

Tackling alcohol misuse in NHS hospitals

a Resource Pack

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Foreword

Alcohol misuse places a considerable burden on the NHS and wider society.

Alcohol misuse places a considerable burden on the NHS and wider society. One in five adults in England drink above the Chief Medical Officer's safe drinking guidance and 1.6 million people have alcohol dependence. Alcohol contributes to a wide range of mental and physical illness and causes significant social problems for individuals and their families. Deaths from alcoholic liver disease have increased 400% since 1970 and alcohol related hospital admissions have doubled in the eight years to 2014.

Against a background of NHS services under unprecedented pressure from rising demand, there is an urgent need to reduce the burden of preventable alcohol related disease. The NHS and local authorities have a crucial role to play in this effort.

A series of reports from government and the Royal Colleges, together with a suite of recent NICE guidelines, set out the evidence based approaches to tackling alcohol related harm. Alcohol brief interventions for hazardous and harmful drinkers in primary and secondary care and specialist treatment for people with alcohol dependence have a strong evidence base and are cost effective. While some progress has been made in implementing these approaches this is not yet having sufficient impact on reversing the rising disease burden from alcohol. Less than 10% of people with alcohol dependence access alcohol treatment services each year and implementation of brief interventions remains a long way short of what has been achieved with smoking cessation interventions in the NHS.

This Resource Pack sets out the steps that need to be taken in NHS hospitals to tackle the rising burden. While hospitals are only one of several NHS settings in which wider implementation is needed, there is a particularly high concentration of people with complex alcohol related disease in hospitals, including people who have frequent alcohol related attendances. This places hospitals in a pivotal position to identify and help people with the highest level of unmet alcohol-related needs.

However hospitals and NHS professionals who work in them cannot solve these problems in isolation. There needs to be coordination between hospitals, NHS and local authority commissioners, specialist

addiction services in the community, primary care, and social services in each locality, to develop a concerted response. Local Health and Wellbeing Boards have a key role in bringing these groups together to develop a coherent plan. Local Sustainability and Transformation Plans should, as some already have, include a coordinated response to alcohol as a key strategy to reduce pressure on the NHS.

Both this resource and key government and Royal College reports on the response to alcohol in hospitals identify the importance of local alcohol champions, usually senior clinicians, as key drivers of this transformation. These were also key recommendations of *Health First: An evidence based alcohol strategy* for the UK and Public Health England's recent evidence review of alcohol policy options. This Resource Pack goes further and emphasises the importance of developing a local hospital alcohol strategy, bringing together the key actors in the NHS, commissioning and the local community, to support optimal and sustained change in tackling alcohol problems in the NHS. It shares the experiences within King's Health Partners in South East London; inevitably the experience in one inner city Academic Health Science Centre will need to be adapted to fit the particular circumstances and needs elsewhere. However, the core principles and building blocks for successful implementation described here are widely applicable.

While considerable progress has already been made in implementing effective alcohol care in hospitals in many parts of England, this is not yet universal. So the main aim of this resource is to share knowledge and experience to drive sustainable change in tackling alcohol misuse across NHS hospitals.



Ian Gilmore

Professor Sir Ian Gilmore
Chair, Alcohol Health Alliance UK
Past President, Royal College of Physicians
Chair, Liverpool Health Partners and Professor of Hepatology, University of Liverpool

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Introduction

Tackling Alcohol Misuse in NHS Hospitals Resource Pack

Welcome to **“Tackling Alcohol Misuse in NHS Hospitals”** produced by the Health Innovation Network (HIN) in collaboration with the CLAHRC (Collaboration for Leadership in Applied Health Research and Care) South London. Providing excellent alcohol care in hospitals offers real opportunities to improve patient outcomes and reduce NHS expenditure in the longer term. This Resource Pack has been designed for both clinicians and hospital managers looking to develop hospital based responses to alcohol, and for commissioners who wish to determine the local need for different levels of response.

This Resource Pack contains quick reference key messages and resources in an interactive clickable PDF document, but you can also download the full report [here](#). Some context and policy background has also been provided to better understand where we are in improving alcohol care in hospitals across England.

This Resource Pack is intended for use across England, and drawing from our own experience, and the HIN's remit, we refer to work undertaken in South London, and offer the King's Health Partners Alcohol Strategy. Similarly, more detailed data is provided for the twelve south London boroughs, and we urge organisations elsewhere to use these resources as a guide to seek equivalent local data.

The Health Innovation Network

The Health Innovation Network is the Academic Health Science Network (AHSN) for south London, one of 15 AHSNs across England. We work across a huge range of health and care

services through each of our clinical and innovation themes, to transform care in diabetes, musculoskeletal disease, alcohol and healthy ageing, to accelerate digital health uptake into the NHS, and we're passionate about education. HIN acts as a catalyst of change – identifying, adopting and spreading innovation across the health and care system in south London.

The HIN would particularly like to thank Professor Colin Drummond, King's College London, Alcohol Theme Lead, NIHR CLAHRC South London and Professor of Addiction Psychiatry at King's College London, for his extensive time and input to this document, sharing the learning from his and colleagues' research and service development work currently underway in south London.



Professor Paul Wallace,
Clinical Lead for the Alcohol Theme,
Health Innovation Network

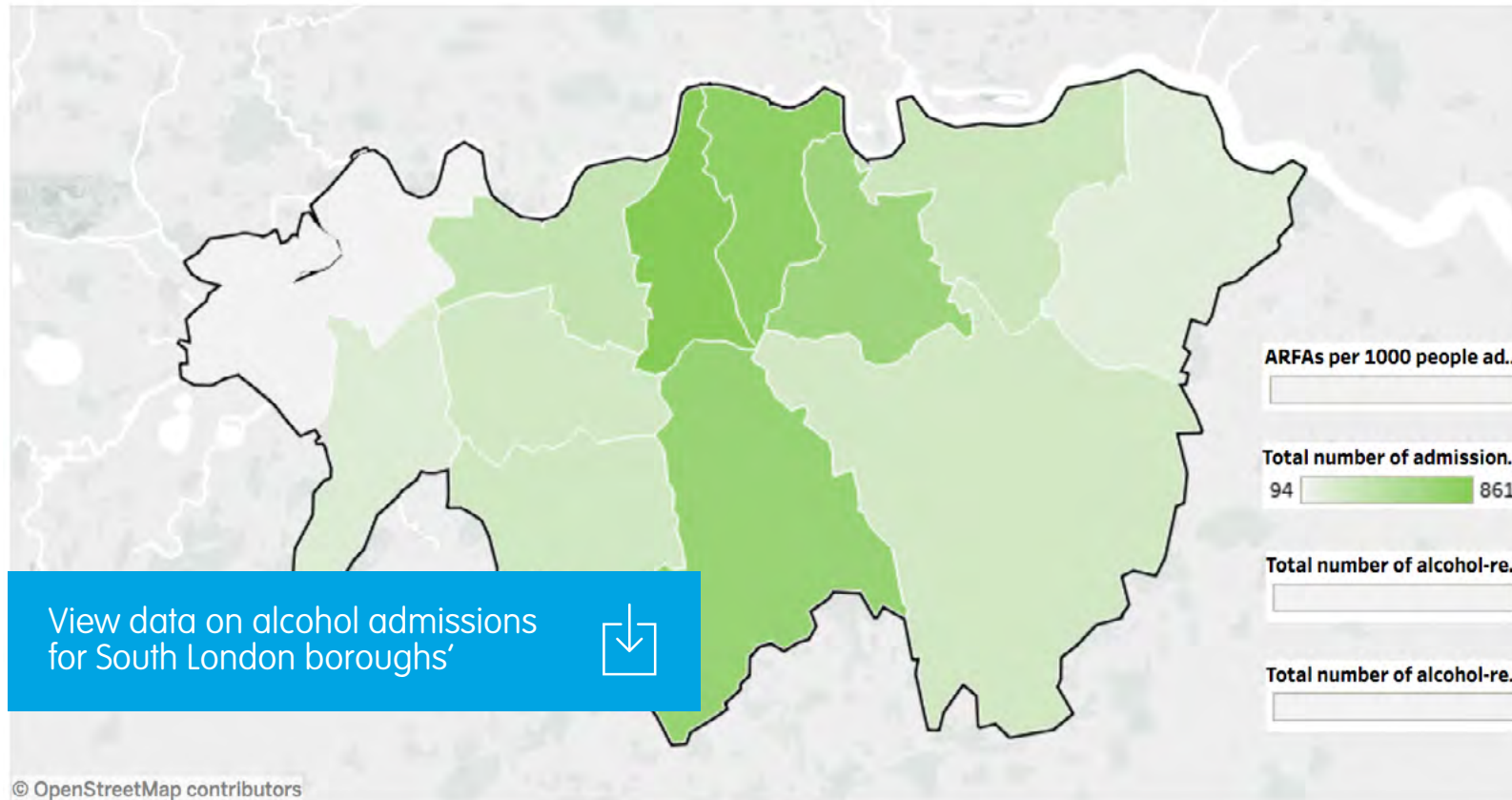


Professor Colin Drummond,
King's College London,
Alcohol Theme Lead,
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Introduction

Tackling Alcohol Misuse in the NHS Hospital Setting Resource Pack



We have created an interactive visual display of the relevant data across the twelve boroughs of south London (the HIN's jurisdiction), as both a tool for our immediate stakeholders and partners, but also an example of how to interpret the data available across all boroughs within England. Please click on a borough to investigate further the local situation.

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1.

Why do hospitals need to take alcohol misuse seriously?

Excessive alcohol use is placing a considerable burden on the NHS – in England alone, one in five adults drink at levels that increase the risk of ill health while 1.6 million adults are alcohol dependent.

This section looks at how these trends are impacting on the NHS and why hospitals must put in place appropriate alcohol misuse treatments and processes, not only to help patients – but to safeguard the future of the public healthcare sector and its budgets.

1.1

Alcohol Misuse: The Impact on the NHS

1.2

Why does alcohol misuse impact so much on hospitals?

1.3

Why does alcohol misuse need to be tackled in hospitals?

1.4

Why are hospitals failing to treat alcohol misuse adequately?

1.5

What targeted policies currently exist?

1.6

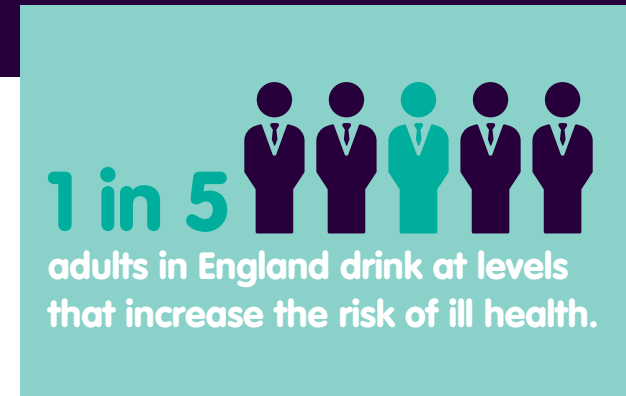
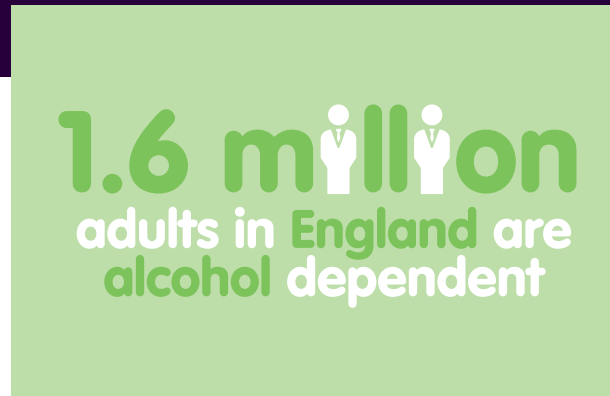
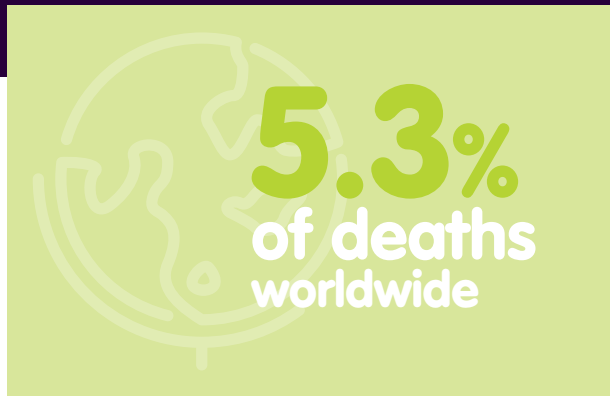
What value does treating alcohol misuse offer the NHS?

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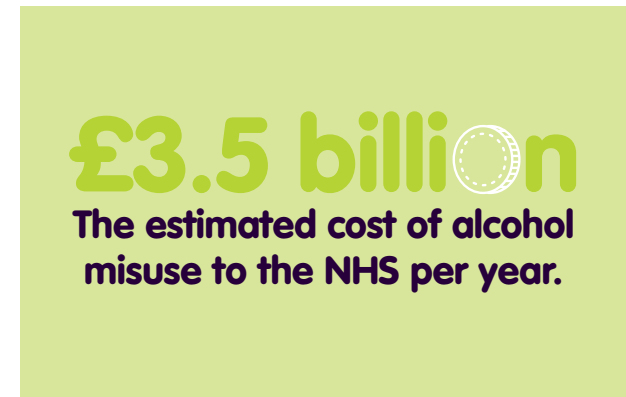
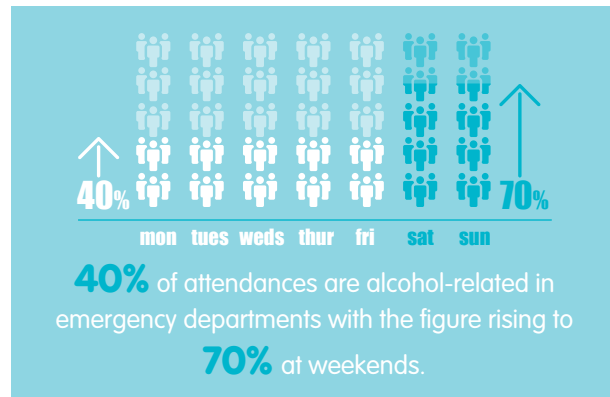
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1.1 Alcohol Misuse: The Impact on the NHS

Excessive alcohol use places a considerable burden on society and public healthcare services



Alcohol represents a significant challenge for the NHS:

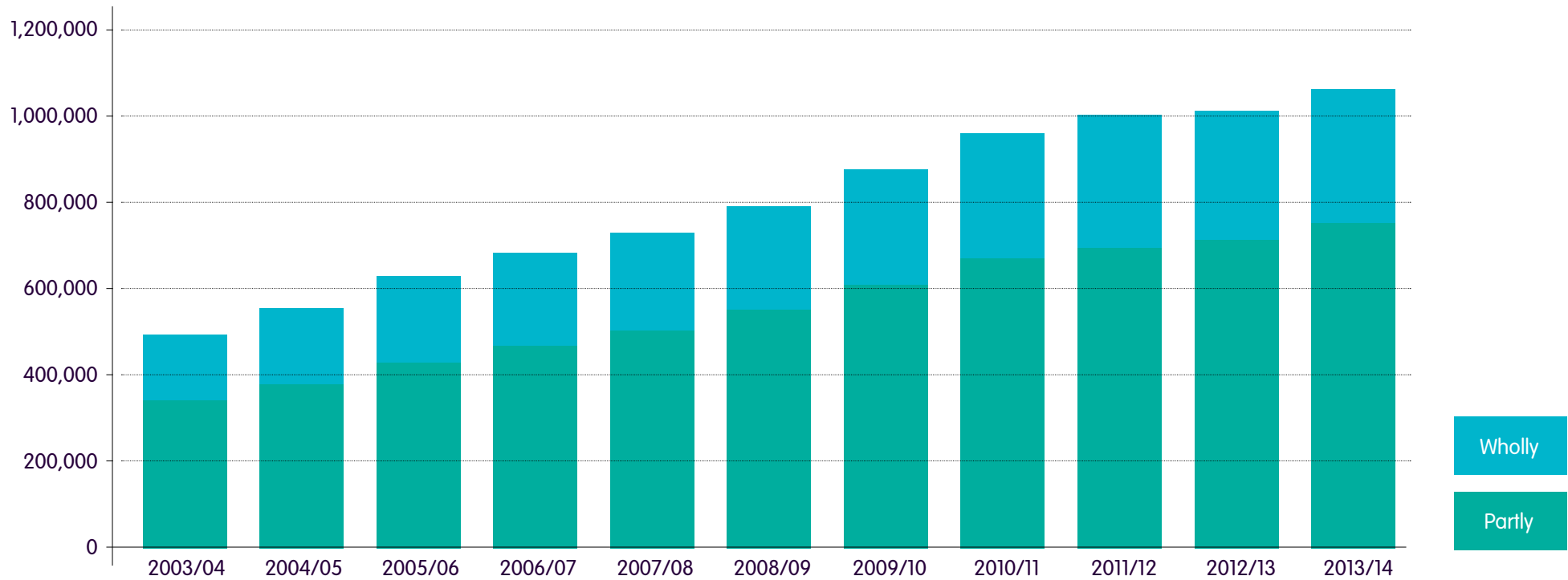


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1.1 Alcohol Misuse: The Impact on the NHS

Excessive alcohol use places a considerable burden on society and public healthcare services

Alcohol related hospital admissions England 2003-2014 (Wholly and partly attributable to alcohol)
(NHS Digital, 2016)



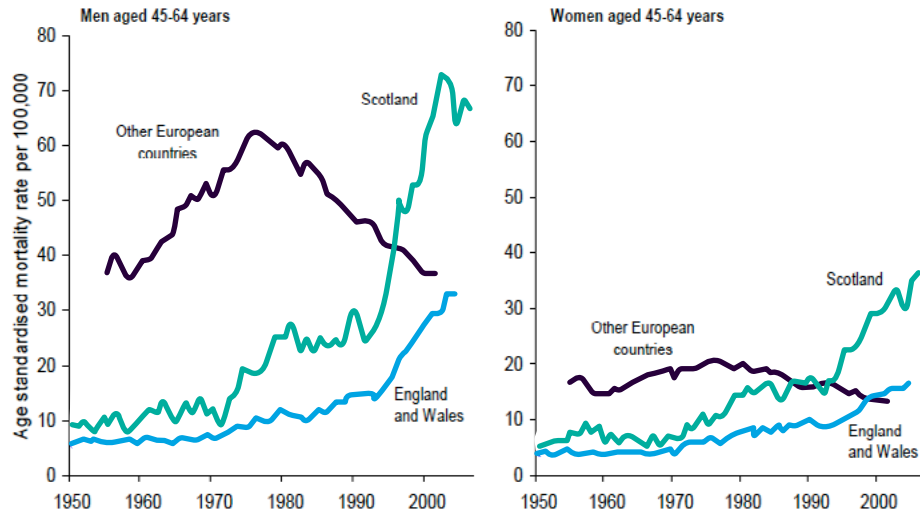
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1.1 Alcohol Misuse: The Impact on the NHS

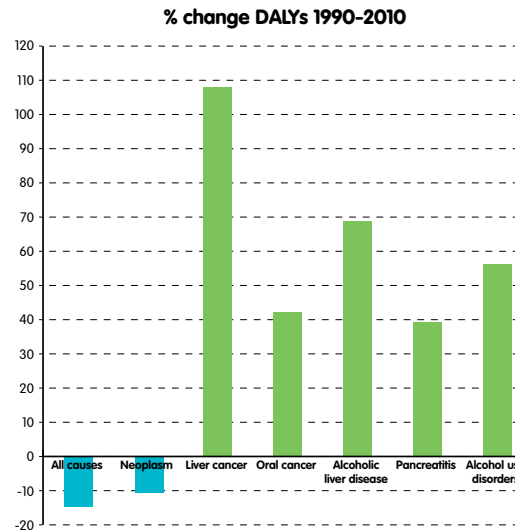
Excessive alcohol use places a considerable burden on society and public healthcare services

Chronic liver disease and cirrhosis mortality rates per 100,000 population, 1950-2006 (Leon & McCambridge, 2006)



This graph shows the changes in chronic liver disease and cirrhosis mortality rates per 100,000 population, for men and women aged 45-64 years over a 52 year period. Compared to other European countries where deaths have declined, in England, Wales and Scotland death rates have risen steeply in both men and women

UK Health Performance (Murray et al., 2013)



This graph shows the changes in overall disease burden in the UK, comparing all causes with those illnesses associated with alcohol. It can be seen that while the burden of disease from all causes has fallen in the UK over the last 20 years, diseases wholly or partly caused by alcohol have risen steeply. The underlying cause is a steep rise in population alcohol consumption over this period.

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1. 1.2 Why does alcohol misuse impact so much on hospitals?

The World Health Organisation has identified over 200 different disease conditions that are wholly or partly attributable to excessive alcohol use.

Wholly attributable conditions include:

- Alcohol intoxication and alcohol poisoning
- Alcoholic liver disease
- Alcoholic pancreatitis
- Alcohol dependence
- Acute alcohol withdrawal.

Partly attributable conditions include:

- Cardiovascular diseases
- Gastrointestinal disorders
- Hypertension
- Strokes
- Cancer.

But there is a bigger issue at play here – research shows directly attributable conditions are currently under-diagnosed in hospitals, meaning actual admission figures are underestimated.

For example:

At King's College Hospital, only 17% of medical admissions have a documented alcohol history compared to 35% who have a documented smoking history.

Similarly, patients are not routinely screened for alcohol-use disorders in most hospital emergency departments, meaning patients presenting with obvious alcohol intoxication represent only the tip of the iceberg.

x2

**increase in admissions
for these conditions
over eight years**

**with
300,000**

**admissions
per annum**

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1. 1.3 Why does alcohol misuse need to be tackled in hospitals?

There are a raft of issues associated with alcohol misuse that impact on healthcare.

Patients admitted with alcohol-related conditions have longer hospital stays:

Average Length of Stay (ALOS) for South London in 2013/14 is 5.69 days for alcohol related admissions versus 2.25 days for non-alcohol admissions.

(Drummond et al., 2016)

This is often due to more complex multi-morbidities, poor social circumstances and greater clinical complications during admission, while some alcohol-related complications can occur because alcohol dependence is not diagnosed early enough.

Once untreated acute withdrawal states occur, they are difficult to clinically manage, in turn unnecessarily prolonging hospital stays.

Partly attributable conditions include:

- Wernicke's encephalopathy and potentially profound and permanent brain damage
- A greater likelihood of previously admitted patients being readmitted over the following two years
- More frequent emergency department attendances than other kinds of patient groups:



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1. 1.3 Why does alcohol misuse need to be tackled in hospitals?

There are a raft of issues associated with alcohol misuse that impact on healthcare.

Exacerbating the Problem

Hospital staff

... sometimes believe that the diagnosis and treatment of alcohol misuse is not part of their remit and should be managed elsewhere in the NHS or by the local authority.

Patients

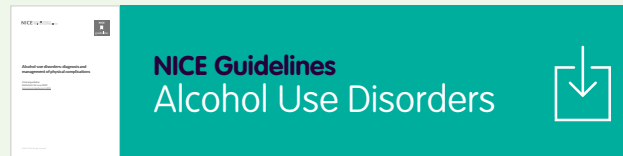
... less than 10% of patients with alcohol dependence access specialist treatment services per annum because:

- Patients are often reluctant to seek treatment for alcohol problems due to perceived stigma, a lack of awareness about the need for treatment and what resources are available
- Many with alcohol dependencies and mental/physical ill health issues lead chaotic lives, making their health more difficult to manage
- Those who are also homeless (or are without state registration) are not likely to be registered with a GP.

Hospitals may be the only part of the NHS with which a patient is in contact and could provide:

- Adequate routine screening
- History taking
- Diagnosis and treatment
- Referral to specialist services

Adopting these processes will not only contribute to shortened length of stay but also to the prevention of need for future alcohol-related admissions, in turn providing better clinical and cost outcomes.



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1.4 Why are hospitals failing to treat alcohol misuse adequately?

Research has identified many factors contributing to the inadequate diagnosis and treatment of alcohol misuse in hospitals:

Limited training

... on alcohol misuse at both undergraduate and postgraduate level for health professionals; this has not kept pace with the rising prevalence of alcohol use disorders

Busy, Pressurised working environments

... staff can view alcohol misuse as 'one task too many' to add to an already long list

Stigma

Patients with alcohol problems can be an unpopular group, viewed as only having themselves to blame for their health problems.

Evidence shows that the strategic landscape is also complicating the situation:

Local authority commissioning of alcohol services

... has not kept pace with the increasing number of alcohol use disorders.

The Health and Social Care Act

... has moved the commissioning from the NHS to local authorities who are already struggling with reduced public health budgets.

NHS commissioning response

... has been patchy and often short term despite exhortations from several public bodies.

Improved prioritisation

... in the hospital setting only tends to happen where there is a strong local champion to persuade hospital authorities.

To the Future

The increasing burden caused by alcohol misuse means that adequate alcohol care provision must be seen as a core NHS service activity rather than an optional extra.

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1.

1.5 The Policy Context

Many reports offer guidance for implementing successful alcohol misuse treatment programmes. For instance:

The Royal College of Physicians

... recommends dedicated alcohol liaison nurses and named senior clinical leadership to provide a focus within hospitals for:

- Medically managing patients with alcohol problems
- Educating and supporting other healthcare workers
- Implementing a case-finding strategy and providing brief advice
- Liaising with community alcohol and other specialist services.

NICE NHS Evidence (2012;2014) ... provides a case study for quality and productivity

... provides guidelines for increased quality and productivity by:

- Rolling out alcohol care teams and services to address the needs of alcohol-related frequent attenders
- Making the case for 7 day multidisciplinary alcohol care teams as many services are only provided during office hours, whereas many alcohol-related admissions take place on evenings and weekends.

These numerous reports demonstrate that there is strong national policy support for improving alcohol care across England.



“

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

The Government's Alcohol Strategy's 'Health First: An Evidence-Based Alcohol Strategy for the UK'

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1. 1.6 What value does treating alcohol misuse offer the NHS?

In the face of rising alcohol-related hospital admissions, many of which are preventable, the case for change is now stronger than ever.

According to Public Health England, optimised alcohol care in hospitals:

- Improves quality and efficiency of care
- Reduces admissions, readmissions and length of stay for patients with alcohol-related problems
- Potentially reduces A&E attendances
- Reduces mortality related to the misuse of alcohol by systematically identifying alcohol-related conditions
- Reduces duration of detoxifications in hospital via working with services in the community to complete detoxification after discharge.

Return on Investment Case Studies

Royal Bolton Hospital

The cost of investing in a specialist nurse service is **£165,000** annually. As a result of this investment, **2,000 bed days** are saved, liberating 4-6 hospital beds. This equates to a saving of **£636,000**, representing a return of **£3.85** for every **£1.00** invested.

Salford Royal Hospital

An **assertive outreach service** targeting the most frequently admitted patients with alcohol related problems resulted in a **59%** reduction in emergency department attendances in the **three-month** period post intervention. There was also a **66%** reduction in average monthly hospital admissions. The annual service cost is **£300,000**, liberating 2-3 hospital beds and amounting to **£556,500** in benefits – this represents a return of **£1.86** for every **£1.00** invested

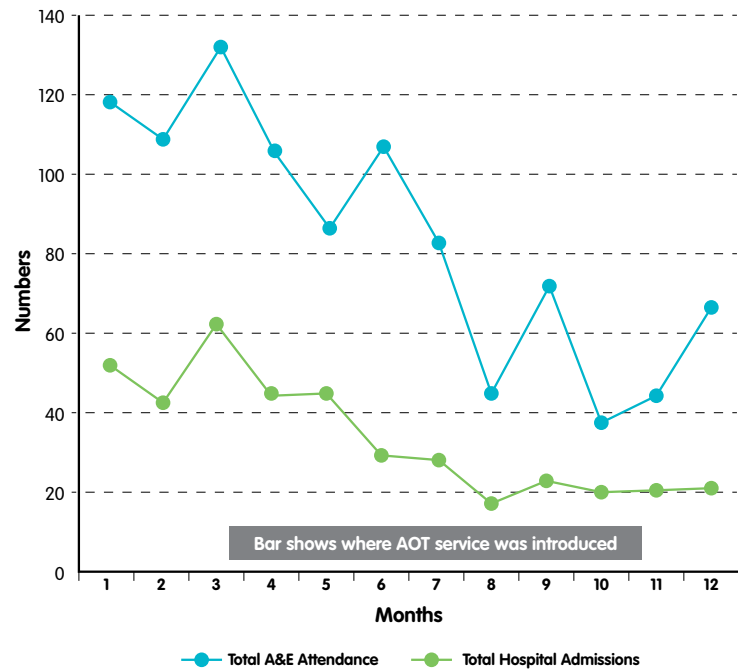
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1.6 What value does treating alcohol misuse offer the NHS?

In the face of rising alcohol-related hospital admissions, many of which are preventable, the case for change is now stronger than ever.

Salford alcohol assertive outreach service change in A&E attendances and admissions with 54 patients (bar where AOT service introduced) (Hughes et al., 2013)



NICE Guidelines
Alcohol Use Disorders:
Prevention

NICE Guidelines
Alcohol Use Disorders:
Diagnosis, assessment and
management

NICE Guidelines
Alcohol Use Disorders:
Diagnosis and management of
physical complications

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2.

Types of alcohol related presentations to hospital

Alcohol misuse may often be a 'hidden' underlying problem in a wide range of health conditions and can be easily missed without clinicians routinely enquiring about alcohol consumption.

This section explores how alcohol misuse can present in many different ways. It also details the most efficient responses to/strategies for a myriad of often "hidden" alcohol-related conditions.

2.1

Alcohol intoxication/poisoning

2.2

Admissions wholly caused by alcohol

2.3

Presentations wholly caused by alcohol

2.4

High impact users/alcohol related frequent attenders

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2.

2.1 Alcohol intoxication/poisoning

The adverse effects of alcohol intoxication are commonly seen in emergency departments:



Accidents and injuries
(including head injury)



Assaults and collapse



Falls and unconsciousness

Intoxicated patients in pain can often be disruptive and challenging for staff, in turn increasing instances of assault and, in severe cases, patients may also require hospital admission.

However, intoxication and poisoning only account for a small proportion of overall alcohol-related attendances.

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2. 2.2 Admissions wholly caused by alcohol

NHS Digital provides **34 ICD-10 diagnostic codes** that are wholly attributable to alcohol. Often these are not the primary reason for admission. So both primary and secondary diagnostic fields in Health Episode Statistics (HES) need to be searched to identify all relevant patients.

Proportion of hospital admissions wholly caused by alcohol:-

The largest proportion...

...are for mental/behavioural disorders created by alcohol misuse. Complications of alcohol dependence include acute alcohol withdrawal, withdrawal related seizures and delirium

The second largest category...

...is liver disease including acute alcoholic hepatitis, acute alcohol-related liver failure and alcohol-related cirrhosis.

Other categories include...

...alcoholic gastritis, alcoholic cardiomyopathy and alcohol-related pancreatitis.



My A&E attendance was more crisis-driven. Problems with my liver, epilepsy and osteoarthritis (from repeated falls), pancreatitis and pneumonia. Osteoporosis was probably caused partly by my alcohol intake. The more fits I had, the more I banged my head and that too accounted for a number of presentations

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2.

2.3 Presentations wholly caused by alcohol

Official statistics have been generated by using 'Alcohol Attributable Fractions', which estimate the probability that a particular disease condition has been caused by alcohol.

Based on these fractions, the largest group is:

Hypertensive diseases

Followed by:

Cardiac arrhythmias

Injuries/self harm

Epilepsy

Diseases of the digestive system

Cancers including oral, oesophageal, breast and gastrointestinal.

This emphasises the importance of systematic screening in order to identify alcohol as an underlying, otherwise hidden cause, and to provide appropriate advice, treatment and referral.



As it comes from statistical modelling it does not allow for the identification of individual patients.

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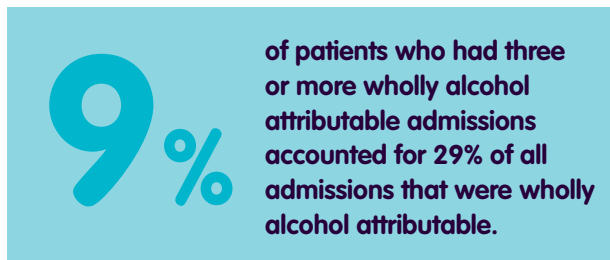
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2.4 "High impact users" / "Alcohol related frequent attenders"

These patients have multiple and sometimes complex mental, physical and social care needs, and are not typically in contact with specialist alcohol services.

Often they are unaware that alcohol is contributing to their problems and can be challenging to engage in conventional treatment service models. So by ensuring the appropriate targeted responses are in place, savings to the NHS will be substantial. For instance:

Local analysis of two inner south London boroughs revealed that:



Applying these figures as an average across England sees:



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3.

Interventions for alcohol misuse

Implementing appropriate interventions are key to coping with the impact of alcohol misuse – but only if they are coordinated effectively.

This section examines what key interventions are available to manage the many complex challenges presented by patients with alcohol issues from screening and brief intervention through to longterm aftercare.

It offers guidance on the skill sets and specialisms that staff should have in order to be able to effectively and confidently deliver this care.

3.1

Screening and brief intervention

3.2

Managing alcohol dependence in hospital

3.3

Referral and aftercare

3.4

Assertive outreach for high impact alcohol-related frequent attenders

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3.

3.1 Screening and brief intervention

Alcohol screening and brief intervention (identification and brief advice / IBA) is designed to reduce drinking in hazardous and harmful drinkers, and is usually delivered opportunistically during a healthcare consultation.

While IBA is effective and cost effective in research trials, it can be challenging to implement on the scale needed to make a significant impact on public health.

- Offer frontline employees ongoing support from specialist staff as well as providing a referral route for more complex cases
- Embed IBA into clinical systems (e.g. computerised screening and intervention tools) and provide financial remuneration
- Incentivise hospital services to implement IBA via Commissioning for Quality and Innovation (CQUINs).



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3.

3.2 Managing alcohol dependence in hospital

Patients with alcohol dependence who are admitted to hospital can be complex to manage in a non-specialist setting.

While interventions can be provided by non-specialist staff, many healthcare professionals lack the training or competencies, and therefore confidence to:

- Diagnose alcohol use disorders
- Deliver the interventions effectively
- Make the appropriate referrals

Therefore the following is required:

- Nurses, doctors and counsellors with specialist alcohol training working in an alcohol care team can significantly improve the management of alcohol misusing patients, reducing the length of stay and readmissions
- Addiction specialists including addiction trained nurses (both mental health and general), addiction psychiatrists, alcohol counsellors or health workers, and liaison psychiatrists and physicians with specialist addictions training



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3.

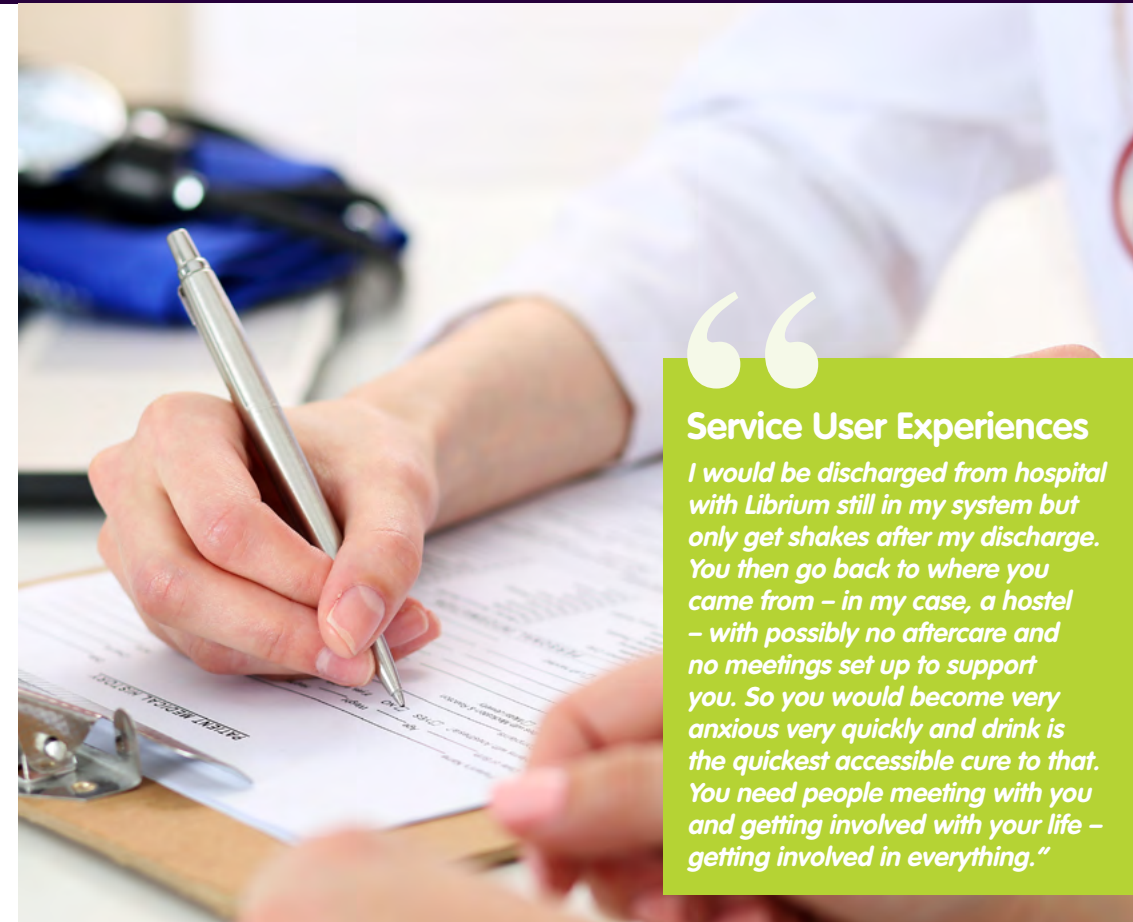
3.3 Referral and aftercare

Referral on to appropriate specialist services or aftercare (post-assisted withdrawal) is an essential part of achieving effective and enduring treatment for alcohol use disorders.

Admission to hospital is often the first time alcohol dependence is identified and diagnosed as an underlying or primary condition.

It means hospital admission provides an ideal opportunity for early intervention and access to more comprehensive alcohol treatment:

- Complete detoxification during the hospital admission
- Begin evidence-based relapse prevention medications (e.g. acamprosate, naltrexone) to reduce the risk of relapse following discharge
- Alternatively, work jointly with community services to complete detoxification after discharge
- Establish good working relationships with local specialist alcohol services via specialist alcohol care teams who are well placed to foster the necessary links plus prescribe appropriate relapse prevention treatments if applicable.



Service User Experiences

I would be discharged from hospital with Librium still in my system but only get shakes after my discharge. You then go back to where you came from – in my case, a hostel – with possibly no aftercare and no meetings set up to support you. So you would become very anxious very quickly and drink is the quickest accessible cure to that. You need people meeting with you and getting involved with your life – getting involved in everything.”

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3.4 Assertive outreach for high impact alcohol-related frequent attenders

While high impact alcohol-related frequent attenders make up a small proportion of all patients admitted with alcohol problems, they place a disproportionate burden on the NHS.

... a more assertive engagement approach has been shown to help patients to access and engage with treatment. Instead, the group requires an assertive outreach approach.

Research shows that:

- This is a heterogeneous group but with shared commonalities including social exclusion and a lack of social capital
- Staff with a high level of competence and training are needed to provide a more appropriate and intensive response supported by specialist community outreach staff
- Assertive outreach workers can help patients with complex needs to achieve a high level of engagement in specialist treatment and reduce unplanned healthcare use including emergency department attendances and emergency admissions to hospital.



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4.

Service models and systems to deliver alcohol care

Appropriate systems and service models should form the backbone of any drive for effective alcohol care delivery.

This section explores why these systems also need the appropriate specialist staff in place to deliver positive outcomes for patients – from individual champions and Alcohol Care Teams to senior clinical and management support.

With the right balance of human resources, hospitals will be better placed to deploy specialist alcohol care teams who are able to deliver responses seven days a week.

4.1

Making every contact count

4.2

Alcohol Care Teams

4.3

Referral and aftercare

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4.

4.1 Making every contact count

Routine enquiry about alcohol using validated screening tools is needed in all clinical contacts to provide appropriate advice and care

To embed IBA into clinical practice successfully requires:

- A senior clinical specialist champion
- Alcohol specialist staff to oversee and support implementation, including providing training and developing clinical protocols
- Senior clinical and management support for implementation
- Adequate resources (e.g. CQUINS, specialist alcohol care staff)
- An implementation plan including methods to embed IBA into clinical information and patient management systems
- Ongoing monitoring of implementation.

Clinical protocols should:

...detail the appropriate screening and intervention tools and clinical criteria for delivering IBA and referrals to specialist services

...be specific to the hospital's systems and settings.

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4.2 Alcohol care teams

The number of hospitals with alcohol care teams has increased considerably over the last 10 years

But there is no predominant service model/configuration in England meaning services can differ widely:

- A lone worker from local community alcohol services visiting the hospital to accept referrals on a once-a-week basis
- Psychiatric liaison services with a remit for alcohol referrals
- A comprehensive hospital-based and consultant- or nurse-led seven-day alcohol care team that provides direct clinical care as well as training and support for non-specialist staff.

The bigger, the better

Research shows that the more comprehensive the alcohol care team, the greater the proportion of alcohol-related inpatients will be reached, and hence the greater the impact on admission lengths, readmissions and clinical outcomes – and cost savings to the NHS.



Guy's and St Thomas' NHS Foundation Trust runs a seven day a week alcohol care team. Embedded in this is excellent partnership working, including daily handovers with other specialist teams (homeless, mental health liaison, emergency department) and sustained links with community services who regularly attend their multidisciplinary team meetings. The alcohol care team provides screening and brief intervention, training (pharmacological management of alcohol withdrawal, complications of this, & screening and brief intervention) to pre-registration nursing students, qualified nursing staff, medical teams and therapy services.

An outpatient clinic increases patients' options and reduces bedstay days for stable patients. It also enables smooth transfer to community services with an initial joint service session prior to discharge.

A trust alcohol steering group includes general medicine, toxicology, gastroenterology, hepatology, principal pharmacist, alcohol commissioning support - supporting alcohol work throughout the Trust.

The outcomes measured are:-

- Supporting effective discharges
- Reduced bed days
- Reduced re-attendances

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4.

4.3 Alcohol assertive outreach services

Research shows there is considerable variation in what care is being provided to patients:

26% of hospitals identified themselves as providing assertive outreach treatment for frequent attenders but only:

11% met the full criteria for assertive outreach.

These services also varied greatly across hospitals:

6 weeks – 12 months
Duration of contact with patients

1-7.7 wte
Size of team

10-40 Patients
Avg. caseload per worker.



Service User Experiences

When you have mobility/physical illness issues related to being heavily alcohol dependent (and with no carer), it can be very difficult to get along to things or even be motivated to do – so knowing that someone is interested and cares makes all the difference. It's too much to get up, make an appointment and fill in all the forms. In my case, it was help with those sorts of things that really made a difference."

Given the complexity of high impact alcohol-related frequent attenders, these services need to be equipped to provide a sufficiently intensive level of response. For positive treatment outcomes, recommendations include:

15
patients maximum per assertive outreach practitioner

1
contact minimum with patient per week

50%
of contacts outside of the service setting either in the patients' home or neighbourhood with a focus on both health and social needs

1 Year
of extended care provision.

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5.

How to develop and implement an alcohol care strategy

With system and staffing requirements identified, hospitals can now create a strategy that is tailored to suit the needs of their own unique operations.

This section covers each stage of a creating an efficient hospital alcohol strategy, including data assessment, commissioning issues, staff training and funding sources.

Monitoring of outcomes is key to ensuring the sustainability of any strategy.

5.1
Needs assessment

5.2
Developing a hospital alcohol strategy

5.4
Commissioning

5.5
Staff training

5.6
Monitoring the impact

5.7
Sustainability

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5. 5.1 Needs assessment

The first step towards developing effective alcohol care services is to establish the scale of the problem:

Using the right data

- Source data from hospital episode statistics (HES) using the 34 wholly attributable diagnostic codes available in the [Resources](#) section.
- Results can be expressed either as the total number admitted with a Wholly Alcohol Attributable primary or secondary Diagnosis (WAAD) in the past year, or as the rate of WAAD admissions per 100,000 population.
- For hospitals that mainly serve one borough or Clinical Commissioning Group area, borough-level data can be used.
- For hospitals that service multiple boroughs, use whole hospital-level data instead.

Definition of an Alcohol Related Frequent Attender

To estimate the number of alcohol-related frequent attenders, several definitions can be used:

- The King's Health Partners development work has chosen three or more WAAD admissions in the past year as a working definition.
- Assumes if one of three admissions has a WAAD admission, the other two admissions are likely to have been alcohol-related as well.
- This means of the three admissions in the past year, one admission was a primary or secondary WAAD. For instance, this gave a total number of 324 alcohol frequent attenders across Lambeth and Southwark in 2014/15.

Remember

1. Existing data is likely to be a gross underestimate of the total burden of alcohol admissions on the hospital
2. There are likely to be at least three times as many admissions that are partly attributable to alcohol
3. This disparity must be taken into account when planning alcohol care service provision.

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5.2 Developing a hospital alcohol strategy

The purpose of the strategy is to provide the necessary leadership and guidance to staff to tackle alcohol misuse appropriately.

Recommendations from the Royal College of Physicians:

- a) Screening strategy for hazardous and harmful drinkers, administered as part of routine admission procedures through lifestyle questionnaires
- b) Early assessment of dependence severity by appropriately trained staff
- c) Widely available protocols for management of alcohol withdrawal
- d) Adequately resourced alcohol care team for the management of more complex patients undergoing alcohol withdrawal
- e) Referral of patients with alcohol dependence to specialist community alcohol services
- f) Provision of brief interventions for hazardous and harmful drinkers
- g) Training for all clinical staff on identification and appropriate management of alcohol misusing patients
- h) Appropriate occupational alcohol policies for all staff
- i) Close liaison with general practitioners on discharge
- j) Creation of a steering group comprising hospital and community stakeholders to oversee implementation of the alcohol strategy



Royal College of Physicians (2001) Alcohol - Can the NHS Afford it?



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5. 5.3 Commissioning

Addiction services are largely commissioned by local authorities. Public Health England has identified a range of funding options for alcohol care teams, including by local authorities as part of the public health grant, by Clinical Commissioning Groups or acute trusts themselves, or by joint funding from a variety of these sources.

There is a current lack of local and national consensus on appropriate funding models for in-hospital alcohol care teams.

While the value proposition of CCGs investing in alcohol care teams to reduce the burden of alcohol on hospital services is clear, there is a risk that CCGs view alcohol care as being the responsibility of local authorities. Given the benefits to both the NHS and the local community, the most appropriate funding model for hospital based alcohol care teams should be shared between CCGs, hospital trusts and local authorities.

These unresolved issues further emphasise the importance of a hospital alcohol strategy group, which has effective high level engagement with local commissioners including local authorities and CCGs. A business case needs to be developed to provide a compelling case for investment in alcohol care teams, drawing on local intelligence, including comprehensive alcohol needs assessment.



5.4 Staff training

It is essential to develop a sufficiently trained and competent workforce to support implementation of effective alcohol care in hospitals and the community. This needs to extend from undergraduate training through postgraduate and continuing education for all staff.

All clinical staff in the NHS should be competent to identify, advise, manage and appropriately refer alcohol misusing patients. A recent report from the Academy of Royal Colleges has set out the core medical competencies for alcohol and other drugs (AMRC, 2012).

The Royal College of General Practitioners provides a certificate course in the management of alcohol problems in primary care and several universities provide courses on alcohol and substance misuse at postgraduate certificate, diploma and masters level.

Several NHS trusts offer training on alcohol including e-learning courses and Health Education England is developing e-learning resources.

Public Health England provides a wide range of alcohol learning resources through the online Alcohol Learning Centre platform (PHE, 2017).

Many hospital-based alcohol care teams provide structured and ad hoc training for frontline NHS clinicians in identification and management of alcohol misuse as part of their core remit

The Health Innovation Network South London in conjunction with King's College London and Health Education England has developed a film and training pack for NHS staff and health educators to raise awareness and reduce the stigma encountered by this patient group. This is available in two formats: 1) a film and facilitator's notes for face to face group training, and 2) an e-learning individual study session – via the link to e-Learning for Health in further resources at the end of this document.

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5. 5.5 Monitoring the impact

The Secondary Uses Service (SUS) database includes diagnostic codes, which can be used to identify wholly attributable hospital admissions at hospital, Clinical Commissioning Group or local authority level.

We recommend using the 34 diagnostic codes used by NHS Digital in its annual alcohol reports, signifying wholly attributable admissions. This should be examined in both primary and secondary diagnostic fields since alcohol conditions are often not the primary reason for an admission. Information departments in hospitals should be able to provide regular reports on the number of wholly attributable alcohol admissions, the number of individuals admitted with these conditions, and the number of individuals who have frequent (defined in King's Health Partners as 3 or more in a year) alcohol related admissions.

Emergency department alcohol attendance data is more difficult to obtain from SUS - since no specific diagnostic information is provided. PHE and NHS England currently developing a national minimum data set for alcohol attendances which will provide an important new method to monitor the impact of implementation of alcohol care and intervention initiatives both locally and nationally.

Some hospitals already have local systems in place. These include having a routine field in electronic patient records for alcohol screening score for short screening tools such as AUDIT-C (Alcohol Use Disorders Identification Test – Consumption) and FAST (Fast Alcohol Screening Test). When routinely applied this provides a measure of the success of implementation of screening and brief intervention, as well as an estimate of the proportion of hazardous and harmful drinkers attending the hospital. Routine implementation of AUDIT-C screening and recording across the NHS would be a huge step forward.

For assertive outreach interventions for alcohol-related frequent attenders, hospitals often track subsequent admissions and emergency department attendances of these cohorts of patients – this can be easily done through SUS data when it is appropriately set up.

5.6 Sustainability

Hospital alcohol care initiatives are often set up on short term (e.g. one year) funding, inadequate resourcing, a lack of clear objectives for the work, and a lack of agreed monitoring or 'success' criteria.

This results in a stop-start form of service delivery, poor staff morale, and a lack of impact. Under-resourced alcohol care teams may fail to achieve a significant impact because they reach only a small proportion of the total in need alcohol population attending the hospital. Staff working in these services can become overwhelmed by the volume of referrals and a continual feeling of failure, resulting in high staff turnover and a consequent interruption of services.

Given the high and increasing level of alcohol need presenting to NHS hospitals, the preventable nature of many of these often repeated admissions, and the imperative of reducing the burden of alcohol on the NHS, we need to move to a situation where alcohol care teams are seen as core clinical services in the same way as diagnostic radiology or intensive care units.

Crucially, these services need to be adequately resourced [consultant-led, with 7-day coverage, at a level of staffing commensurate with the level of identified needs, and funded in a sustainable way].

The impact of such services need to be measured in years rather than months in order to make a lasting impact on the burden of alcohol on the NHS. This will require a commitment from NHS clinicians, hospital managers, NHS and local authority commissioners, and engagement with local community services, to develop integrated care for this complex patient group.

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Case Study

King's Health Partners developed an alcohol strategy in 2013 to improve the care of alcohol misusing patients across the three NHS trusts.

For the full **KHP case study**, click here to view its **'Good Health: An Alcohol Strategy for King's Health Partners'** report



While this is by no means prescriptive, we invite you to use this as a template for your own local development work

Alcohol Strategy Development

Trusts: King's Health Partners including Guy's and St Thomas', King's College Hospital and South London & Maudsley NHS Foundation Trusts

Start Date: 2013

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Alcohol Strategy Development

King's Health Partners including Guy's and St Thomas', King's College Hospital and South London & Maudsley NHS Foundation Trusts

An alcohol strategy was developed at King's Health Partners with the aim of reducing alcohol-related disease within the local population. A senior stakeholder strategy group, including clinicians, managers, and local commissioners, was established and scoping conducted to identify gaps in existing alcohol care services. This was supported by a grant from the Guy's and St Thomas' Charity.

a) Raising investment and awareness

As a consequence, it was possible to attract significant new investment to establish a comprehensive and seven-day alcohol care team at Guy's and St Thomas' Trust and a new specialist alcohol assertive outreach team for alcohol-related frequent attenders. Further service developments are ongoing in the other partner trusts.

In addition, e-learning resources in IBA were developed for frontline staff along with shared clinical protocols to manage alcohol misusing patients while Health Education South London provided funding for alcohol short courses for frontline staff:

- In the past three years, the total new investment in clinical services and training has been £3.5 million
- A further £11 million in research income has been attracted to KHP to evaluate the implementation of alcohol interventions. None of this would have been as successful without having an alcohol strategy with senior management support.

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Alcohol Strategy Development

King's Health Partners including Guy's and St Thomas', King's College Hospital and South London & Maudsley NHS Foundation Trusts

b) Establishing specialist alcohol services

The most effective way to improve alcohol care within hospitals is to develop a specialist multidisciplinary alcohol care team; other models do exist but offer less impact. This requires adequate resourcing, including senior clinical leadership with dedicated clinical and management sessions by a consultant in a relevant speciality (e.g. addiction psychiatry, gastroenterology, emergency medicine) and nursing staff to provide a wide range of alcohol care functions.

The following are the functions of the KHP alcohol care team established in 2014:

1. To provide a seven-day-per-week alcohol service for KHP inpatients.
2. To provide training for frontline staff in acute and mental health care inpatient units and emergency departments to identify and appropriately manage patients with alcohol use disorders (AUD). This includes training in alcohol screening and brief interventions.
3. To develop effective systems and care pathways for inpatients with AUD.
4. To liaise with and support frontline staff caring for acute and mental health inpatients and emergency departments in the appropriate NICE-compliant management of patients with AUD.
5. To provide direct clinical care for inpatients with AUD including diagnosis, clinical assessment, prevention and management of alcohol withdrawal and Wernicke's encephalopathy including appropriate medication prescribing.
6. To advise on and effect appropriate referrals and community engagement with patients with AUD, including the inpatient care pathway to the addictions assessment unit at the Maudsley Hospital.
7. To provide ongoing outpatient clinical support to patients with alcohol dependence.
8. To support the development and implementation of the KHP alcohol strategy in acute and mental health care.



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Alcohol Strategy Development

King's Health Partners including Guy's and St Thomas', King's College Hospital and South London & Maudsley NHS Foundation Trusts

c) Structuring staff and their scheduling

The KHP alcohol care team's bid included the following staffing structure to provide a seven-day service in one NHS Trust:

- Lead Clinician (0.5 wte) with a clinical background in gastroenterology, hepatology, acute medicine or addiction psychiatry/addiction medicine to provide clinical leadership
- Addiction psychiatry/addiction medicine (0.2 wte) to provide specialist addictions input
- Senior alcohol clinical nurse specialist (1.0 wte) to act as lead nurse for the service with a background in either acute medicine, gastroenterology or addiction nursing
- Alcohol clinical nurses (4.0 wte)
- Specialist addictions clinical psychologist (0.2 wte) to support training and psychological assessment
- Senior management time (0.2 wte)
- Data and administrative support (0.2 wte).



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7. Resources

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A LOCAL ALCOHOL STRATEGY



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NATIONAL AND LOCAL DATA SOURCES



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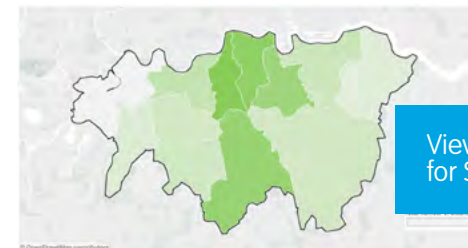
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View data on alcohol admissions for South London boroughs



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34 ALCOHOL ATTRIBUTABLE DIAGNOSTIC CODES

Wholly attributable conditions	
ICD10 code	ICD 10 Diagnoses
F10	Mental and behavioural disorders due to use of alcohol
F10.0	Acute intoxication
F10.1	Harmful use
F10.2	Dependence syndrome
F10.3	Withdrawal state
F10.4	Withdrawal state with delirium
F10.5	Psychotic disorder
F10.6	Amnesic syndrome
F10.7	Residual and late-onset psychotic disorder
F10.8	Other mental and behavioural disorders due to the use of alcohol
F10.9	Unspecified mental and behavioural disorders due to the use of alcohol
K70	Alcoholic liver disease
K70.0	Alcoholic fatty liver
K70.1	Alcoholic hepatitis
K70.2	Alcoholic fibrosis and sclerosis of liver
K70.3	Alcoholic cirrhosis of liver
K70.4	Alcoholic hepatic failure
K70.9	Alcoholic liver disease, unspecified

Wholly attributable conditions	
ICD10 code	ICD 10 Diagnoses
T51^o	Toxic effect of alcohol
T51.0	Ethanol poisoning
T51.1	Methanol poisoning
T51.9	Toxic effect of alcohol, unspecified
Other wholly attributable conditions	
E24.4	Alcohol-induced pseudo-Cushing's syndrome
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
G72.1	Alcoholic myopathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K85.2	Alcohol-induced acute pancreatitis
K86.0	Alcohol-induced chronic pancreatitis
Q86.0	Fetal alcohol syndrome (dysmorphic)
R78.0	Excess alcohol blood levels
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent
Y90	Evidence of alcohol involvement determined by blood alcohol level
Y91	Evidence of alcohol involvement determined by level of intoxication

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7. Resources

COMMISSIONING



NHS England (2016) Commissioning for Quality and Innovation (CQUIN): Guidance for 2017-2019. NHS England.
<https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf>



Health Innovation Network, Intervention and Brief Advice Toolkit
<http://www.hin-southlondon.org/clinical-areas/alcohol/projects/IBA-toolkit>

TRAINING AND COMPETENCIES



Public Health England (2017) Alcohol Learning Centre Training resources
<https://www.alcohollearningcentre.org.uk>



Medical Council on Alcohol – resources
<http://www.m-c-a.org.uk/education/education>



Academy of Medical Royal Colleges (2012) Alcohol and Other Drugs: Core Medical Competencies. Royal College of Psychiatrists, London. <https://orca.cf.ac.uk/69084/1/Alcohol%20and%20drugs.pdf>



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Alcohol Stigma. An e-learning resource to support understanding of alcohol dependency. <http://www.e-lfh.org.uk/programmes/alcohol-stigma>

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Further reading

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8. Further Reading

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