screen and detect alcohol misuse and alcohol-related harm, especially liver disease, at an early stage. ATPs should be developed for drug and alcohol misusers, since patients can have multiple problems, requiring co-ordination of treatment by several specialists and generic service providers. All ATPs need a coordinated strategy to address both the medical and psychiatric aspects of actual or potential alcohol-related harm.

Better National Indicators, with more accurate hospital episode, workload and mortality statistics, are needed, as well as Quality metrics, to facilitate assessment of the local alcohol strategy. There should be mandatory targets on providing alcohol services and on reducing alcohol-related admissions and readmissions. Quality assessments should include service evaluation by patients, families and carers.

In order to facilitate this, training modules should be established, run jointly for psychiatrists and physicians, including hepatologists, gastroenterologists, A & E and acute physicians and for alcohol and mental health specialist nurses. They would focus on the assessment and treatment of both the psychiatric and medical aspects of alcohol-related problems, substance and drug misuse and addiction. Accreditation of competencies at a national level should be developed for clinicians, nurses and for Units treating people with alcohol-related disease.

There needs to be targeted research into the causes, prevention and treatment of alcohol-use disorders, especially liver disease, as well as educational initiatives to

maximise the effectiveness of public awareness and deterrence and bring about a change in social attitudes and our drinking culture. Clinical trials are needed to assess the efficacy of pharmacological and psychosocial interventions, which may assist abstinence. Cost-effective alcohol strategies, including the Department of Health “High Impact Changes”, should be implemented, with sharing of model practice via the National Treatment Agency for Substance Misuse and the Department of Health Alcohol Learning Centre.

Future Care

Currently, alcohol treatment services are not adequately equipped to cope with the nation’s alcohol problem. However, there are hopeful signs. The 3 NICE guidelines on alcohol-use disorders, together with the National Plan for Liver Services 2009, will emphasise Public Health, prevention and treatment measures and the need for a specialist alcohol workforce, especially for Consultants in gastroenterology and hepatology and alcohol specialist nurses.

In Parliament, there is increasing cross-party consensus to introduce a range of coordinated measures, related to minimum unit pricing, advertising and licensing, to reduce alcohol consumption at a population level. Reports from the All Party Parliamentary Group on Alcohol Misuse, the House of Commons Public Accounts Committee and the House of Commons Health Select Committee have highlighted the gaps in our alcohol services and the urgent need for the development of cost-effective pathways of alcohol care. Implementation of our key recommendations will achieve this.

For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower risk levels. This compares favourably with smoking, where only one in twenty will act on the advice given. Thus, brief interventions can work well.

Moreover, specialist alcohol care can pull people back from the brink of the most devastating consequences of alcohol misuse, especially alcohol-related liver disease, give them back their self-respect and restore them to their families and communities. The development of high quality, integrated prevention and treatment services for people with alcohol-related disease will prove to be a wise investment for the future health of our nation, especially that of our young people.

KEY RECOMMENDATIONS

In a typical British District General Hospital, serving a Population of 250,000, there should be:

1. A multidisciplinary “Alcohol Care Team”, 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 implement a district alcohol strategy.
2. Coordinated policies on detection and management of alcohol-use disorders in Accident and Emergency departments and Acute Medical Units, with access to Brief Interventions and appropriate services within 24 hours of diagnosis.
3. A 7-Day Alcohol Specialist Nurse Service and Alcohol Link Workers’ Network, consisting of a lead healthcare professional in every clinical area.
4. Liaison and Addiction Psychiatrists, specialising in alcohol, with specific responsibility for screening for depression and other psychiatric disorders, to provide an integrated acute hospital service, via membership of the “Alcohol Care Team”.
5. Establishment of a hospital-led, multi-agency Assertive Outreach Alcohol Service, including an emergency physician, acute physician, psychiatric crisis team member, alcohol specialist nurse, Drug and Alcohol Action Team member, hospital/community manager and Primary Care Trust Alcohol Commissioner, with links to local authority, social services and third sector agencies and charities.
6. Multidisciplinary, person-centred care, which is holistic, timely, non-judgmental and responsive to the needs and views of patients and their families.
7. Integrated Alcohol Treatment Pathways between primary and secondary care, with progressive movement towards management in primary care.
8. Adequate provision of Consultants in gastroenterology and hepatology to deliver specialist care to patients with alcohol-related liver disease.
9. National Indicators and Quality metrics, including alcohol-related admissions, readmissions and deaths, against which hospitals should be audited.
10. Integrated Modular Training in alcohol and addiction, available for alcohol specialist nurses and trainees in gastroenterology and hepatology, acute medicine, accident and emergency medicine and psychiatry.
11. Targeted funding for research into detection, prevention and treatment strategies and outcomes for people with alcohol-use disorders.

Many of these recommendations can be implemented by intelligent re-organisation and coordination of existing alcohol services, while some require investment in people.

INTRODUCTION

Alcohol misuse and alcohol-related problems, especially binge drinking and alcohol-related liver disease, are major public health concerns. Rising alcohol consumption and increasing incidence of cirrhosis are seen across all ages and sections of society. As a nation, we need to reduce the increasing dependency on alcohol and the burden this places on the NHS and society as a whole.

In 2008, in England, there were 9,031 deaths directly related to alcohol.

<http://www.statistics.gov.uk/pdffdir/ghs.0110.pdf>

The majority die from alcohol-related liver disease (ALD). These figures are probably a gross underestimate, with possibly as many as 40,000 deaths annually being due to alcohol misuse. In England, liver cirrhosis mortality approximately trebled between 1970 and 1998. In the 35 to 44 years age group, the death rate increased eight-fold in men and almost seven-fold in women, while there was a four-fold increase in 25 to 34 year olds.¹

The rapid escalation of liver-related deaths is shown in Figure 1. All mortality data are relative to 1970 and show a fall from most common diseases, but a rapid escalation in liver-related deaths, mainly due to alcohol.

There is an urgent need for more liver donors, as illustrated by the tragic cases of young people in their 20's dying from ALD, without having the chance of a liver transplant. Consultants in gastroenterology and hepatology are now caring for teenagers with end stage ALD or severe, life-threatening pancreatic necrosis, after just five years of sustained heavy binge drinking.

In 2006/7, the NHS expenditure on alcohol services was £2.7 billion.² In 2008, over 78% of costs were incurred as hospital-based care, including both outpatient and inpatient costs. Inpatient NHS costs alone were responsible for ~ 45% of the £2.7 billion.³ Ambulance costs were 14% and General Practice costs 4%. In 2001, only 12% of alcohol costs were related to inpatient care.⁴ Hospitals and community-based services need to provide high quality, cost-effective, person-centred care in an appropriate setting. However, a 2009 survey showed that only 42% of acute hospitals surveyed had any alcohol specialist nurse support.⁵

Alcohol harms health through three mechanisms: namely acute intoxicating effects, occurring after a single binge; chronic toxic effects, following years of harmful drinking; and a propensity for addiction, leading to physical and psychological dependency. There are around 70 diseases and injuries, where alcohol contributes to causation.⁴

Economic Burden in the UK

The cost of alcohol misuse in the UK can be divided into four categories:

- **Healthcare service costs** – including costs to primary care services and hospital services (A & E, medical and surgical inpatient services, paediatric services, psychiatric services and outpatient departments) of alcohol-related morbidity and mortality
- **Cost of alcohol-related crime, disorder and anti-social behaviour** – including costs to the criminal justice system, cost to services (e.g. social work services), costs of drink driving and the human cost of alcohol-related harm (e.g. assault)
- **Loss of productivity and profitability in the workplace** – including costs to the economy from alcohol-related deaths and alcohol-related lost working days
- **Impact on family and social networks** – including human and emotional costs, such as breakdown of marital and family relationships, poverty, loss of employment, domestic and child abuse, homelessness and other drug use. This includes the effects of “passive drinking” on “significant others”. On average, the problem drinker affects the lives of six other people.⁶

In 2006/7, while alcohol misuse cost the NHS £2.7 billion, it cost the overall UK economy £25.1 billion.² Indeed, the National Social Marketing Centre estimated that the total annual societal cost of alcohol misuse in England in 2007 was £55.1 billion, including:

- £21 billion cost to individuals and families/households (e.g. loss of income, informal care costs)
- £2.8 billion cost to public health services/care services
- £2.1 billion cost to other public services (e.g. criminal justice system costs, education and social services costs)
- £7.3 billion cost to employers (e.g. absenteeism)
- £21.9 billion in human costs (DALYs).⁷

Alcohol and Health Inequalities

Emerging data are beginning to identify the effects of alcohol misuse in specific groups, allowing for more targeted intervention:

- The most deprived 20% of the UK population suffer 2-5 times greater alcohol-related admissions to hospital or alcohol-related mortality, compared to the least deprived⁸

- The most deprived lifestyle group have 4-15 times greater alcohol-specific mortality and up to 10 times greater alcohol-specific admissions to hospital
- Men aged over 35, unskilled or manual workers or unemployed, are at the highest risk of being admitted to hospital with an alcohol-related problem
- 50% of homeless people are dependent upon alcohol
- Psychiatric co-morbidity is common among problem drinkers – up to 10% for severe mental illnesses and 50-80% for personality or neurotic disorders.

NATIONAL ALCOHOL STRATEGY

In his 2001 Annual Report, Sir Liam Donaldson, the Chief Medical Officer at the Department of Health, highlighted Britain's growing alcohol epidemic.¹ Between 2001-2010, the Government has developed its National Alcohol Strategy in a series of publications from the Cabinet Office and the Department of Health. There is wide support for the CMO's call for a substantial increase in the effective cost of alcohol. Moreover, an evidence-based policy would ban advertising and promotions likely to influence young people. However, effective preventive measures may take 10 years to impact on the scale of the problem. In the meantime, it will grow, probably at an increasing rate.

In 2010, the National Institute for Health and Clinical Excellence (NICE) will publish three guidelines on the prevention and treatment of alcohol-use disorders and of alcohol dependence. These include evidence-based recommendations, especially regarding the optimal management of alcohol detoxification, in appropriate settings, by specialist staff. There is also a need for earlier assessment for possible liver transplantation for patients with decompensated alcohol-related liver disease, who are not responding to treatment. Implementation of these proposals will require a major investment of resources, but this investment will yield significant savings if it effectively reduces the burden of alcohol misuse on the NHS and society.

AIMS OF THIS PAPER

This paper, written jointly by the British Society of Gastroenterology (BSG), the Alcohol Health Alliance UK (Appendix 1) and the British Association for Study of the Liver (BASL), makes recommendations to Government, the Department of Health, commissioners, NHS Trusts, the multi-agency partnership, service providers and patients, advocating collaborative, integrated, person-centred alcohol care. It also supports the National Plan for Liver Services 2009, with its key recommendation for expansion of the Consultant workforce in hepatology.

http://www.BSG.org.uk/attachments/1004_National%20liver%20plan%202009.pdf

The paper aims to provide an evidence-based description of the specialist workforce required to provide collaborative, person-centred care for patients with alcohol-related problems, who attend a typical British District General Hospital, serving a population of 250,000. This includes the consultant workforce across specialties, such as gastroenterology and hepatology, psychiatry, A&E and acute medicine, as well as the Alcohol Specialist Nurse Service needed to implement the national alcohol strategy.

In the current economic climate, there is inevitably competition for resources. This is especially difficult for hospital Trusts (Tier 4), since the Government and Primary Care Trusts are preferentially funding Tier 1, primary care services. Therefore, this paper aims to give hospital consultants, alcohol specialist nurses, chief executives and managers evidence-based data to make the business cases for the workforce and resources required to provide high quality, collaborative, hepatology, gastroenterology, psychiatry alcohol care, which is accessible, timely, non-judgmental, cost-effective and responsive to the needs of patients and their families.

CURRENT MANAGEMENT OF PEOPLE ADMITTED TO HOSPITAL WITH ALCOHOL-RELATED PROBLEMS

ACCIDENT AND EMERGENCY

Most hospital admissions for alcohol-related problems occur acutely via the Accident & Emergency Department. Evidence of alcohol-related harm may be missed or ignored. Doctors and other health professionals should use the one minute Paddington Alcohol Test⁹ to screen for alcohol misuse. Early Identification and Brief Advice (IBA), that is 1-2 minutes use of “The Teachable Moment”, by any trained healthcare professional, to relate drinking to A & E attendance, should be combined with the offer of a Brief Intervention (BI), which is a 20-40 minutes consultation with an alcohol specialist nurse.

The top 10 presentations are fall, collapse, head injury, assault, accident, generally unwell, gastrointestinal symptoms, cardiac symptoms, psychiatric problems (especially self-harm) and frequent attendance. Intoxicated patients may require overnight admission to an observation ward for their safety. Others may require greater medical or psychiatric care. Serial blood alcohol estimations and/or a breathalyser may be valuable.

ACUTE ALCOHOL WITHDRAWAL

Indications for Admission to Hospital

A coordinated, hospital-led, Assertive Outreach Alcohol Service (AOAS) can avoid many admissions for detoxification (see Key Recommendation 5). Following assessment and brief advice by an alcohol specialist nurse, many patients, who are admitted overnight, can be safely discharged, with an appointment with the Community Alcohol Team, who can then arrange a planned community detoxification. Patients may be admitted to hospital from the community for a planned alcohol withdrawal, or via A & E for

unplanned withdrawals. Admission to hospital for medically-assisted withdrawal should be offered to:

- People assessed to be at high risk of developing alcohol withdrawal seizures or delirium tremens
- Vulnerable people (eg those who are frail, have cognitive impairment or co-morbidities, lack social support, have learning difficulties, or are aged 16 or 17 years).

Young people under the age of 16 years, with acute alcohol withdrawal, should be admitted for physical and psychological assessment, as advised in the NICE Guidelines “Alcohol use disorders – clinical management”.

<http://guidance.nice.org.uk/CG/Wave15/77>

Treatment for Acute Alcohol Withdrawal

The staff on all wards should be trained in assessing and monitoring symptoms and signs in patients with acute alcohol withdrawal. Alcohol specialist nurses play a pivotal role in training and supervising care and risk management. Delirium tremens or withdrawal seizures are treated with a tapering dose of benzodiazepines. Dietetic input, with replacement of micronutrients, including thiamine, is essential, since many patients are severely malnourished. Management is usually commenced on an acute medical unit, with subsequent transfer to a gastroenterology/hepatology ward.

DETECTION AND MANAGEMENT OF UNDERLYING PSYCHIATRIC ILLNESS

There should be a Consultant-led liaison psychiatry service in all clinical areas, especially accident and emergency, acute medicine, gastroenterology and hepatology wards. A consultant psychiatrist should liaise closely with the Lead Alcohol Clinicians in A & E and acute medical units to ensure that all patients are assessed for possible psychiatric illness, especially depression and suicidal ideation.

This will involve staff training and collaboration between A & E doctors and nurses, the Mental Health Crisis Team and alcohol specialist nurses, particularly psychiatric liaison nurses, together with the Community Alcohol Team. The hospital Psychiatry Alcohol Lead should ensure that there are clear mechanisms and pathways for rapid referral to a psychiatrist specialising in alcohol dependency.

Choice of Ward

At present, management tends to be partial, depending upon the ward to which the patient is admitted. Patients perceived as medical admissions are usually managed on hepatology/gastroenterology wards. Conversely, psychosocial interventions are usually commenced during admission to psychiatry wards.

Optimal Specialist Inpatient Alcohol Care

Dual diagnosis, co-morbidity, mental health disorders and social problems are common. Management should be by a multidisciplinary team, but currently seldom is. Joint initial triage and assessment of all alcohol-related admissions to an acute medical unit, on the morning after admission, by a Liver Nurse Practitioner (LNP) and Psychiatric Liaison Nurse (PLN), followed by structured multidisciplinary management, would be far superior and more cost-effective than the current patchwork approach in most hospitals. Nurses can give Identification and Brief Advice (IBA) to patients about their alcohol consumption. Outpatient appointments can then be arranged with a Community Alcohol Team. The waiting time has to be no longer than 1-2 weeks. Otherwise, the relapse rate is high.

The liver nurse practitioner is frequently the first to recognise the severity of underlying liver disease in patients admitted to acute medical units. By informing the liver specialist, rapid assessment, prompt treatment and transfer to a gastroenterology, hepatology or critical care ward is facilitated.

Psychosocial interventions involve group work and one to one key-working sessions, addressing psychosocial issues. These depend on local facilities and the availability, if any, of addiction or liaison psychiatrists specialising in alcohol misuse. Adjunctive pharmacological therapy, with acamprosate or disulfiram, may be commenced, with education about use and side-effects. Further clinical trials of the role of baclofen are urgently needed.

FOLLOW UP AND PROGNOSIS

Psychiatry Patients

Patients discharged from a psychiatry ward may be transferred to continued care, for example a residential rehabilitation facility, structured day programme or home with identified support and access to a Community Alcohol or Drug and Alcohol Action Team. This depends on the care plan, funding and local facilities.

Relapse prevention medication prescribing may be transferred to the GP. Shared primary care, with specialist support, will depend on local arrangements. The Cochrane collaboration review by Kaner et al¹⁰ of the effectiveness of brief alcohol interventions in primary care populations found that brief interventions lowered alcohol consumption at one year of follow up. In routine primary care, longer duration of counselling had little additional effect.

Liver Disease Patients

Many doctors have a pessimistic and negative attitude towards patients with alcohol-related liver disease, but trying to achieve abstinence is worthwhile. The 10 year survival of patients presenting with compensated alcohol-related cirrhosis, who remained

abstinent, or who substantially reduced their intake, was around 60%, compared to around 30% in those who continued to drink. The respective figures in those with decompensated cirrhosis were 50% and less than 10%.¹¹ A more recent study showed that patients who stop drinking alcohol, even at the time when they present with advanced cirrhosis, have a much better outcome than those who continue to drink, with 50% of patients, who continue to drink alcohol, being dead within 2 years, and 75% of those who stop drinking, being alive at 10 years.¹²

Many patients with alcohol-related liver disease achieve abstinence from alcohol after simple advice to do so. Follow up in simultaneous clinics, attended by the consultant gastroenterologist or hepatologist, psychiatrist and specialist nurses, is recommended.

Since alcohol-related liver disease does not show symptoms until the most advanced stages, where mortality is high, detection of harmful or hazardous drinkers at an early stage in primary care settings is a key aim for secondary preventive work. Improving the support provided to liver disease patients to remain abstinent and reduce their risk of progressing to a more advanced stage is vital.

RELAPSE

Relapse isn't the end of the road. Most people will drink again, whatever the original goal of treatment, often because of complacency and over-confidence that the problem is now in the past. This need not imply a catastrophic relapse, involving the loss of all that has been achieved. It is more profitably viewed as an opportunity for the person to learn more about their nature and the problem itself. Dealing with, and learning from, relapses is part of recovery. A closer study of relapses should help all parties identify the triggers, and it is helpful to list these. The family often feels particularly threatened and confused and will need extra support at this time. Although setbacks may occur, therapeutic pessimism is misplaced, because the long-term prognosis for problem drinkers is often surprisingly good.

KEY RECOMMENDATIONS AND THEIR EVIDENCE-BASE

In a typical British District General Hospital, serving a Population of 250,000, there should be:

- 1. A multidisciplinary "Alcohol Care Team", 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 implement a district alcohol strategy**

Recommendations

- 1.1 Each District General Hospital should appoint an "Alcohol Care Team". This would be a formalised group of individuals, with an overall Lead Clinician. It would include a Lead from hepatology, gastroenterology,**

psychiatry, accident and emergency and acute medicine, other key specialist Leads, the Lead alcohol specialist nurse and an executive member of the Trust Board, with a locally appropriate balance of representatives from primary care and patient groups.

- 1.2 The Alcohol Care Team should work closely with Public Health , Primary Care Trusts, key stakeholders and patient groups to develop and deliver a strategy for reducing alcohol-related problems in the district.
- 1.3 Patient groups should be encouraged and supported to develop their own pathways of care, in collaboration with service providers.
- 1.4 The Lead Clinician would have shared responsibility, with Public Health and primary care, for delivering timely and responsive high quality support services and achieving targeted
 - reductions in alcohol-related admissions, readmissions and mortality
 - improvements in public understanding and awareness of alcohol
 - increased rates of early detection of alcohol misuse.
- 1.5 Five Contracted Programmed Activities (5 PAs) per week should be allocated to this post, probably as part of a 10-12 PA contract.
- 1.6 The Lead Clinician would usually be a hepatologist, gastroenterologist or liaison psychiatrist, but could be an acute medicine physician or accident and emergency consultant, or a doctoral level nurse consultant. The Lead Clinician would identify individuals responsible for alcohol policy, with a dedicated clinical session, in key clinical areas.
- 1.7 The Lead Clinician requires the skills and knowledge to be able to develop, implement, monitor and evaluate effective treatment pathways across disciplines and services and the ability to provide clinical supervision and support to a range of care providers of different professional groups and specialties. The Lead will also provide clinical expertise to policy makers at local, regional and national level.

Background and Evidence-Base

In 2001, the Royal College of Physicians' Working Party produced a definitive, evidence-based blueprint for managing alcohol-use disorders.⁴ This was reaffirmed at a joint Royal College of Physicians/British Society of Gastroenterology conference in 2005, entitled "Alcohol-related harm – a growing crisis, time for action!" The RCP made recommendations about national policy, research and education, but the key recommendations were for local care

by acute hospitals receiving unselected medical admissions. These were included in the BSG Strategy Document¹³ and the National Plan for Liver Services 2009.

Nationally, 13-20% of all hospital admissions are alcohol-related. This figure is undoubtedly an underestimate, since coding of alcohol-use disorders is notoriously inaccurate. Moreover, patients with alcohol-related problems are often very ill, with complex needs. Hence, they constitute at least 20% of the overall Consultant Direct Clinical Care (DCC) workload.

The estimated Consultant workload, in Programmed Activities (PAs), across all specialties, involved in providing quality, collaborative alcohol care in a District General Hospital, serving a population of 250,000, is shown (Appendix 2).

2. Coordinated policies on detection and management of alcohol-use disorders in Accident and Emergency departments and Acute Medical Units, with access to Brief Interventions and appropriate services within 24 hours of diagnosis

Recommendations

- 2.1 There should be coordinated policies on alcohol misuse in accident and emergency and acute medicine departments, including a 7-Day Alcohol Specialist Nurse Service and an Alcohol Link Workers' Network. This would provide access to Brief Interventions and services within 24 hours of diagnosis.
- 2.2 To achieve this aim, there should be a Lead Consultant and a Lead Nurse for Alcohol, responsible for policy in each A&E department and acute medical unit. The Lead Consultant and Nurse should be allocated at least one Programmed Activity (4 hours) for this administrative role, in addition to their alcohol-related clinical care. A & E departments should work closely with multiple agencies, such as Public Health, Primary Care Trusts, local authorities, police and social services.
- 2.3 The College of Emergency Medicine recommends a total of 16 consultants to provide a 168 hour per week consultant input into a typical DGH. It is estimated that the alcohol-related workload is up to 20 Programmed Activities per week. This should be recognised in job plans.
- 2.4 Individuals with alcohol problems should be able to access services locally, regardless of their location, occupation, disability, family status, gender, sexuality, ethnicity, language, ability, age or legal status.¹⁴ Services should be available in prison health centres.
- 2.5 Mental Health Crisis Teams should liaise closely with A & E staff and alcohol specialist workers, with consultant psychiatrist leadership.

- 2.6 An A & E department should be a “place of safety” for patients, families and staff.
- 2.7 There should be access to link workers, translators and social workers. This may prove invaluable, facilitating communication and financial provision for discharge prescriptions.
- 2.8 Health information leaflets, in various languages, should be available, especially to patients being discharged.

Background and Evidence-Base

Extent of the problem

Approximately 35% of all A & E attendances are alcohol-related,¹⁵ and this increases to 70-80% at weekends. A 2009 audit at St James Hospital, Leeds observed that 21.4% of general medical admissions via A & E were alcohol-related.³

Detection in Accident and Emergency

Robin Touquet and colleagues have engaged and trained staff to use the Paddington Alcohol Test 2009 (PAT)⁹ to give Brief Intervention, education, audit and feedback to patients presenting to A&E. This resulted in a 10-fold increase in referrals to an Alcohol Health Worker (AHW). Brief Intervention by the AHW resulted in a reduction of 43% in alcohol consumption. Every two referrals to an AHW resulted in one fewer reattendance during the following year. If patients are offered an appointment with the AHW on the same day, almost two-thirds attend; when the gap is two days, the attendance drops to 28%. The half-life of the “teachable moment” is thus 24-48 hours.

For further details of their model practice, access the Alcohol Learning Centre: HubCAPP Link: GWAQ www.hubcapp.org.uk/GWAQ

Identification and Brief Advice (IBA) and Brief Intervention (BI)

IBA is a minimal intervention, which comes under the umbrella of Brief Intervention. IBA can be delivered by generic healthcare staff, a GP or nurse, or other professional, including pharmacists, social workers and probation officers. However, Brief Interventions, delivered within a motivational interviewing framework, need to be delivered by dedicated trained staff.

The structured advice lasts 20-40 minutes and involves personalised feedback to individuals about their level of health risk due to alcohol, practical advice about reducing alcohol consumption, with a range of options for change, and written information to support the advice. A key component of Brief Intervention is that

it is delivered empathically and in such a way as to promote recipients' confidence about behavioural change. Brief Intervention is effective in reducing alcohol consumption in hazardous and harmful drinkers, and while not intended for dependent drinkers, is often also successful in this group.

Several Brief Intervention packs have been developed, including the Universities of Newcastle and Northumbria's *How much is too much?*

<http://www.ncl.ac.uk/ihs/enterprise/>

The Cochrane collaboration review by Kaner et al¹⁰ of the effectiveness of brief alcohol interventions in primary care populations found that brief interventions lowered alcohol consumption at one year of follow up.

Value of Multi-agency Partnerships on Alcohol

A & E departments are capable of collecting valuable data on patients attending as a result of alcohol misuse. Working in partnership with local organisations, such as Public Health, police, social services and local authorities, effective strategies for local intervention can be developed. The sharing of data across services, to develop a full picture of premises and factors that are contributing to alcohol harms in a community, promotes community-based interventions, which target specific premises and areas.

3. A 7-Day Alcohol Specialist Nurse Service and Alcohol Link Workers' Network, consisting of a lead healthcare professional in every clinical area

Recommendations

- 3.1 An average DGH should employ 4 alcohol specialist nurses (ASNs), with a balance of psychiatric, hepatology and A & E expertise.
- 3.2 In collaboration with neighbouring Trusts, ASNs should work as a team to provide a 7-day alcohol service.
- 3.3 ASNs should train and establish a network of alcohol link workers in all clinical areas.
- 3.4 ASNs should work closely with colleagues in the community to ensure seamless transition of care.

Background and Evidence-Base

Definitions

An Alcohol Specialist Worker (ASW) is the generic term for the specialists who have made such a major impact on the detection and care of patients with

alcohol-use disorders. The majority are Alcohol Specialist Nurses (ASNs), of whom there are two types. The Psychiatric Alcohol Liaison Nurse (PLN) is based in the mental health services and is primarily trained in the psychiatric aspects of alcohol misuse. The Gastroenterology-based Liver Nurse Practitioner (LNP) focuses on helping patients understand the role of alcohol in their medical co-morbidity and its management. The PLN and LNP, working seamlessly in partnership, complement and overlap each other's activities and specialist expertise.

The benefits of employing ASNs, rather than ASWs without nursing skills, is that nurses can manage patients with decompensated liver disease and other co-morbidities. Moreover, Nurse Consultants can oversee ASNs and prescribe detoxification medication.

Gaps in Acute Hospital Alcohol Services

A survey of acute medical units in 104 hospitals across the UK showed that 58% of hospitals had no formal alcohol-related support services.⁵ Moreover, in those with services, only 25% were available outside office hours, Monday to Friday. The particular need for ASNs was in the management of patients with alcohol withdrawal, especially for their expertise in supervising a symptom-triggered, rather than the inferior fixed-dose sedation regime. Given that detoxification for the vast majority of medical admissions commences in acute medical units, guidance and supervision from ASNs is of paramount importance. Availability and accessibility of ASNs also enhances the detection and management of co-morbidities and quality of care.

Alcohol Specialist Nurses in Inpatient Care

The extension of the role of the ASN from Accident & Emergency to inpatient care has been pioneered by Lynn Owens and colleagues in the Royal Liverpool Hospital, where the appointment of an ASN resulted in:

- Reduction in the average alcohol consumption of patients treated
- Earlier patient discharge
- Reduced re-attendances
- Improved staff attitudes and knowledge.

The ASN saved >£175,000 in hospital costs over 20 months, solely through the earlier discharge of patients. The DH acknowledged this "Invest to save" methodology in describing the Liverpool service as follows:

"This service saved an estimated 150 admissions per year, resulting in substantial cost-savings to the hospital. Preventing the admission of 30 patients could cover one year's salary for the ASN. The scheme was also shown to improve clinical practice and patients' satisfaction and to increase the confidence and skills of

nurses caring for these patients. Significant reductions in alcohol consumption by increasing-risk and higher risk drinkers and reductions in the use of healthcare by dependent drinkers were also recorded".¹⁶

Cobain et al presented data at the National Harm Reduction Conference (2009). Six months post-treatment, 49% of severely dependent patients were no longer dependent and 40% were abstinent. Furthermore, only 23% of patients did not improve ($p < 0.0001$). Similarly, on measures of alcohol consumption, there were significant improvements in the treatment group, when compared to controls ($p < 0.0001$). These data show that acute hospitals could be an ideal setting in which to both identify and treat alcohol-dependent patients. A key component is the ability to provide follow-up within either an outpatient or primary care setting.

An additional role of ASNs is to improve risk management, with fewer clinical incidents and assaults on other patients and nursing staff. These occur especially at weekends and night-time, when nursing establishment tends to be lowest. This leads to increased staff sickness, damaged morale and sometimes to the loss of dedicated, skilled gastroenterology nurses.

Primary and Secondary Care Interface

The role of ASNs in Liverpool has since been further developed into a Nurse-led Alcohol Services Lifestyle Team, with daily clinics in different locations in the city every day of the week. They reduce patients' fear of stigma and labelling and provide access for GPs to refer patients to the ASN service, which is independent of the default option of sending patients to A & E departments.

For further details, see HubCAPP Link:TUL3 www.hubcapp.org.uk/TUL3

Patient and Family Support

Patients, families, carers and friends most often turn to the alcohol specialist nurse, with whom they have established a close bond, for continuing care, in relapse and other crises, and for support, in all its forms. When a consultant or nurse has cared for a patient with an alcohol-use disorder for many years, one of the most difficult decisions is when to gradually withdraw active treatment and commence end-of-life care. Many years of devoted care may be forgotten if families feel let down in these situations. It is here that sensitivity and compassion are most needed in helping patients to die in peace and with dignity and in supporting families in making extremely difficult decisions.

Joint Liver and Psychiatry Alcohol Nursing

In The Royal Bolton Hospital, there is both a Psychiatric Alcohol Liaison Nurse (PLN) and a Gastroenterology-based, Liver Nurse Practitioner (LNP). The LNP/PLN assess and treat patients with alcohol-related problems in all clinical areas. They

have established patient support groups and a network of over 50 alcohol link workers throughout the Trust.

The LNP partners the PLN. On Monday to Friday, at 8.00 am, they go to the Acute Medical Receiving Unit and jointly triage all alcohol-related admissions. They undertake an immediate and Brief Intervention with patients in need, initiate care plans and arrange rapid outpatient appointments with the Community Alcohol Team (CAT). Inpatient detoxifications have been reduced by 50%, **saving the Trust more than 1000 bed days annually.**

See HubCAPP www.hubcapp.org.uk/6QTM

Similar savings by specialist nurses have previously been reported in Liverpool and Southampton. The average daily cost for treating patients, with ASN supervision, across all NHS Trusts in England and Wales, is around £219 for an inpatient and £271 in an A & E Observation Ward.¹⁷

Need for a 7-Day Alcohol Specialist Nurse Service

The dramatic impact of ASNs during a 5-day working week highlights the need for a 7-day ASN input into our hospitals, especially since such a large proportion of binge-drinking, alcohol-related problems present out-of-hours, particularly at weekends. The human and financial resources required to provide such a service are described (Appendix 3). Alcohol specialist nurses pay for themselves many times over, in terms of improved detection of alcohol misuse, accessibility, waiting times, DNA rates, reduced inpatient detoxifications and length of stay, thus achieving 4-hour trolley waits and relieving bed pressures.

- 4. Liaison and Addiction Psychiatrists, specialising in alcohol, with specific responsibility for screening for depression and other psychiatric disorders, to provide an integrated acute hospital service, via membership of the “Alcohol Care Team”**

Recommendations

- 4.1 Linking acute hospital and community services for the collaborative psychiatric and medical care of hazardous, harmful and dependent drinkers is essential.
- 4.2 A Liaison or Addiction Psychiatrist, with a special interest in alcohol, could be the overall Lead Clinician in alcohol-use disorders.
- 4.3 The Lead Psychiatrist should liaise closely with the Lead Gastroenterologist or Hepatologist, the alcohol specialist nurse and community services to coordinate all services for patients with alcohol-use disorders, substance misuse, addiction and hepatitis B and C.

- 4.4 The Lead Psychiatrist should ensure that all patients detected with alcohol-use disorders, particularly in Accident and Emergency and acute medical units, are screened and treated for depression and other psychiatric illnesses.
- 4.5 Specialist psychiatry input is essential in the assessment and management of harmful drinkers with permanent brain damage.
- 4.6 Patients, including those with recent detoxifications, referred to a Community Alcohol Team from a district hospital, should be seen within 1-2 weeks. If not, the relapse and readmission rates are high.

Background and Evidence-Base

Current Psychiatry Services

33% of alcohol services in England are provided by the National Health Service. 66% are provided by non-statutory agencies, third sector agencies and charities. Only a small minority of patients with alcohol problems have access to psychiatric alcohol support services and this varies geographically (1 in 12 in London vs 1 in 27 in the North of England). The situation that most acute hospitals do not provide psychiatric alcohol support services is most unsatisfactory.

Addiction and Liaison Psychiatry

Addiction psychiatrists provide substance misuse services mainly to alcohol and opioid-dependent patients, generally in specialist units, with little input into acute hospitals. Liaison Psychiatrists assess and treat hazardous and dependent drinkers in hospital and community settings. Where collaborative psychiatry and medical links exist in a DGH, they may also assess harmful drinkers, including those with liver disease and cognitive impairment, with personality change impacting on their behaviour, leading to difficulties in caring for these patients in a medical ward setting.

Addiction services link with liaison services by providing psychosocial interventions, relapse prevention work and education and training of generalist staff. Both link with local mental health and alcohol services. However, there are no agreed, standardised general alcohol or substance misuse, addiction or liaison psychiatry services to district general hospitals.

Benefits of a Hospital Liaison Psychiatry Service

Strategic health authority (SHA) funding has been provided to a North East Trust to evaluate the development of a liaison psychiatry alcohol service for a district general hospital. The aim is to improve detection and ensure appropriate

management of patients with alcohol problems and to implement an alcohol pathway to facilitate rapid, but appropriate discharge.

The potential cost savings, during the development of the bid for this post, were calculated. Over a six-month period, there were 113 admissions associated with 343 bed days (primary code alcohol). The cost of the alcohol intoxication group was based on 78 patients. Using the S16 tariff, the total cost for these patients was £60,022. Reducing the length of stay of these patients by an average of one day would result in savings of £69,974 per annum. The cost of the liaison psychiatry service is £32,000. There is a potential to save £37,974 per year, whilst patients would receive a much improved quality of care.³

Integrated Psychiatry Care

An integrated alcohol treatment pathway between the DGH and the community is required. Three key issues connect both hazardous and dependent drinkers, namely the issue of complexity and chronicity, a clear pathway between hospital and community, and finally, an outcome recovery approach.

An excellent aftercare pathway, based partially in the district general hospital, but mainly in a community setting, utilising abstinence, outpatients, day programmes and residential rehabilitation, needs to be in place. An addiction psychiatrist could coordinate such a pathway, as well as the hospital's internal care and the community aftercare pathways. This would clarify the care pathways surrounding the local acute hospital, in terms of the psychosocial interventions, community services and recovery groups available and would facilitate the transfer of patients to the appropriate care pathway.

Such a system would also require two Band 7 psychiatry nurses and input from a clinical psychologist. They would provide triage, fully comprehensive assessment services, pre-liver transplant services, one-to-one psychosocial and group interventions, strategic leadership and management within the acute hospital setting, liaison with medical and surgical wards and accident and emergency, as well as a training function.

Community Alcohol Services

Most NHS-funded community units will provide an assessment of some kind. There may or may not be medical staff and nurses working there. If so, there may be dual physical health and psychiatric assessments. Some units with medical staff provide a full physical examination and may administer vitamin injections. However, this is uncommon.

Most NHS units that provide community alcohol services see the non-hazardous dependent drinkers. They will offer several forms of detoxification. It could be a

walk-in detoxification, home detoxification or referral to inpatient detoxification units. These are Tier 4 units, either in the acute or psychiatric hospital systems. Most community NHS units are not funded to provide aftercare, or if they are, it is very limited. Within the care pathway system, there may be recovery meetings, such as Alcoholics Anonymous meetings and counselling services, which see individuals for one-to-one counselling and for group work. A system of community care assessment for rehabilitation and for inpatient detoxification exists, but it is not widespread.

Community Alcohol Teams (CATs) provide Tier 3 services for alcohol-dependent clients, who are motivated to address their drinking problem. Input from a Consultant Psychiatrist specialising in Alcohol and Substance Misuse, together with a specialist dual diagnosis worker, is essential. There is no agreed evidence-base to define how many staff are required for this service. Hence funding is often preferentially directed into Tier 1 (Primary Care) and Tier 2 (Drug and Alcohol Action Team) services, resulting in staff shortages in CATs, long waiting lists and high relapse and readmission rates.

5. **Establishment of a hospital-led, multi-agency Assertive Outreach Alcohol Service, including an emergency physician, acute physician, psychiatric crisis team member, alcohol specialist nurse, Drug and Alcohol Action Team member, hospital/community manager and Primary Care Trust Alcohol Commissioner, with links to local authority, social services and third sector agencies and charities**

Recommendation

- 5.1 Each health district should establish a hospital-led, multi-agency Assertive Outreach Alcohol Service (AOAS), with the necessary skills and expertise to coordinate the care of patients who spend more than 10 days per year in hospital, due to alcohol-related problems.

Background and Evidence-Base

North West Chief Executives' Challenge

All North West PCTs are in the national 'worst-half' for hospital admissions for alcohol-related harm. Led by David Dalton, Chief Executive of Salford Royal NHS Foundation Trust, the Chief Executives' Challenge is to reduce alcohol-related admissions by 5%, across the North-West, by 2011. Using the latest healthcare modelling methodology, it has been possible to test assumptions relating to potential therapeutic interventions in a DGH serving a 250,000 population.

The review identifies two principal patient cohorts and determines that organised service intervention could result in a 5% reduction in National Indicator Set 39 admissions. The first cohort is patients staying in hospital for 0-1

day. They constituted 50% of alcohol-related admissions to Salford Royal. The solution modelled would be to establish a 7-day alcohol specialist nurse service to screen, triage and provide brief interventions. The service cost would be £279,000, liberating 2 hospital beds, saving £698,000 annually. There would be 400 fewer admissions per year, equating to 133 NI 39s and a 1% reduction in alcohol-related admissions.

The second cohort is patients whose admission has an alcohol attributable fraction of > 1, that is a length of stay of 10 or more days. These patients constituted 17% of alcohol-related admissions, but occupied 66% of bed days. The treatment proposed is a hospital-led Assertive Outreach Alcohol Service (AOAS). This service would target two defined patient groups:

- The top 30 'frequent flyers' for alcohol-related admissions
- Users, such as patients with alcohol-related liver disease, who exceed the threshold of two alcohol-attributable fractions (AAFs), who are increasingly using acute hospital services.

The AOAS cost would be £390,000, liberating 8 hospital beds, saving £895,000 annually. There would be 475 fewer admissions, equating to 475 NI 39s and a 4% reduction in alcohol-related admissions.

The combined cost for the two initiatives would equate to £660,000 and a potential reduction of 5% in alcohol-related admissions to a district general hospital serving a 250,000 population. The case is predicated on the commissioner and provider agreeing to share the cost benefits of bed reduction and tariff avoidance. These cost benefits amount to a potential £1.6 million per locality.

Salford Royal NHS Foundation Trust has recently established a hospital-led AOAS, as part of a "Healthy Hospital Project". Of the 20 most frequent A & E attenders, 19 had an alcohol-related problem. Following implementation of their AOAS, preliminary data suggest a 15% reduction in both A & E attendances and admissions for this patient cohort during the 3 month pilot, compared with the preceding 3 month period. The key elements of the service are:

- A multi-professional review team, comprising an emergency physician, acute physician, psychiatric crisis team member, hospital alcohol specialist nurse (ASN), Drug and Alcohol Action Team (DAAT) member, Healthy Hospital manager and PCT Alcohol Commissioner, with links to local authority, social services and third sector agencies and charities
- Regular multi-professional review of the current Top 20 frequent A & E attenders via a live database

- An assertive action plan, usually implemented by the DAAT member. Patients are fast-tracked into detoxification programmes, accommodation in extended rehabilitation, referral to life trainers etc. This is thought to have made the greatest impact
- Development of action plans, such as a management protocols for junior staff, describing an alternative strategy to inevitable admission
- Focused screening, using the Paddington Alcohol Test,⁹ within the Emergency Clinical Decision Unit (ECDU) and Emergency Assessment Unit (EAU)
- Daily input by the ASN on the ECDU
- Raised awareness amongst medical and nursing staff on the ECDU and EAU, leading to increased numbers of patients receiving IBAs by ward staff or ASNs. The time frame for delivery of this intervention has been greatly reduced.

6. Multidisciplinary, person-centred care, which is holistic, timely, non-judgmental and responsive to the needs and views of patients and their families

Recommendations

- 6.1 Collaborative, integrated, hepatology, gastroenterology, psychiatry and community primary and secondary alcohol care is essential.
- 6.2 Alcohol care should be people-centred, holistic and responsive to the needs of patients and their families.
- 6.3 A multidisciplinary team, involving all healthcare professionals, is essential for optimal, integrated care. A dedicated social worker and link worker are vital.

Background and Evidence-Base

Collaborative Hepatology, Gastroenterology and Psychiatry Alcohol Care

Collaborative care is a person-centred, multidisciplinary, integrated, holistic, hepatology, gastroenterology, psychiatry, community model of alcohol care, teamworking, governance, research, training, education and health promotion.¹⁸ Following the introduction of this model in The Royal Bolton Hospital in 1994, 80-95% of the multidisciplinary team were better able to detect alcohol misuse and more confident in caring for, and communicating with, patients, carers and

families. Patients and carers also expressed their improved satisfaction in receiving one-stop, joined-up care. The essentials of the service include:

- Unified primary, secondary and community alcohol care, including nurse-supervised home detoxifications, often commenced in hospital
- Consultant gastroenterologists and a liaison psychiatrist provide joint inpatient and outpatient care
- Close working with local Liver Centres
- Joint outpatient clinics by a multidisciplinary medical, nursing and psychiatric team enable joint medical and psychiatric care at one visit, reducing DNA rates
- Telephone hotline, rapid access is provided to patients, their families and carers, either directly to the Liver Nurse Practitioner or Psychiatric Liaison Nurse, or via the secretaries or ward, where a close relationship has developed
- The Multidisciplinary Team (MDT) meets daily to discuss all inpatients
- Given the intensity of nursing patients with alcohol-related diseases, it is vital that the nursing establishment is adequate, especially out-of-hours
- A dedicated social worker greatly influences length of stay and facilitates discharge to a suitable environment. Discharge and ongoing care of inpatients, who are out-of-area, may be problematic, and the daily involvement of the appropriate social worker is vital. There is particular difficulty in providing care for the homeless and rough sleepers. There are increasing numbers, particularly of young men, with alcohol-related dementia, including Wernicke-Korsakoff Syndrome, for whom there is a major shortage of suitable long-term care
- The establishment of an integrated, multi-agency alcohol strategy with Public Health, commissioners, the local authority, voluntary agencies, health promotion, police, social workers and other stakeholders has had considerable mutual benefits. This approach helped persuade the Department of Health Team for Health Inequalities to make Bolton one of the 20 early implementers of the National Alcohol Strategy. The benefits of extra funding to similar socially-deprived, high alcohol disease prevalence areas will be rolled out nationally.

See HubCAPP www.hubcapp.org.uk/6QTM

Importance of Philosophy of Care

A non-judgmental approach helps to remove the concept of alcohol misuse as a 'self-inflicted disease'. The stigma is especially prevalent in the Asian community, where it can result in exclusion from a community or place of worship. For men, alcohol misuse is a taboo subject, which can make them very loathe to confide in a female ASN. Link workers play a crucial role in patient care, as vital members of the MDT and in all clinical areas. A close partnership with link and community workers helps overcome the stigma and barriers to alcohol care.

Patient Perspectives on Alcohol Services

There is little published research on patients' perspectives of being diagnosed with, or of accessing treatment for, liver disease. There are some qualitative data from the British Liver Trust (BLT), which describe patients' and carers' experiences of liver services.¹⁹ Some patients reported a reluctance from GPs to refer them to specialist centres. The survey found an average of a **564 day delay** from the onset of symptoms to diagnosis. This wait was due to delays in primary care, rather than waiting times for specialists. Patients wanted **holistic treatment**, with the support of specialist nurses, counsellors, social workers and seamless access to other professionals.

Many reported experiencing stigma, leading to poor quality of care and influencing referral and treatment decisions. Patients with mental health problems, who had taken drug overdoses, had not received liver treatment after their emergency care.

Williams et al, in their review of gastroenterology services in the UK,²⁰ held a patient workshop. Cautious support was expressed for greater self management, provided care was taken to assess the ability of patients to self manage, continuity of care could be maintained and services could be accessed when required. Some participants expressed a preference for local care and others valued specialist care, even at a distance. The needs of minority groups were emphasised. A mechanism for patient feedback as part of service evaluation should be developed (see Recommendation 9.4).

7. Integrated Alcohol Treatment Pathways between primary and secondary care, with progressive movement towards management in primary care

Recommendations

- 7.1 Each PCT should have a GP, who is the sole Alcohol Lead, or a Lead for Substance Misuse including alcohol.

- 7.2 Alcohol treatment pathways (ATPs) should be developed from secondary to primary care, either through Practice-based Commissioning or through the use of any willing provider. This will help drive the shift from secondary to primary care and reduce costs.²¹
- 7.3 ATPs should be collaboratively developed and personally tailored and provide access to a range of services and interventions that meet an individual's needs in a comprehensive way (MoCAM).¹⁴
- 7.4 ATPs for those with both drug and alcohol misuse should be coordinated.
- 7.5 Immediate medical care for dependent drinkers should be combined with longer term support, including housing, employment and social care.
- 7.6 It is important to identify a "Lean" Champion in Healthcare, a "Lean" development group and learning from model practice elsewhere.
- 7.7 Enhanced Alcohol Services in Primary Care should be developed to screen for alcohol misuse and must be accompanied by major Government investment in community alcohol teams and hospital services. If not, GPs will be less motivated to screen for hazardous and harmful drinkers, since it is unethical to screen and then not to be able to refer to secondary care.
- 7.8 It is essential to provide a seamless transfer of care of inpatients, who are discharged from hospital, back via the Community Alcohol Team to the GP.
- 7.9 Early, community-based Brief Interventions should be facilitated.
- 7.10 All ATPs need a coordinated strategy to address both the medical and psychiatric aspects of actual or potential alcohol-related harm.
- 7.11 National guidelines should be developed for the assessment of patients with abnormal liver biochemistry in primary care, so as to enable devolution of routine investigation and management of liver disease from secondary to primary care.

Background and Evidence-Base

Gaps in Alcohol Care

People with alcohol-related problems do not traditionally command as much attention or sympathy from doctors and commissioners as they should. Evidence given to the All Party Parliamentary Group on Alcohol Misuse inquiry into alcohol treatment services raised several concerns around commissioning.

Commissioners felt that there were significant challenges in being able to meet the needs of alcohol misusers in their areas, in terms of both scale and variety of need. They highlighted problems in developing collaborative working, such as building partnerships and developing detailed pathways between mental health services and A & E departments. They also pointed to a lack of national guidance for dealing with patients who are intoxicated and presenting with mental health problems to A & E departments.²² Clearly, liaison psychiatry input is essential.

Models of Care for Alcohol Misusers (MoCAM)

Quality alcohol services are usually structured around patients, using a tiered model, as summarised in MoCAM (Appendix 4).¹⁴ Alcohol care involves the community, primary care (Tier 1), the Drug and Alcohol Action Team (Tier 2), the Community Alcohol Team (Tier 3) and hospital and residential care (Tier 4), in partnership with Public Health and other stakeholders. Acute Hospital Trusts do also deliver Tier 2 services. The resource implications are particularly important for hospitals, since the Government's alcohol strategy is to make its major investment in prevention in primary care.

Service User Outcomes (MoCAM)

Service user outcomes may be assessed through progress towards measurable outcomes in the following domains:

- Reduction of alcohol consumption or abstinence
- Reduction in alcohol dependence
- Amelioration of alcohol-related health or social problems
- General improvement in health and social functioning.¹⁴

Patient and patient group input into alcohol care will become increasingly important as we focus more on ideas, such as personalisation, or where Foundation Trusts have increasing input from local patients.

Alcohol Treatment Pathways

An integrated alcohol treatment pathway describes the nature and anticipated course of treatment for a particular person and a pre-determined plan of treatment.²¹ Alcohol treatment pathways (ATPs) are locally agreed templates for best practice. They map out the local help available for people with alcohol-related problems at the various stages of a treatment journey. They are commonly made up of a flow diagram, showing the particular pathway and decision points, alongside background documentation giving explanatory narrative and clarifying details of criteria and protocols to be used in conjunction

with the diagram. This allows for a wide variation in size, scope and detail. Before mapping out the details of the new ATP, it is usually necessary to map current local alcohol treatment pathways.

The purpose of developing alcohol treatment pathways is to have ‘the right people, doing the right things in the right order at the right time, with the right outcome, right first time, all with attention to the service user’s experience and allowing for comparison of the planned care with the care that was actually delivered’ (adapted from:Scottish Effective Interventions Unit Integrated Care Pathways Guides).

www.drugmisuse.isdscotland.org/eiu

The DH Local Routes guidance describes 5 excellent ATPs, together with the specialist workforce required for their implementation:

- Primary Care ATP, with IBA or referral for specialist assessment
- Structured treatment in community specialist clinical alcohol services
- Specialist inpatient assisted alcohol withdrawal (detoxification)
- Specialist clinical alcohol service, assessing referrals for those with evidence of co-morbid alcohol and possible mental health problems
- An ATP for homeless people needing alcohol treatment.

Alcohol- related problems in Children, Older and Vulnerable Adults

Alcohol misuse can present to all specialists, from the paediatrician to the geriatrician. The NICE Guidelines on “Alcohol use disorders – clinical management” will include a pathway of care for children with alcohol problems.

<http://guidance.nice.org.uk/CG/Wave15/77>

Alcohol misuse is often missed in older people, because it is not suspected and can simulate the ageing process. There is a high prevalence in elderly care wards and especially in residential and nursing homes. It has protean presentations, including falls and confusion.²³ There are two categories, namely early-onset and late-onset alcohol misuse. The former group may develop alcohol-related physical harm, such as liver disease. Late-onset misuse is often associated with bereavement, social isolation and psychiatric co-morbidity. Psychosocial interventions are often effective.

Tackling Alcohol-Misuse in Primary Care

There are considerable benefits in detecting and treating alcohol misuse at an early stage in primary care. General Practitioners are generally trusted by their

patients and they access the wider population. Moreover, there is an absence of stigma attached to attending primary care services. Heavy drinkers and their families consult their GP more frequently than average. However, in 2001, alcohol misuse was not recognised in 98% of patients in general practice.⁴

The Quality and Outcomes Framework (QOF) is the incentive scheme, under which GPs are paid according to achievement or delivery of services, against a set of specific criteria. It was introduced as part of the GP contract in 2004. **No QOF points were awarded for identifying patients with alcohol misuse.**

Enhanced Alcohol Services in Primary Care

These are services that go beyond the normal daily activities of general practice and may require specialist skills.

- Directed Enhanced Services (DESs). Five new clinical DESs have been agreed for 2009-10, including one for brief interventions on alcohol for new patients registering with a General Practice
- Local Enhanced Services (LESs) are locally developed services, designed to meet local health needs. There are few LESs for alcohol care in England. Critical elements include 'opportunistic screening' and looking for 'capture points'. Schemes should be 'Systematically Applied', that is all GPs are doing the same, and 'Industrially Scaled', meaning all appropriate patients are screened.

Screening can be done by the GP or practice nurse, by clinical assessment and using the AUDIT questionnaire, or shorter versions. If the patient scores significantly, an IBA or brief intervention may be given.

Enhanced services are primarily designed to detect harmful or hazardous drinkers. However, they also identify dependent drinkers. The 'single point of access' to more specialised treatments is often via triage by Tier 2, Drug and Alcohol Action Teams (DAATs). However, some patients would more appropriately be referred to Tier 3 (Community Alcohol Team or CAT) or Tier 4, which includes gastroenterological, hepatological and hospital addiction and liaison psychiatry services.

Piloting of access to community-based 'Lifestyle Advisers' for preventative Brief Interventions (BIs)

Early opportunities to use BIs in a preventative way have not been fully explored. Some people, who are at the point of recognising that they have an alcohol problem, sometimes allied to weight gain and low self-esteem, are susceptible to information and advice. A number are motivated to contact the British Liver Trust for advice and guidance. For these people, community-based BIs are likely

to be a cost-effective means of support, with prevention of progression to severe alcohol-related harm.

8. Adequate provision of Consultants in gastroenterology and hepatology to deliver specialist care to patients with alcohol-related liver disease

Recommendations

- 8.1 There should be a Consultant-led service, with adequate numbers of consultants in gastroenterology and hepatology to serve the needs of patients who present with alcohol-related problems, especially alcohol-related liver disease.
- 8.2 As recommended in the National Plan for Liver Services 2009, there must be a major expansion of the consultant hepatology workforce, so as to embed at least one trained hepatologist throughout existing District General Hospitals by 2016. There should be 6 Consultants in gastroenterology and hepatology, of whom at least two might reasonably have had some specialist hepatology training, per 250,000 population.
- 8.3 Access to liver transplantation should be equitable.

Background and Evidence-Base

The blueprint for a model hospital service in general medicine and gastroenterology is described in the Royal College of Physicians' document 'Consultant physicians working with patients'.²⁴ This reflects the importance placed on patient care and multi-professional team working. It also defines the consultant gastroenterology and hepatology workforce and requirements to provide a quality service, at an individual, district and national level.

The number of Programmed Activities (PAs) required depends on the volume of inpatient, outpatient and endoscopic work. This is around 69 PAs, indicating that 6 Consultants, each with 10-12 PAs per week, are required.²⁴

This equates to around 1440 Whole Time Equivalents (WTE) for the whole of the UK. As of March 2010, there are 1075, including academic and part-time posts. It is important that expansion continues, because the workload will continue to increase. New posts may include sessional commitments in the community, linking closely with primary care.

Gastroenterology and hepatology is a multidisciplinary team activity. Expansion in consultant numbers must be matched by an expansion of the clinical team, especially alcohol specialist nurses. A matching of skill mix is essential. Treatment by specialists experienced in advanced liver disease results in improved patient survival and outcome.²⁵ This will help considerably to prevent alcohol-related

problems and to reduce the number of deaths from alcohol-related liver disease. Moreover, the DH needs to consider supporting an expansion of consultant academic posts or sessions to fulfil the BSG's national research plan, currently under discussion with the National Institute for Health Research (NIHR). This will include strategies to prevent and reduce alcohol-related deaths.

Hepatopancreatobiliary (HPB) Services

Biliary surgery is likely to remain in the district hospital setting. Elective surgical complications of alcohol-related liver disease, requiring assessment for transplantation, requires specialist input. Large, high volume HPB centres, serving a population of 3-4 million, improve outcomes and this should lead to cost savings.

Liver Transplantation

Liver transplantation is the final and definitive treatment for patients with end-stage liver disease. The greatest proportion of patients listed for liver transplants have alcohol-related liver disease.

In England, there are 6 transplant centres and one in Scotland. Scotland has the highest death rate from alcohol-related cirrhosis in the UK. There are no transplant centres in Northern Ireland, the South West or the North West of England. Data suggest that the availability of transplant centres, rather than case need, is the main determinant for receiving a transplant. The criteria for listing patients for liver transplantation in the UK are agreed. Therefore, patients listed should have comparable levels of disease severity across all transplant centres.²⁶

9. National Indicators and Quality metrics, including alcohol-related admissions, readmissions and deaths, against which hospitals should be audited

Recommendations

- 9.1 National Indicators and Quality metrics should be established to facilitate audit and evaluate service delivery.
- 9.2 A Health District's targets should include fulfilment of the aims of the National Alcohol Interventions Improvement Programme Board.
- 9.3 There should be targets for reducing alcohol-related admissions and readmissions, accompanied by appropriate audit.
- 9.4 Quality metrics should include a systematic patient evaluation of the service.

- 9.5 Hospital Episode Statistics must be greatly improved to record the accurate prevalence, workload and deaths due to alcohol-use disorders.
- 9.6 The National Liver Plan advocates the development of Managed Clinical Networks. All patients, regardless of geography, should be offered good and equal access to liver healthcare. Networks can establish a database, which captures activity and outcomes, to develop strategies for future care models for alcohol-related problems.

Background and Evidence-Base

The National Alcohol Interventions Improvement Programme Board

This aims to reduce alcohol-related hospital admissions. There are three key support components for PCTs to deliver against three national targets:

- The National Indicator Set 39 (NIS 39); reducing the rate of increase in alcohol-related hospital admissions, as measured by Health Episode Statistics data (HES)
- National Vital Signs Indicator (VSC 26); reduce the rate of alcohol-related hospital admissions
- Home Office, Public Service Agreement (PSA 25) to reduce harm caused by alcohol (and drugs). Specifically (a) fall against trend of alcohol-related hospital admissions each year until 2010/11, (b) a reduction in alcohol-related injury and accidents.

National Indicators, Quality metrics and Audit

In 2006, the BSG produced a quality standards document.¹³ This provides information on all aspects of gastroenterological practice. The BSG has produced guidelines for the highest standards of care in all areas of clinical practice in gastroenterology. These have been published by *Gut* and are available on the BSG website.

www.bsg.org.uk

In 2009, the NHS Information Centre published a list of some 200 quality indicators. Possible new indicators for quality care for patients with alcohol-related problems might include:

- Alcoholic hepatitis survival
- Access to an alcohol specialist nurse within 24 hours of a detected problem

- Maintaining a register of patients with cirrhosis
- Adherence to, and supervision of, detoxification regimes and vitamin supplementation
- Clinical Governance structures
- A patient, family and carers satisfaction mechanism for inpatients and outpatients, with evidence of feedback adaptation.

The National Plan for Liver Disease suggests an outline of how quality of care might be assessed, again emphasising that the most robust assessments are patient-centred.

10. Integrated Modular Training in alcohol and addiction, available for alcohol specialist nurses and trainees in gastroenterology and hepatology, acute medicine, accident and emergency medicine and psychiatry

Recommendations

- 10.1 Modular training, with assessment and accreditation of generic and specific competencies in alcohol, substance misuse and addiction, should be developed for all specialists (clinicians and nurses) and for Units treating people with alcohol and drug-related problems. This would be at a national level.
- 10.2 A new training course should be established, run jointly for both psychiatrists and physicians, including hepatologists, gastroenterologists, emergency and acute physicians and alcohol and mental health specialist nurses. It would focus on the assessment and treatment of both the psychiatric and medical aspects of alcohol-related problems, substance and drug misuse and addiction.
- 10.3 Robust and measurable competency frameworks, within which healthcare professionals can work, should become mandatory. This will enable the emergent evidence-base for the effectiveness of clinical interventions and treatment modalities to be included in the competency requirements for healthcare professionals to work effectively and safely.
- 10.4 Current trainees in gastroenterology should consider undertaking the hepatology subspecialty year, enabling inclusion in the “hepatology register”.

Background and Evidence-Base

Hepatology and Gastroenterology

Some Deaneries have developed regional training schemes for trainees in gastroenterology and hepatology. Universities have accredited modules for higher degrees. Feedback from participants and module assessors has been very positive.

The National Curriculum is currently being revised and includes competencies for basic and advanced hepatology. The National Liver Plan recommends that the BSG Liver Section and BASL develop a system to ensure a quality service and standards for liver centres and details specific competencies for accreditation in hepatology. Revalidation and re-accreditation of hepatologists and liver units will ensure that quality standards are maintained.

Psychiatry

The Royal College of Psychiatrists and the Faculty of Addiction have well established training programmes for alcohol and substance misuse. Trainees often, but not always, receive six months' training in substance misuse, including alcohol.

Alcohol Specialist Nurses

Alcohol specialist nurses deliver interventions with competencies in accordance with Drugs and Alcohol National Occupational Standards (DANOS).²⁷ These include competencies in motivational approaches and brief interventions. Joint liver and psychiatry nursing courses have been established, also with University degree accreditation.

11. Targeted funding for research into detection, prevention and treatment strategies and outcomes for people with alcohol-use disorders

Recommendations

- 11.1 Research into the causes, prevention, consequences and treatment of alcohol-use disorders should be a priority of funding bodies such as the Medical Research Council and the National Institute for Health Research, since current tools are limited.
- 11.2 Research must engage patients and patient groups in service delivery and development.
- 11.3 Research should be commissioned into the most effective public education strategies. These might include DH and alcohol charity campaigns, advertising to different age groups, health promotion leaflets in various languages and patient fora with patient advocates.

- 11.4 Low levels of public awareness of alcohol, units of alcohol, liver disease and alcohol-related problems need to be addressed with a national comprehensive public education and health promotion strategy to reduce the population risk of alcohol-related harm.
- 11.5 Education of the public about alcohol and alcohol-related problems should begin in childhood, both in the home and at school, with particular emphasis on people and their families affected by alcohol misuse. Link worker networks should be developed in the community.

Background and Evidence-Base

Research

The lack of rigorously conducted research on patients' views is a significant gap in our knowledge about gastroenterology and liver disease treatment and service provision and should be addressed in future research work.

Commissioned by the DH, Kaner et al of the Institute of Health and Society, Newcastle University, produced a superb review on the epidemiology, treatment and service provision for liver disease in England.²⁸ They identified gaps in the evidence-base. They reported a lack of high quality epidemiological data on:

- Experience of liver disease in ethnic minority groups. Among ethnic groups, there is variability in the dose and pattern of alcohol consumption²⁹ and also in the susceptibility to develop alcohol-related liver disease^{30,31}
- Rates of liver disease by age/gender/region/socio-economic status.

The BSG, AHA UK and BASL are exploring how they can contribute to patient support and redemption and on how best to get patients to engage in treatment. It is our patients who are best placed to give feedback on alcohol services, but there is remarkably little systematic evaluation of what they think.

Education and Health Promotion

The House of Commons Committee of Public Accounts highlighted the "widespread and long-standing lack of clarity in the minds of the public" on the Government's drinking guidelines and recommended to the DH a review of whether the current guidelines were fit for purpose or should be replaced with something more "readily understood".³² In fairness, the DH has "invested £10 million in the 'Know your limits campaign', which arms people with the facts about the number of units in different drinks. The campaign also targets 18-24 year old drinkers and challenges public acceptability of drunkenness and binge drinking".

Smoking cessation by doctors played a major role in educating the public about the dangers of smoking and in leading the campaign to reduce smoking overall and to ban it in public places. Doctors are leading by example by reducing their average alcohol consumption, partly because many abstain completely from alcohol for cultural or religious reasons. Role models in sensible drinking can be influential.

Hospital workplace policies on alcohol and hospital occupational physicians can play an important role by recognising an alcohol-related problem at an early stage, rather than when it has become a disciplinary matter. Similar concerns in the community, together with the “stigmatisation” associated with alcohol-use disorders, often prevent people from seeking help at an early stage.

Until recently, if an alcohol-related disorder was a cause of death, the coroner had to be informed. Hence, doctors, sensitive to the feelings of bereaved relatives, who did not want a post-mortem, frequently wrote “liver disease”, rather than “alcohol-related liver disease”, on a death certificate. Historically, therefore, alcohol-related deaths in the UK have been grossly under-estimated. This has been compounded by notoriously inaccurate disease coding.

A non-judgmental attitude will help to overcome these barriers, by removing the stigma traditionally associated with alcohol-use disorders. Hopefully, this will encourage people to present at an early stage for care by the specialist, well-trained and highly motivated workforce required to implement our National Alcohol Strategy.

COST-EFFECTIVE ALCOHOL STRATEGIES AND MODEL PRACTICE

Cost-Effectiveness of our Key Recommendations

Many of our recommendations involve the intelligent coordination of services, but there also needs to be investment. Some of this has already been implicitly committed to in the National Plan for Liver Services 2009. The Plan describes the expansion in consultant numbers needed for this strategy and this must be matched by an expansion of the clinical team, especially alcohol specialist nurses.

Alcohol-related problems attract a disproportionately small fraction of the drugs and alcohol budget, which should be refocused to give a higher priority to alcohol-use disorders. However, the importance of our proposals is not only that they are an overdue response to an important medical and social problem, but that if implemented, they will result in major net cost savings to the NHS.

Costs

Based on national indicators and length of stay costs:

- On average, an alcohol-related admission costs a PCT £1824
- On average, an alcohol-related A & E attendance costs a PCT £80
- On average, each avoided admission will save a provider £300.

In terms of responding to these statistics, the key issues with the range of potential alcohol treatments are a reluctance to use Brief Interventions systematically, the lack of targeted funding and resource constraints, especially in the current economic climate.

Existing Funding Models

Within a population, responding to alcohol-related problems requires the provision of a range of interventions from simple brief advice to highly complex treatment. Determining the appropriate pathway for a given patient is crucial to ensuring the cost-effectiveness of a whole system.

The funding which currently exists is often part of the pooled treatment budget for drugs and alcohol. Within these budgets, most of the funding is dedicated to drug treatment. On average, in 2002/3, PCTs were only spending 0.1% of their money on alcohol services every year, working out at £197 per dependent drinker, whereas the amount spent annually on dependent drug users equated to £1744 per dependent person.³³ There should be integrated care for both drug and alcohol users.

Moreover, for every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels.³⁴ This compares favourably with smoking, where only one in twenty will act on the advice given.

Cost Effectiveness of Alcohol Treatments

It is essential that pathways are developed to determine who is best placed and most cost-effective in the delivery of a given treatment modality. Additionally, ensuring that transitional care, between and within services, is optimal, is a key component in the effectiveness of both a given treatment and the treatment system.

This paper has detailed many examples of cost-saving and cost-effectiveness, which are echoed in the NICE Guidelines "Alcohol-use disorders: preventing harmful drinking".

<http://guidance.nice.org.uk/PHG/Wave15/1>

The guidance includes cost-effective, evidence-based recommendations related to alcohol pricing, availability, marketing and licensing, as well as for resources for appropriate screening and brief interventions, supporting and motivational counselling for children, young people and adults.

Previously, the Department of Health’s chief source of evidence has been a major review published by the National Treatment Agency for Substance Misuse.³⁵ This review covered the full range of interventions, from screening and brief advice to specialist treatment. The main findings were:

Brief Intervention and Identification and Brief Advice

Although not assessing cost-effectiveness, a meta-analysis of 22 randomised control trials concluded that brief interventions in primary care lowered alcohol consumption.¹⁰ Further, a US study review of existing evidence suggested that brief advice had one of the highest cost-effectiveness rankings of the 25 primary care services evaluated.³⁶

Psychosocial Interventions

“Behavioural self-control training”, “coping and social skills training” and “cognitive behavioural marital therapy” were effective for different patients. For some types of psychosocial treatment for dependent drinkers, the public sector would save £5 for every £1 spent on treatment.³⁷

Pharmacotherapies

Medication to assist detoxification, prevent relapse and provide nutritional supplements can reduce longer-term health costs of problem drinkers.

Department of Health High Impact Changes

The Department of Health has identified 7 High Impact Changes, which are calculated to be the most effective actions for those local areas that have prioritised the reduction in alcohol-related harm.¹⁶

1. Work in partnership
2. Develop activities to control the impact of alcohol misuse in the community
3. Influence change through advocacy
4. Improve the effectiveness and capacity of specialist treatment
5. Appoint an Alcohol Health Worker
6. Identification and Brief Advice – provide more help to encourage people to drink less
7. Amplify national social marketing priorities.

The HubCAPP on the Alcohol Learning Centre gives more detail. HubCAPP is the Hub of Commissioned Alcohol Projects and Policies, commissioned by the DH and run in partnership through Alcohol Concern. The DH estimates that delivery of these high impact changes can produce average annual savings for a PCT of £650,000.³⁸

The Alcohol Learning Centre

The Department of Health Alcohol Learning Centre aims to share resources, learning and model practice from across the NHS and other stakeholders for those working to reduce alcohol-related harm. It is a repository of policy and promising practice that will support Commissioners and local areas in implementing the High Impact Changes. The website contains alcohol-specific policy documents, guidance and tools and provides training resources to support frontline practitioners in delivering identification and brief advice.

www.alcohollearningcentre

Cost-effective alcohol strategies, including the Department of Health “High Impact Changes”, should be implemented, with sharing of model practice via the National Treatment Agency for Substance Misuse and the Department of Health Alcohol Learning Centre.

CONCLUSION

Currently, alcohol treatment services are not adequately equipped to cope with the nation’s alcohol problem. However, there are hopeful signs. The 3 NICE guidelines on alcohol-use disorders are being published. Together with the National Plan for Liver Services 2009, they emphasise Public Health, prevention and treatment measures and the need for a specialist alcohol workforce, especially for consultants in gastroenterology and hepatology and alcohol specialist nurses. This paper further emphasises the need for the establishment of multidisciplinary teams, with high level leadership, to provide quality care for people with alcohol-related disease, within both primary and secondary care.

In Parliament, there is increasing cross-party consensus to introduce a range of coordinated measures, related to minimum unit pricing, advertising and licensing, to reduce alcohol consumption at a population level. Reports from the All Party Parliamentary Group on Alcohol Misuse,²² the House of Commons Public Accounts Committee³² and the House of Commons Health Select Committee³⁹ have highlighted the gaps in our alcohol services and the urgent need for the development of cost-effective pathways of alcohol care. Implementation of our key recommendations will achieve this.

In 2001, there were two seminal publications on alcohol-related disease. Firstly, Sir Liam Donaldson, the Chief Medical Officer, in his 2001 Annual Report, highlighted Britain’s growing alcohol epidemic, particularly the huge increase in death rates, in young and old, from alcohol-related liver disease. Secondly, Professor Ian Gilmore, the current President of the Royal College of Physicians of London (RCP), chaired a RCP Working Party, which highlighted the alcohol-related harm and costs to Britain’s hospitals, and provided a blueprint for managing alcohol-use disorders.

In 2010, Sir Liam Donaldson and Professor Gilmore retire from their respective offices. They were accorded a fitting valediction by the House of Commons Health Select Committee in their report on Alcohol: “It is time the Government listened more to the Chief Medical Officer and the President of the Royal College of Physicians and less to the drinks and retail industry”.

REFERENCES

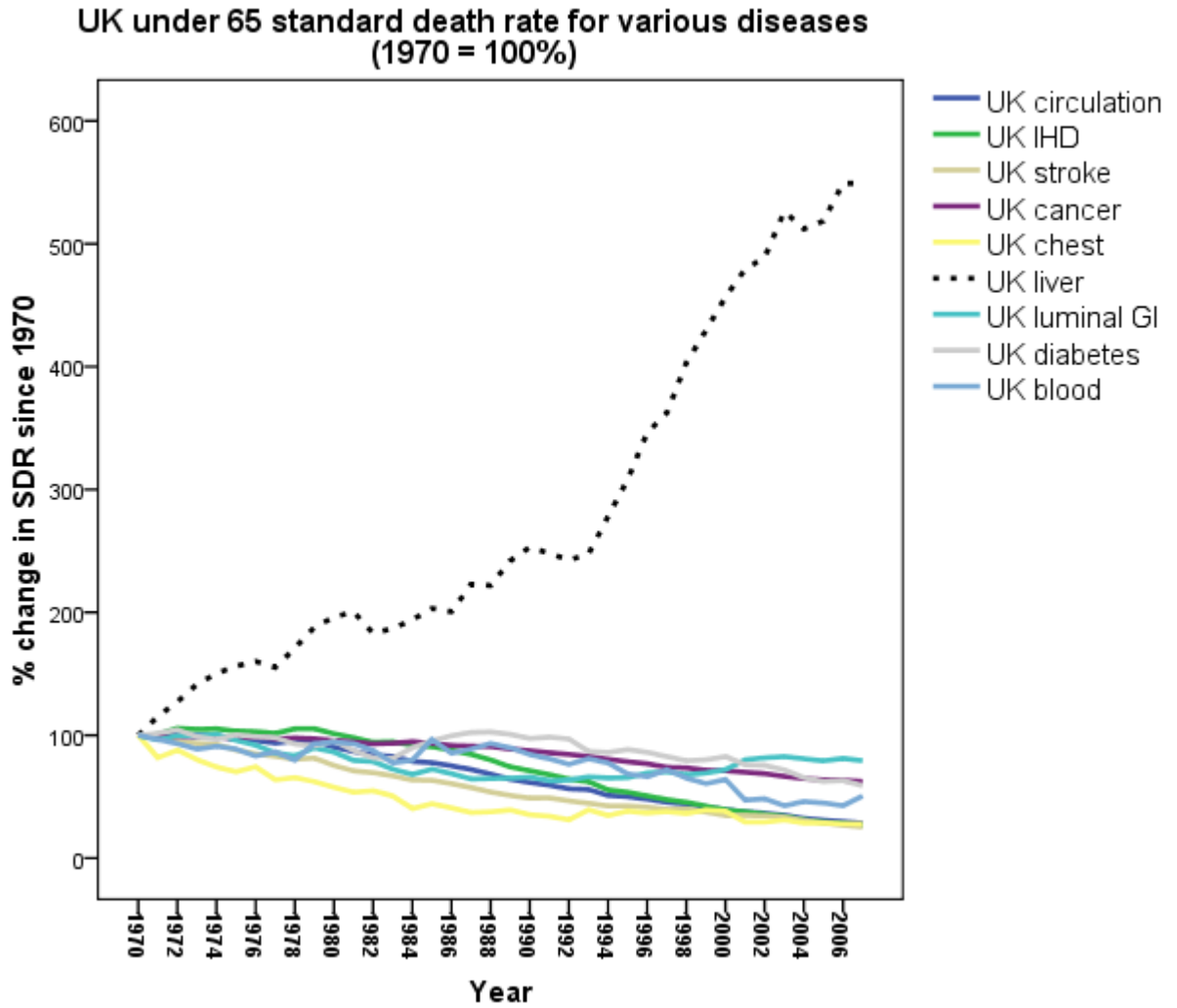
1. Department of Health. The Annual Report of the Chief Medical Officer of the Department of Health 2001. London: Department of Health, 2001.
2. Department of Health. The cost of alcohol harm to the NHS in England: an update to the Cabinet Office (2003) study. London: Department of Health, 2008.
3. NHS Confederation and Royal College of Physicians. Briefing 2010. Too much of the hard stuff: what alcohol costs the NHS. London: The NHS Confederation, 2010.
4. Royal College of Physicians. Alcohol – can the NHS afford it? Recommendations for a coherent alcohol strategy in hospitals. London: Royal College of Physicians, 2001.
5. Ward D, Murch N, Agarwal G, Bell D. A multi-centre survey of inpatient pharmacological management strategies for alcohol withdrawal. *QJM* 2009;102(11):773-780.
6. Touquet R. Problems in accident and emergency departments. In: Paton A, Touquet R. *ABC of Alcohol*. 4th rev ed. London: BMJ Publishing, 2005: 22-25.
7. Lister G. Evaluating social marketing for health – the need for consensus. Proceedings of the National Social Marketing Centre, 24-25 September, Oxford, 2007.
8. Association of Public Health Observatories. Indications of Public Health in the English Regions 8: Alcohol. Liverpool: NWPFO, 2007.
9. Touquet R, Brown A. PAT (2009) - revisions to the Paddington Alcohol Test for early identification of alcohol misuse and brief advice to reduce emergency department re-attendance. *Alcohol & Alcoholism* 2009 May;44(3): 284-6.
10. Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews* 2007, Issue 2. Art. No.: CD004148. DOI: 10. 1002/14651858. CD004148.pub3.
11. Saunders JB, Walters JRF, Davies P, Paton A. A 20-year prospective study of cirrhosis. *BMJ* 1981; 282(6260): 263-6.
12. Verrill C, Markham H, Templeton A, Carr NJ, Sheron N. Alcohol-related cirrhosis – early abstinence is a key factor in prognosis, even in the most severe cases. *Addiction* 2009 May; 104 (5): 768-74.

13. British Society Of Gastroenterology. Care of patients with gastrointestinal disorders in the United Kingdom: a strategy for the future. London: BSG, 2006.
14. Department of Health, National Treatment Agency for Substance Misuse. Models of Care for Alcohol Misusers. London: Department of Health, 2006.
15. Prime Minister's Strategy Unit. Strategy Unit alcohol harm reduction project: interim analytical report. London: Cabinet Office, 2003.
16. Department of Health. Signs for improvement: commissioning interventions to reduce alcohol-related harm. London: Department of Health, 2009.
17. Personal, Social Services Research Unit. Unit costs of health and social care 2008. Canterbury: Personal Social Services Research Unit, 2008.
18. Moriarty KJ, Platt H, Crompton S, et al. Collaborative care for alcohol-related liver disease. *Clinical Medicine* 2007; 7(2): 125-28.
19. Shiltoe I, Rodgers, A. An overview of patient's views of liver services: an unpublished report from the British Liver Trust, 2007.
20. Williams JG, Roberts SE, Ali MF, et al. Gastroenterology services in the UK. The burden of disease, and the organisation and delivery of services for gastrointestinal and liver disorders: a review of the evidence. *Gut* 2007; 56 Suppl 1: 1-113.
21. Department of Health. Local Routes: guidance for developing alcohol treatment pathways. London: Department of Health, 2009.
22. All Party Parliamentary Group on Alcohol Misuse, Shenker D, Sorensen N, Davis C. The future of alcohol treatment services. London: Alcohol Concern, 2009.
23. Mehta MM, Moriarty KJ, Proctor D, Bird M, Darling W. Alcohol misuse in older people: heavy consumption and protean presentations. *J Epidemiol Community Health* 2006; 60(12):1048-1052.
24. Royal College of Physicians. Consultant physicians working with patients. 4th ed. London: RCP, 2008.
25. Cholongitas E, Betrosian A, Senzolo M, Shaw S, Patch D, Manousou P, O'Beirne J, Burroughs AK. Prognostic models in cirrhotics admitted to intensive care units better predict outcome when assessed at 48 h after admission. *J Gastroenterol Hepatol* 2008; 23 (8 Pt 1): 1223-7.
26. Neuberger J, Gimson A, Davies M, Akyol M, O'Grady J, Burroughs A, Hudson M. Liver Advisory Group; UK Blood and Transplant. Selection of patients for liver

- transplantation and allocation of donated livers in the UK. *Gut* 2008; 57(2): 252-57.
27. Skills for Health (formerly Healthworks UK) Drugs and alcohol national occupational standards (DANOS), London: Skills for Health, 2002.
www.skillsforhealth.org.uk
 28. Kaner E, Newbury-Birch D, Avery L, Brown N, Jackson K, Mason H. A rapid review of liver disease epidemiology, treatment effectiveness and service provision in England. Final report for NIHR, 2008. Grant 078/0001.
<http://www.ncl.ac.uk/ihs/assets/pdfs/liverreview.pdf>
 29. Caetano R, Clark CL, Tam T. Alcohol consumption amongst racial/ethnic minorities: theory and research. *Alcohol Health and Research World* 1998; 22 (4): 233-241.
 30. Fisher NC, Hanson J, Phillips A, Rao JN, Swarbrick ET. Mortality from liver disease in the West Midlands, 1993-2000: observational study. *BMJ* 2002; 325 (7359): 312-313.
 31. Stinson FS, Grant BF, Dufour MC. The critical dimension of ethnicity in liver cirrhosis mortality statistics. *Alcoholism: Clinical and Experimental Research* 2001; 25 (8): 1181-87.
 32. House of Commons Public Accounts Committee. Reducing alcohol harm: health services in England for alcohol misuse. Forty-seventh report of session 2008-09. Report, together with formal minutes, oral and written evidence. HC 925 [incorporating HC1197-i, session 2007-08]. London: The Stationery Office Limited, 2009.
 33. Department of Health. Alcohol Needs Assessment Research Project (ANARP): the 2004 national alcohol needs assessment for England. London: Department of Health, 2005.
 34. Moyer, A., Finney, J., Swearingen, C., Vergun, P. Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment seeking populations. *Addiction* 2002; 97(3): 279-292.
 35. Raistrick, D, Heather N, Godfrey C. Review of the effectiveness of treatment for alcohol problems. London: National Treatment Agency for Substance Misuse, 2006.
 36. Solberg L, Maciosek M, Edwards N. Primary care intervention to reduce alcohol misuse: ranking its health impact and cost-effectiveness. *American Journal of Preventive Medicine* 2008; 34 (2):143-52.

37. UKATT Research Team. Cost-effectiveness of treatment for alcohol problems: findings of the UK alcohol treatment trial. *BMJ* 2005; 331(7516):544-547.
38. Department of Health. *NHS 2010 – 2015: from good to great. Preventative, people-centred, productive.* London: Department of Health, 2009.
39. House of Commons-Health Committee. *Alcohol: First Report of Session 2009-10.* London: The Stationery Office, 2010.

FIGURE 1



Trends in Standard Death Rates for major diseases since 1970. Data are from the World Health Organisation Health for All Database. Death rates normalised to 100% in 1970 (courtesy of Dr. Nick Sheron).

APPENDIX 1

British Society of Gastroenterology, Alcohol Health Alliance UK and the British Association for Study of the Liver

The British Society of Gastroenterology (BSG) is a professional society, with a multidisciplinary membership, focused on the promotion of high standards in clinical services, research and education in gastroenterology and hepatology within the UK.

The Alcohol Health Alliance UK (AHA UK) is a group of 25 organisations (see list below), whose mission is to reduce damage caused to health by alcohol misuse.

The British Association for Study of the Liver (BASL) is the primary organisation for hepatologists and scientists working in hepatology within the UK, and works closely with the BSG.

Members of the Alcohol Health Alliance UK

Academy of Medical Royal Colleges	National Organisation on Fetal Alcohol Syndrome
Action on Addiction	Royal College of General Practitioners
Alcohol and Health Research Trust	Royal College of Nursing
Alcohol Concern	Royal College of Physicians Edinburgh
Alcohol Focus Scotland	Royal College of Physicians London
British Association for Study of the Liver	Royal College of Physicians and Surgeons Glasgow
British Liver Trust	Royal College of Psychiatrists
British Society of Gastroenterology	Royal College of Surgeons London
College of Emergency Medicine	Royal Pharmaceutical Society
Faculty of Occupational Medicine	Scottish Intercollegiate Group on Alcohol
Faculty of Dental Surgery	
Faculty of Public Health	
Institute of Alcohol Studies	
Medical Council on Alcohol	
National Addiction Centre	

APPENDIX 2

Lead Alcohol Clinician and Consultant Programmed Activities (PAs) required to provide collaborative alcohol care in a District General Hospital serving a population of 250,000	
SPECIALTY	Programmed Activities (PAs) per week
Lead Clinician in Alcohol	20-24 Total. 5 PAs for Lead Role. 15-19 other PAs between Psychiatry and Lead Hepatologist or Gastroenterologist
Addiction and Liaison Psychiatry – Alcohol, Substance Misuse and Addiction	
5 other Gastroenterologists (department)	10
A & E Consultants (department)	20
Acute Physicians (department)	8
Sexual Health Physician	1.5 each
Orthopaedic Surgeons (department)	7
Faciomaxillary Surgeons (each)	2
Radiologists	1 each
Histopathologists	1 each
Clinical Psychology (department)	3
Pain Relief (department)	3
Palliative Care (department)	3
Elderly Care Physicians	0.75 each
Average Consultant	0.5 each

These PAs are best estimates, since Consultants are often unaware of when a patient has an alcohol-use disorder. As the decade progresses, these figures are highly likely to increase.

Alcohol-related disease prevalence in a district will influence calculations. Where available, national statistics have been included. Audit data have also been obtained from departments at the Royal Bolton Hospital NHS Foundation Trust. This serves a population of 260,000, where there is a high alcohol-related disease prevalence.

APPENDIX 3

Alcohol Specialist Nurses – Provision of a 7-Day Service in a District General Hospital, serving a 250,000 population

Ideally, a Trust should employ 2 Gastroenterology-based, Liver Nurse Practitioners and 2 Psychiatry-based, Alcohol Liaison Nurses. This would entail a 1 in 4 rota and may suit nurses who prefer to work at weekends. However, to establish a more acceptable rota, ASNs might wish to pair with a neighbouring Trust or Community ASNs. The ASNs would input into Accident & Emergency, the Acute Medical Receiving Unit, Hepatology, Gastroenterology and General wards.

The 2009 salary costs (including National Insurance etc) are:

a) Gastroenterology-based Liver Nurse Practitioners (LNPs):

1 WTE Band 7 = £39,000 p.a.

1 WTE Band 6 = £36,000 p.a.

Depending on workload, one of these nurses could help provide a service for patients with Hepatitis C. This would help in applying for funding.

b) Psychiatry-based Alcohol Liaison Nurses (PLNs):

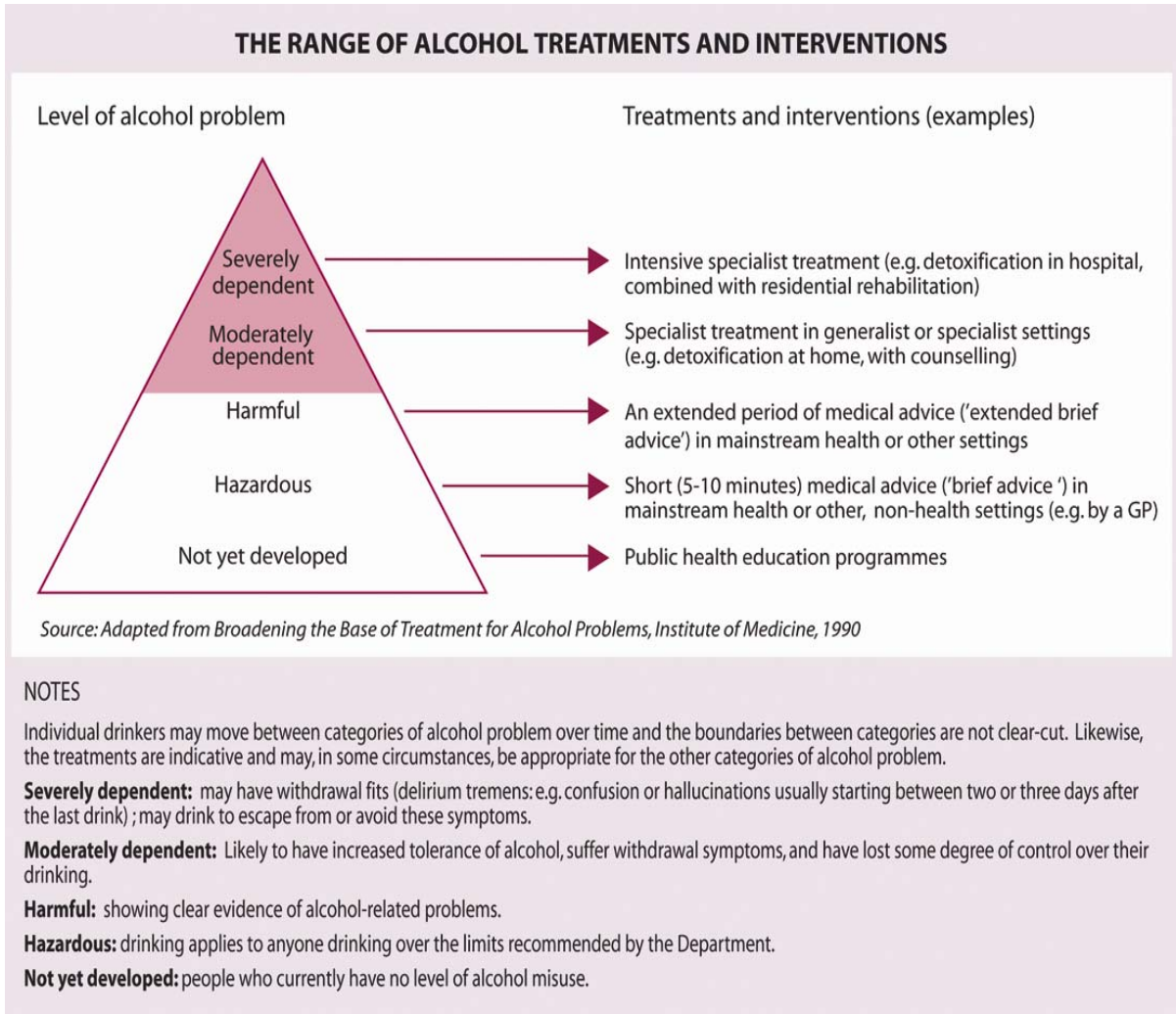
2 WTE Band 6 (£36,000 x 2) = £72,000 p.a.

c) Secretary

1 WTE Band 4 = £19,000 p.a.

TOTAL SALARY COST £166,000 per annum.

APPENDIX 4



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USEFUL WEBSITES AND CONTACT DETAILS

NATIONAL STRATEGY BODIES

British Society of Gastroenterology	http://www.bsg.org.uk//
Alcohol Health Alliance UK	http://www.rcplondon.ac.uk/alcohol
Royal College of Physicians of London	http://www.rcplondon.ac.uk
British Association for Study of the Liver	http://basl.org.uk/
National Institute for Health and Clinical Excellence (NICE)	http://nice.org.uk/

HELP WITH ALCOHOL, DRINKING AND ADDICTION

- Contact **Drinkline**, the National Alcohol Helpline, on : 0800 917 8282

Drinkline is a free, confidential helpline for information and advice on alcohol and drinking. Advisers can talk to you about your own or someone else's drinking, and can help you to contact support services in your area.

- Find a local **Alcoholics Anonymous** meeting

telephone 0845 769 7555

email: helpline@alcoholics-anonymous.org.uk
<http://www.alcoholics-anonymous.org.uk>

Alcoholics Anonymous is a network of anonymous support meetings for alcoholics. The meetings are free and the only requirement for membership is a desire to stop drinking. The contact details above can provide you with more information and help you to find a local meeting.

- Find information from **Alcohol Concern**:

<http://www.alcoholconcern.org.uk>

Alcohol Concern is the national agency on alcohol misuse and offers a range of information materials, including fact sheets and advice. Alcohol Concern also operates a services directory, through which you can find a local advice service or treatment agency.

- Find out how much is safe to drink with Know your Limits:

<http://units.nhs.uk/>

NHS choices host the Know your Limits website, which provides information on recommended allowances of alcohol and the number of units in different drinks.

HELP WITH ALCOHOL-RELATED HEALTH PROBLEMS

- Contact the **British Liver Trust**: 0800 652 7330;
<http://www.britishlivertrust.org.uk/home/support.aspx>

The British Liver Trust offers support for anyone affected by liver disease, operates a free helpline, coordinates local support groups and hosts an online support forum.

- Find information from **CORE** <http://www.corecharity.org.uk/Information.html>

CORE provides free information on gut and liver disease and raises funds to support research workers and their projects.

HELP FOR YOUNG PEOPLE

- Find a local **Al-Anon** group: <http://www.al-anonuk.org.uk/>

Al-Anon is the organisation for families and friends of alcoholics, offering support for all those affected by someone else's drinking.

- Contact **NACOA**: 0800 358 3456
helpline@nacoa.org.uk
<http://www.nacoa.org.uk>

NACOA is the National Association for Children of Alcoholics. NACOA provides information, advice and support for these vulnerable children and people concerned for their welfare.

DEPARTMENT OF HEALTH

Alcohol Misuse index

<http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/index.htm>

Alcohol misuse useful links

http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_4066593

Alcohol Statistics

http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_085391

Alcohol publications

http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_4001740