



Intensive Support in Reducing Alcohol- Related Hospital Admissions

A Report describing Intensive Support provided to 10 London Primary Care Trusts (PCT)/Drug and Alcohol Action Team (DAAT) Partnerships.

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Contents

Introduction.....	3
Scope of the Work.....	3
Programme Outcomes	3
Support.....	4
Partnerships identified for Intensive Support.....	4
Key Areas for Improvement.....	5
Needs Assessment	5
Alcohol strategy and strategy group.....	6
Alcohol Co-ordinator/Alcohol Commissioning Manager	7
Direct/Local Enhanced Service (DES/LES)	8
Analysis of admissions and targeted interventions.....	10
Clinical coding.....	10
Targeted interventions.....	10
Community Matron.....	11
Alcohol Health Worker at Emergency Departments.....	12
Identification and Screening at the ED	13
IBA in the Custody Suite	14
Treatment pathways	14
Specialist Practitioner	14
Numbers in Treatment target	15
Polysystems	15
Conclusion.....	16
Bibliography	17

Introduction

As part of the London Local Alcohol Programme Survey conducted in 2009 the need for specific intensive support for local alcohol leads to address problems and initiate parts of the local programme was identified.

The aim of the programme was to provide intensive support to a number of local alcohol leads to address key roadblock issues they are dealing with and to support a number of local alcohol leads in creating the conditions for initiating or continuing a successful local alcohol programme.

Scope of the Work

Local Alcohol Leads (LALs) face roadblocks in five areas and this is having an impact on the delivery of reductions in the rates of alcohol-related hospital admissions across London. LALs are not able to apply intensive resource to the solution of these issues, and some do not have direct experience in resolving these issues.

The scope of work was to apply experience in solving these issues to investigate, analyse and provide solutions for these issues to be applied by the relevant LALs. The following five areas that were identified for this approach:

- Understanding local alcohol data and using it effectively to deliver reductions in alcohol related hospital admissions;
- Implementing effective alcohol harm screening and referral protocols and mechanisms in acute settings;
- Designing effective Alcohol Health Worker roles and the contexts in which the roles are set;
- Designing and establishing effective Direct and Local Enhanced Services (DES/LES) and effective General Practice responses to alcohol related harm; and,
- Setting up effective Emergency Department (ED) alcohol and violence data collection and sharing systems.

Programme Outcomes

The key outcomes of the programme were:

- An enhanced understanding of the barriers and roadblocks to making progress around reducing alcohol-related hospital admissions.

- An Improvement Plan tailored to each individual participating PCT that includes intensive actions on a particular issue critical to achieving alcohol-related hospital admissions targets in the locality (i.e. one of the High Impact Changes)
- A better understanding of the drivers for alcohol-related health harm in a locality and a clear and coherent plan for making improvements across Primary Care, Community based treatment and Hospital-based interventions

Support

Support was provided over a twelve week period to 10 London Partnerships. An assessment was carried out in conjunction with the local alcohol lead and other local key stakeholders. Partnerships were offered a week's worth of support by the Consultant (this did not need to be a calendar week and was flexible to local requirements). Support came in the form of:

- One to one meetings
- Interviews
- Problem solving
- Shadowing (mainly at relevant Partnership meetings providing advice)

A diagnostic tool to determine strengths and gaps in local alcohol systems was developed to inform the content of the Improvement Plan. The key areas included in the diagnostic tool and the Improvement Plan are:

- Strengthening commissioning
- Intelligence gathering and data
- Improvements in specialist treatment
- Work in partnership
- Identification and Brief Advice (IBA) and Primary Care
- ED Alcohol Health Workers
- ED data sharing
- Alcohol Treatment Requirements
- Alcohol Arrest Referral
- Social Marketing

These key areas are based on the key areas that Early Implementer PCTs on the Alcohol Improvement Programme are expected to construct Project Plans on. They are matched with the High Impact Changes in reducing alcohol-related hospital admissions outlined in *Signs for Improvement – commissioning interventions to reduce alcohol-related harm* (Department of Health, 2009).

Partnerships identified for Intensive Support

- Barking and Dagenham

- City and Hackney
- Hillingdon
- Hounslow
- Brent
- Westminster
- Lewisham
- Camden
- Ealing
- Islington

Key Areas for Improvement

Needs Assessment

All PCT's/Local Authority Partnerships must produce a Joint Strategic Needs Assessment (JSNA) (Department of Health, 2007). Some Partnerships have included alcohol harm reduction in their top ten priorities. PCT's produce a Commissioning Strategy Plan with an annual Operating Plan, which outlines alcohol related commissioning intentions (if reducing alcohol-related harm is a priority for a PCT).

The inclusion of alcohol in these plans and assessments ensures that alcohol harm reduction is firmly embedded in the strategic objectives of Local Authority/PCT Partnership with the relevant partnership Boards accountable for the activity planned. Key individuals in these processes include the Chief Executive of the Local Authority, Chief Executive of the PCT, Director of Commissioning and Director of Public Health.

In addition to the high level needs assessment and planning processes some Partnerships have conducted more robust needs assessments to inform commissioning decisions around alcohol harm reduction.

Excellent examples of alcohol needs assessment can be found in London and contain the following:

- Size and composition of the local alcohol using population
- Current expenditure on alcohol-harm reduction initiatives
- Review of the current alcohol treatment system
- Data analysis
- Patient and service user consultation
- Assessment and analysis of the interface between Health, Criminal Justice and Children and Young People's services

However, some Partnerships cited capacity issues for not being able to carry out more robust needs assessment on alcohol misuse. Advice was given to those Partnerships on how to best use the existing capacity within their Public health teams to understand liver disease/cancer, mortality in the context of

available admissions data. Partnerships were advised to overlay this with Primary Care collected data on alcohol consumption and NATMS treatment data (where all were available). Existing patient and service user groups are also a good source of information in determining need and shaping service design.

Examples of Best Practice: City and Hackney, Westminster, Lewisham, Camden, Islington

Alcohol strategy and strategy group

Community Safety Partnerships have a statutory obligation to develop an alcohol harm reduction strategy (Police and Justice Act 2009). Many Partnerships have sensibly developed integrated strategies that include strategic objectives not confined to Community Safety but also Health and Children and Young People.

Underpinned by a robust needs assessment, an integrated alcohol strategy should provide more detail to the alcohol-related strategic objectives of the PCT's Commissioning Strategy Plan and the Local Authority's Strategic Crime Reduction Plan and Children and Young People's Plan.

Those strategies that have senior buy-in from Champions in these areas have the best chance of achieving their strategic vision for alcohol. Alcohol Champions often come in the form of:

- Chief Executive of the PCT
- Director of Public Health
- ED Consultant
- Borough Commander
- General Practitioner with Special Interest in Substance Misuse/Alcohol

The existence of an alcohol strategy, with senior buy-in, ensures agencies and departments are accountable for any actions and that they are carried out in a timely fashion. If a strategy is not signed off there is the potential for actions to slip and the strategic vision not realised.

Most localities have a Strategic Alcohol Group overseeing the progress of the Alcohol strategy. This is typically Chaired by a Senior Local Alcohol Champion with representatives from PCT Commissioning, Public Health, Police, Community Safety, the Acute Trust, Licensing and Children and Young People's Trust supporting the Chair.

Examples of Best practice: Barking and Dagenham, City and Hackney, Hillingdon, Westminster, Lewisham, Islington

Alcohol Co-ordinator/Alcohol Commissioning Manager

Having a full-time alcohol lead within the PCT and/or DAAT is key to realising the health objectives of a local alcohol strategy.

There are plans to make the Alcohol Co-ordinator role a nationally transferable role. Nationally Transferable Roles are described as:

“A nationally transferable role (NTR) is a named cluster of competences and related activities leveled to the career framework that is applicable, relevant and replicable across different geographic locations in the UK. An NTR may be either a subset of a job at more than one level of the career framework, e.g. supplementary prescribing, or a whole job at one level of the career framework e.g. physiotherapy orthopedic practitioner.” (AERC Alcohol Academy, 2010)

Key competences of an Advanced Practitioner of which the Alcohol Co-ordinator are:

Leadership

- Has power to act
- Has authority with line management responsibility to the Specialist Practitioner
- Has influence
- Enabled to promote a learning culture
- Leadership role in guideline development, monitoring and evaluation
- Demonstrates leadership and innovation in work contexts that are unpredictable and that require solving problems involving many interacting factors

Mastery

- Higher level clinical/technical/research skills
- Breadth and depth of knowledge of their specialist alcohol field
- Appropriate experience record (management and clinical)
- Vision
- Innovates through reflection in and on practice
- Deals with complexity
- Creative reasoning

Innovation

- Sophisticated Learning skills
- Develops new skills in response to emerging knowledge and techniques
- Advances professional practice
- Works across professional boundaries using creative reasoning and problem solving

- Development of others
- Instigates and manages change within a complex environment

Excellence

- Quality at the heart of practice
- Actively integrates theory and practice
- Demonstrates evidence based practice
- Active continuing professional development
- Striving to better previously established standards
- Focus on ethical and moral dimensions

For a complex programme of work to be commissioned to reduce alcohol-related harm it is essential that the work is led by an individual with these competencies. This is equally important to having senior strategic buy-in. Alcohol Co-ordinators/Alcohol Commissioning Managers, are usually located in a DAAT or PCT setting although some are co-located. These functions often work across the three areas of Health, Community Safety and Children and Young People's Trusts.

For those Partnerships with no local alcohol lead capacity was always cited as an issue in the commissioning of any alcohol interventions.

Some local alcohol leads reported feeling detached from other areas of work, namely DAAT Local Authority based leads being detached from the PCT and particularly Public Health. PCT based local leads found the Criminal Justice agenda sometimes difficult to engage with. A possible solution to this "fracture" would be to co-locate local alcohol leads between the Local Authority and Public Health. This would also go some way to aligning with the future policy directive of Directors of Public Health being located in the Local Authority.

Areas with a full time local Alcohol lead: Barking and Dagenham, Brent, Ealing, Islington

Direct/Local Enhanced Service (DES/LES)

The Direct Enhanced Service for alcohol incentivises the delivery of Identification and Brief Advice (IBA) in Primary Care settings (Department of Health, 2009). The DES pays £2.33 for every newly registered patient over the age of 16 screened for alcohol misuse using the AUDIT/FAST screening tool. The DES specification applies nationally.

Some Partnerships have developed a Local Enhanced Service for alcohol misuse tailored to the needs of their population. A three-tiered spec has proven popular with practices also being incentivised for the delivery of Community based detox. Practices are paid at an average of about £230-

£250 per patient. This cost must be weighed up against any costs for a Community Alcohol Team (CAT) within a locality and duplication of provision must be considered when establishing a LES such as this where a CAT also exists.

Where there are little to no alcohol interventions in a locality, the establishment of a DES/LES is a practical start, particularly around the Early Identification and Intervention of alcohol misuse. In addition, the identification of those with higher risk drinking patterns facilitates better numbers into structured treatment.

Key considerations for the establishment of a DES:

- The existence of a template for recording alcohol related data in Primary Care settings – good templates with the relevant read codes are available.
- Competence of staff to deliver AUDIT – however, for those patients that are literate they can fill out AUDIT whilst waiting for the Nurse/GP.
- Resources for the delivery of Brief Advice are freely available
- The existence of a robust referral pathway to treatment from Primary Care for those identified as being dependent drinkers (Brief Advice not being suitable for this group).
- Support being available to Primary Care on alcohol interventions, particularly with regard to the delivery of Brief Advice and data recording

Key considerations for the establishment of a LES:

- In addition to the considerations above staff must have the competences to manage detox in the community
- Having a pool of GPs complete the Royal College of General Practitioners Certificate of Management of Alcohol Problems in Primary Care
- Cost implications, particularly where there is already a Community Alcohol Team in place

A number of PCTs have reported some varied screening results across their Boroughs. Namely:

- Not all new patients over the age of 16 are being screened, suggesting selective screening is taking place
- Significantly low numbers of patients being identified as being dependent drinkers (based on NWPHO estimates)
- Significantly low numbers of patients receiving Brief Advice
- Significantly low numbers of patients being referred to Community Alcohol Teams for structured treatment

Haringey PCT propose to undertake an audit of their DES activity in order to understand the issues listed above. There may be significant learning for this audit for other local alcohol leads in establishing high quality DES/LES.

Examples of Best Practice: Haringey audit

Analysis of admissions and targeted interventions

Key to reducing alcohol-related hospital admissions is understanding who and under what circumstances patients are being admitted.

Few partnerships have carried out detailed analysis of their admissions data and this is largely due to the complexity of the query that is required to extract the raw admissions data from Secondary Uses Service (SUS). The nature of admissions being wholly and partially attributable to alcohol adds to the complexity of the query.

To facilitate the development of a query that can be shared between Information Analysts across London, an email based Peer Support Forum has been established so that analysts can share ideas, information and Best Practice when extracting and analysing alcohol-related hospital admissions data.

Clinical coding

Clinical coding has emerged as a major issue in relation to alcohol-related hospital admissions. Specifically, there does not appear to be any guidance for clinical coders on how to code alcohol-related hospital admissions. There is also a perception that clinical coders may not be aware of the attributable fractions attached to ICD codes and their role in the rate of alcohol-related hospital admissions.

To this end a study is being planned to look at current clinical coding practice in major London hospitals with a view to constructing and piloting a set of guidance in coding alcohol-related admissions. This may go some way to accurately measuring the influence and cost of alcohol admissions.

Targeted interventions

A Partnership approach involving the PCT, Primary Care and local treatment providers, this model is roughly based on a successful model for reducing admissions in the North East.

The model involves analysis of raw admissions data that includes NHS number and GP practice of the patient admitted. Partnerships may identify the 3 most common alcohol-related admissions that are wholly attributable to alcohol and target those patients. The North of Tyne has identified the following three codes as the basis for targeted intervention:

- F10 Mental and Behavioural Disorders due to the use of alcohol
- K70 Alcoholic Liver Disease
- T51 Intoxication

Commissioning Managers should from this analysis be able to provide a list of the top 10 most admitted individuals in the locality in a given period. They should also be in a position to provide individual Practices with their top 10 most admitted patients. The PCT only needs to provide the list of NHS numbers in an nhs.net to nhs.net encrypted email account marked "Private and Confidential". This is in line with Information Governance requirements.

Commissioning Managers, in conjunction with Primary Care commissioning must encourage the GP and local treatment providers to construct a bespoke model of intervention in order to target those individuals. Those patients accepting interventions from the treatment provider receive a comprehensive care plan geared to preventing re-admission to hospital.

This model has significant benefits for all stakeholders. The GP has specialised and dedicated support for a group of patients that may have been difficult to engage and motivate in the past, the treatment provider increases numbers into treatment (particularly beneficial if there is a CQUIN component to the contract), the PCT should observe a difference in the admission trajectory and the patient has access to bespoke responsive treatment.

Examples of Best Practice: NHS North of Tyne

Community Matron

Community Matrons are senior nurses who case-manage those patients with a serious long term condition or complex range of conditions in a community setting.

Community Matrons proactively manage high risk patients with complex Long Term Conditions, deliver high quality care in partnership with the patient, carers and other statutory and third sector agencies in order to maintain independence and quality of life.

They have advanced clinical skills to be able to recognise the early symptoms of disease exacerbation, acute illness and injuries based upon the understanding of alcohol specific disease, chronic disease management, and disease processes, ensuring the delivery of high quality evidenced based care. They are ultimately responsible for the management of care and service provision for individual patient pathways across the primary, secondary care interface, preventing and avoiding unnecessary hospitalisation and utilisation of secondary care resources. They will also be pivotal to the effective discharge process from secondary to primary care for this patient providing the patient with clinical and psychological support as needed to prevent readmission.

Community Matrons have emerged as another tool in reducing repeated alcohol-related hospital admissions particularly those patients who are at risk of social exclusion and may not have access to Primary Care.

Although there are no alcohol specific Community Matron posts in the London area Hillingdon has a Dual Diagnosis Nurse that fulfils some similar functions. Co-located between the local drug and alcohol service HDAS and the mental health service the post is responsible for developing pathways between SM and mental health, improving the interface between community based treatment and the hospital.

Examples of Best Practice: North of Tyne, Hillingdon

Alcohol Health Worker at Emergency Departments

Pioneered by Robin Toucquet and Adrian Brown at St Mary's Hospital in Paddington, this intervention is widely commissioned across London and nationally. Six of the London Boroughs on the Intensive Support programme have an Alcohol Health Worker in place.

Recognising the significant role that alcohol plays in ED attendances, particularly on Friday and Saturday nights, the objective of the worker is to provide Brief Advice and referral to those identified as engaging in higher and increasing risk drinking with a view to preventing further attendances and admission. Dependent drinkers can also be assessed and referred into community based treatment services

Specific competence descriptors are to be added for this role alongside the Alcohol Co-ordinator and the Specialist Practitioner.

Hounslow have an Alcohol Liaison Clinical Nurse Specialist (Band 7) working from the Emergency Department of West Middlesex University Hospital providing:

- Assessment of patients at ED liaison sessions and on the wards
- Brief advice, health education, advice and information about the patient's drinking and local services
- Promotion of alcohol misuse screening
- Specialist clinical advice, training and support to other hospital colleagues on the management of patients with alcohol dependence
- Advice on medication issues for ward nursing and medical staff
- Management of in-patient and ambulatory detox and referral to community based aftercare services

The "front to back" nature of this post is evident as they have a role to play in various parts of the alcohol-affected patient journey through the ED. From the support provided to non-specialist staff in screening and identification, to

delivery of Brief Advice and management of detox and aftercare arrangements, this project has observed a low number re-attenders.

In reducing alcohol-related hospital admissions, a robust system for responding to emergency presentations is key to diverting individuals back into community based services and ultimately saving money. However, the role of the ED Consultant is key and those hospitals with strong and robust systems for responding to alcohol-affected patients have good buy-in and co-operation from the ED Consultant. These systems also provide the best short term opportunities for reducing alcohol-related hospital admissions. More work is required to educate hospital staff, including ED Consultants around the role of alcohol in ED presentations, the efficacy of IBA and the financial benefits of diverting people away from the acute setting.

Significant improvements are also required around the referral pathways between the ED and community based treatment services and Primary Care. It is essential that patients who have presented to ED have a prompt follow up in the community and that the referral is monitored to ensure that the patient has engaged and if not what support is required for that individual.

Another good example of an ED detox protocol can be found at the Royal Liverpool where the protocol clearly states that management of alcohol withdrawal should not be the prime reason for admission to hospital. It has been reported that 80% of those who commence ambulatory detox here complete it.

Identification and Screening at the ED

Across the areas provided with support, identification and screening of ED attenders for alcohol misuse coverage was varied. About half of the participating partnerships had an alcohol screening tool implemented in their local EDs.

The time taken to screen a person for alcohol misuse has often been cited as a barrier to identification in an ED setting. However, for those patients who are literate, screening tools such as AUDIT and PAT are fairly easy to complete and can be handed back to reception staff/triage nurses. This would go some way to overcoming this barrier although does not solve the problem of screening those who are not literate in English.

For there to be sufficient throughput to the AHW, patients need to be identified at the front end. Commissioners should be aware of this when commissioning an AHW service, as this will have an impact on the cost-effectiveness of the AHW. It is essential that non-specialist staff can deliver/assist with screening as referral to the AHW for screening would hinder them from carrying out specialist functions such as assessment and management of detox.

For those Boroughs with no AHW, the cost of such a post/service was cited as a barrier. An alternative that was suggested and has been included in the

respective Improvement Plans was that of re-specifying the contract for the 24 hour Psychiatric Liaison Service (where it exists). This would require consultation and co-operation from the Mental Health Commissioning Manager and Acute Commissioning Unit but has significant potential for delivery of alcohol interventions at ED at a significantly low cost.

IBA in the Custody Suite

As there are no ring-fenced funds for Alcohol Arrest Referral, coverage and depth of activity varies markedly. As there is very little evidence to demonstrate alcohol arrest referral it may be more useful to consider the existence and impact of IBA in the custody suite.

IBA is being delivered in some of the participating Boroughs. It is largely delivered alongside Brief Interventions and harm minimisation for drug use. Improvement Plans have included actions around the review of CRIS data to determine the presence and prevalence of alcohol in the custody suite records.

Lewisham DAAT are planning an Alcohol Arrest Referral pilot commencing in September 2010.

Treatment pathways

There was limited time to assess the treatment systems of the participating Boroughs in detail but some themes did emerge as part of the diagnostic work.

As mentioned previously, pathways from acute settings to community based treatment services must be improved to reduce alcohol-related hospital admissions. Similarly, pathways from Primary Care into treatment must be improved to reduce admissions.

A common theme was the lack of ring-fenced funds for the commissioning of alcohol treatment particularly when compared with the funds available via the Pooled Treatment Budget for drug misuse. The re-specification of contracts is a lever that Commissioners can use to pilot new initiatives at very little expense. This was included in most of the action plans to alter aspects of their treatment systems to accommodate High Impact Changes.

All Boroughs have or are working towards an integrated alcohol treatment system. Modalities are delivered in a variety of settings some of which have already been detailed in this report.

Specialist Practitioner

The role of the Specialist Alcohol Practitioner has been included alongside the Alcohol Co-ordinator role as a National Transferable Role.

The Specialist Practitioners are:

Roles which require advanced knowledge of a field of work, involving a critical understanding of theories and principles. These roles are specialist and/or have management and leadership responsibilities. The practitioner demonstrates initiative and is creative in finding solutions to problems, has some responsibility for team performance, service development, and consistently undertakes self development (AERC Alcohol Academy, 2010).

The further development and establishment of this National Transferable Role will advance the quality of specialist alcohol treatment.

Numbers in Treatment target

The majority of the Boroughs worked with were advised to establish an alcohol numbers into treatment target. The Department of Health (DH) recommend that Partnerships set a target of 15% of the Borough dependent drinking population (Department of Health, 2009). Although many local Commissioners felt this was a positive step in responding to reducing alcohol-related harm, many felt that numbers of Problematic Drug Users (PDU) into effective treatment were a higher priority as partnerships are actively performance managed on this target by the National Treatment Agency (NTA).

Polysystems

Some Partnerships are considering the alignment of drug and alcohol services to their developing polysystems. The majority are embryonic and emerging public health policy may still have a bearing on how polysystems evolve, but there are opportunities for developing the interface between Primary Care and specialist treatment systems. Significantly important is the role that GP consortia have around the commissioning of community based treatment services for substance misuse. This will become increasingly significant as the new strategy for the NHS becomes a reality (Department of Health, 2010).

Examples of Best Practice: Lewisham

Conclusion

This report has been written as a description of the Intensive Support provided to 10 London Partnerships and some of the best practice examples of work underway in these areas.

As many of these initiatives have not been subject to formal evaluation, the views expressed are that of the reviewer based on their experience of commissioning to reduce alcohol-related harm in a local partnership setting. It should be stated that any adoption of any of the initiatives described in the report be considered in the context of local resources and need, culture and history and general utility.

The publication of Signs for Improvement is an excellent guide to commissioning alcohol harm-reduction successfully but there are still challenges at a local level to realising the potential of the High Impact Changes described in the document.

Senior officer buy-in is key to ensuring the alcohol-harm reduction is embedded in the needs assessment processes and plans of local Partnerships. Specifically, PCT Chief Executives, Directors of Public Health, ED Consultants and Local Authority Chief Executives have an important role to play in “paving the way” for local alcohol Commissioning Managers to have an influence on their local systems.

Senior officers are in a better position to hold key operational staff to account for any new initiatives that may be commissioned to reduce alcohol-related harm particularly in hospital environments.

As the NHS enters a period of profound change particularly around the increased commissioning role of GPs and the locating of Public Health teams within Local Authorities, there is an opportunity to improve integrated commissioning at a local level although it is likely too premature to speculate on how models might look.

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