

## Alcohol care teams: reducing acute hospital admissions and improving quality of care

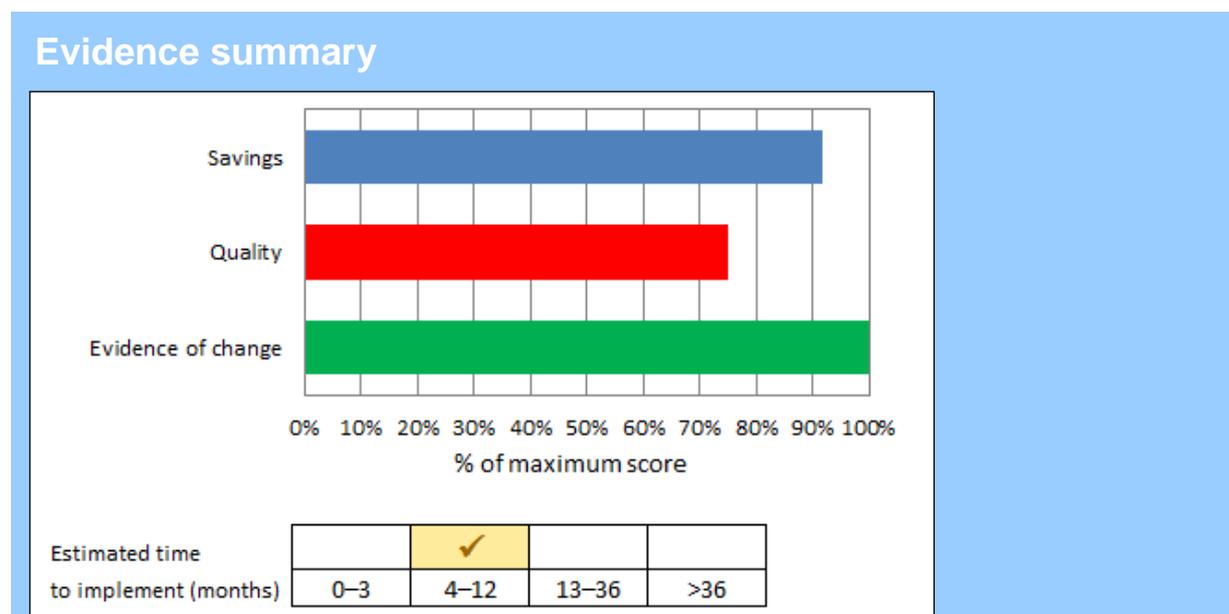
Provided by: The British Society of Gastroenterology and Bolton NHS Foundation Trust

Publication type: Quality and productivity example

### Sharing good practice: What are 'Proven Quality and Productivity' case studies?

The NICE Quality and Productivity collection provides users with practical case studies that address the quality and productivity challenge in health and social care. All examples submitted are evaluated by NICE. This evaluation is based on the degree to which the initiative meets the NICE Quality and Productivity criteria: savings, quality, evidence and implementability. The assessment of the degree to which this particular case study meets the criteria is represented in the summary graphic below.

Proven Quality and Productivity examples are case studies that show evidence of implementation and can demonstrate efficiency savings and improvements in quality.



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## Changes since the previous version

Published Quality and Productivity case studies are reviewed annually. One year after the case study has been published in the Local Practice Collection, the submitter of the case study is contacted to ask if there is further information relevant to the case study, and the case study updated as required. The case study has been amended to meet NICE style and any additional changes to this case study are outlined in the table below.

Case study section	Update
Introduction	No change
Savings	Reference added to 2005 study on cost effectiveness of certain psychosocial interventions for problem alcohol use.
Quality	No change
Evidence	<p>Added that Portsmouth hospital successfully implemented universal alcohol screening, improving diagnosis of dependency and high-risk patients.</p> <p>Updated figures for reduced hospital admissions, for the alcohol outreach service in Salford.</p>
Implementation	<p>Stated that an acute hospital model for an alcohol care team is now outlined in appendix 3.</p> <p>Added details about the relationship between the number of alcohol specialist nurses and the length of stay at Royal Bolton Hospital.</p> <p>Added details of an alcohol service audit framework agreed between Bolton NHS Foundation Trust and the local clinical commissioning group.</p>

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## Details of initiative

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<b>Purpose</b>	To reduce acute alcohol-related hospital admissions and readmissions.
<b>Description (including scope)</b>	<p>The principal component of this initiative is for a multidisciplinary Alcohol care team in each district hospital, led by a consultant with designated sessions, who will collaborate across hospitals and primary care, to develop a coordinated alcohol treatment and prevention programme. This team would organise systematic interventions and alcohol specialist nurses.</p> <p>It is estimated that the annual cost of alcohol-related harm to the NHS in England is £3.5 billion (Public Health England 2013). Of this cost, 78% was for hospital-based care, and 45% was for inpatient care (NHS Confederation and Royal College of Physicians 2010).</p> <p>A significant proportion of this spending is avoidable. Alcohol services could be more effective, cheaper and person-centred if each area had a plan to deliver evidence-based care in an appropriate setting, integrated between primary and secondary care.</p> <p>Until recently, very few hospitals had dedicated alcohol services, and a 2009 survey showed that only 42% of acute hospitals had any alcohol specialist nurse support (Ward et al. 2009).</p> <p>Alcohol care teams coordinate policies of care across acute departments, including accident and emergency (A&amp;E). They provide access to brief interventions and appropriate services within 24 hours of the detection of alcohol-related problems. Structured advice lasts for 20–40 minutes and involves personalised feedback to people about their level of health risk because of alcohol consumption, practical advice about reducing alcohol consumption, with a range of options for change, and written information to support the advice.</p> <p>Hospitals have coordinated policies of care for patients with alcohol-related problems in A&amp;E and acute medicine departments, including a 7-day alcohol specialist nurse service, a mental health crisis team and alcohol link workers' network.</p> <p>Each health area can establish a hospital-led, multi-agency alcohol assertive outreach service to move the most frequent attendees and biggest consumers of hospital resources into a more appropriate, supported, community environment. These initiatives may require a degree of investment to get them up and running.</p>
<b>Topic</b>	Urgent and emergency care, long-term conditions, primary care commissioning and contracting, right care and self-care.

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<b>Other information</b>	<p>Coordinated policies are essential and there is a need for integrated alcohol treatment pathways, developed between primary and secondary care. The savings arise from reduced admissions for detoxification ('drying out') and reduced readmissions because of better management of alcohol addiction, physical and mental health problems.</p> <p>A number of studies (NHS Confederation and Royal College of Physicians 2010; Jewell and Sheron 2010; Department of Health 2001; Royal College of Physicians 2001) demonstrate how alcohol misuse and alcohol-related liver disease are growing problems.</p> <p>A paper that focuses particularly, but not exclusively, on secondary care makes 11 key recommendations relevant to a typical British hospital for future alcohol care (Moriarty et al. 2010).</p>
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## Savings delivered

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<b>Amount of savings delivered</b>	<p>A net saving, in bed days alone, of approximately £715,000 per annum, based on a population of 250,000. This equates to a saving of £286,000 per 100,000 population.</p> <p>However, where individual services are implemented separately, net savings are estimated as follows:</p> <ol style="list-style-type: none"><li>1. 7-day alcohol specialist nurse service - £448,000 per annum, based on a DGH population of 250,000. This equates to £179,000 per 100,000 population.</li><li>2. Alcohol assertive outreach service - £267,000 per annum, based on a DGH population of 250,000. This equates to £107,000 per 100,000 population. This does not take account of the savings, due to prevented admissions in the service's top 100 "fast riser" population, since these cannot be measured.</li></ol>
<b>Type of saving</b>	<p>The savings are cash-releasing from a reduction in acute beds by the provider and reduction in acute admissions paid for by the commissioner.</p>
<b>Any costs required to achieve the savings</b>	<p>Non- recurrent costs are minimal. Recurrent costs have been included in savings.</p>
<b>Programme budget</b>	<p>Problems of the liver and gastrointestinal system and potentially numerous others, given the impact of alcohol on many systems and services.</p>
<b>Supporting evidence</b>	<p>Most hospital admissions for alcohol-related problems come through A&amp;E (where, without intervention, evidence of alcohol-related problems may be missed or ignored). The top 10 presentations are: fall, collapse, head injury, assault, accident,</p>

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generally unwell, gastrointestinal symptoms, cardiac symptoms, psychiatric problems and frequent attendance. Intoxicated patients may require overnight admission to an observation ward, while others may require greater medical or psychiatric care.

Nationally, 13–20% of all hospital admissions are alcohol-related. Moreover, patients with alcohol-related problems are often very ill. Hence, they make up at least 20% of the overall consultant direct clinical care workload.

For some types of psychosocial treatment for dependent drinkers, the public sector saves £5 for every £1 spent on treatment (UKATT Research Team. 2005).

## Quality outcomes delivered

<b>Impact on quality of care or population health</b>	Care quality improves because the alcohol team helps time to be freed up by reducing admissions and readmissions. Targeted brief interventions also improve outcomes for individual patients (Kaner et al. 2007).
<b>Impact on patients, people who use services and/or population safety</b>	Treatment by a specialist alcohol team means that patients' problems are addressed more effectively and future adverse events for individual patients are reduced. Alcohol teams reduce inpatient mortality and length of stay, and enhance multidisciplinary outpatient care.
<b>Impact on patients, people who use services, carers, public and/or population experience</b>	Avoiding admission or readmission to hospital improves patient and carer experience.
<b>Supporting evidence</b>	A large number of patients will avoid hospital admissions. Just as important, a large number of patients will avoid readmissions and be placed on a clinical pathway. At present, many have frequent admissions and are discharged without their underlying problems being addressed.

## Evidence of effectiveness

<b>Evidence base for case study</b>	Based on accredited guidance. 'Alcohol-use disorders: preventing harmful drinking' (NICE public health guidance 24; see 'Contacts and resources').
<b>Evidence of deliverables from</b>	Example is based on experience in 1 or more organisations that have had systematic follow-up and reporting of results.

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<b>implementation</b>	
<b>Where implemented</b>	NHS England. Various NHS hospitals have adopted different ways of introducing a specialist alcohol team. See some examples below.
<b>Degree to which the actual benefits matched assumptions</b>	As expected.
<b>If initiative has been replicated how frequently/widely has it been replicated</b>	<p>Different elements of an alcohol care team approach have been introduced in different places.</p> <p><b>Alcohol specialist nurse service in Nottingham</b></p> <p>Implementation of an alcohol specialist nurse service in Nottingham improved the health outcomes and quality of care of patients admitted to hospital for detoxification, and also of those admitted for the complications of alcohol-related cirrhosis (Ryder et al. 2010).</p> <p>Hospital admissions were reduced by two-thirds, resulting in a saving of 36.4 bed days per month in patients admitted for detoxification. Clinical incidents were reduced by 75%. Liver enzyme abnormalities were halved and there was also a reduction in bed days used in the cirrhotic group from 6.3 to 3.2 days per month (see Appendix 1).</p> <p><b>St Mary's Hospital, London</b></p> <p>St Mary's Hospital, London has engaged and trained staff to give brief intervention, education, audit and feedback to patients presenting to A&amp;E (Touquet and Brown 2009).</p> <p>They have designed the 1-minute Paddington Alcohol Test to identify patients with an alcohol-related problem. This resulted in a 10-fold increase in referrals to an alcohol health worker. The alcohol health worker gave brief intervention and education, which resulted in a reduction in alcohol consumption of 43%. Every 2 referrals to the alcohol health worker resulted in 1 fewer re-attendance during the following year. If patients are offered an appointment with the alcohol health worker on the same day, almost two-thirds attend. If the appointment is delayed for longer than 48 hours, only 28% attend. Hence, the intervention needs to be immediate.</p> <p><b>The Royal Liverpool Hospital</b></p> <p>The Royal Liverpool Hospital has introduced an extension of the role of alcohol specialist nurses from A&amp;E to inpatient care, preventing 150 admissions per year. The roles of alcohol specialist nurses in Liverpool have since been further developed into a nurse-led alcohol services lifestyle team, with daily clinics in different locations in the city. These clinics provide direct access</p>

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for GPs to refer patients to the service (see the DH Alcohol Learning Centre <http://www.alcohollearningcentre.org.uk/LocalInitiatives> for more details).

## **Alcohol specialist nurse service in Portsmouth**

At Queen Alexandra Hospital, Portsmouth, there are 6 alcohol specialist nurses, with 1 administrator. In 2012/13, this service saved NHS Portsmouth 1071 bed days and NHS Hampshire 952 bed days. There are also 4 liver specialist nurses to provide a joint alcohol and liver disease service.

The hospital successfully introduced universal alcohol screening. Over a 3 year period, screening was conducted using a modified electronic version of the Paddington Alcohol Test, for more than 50,000 patients. The test was performed by general, rather than specialist alcohol nurses or doctors. 4% of the patients were found to be at 'high risk'. Further assessment by an alcohol specialist nurse showed that 81% of those patients had a high dependency score. This group was also having more frequent emergency department attendances and multiple hospital admissions, as well as a greater likelihood of alcohol-related liver disease.

## **Alcohol assertive outreach service in Salford**

In 2011, in response to the North West Chief Executives' Alcohol Challenge, led by Salford chief executive, Sir David Dalton, Salford Royal NHS Foundation Trust established a hospital-led alcohol assertive outreach service. The team works with a cohort of the top 30 patients (frequent attenders) with the highest levels of alcohol-related admissions over a 6-month period. Each 6 months, this cohort is refreshed. The team also works proactively with any patient, who has had 2 alcohol-related admissions within a short period of time, the so-called 'fast risers'.

Work with the first top 30 cohort resulted in a 59% reduction in Emergency Department attendances in the 3-month period post-intervention, when compared with the 3-month period before intervention (average monthly attendances were reduced from 120 to 49). There was also a 66% reduction in average monthly hospital admissions (50 to 17). This reduction in admissions was maintained, even though the team moved on to working with the next top 30 cohort (Hughes et al. 2013). In the first year, as the alcohol assertive outreach service was becoming established, no real cost savings were seen. In year 2, looking at the top 30 cohort only, tariff costs reduced by £556,500, liberating 2-3 hospital beds. The alcohol assertive outreach service cost £300,000, representing a £256,500 annual saving. Salford Royal serves a population of 240,000. Hence, the net savings, in bed days alone, equate to £267,000 annually for a typical District hospital serving a population of 250,000. This does not take account of the savings, due to prevented admissions in the service's top 100 "fast riser" population, since these cannot be

measured.

The reduced North West Ambulance Service and police costs also need to be considered.

Between January 2013 and October 2015, the Alcohol Assertive Outreach Service has continued to reduce alcohol-related Emergency Department attendances and hospital admissions by 60-70%, by collaborative physical, mental and social care and by addressing other drug usage of their cohorts of patients.

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**Supporting evidence** See previous section.

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## Details of implementation

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### Implementation details

#### **Alcohol care teams and lead consultant**

Each multidisciplinary alcohol care team should be led by a consultant, with both a clinical and strategic role and dedicated clinical sessions weekly. The lead consultant should also collaborate with public health, primary care organisations, patient groups and key stakeholders to develop and implement a district alcohol strategy. Each hospital has an alcohol care team. This is a formalised group of people, with an overall lead clinician. It includes a lead from hepatology, gastroenterology, psychiatry, A&E 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.

Establishing a consultant-led, multidisciplinary alcohol care team and a 7-day alcohol specialist nurse service were 2 of the principal recommendations of the National Confidential Enquiry into Patient Outcome and Death (2013) 'Measuring the units: a review of patients who died with alcohol-related liver disease'. This study highlighted the delays in referral of patients for specialist alcohol and liver care, and missed opportunities for brief interventions during previous admissions. Only 23% of hospitals had a multidisciplinary alcohol care team. Encouragingly, 79% had an alcohol specialist nurse service, compared with only 42% in a previous survey (Ward et al. 2009).

During 2012-2013, Public Health England conducted a survey of 191 district general hospitals in England and found that at least 73% offered some level of specialist alcohol service (Public Health England 2014). Funding for many services now rests with local authorities, following the transfer of local public health functions from the NHS.

The alcohol care team works closely with primary care organisations, key stakeholders and patient groups to develop and deliver a strategy for reducing alcohol-related problems in the

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district.

Patient groups are encouraged and supported to develop their own pathways of care, in collaboration with service providers.

The lead clinician has shared responsibility, with public health and primary care, for delivering timely and responsive high-quality support services and achieving targeted quality metrics, including:

- reductions in alcohol-related admissions, readmissions and mortality
- improvements in public understanding and awareness of alcohol
- increased rates of early detection of alcohol misuse.

The lead clinician is usually a hepatologist, gastroenterologist or liaison psychiatrist, but could be an acute medicine physician or A&E consultant, or a doctoral-level nurse consultant. The lead clinician identifies people responsible for alcohol policy, with a dedicated clinical session, in key clinical areas.

The lead clinician has 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 also provides clinical expertise to policy makers at local, regional and national levels.

## **The Royal Bolton Hospital**

The Royal Bolton Hospital collaborative care for alcohol-related liver disease and harm is a multidisciplinary team. Before 2012, it consisted of 4 consultant gastroenterologists (a hepatologist was appointed in 2013), a liaison psychiatrist, 1 psychiatric alcohol liaison nurse, 1 liver nurse practitioner and all relevant healthcare professionals, including a dedicated social worker. The social worker greatly influences the average length of stay and facilitates discharge of patients into a suitable environment (Moriarty 2011).

The key features of the Royal Bolton Hospital Alcohol Care Team model are described (see Appendix 2).

The composition of an Acute Hospital Model for an Alcohol Care Team has been published (see Appendix 3).

Between 2006-2011, when there were only 2 specialist nurses working in partnership, inpatient detoxifications were reduced, saving the trust more than 1000 bed days annually, equivalent to £250,000 (during 2006-2011, the average annual bed day tariff was £250) in reduced admissions alone. In January 2012, the Royal Bolton Hospital appointed 2 additional nurses and established a hospital-based, 7-day alcohol specialist nurse service. The alcohol specialist nurses, who are also trained in liver disease, assess all alcohol-related admissions, perform comprehensive physical and mental assessments, provide brief advice to patients and initiate care plans on a daily basis. Patients

are offered rapid appointments with community services and/or detoxification. The nurses are also best placed to identify vulnerable children and adults, and to address safeguarding concerns. The 7-day service cost is £165,000 annually, saving 2000 bed days (current tariff is £318 per day) and £636,000 (£471,000 net) annually, and liberating 4-6 hospital beds. The Royal Bolton population served is 263,000. Hence, the net savings, in bed days alone, equate to £448,000 annually for a typical District hospital, serving a population of 250,000.

These figures for the cost of the 7-day Alcohol Specialist Nurse Service, bed days saved and cost savings have been maintained during 2013-2015, provided that 4 alcohol specialist nurses, with administrative support, are employed by the Trust.

During 2011-2015, the number of alcohol specialist nurses at the Royal Bolton Hospital has varied between 2 and 4 nurses, resulting in a major impact on length of stay: 8.0 days with 2 nurses, 6.0 days with 3 nurses and 5.2 days with 4 nurses, with the attendant cost savings.

For patients, admitted with a primary alcohol problem, a bed day costs the Trust £318.

Downstream, alcohol specialist nurses also reduce future hospital admissions for patients with alcohol-related liver disease. Mean inpatient costs nationally are £513 per day for non-elective admissions with liver disease (Department of Health 2014).

With the 7-day service, readmission rates have been reduced by 3%, compared with an increase across the region.

The alcohol specialist nurses have introduced the Short AUDIT C Alcohol Questionnaire across the trust. All elective and non-elective patients are routinely asked about their alcohol consumption, helping to identify dependent, harmful and hazardous drinkers. More patients with previously undiagnosed liver disease are now being identified. After 12 months of the 7-day service, there was a 63% increase in referrals and more than 600 healthcare staff were trained in identifying alcohol problems and delivering brief advice. The specialist nurses have also trained and established a network of 50 trust alcohol link workers and run an alcohol and liver disease course for staff.

Bolton NHS Foundation Trust and Bolton Clinical Commissioning Group (CCG) agreed an Alcohol Commissioning for Quality and Innovation (CQUIN) for 2014/2015. General nurses on the 4 acute medical and surgical wards were trained by the alcohol specialist nurses to complete [Alcohol Use Disorders Identification Test - Consumption](#) (AUDIT C). 80% were completed, resulting in increased detection of problem drinking and identification of previously undiagnosed liver disease. The AUDIT C data were returned to patients' GPs via the CCG Public Health Lead, who now holds AUDIT C data on 50% of the entire Bolton community of 237,000.

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

Allied to this, the alcohol specialist nurses supervise and optimise the care of all inpatients on the gastroenterology ward and also discuss all new admissions to the acute medical unit at the multidisciplinary meeting, which follows the daily consultant ward round.

The gastroenterology consultant then sees these patients on the acute unit, ensuring rapid assessment and treatment and the selection and prioritisation of appropriate patients for transfer to the gastroenterology ward.

**New way of working:** Since 2009, in order to cope with the large numbers of inpatients with alcohol-related problems, the gastroenterology (and hepatologist, appointed in 2013) consultants have worked in 2-week blocks on the ward. They do daily ward rounds, have daily multidisciplinary team meetings and see all acute medical admissions and ward consultations. Consequently, there was a 37% increase in ward discharges; length of stay was reduced from 11.5 days to 8.9 days, and mortality from 11.2% to 6.0%. The downside has been that, during these 2 weeks, the consultant on the ward loses 10 endoscopy and outpatient clinic sessions (Singh et al. 2012).

The hospital alcohol care team's partnership with public health, council, local authority, GP commissioners, mental health, social services and other stakeholders, and the Bolton Integrated Alcohol and Liver Group of key commissioners and providers aim to optimise resources and ensure integrated primary/secondary/community care alcohol and liver disease treatment pathways and strategy, while the new national and local commissioning arrangements are established.

It is vital that national standards for alcohol care teams, together with an appropriate skill mix and competencies for the team members, are agreed and established, and that these are overseen and implemented at local and national levels.

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<b>Time taken to implement</b>	Can be achieved in the medium term: 4–12 months.
<b>Ease of implementation</b>	Affects a whole organisation across a number of teams or departments. The whole of the hospital or primary care organisation is affected.
<b>Level of support and commitment</b>	Many trusts recognise that addressing alcohol-related admissions and disease is a top priority.

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<b>Barriers to implementation</b>	<p>Leadership and partnership between clinicians, chief executives and commissioners are critical in establishing alcohol teams and ensuring their success.</p> <p>Time is also needed to allow all stakeholders to focus on cost-cutting problems, which will need to be recognised within job plans.</p>
<b>Risks</b>	<p>The main risks are the resource of the team members. Reluctance to deploy these differently has been overcome by pilot schemes, which have demonstrated cost savings.</p>
<b>Supporting evidence</b>	<p><b>Psychiatry alcohol treatment services</b></p> <p>The essential elements of integrated alcohol treatment pathways have been described (NICE clinical guideline 115; see 'Contacts and resources'). The outcomes, especially the prevention of relapse and readmissions, for patients identified and initially treated by alcohol care teams in hospitals, ultimately depend on the quality of the whole care pathway. Models of delivery differ around the UK. Traditionally, addiction psychiatrists have worked in specialist units, and there is a clear need for their input, together with that of liaison psychiatrists, into acute hospitals, which should establish close links with mental health trusts.</p> <p><b>The Birmingham Rapid Assessment, Interface and Discharge (RAID) model</b></p> <p>The Birmingham RAID service is a model of liaison psychiatry, developed in Birmingham City Hospital, which delivers a rapid response, 24-hour, 7-day, age-inclusive service and a comprehensive range of mental health specialties. Alcohol-related problems comprised 13% of their study population (Tadros et al. 2013). In the City Hospital, with 600 beds, the RAID service saved 43–64 beds per day, through linking patients to the right care pathway in the community. The elderly care wards provided most of the bed savings. During the period of the intervention, the City Hospital managed to close 60 beds, without cutting down on services. The internal review estimated the financial savings to be £4–6 million per year, based only on saved beds. Using a conservative calculation, the London School of Economics estimated the saving to be around £3.55 million per year (London School of Economics and Political Science 2011).</p>

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## Further evidence

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<b>Dependencies</b>	<p>There has been a reluctance to use brief interventions systematically because of the lack of targeted funding. However, for every 8 people who receive simple alcohol advice, 1 will reduce their drinking to within lower risk levels. This compares favourably with smoking, where only 1 in 20 will act on the advice</p>
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given. Brief interventions work well (Department of Health 2005; Kaner et al. 2007).

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## Contacts and resources

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### Contacts and resources

If you require any further information please email: [qualityandproductivity@nice.org.uk](mailto:qualityandproductivity@nice.org.uk) and we will forward your enquiry and contact details to the provider of this case study. Please quote reference 10/0021 in your email.

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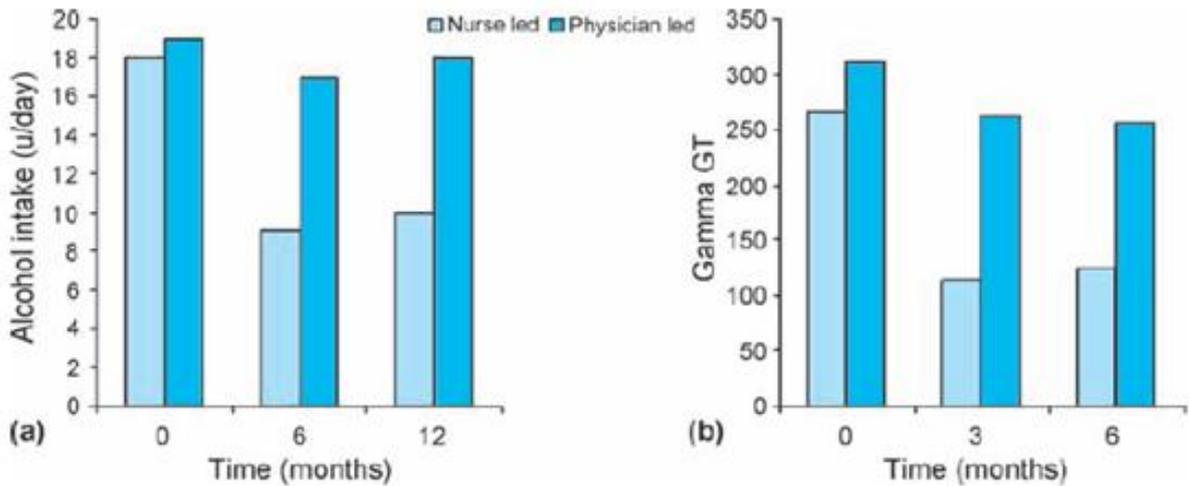
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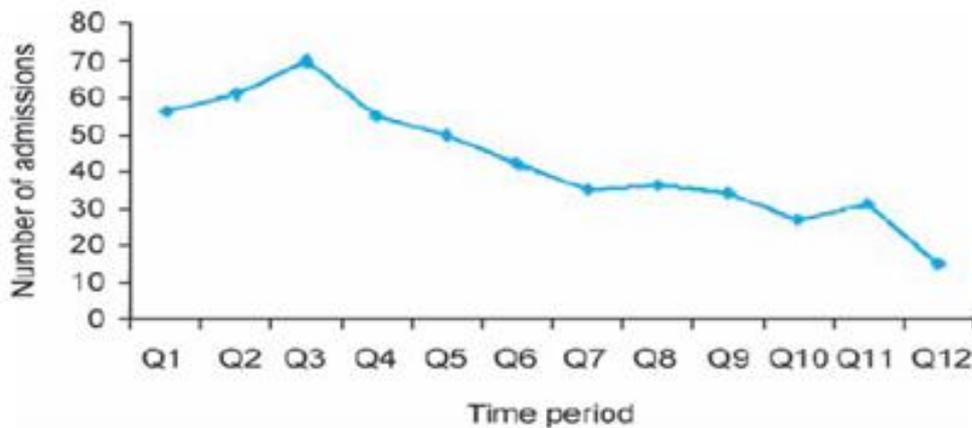
Last reviewed: February 2016

## Appendix 1

**Figure 1** Impact of nurse-led alcohol care team compared with 'conventional' care on (a) self-reported alcohol intake and (b) the liver enzyme gamma GT, showing halving of alcohol intake and liver damage (Ryder et al. 2010).



**Figure 2** Impact of nurse-led alcohol care team on admissions to hospital for alcohol withdrawal. The service was introduced in Q2 (Q1 etc. refer to 3-month periods from 2002). Ryder et al (2010)



## Appendix 2

### **THE ROYAL BOLTON HOSPITAL MULTIDISCIPLINARY ALCOHOL CARE TEAM MODEL**

#### **Key Features**

- The Royal Bolton Hospital Alcohol Care Team aims to provide multidisciplinary, person-centred care, which is holistic, timely, non-judgmental and responsive to the needs and views of patients and their families.
- The team is committed to assessing, planning, implementing and evaluating care, in collaboration with the patient and family. This is developed around an anticipated length of stay, or episode of care. Patients are empowered to make lifestyle changes.
- Consultant Gastroenterologists, a Hepatologist, Alcohol Specialist Nurses (ASNs) and the Rapid Assessment, Interface and Discharge (RAID) Liaison Psychiatry Team provide joint, comprehensive alcohol and liver disease inpatient and outpatient care.
- A 7 Day Alcohol Specialist Nurse (ASN) Service, with Psychiatric Alcohol Liaison Nurses (PLN) and Liver Nurse Practitioners (LNP) working in close partnership, together with A&E, the Acute Medical Units, and all wards, particularly the specialised Gastroenterology and Liver disease ward.
- The ASNs offer daily review of patients, especially those requiring primary or secondary detoxification, so as to ensure safe medication management.
- A multidisciplinary ward team, which meets daily to discuss all inpatients and any outpatient or service issues. The meeting is consultant-led, together with the ward doctors, nurses, ASNs, social worker, dietician, physiotherapist and occupational therapist. All healthcare professionals write in the same notes. The team working ethos makes everyone feel valued and optimises and unifies patient-centred, collaborative care.
- A dedicated social worker greatly influences length of stay and facilitates discharge to a suitable environment. Discharge and on-going care of inpatients, who are out-of-area, may be problematic. 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 brain damage, including Wernicke–Korsakoff Syndrome, for whom there is a major shortage of suitable long term care.
- Telephone hotline, rapid access is provided to GPs, patients, their families and carers, either directly to the ASNs, or via the secretaries or ward, where a close relationship has developed.
- Close liaison with Safeguarding Officers.
- ASNs and doctors trained in implementing Deprivation of Liberty Safeguards (DOLS).

# Quality and Productivity

- Daily Consultant Gastroenterology input into the Acute Medical Receiving Units facilitates the rapid triage and clinical and endoscopic management of gastroenterology emergencies, and their transfer to the Gastroenterology ward or Critical Care Areas.
- Coordinated care pathways across the hospital, including A&E and the Acute Medical Units.
- ASNs have established an Alcohol Link Workers' Network, with a healthcare lead in every clinical area. They have introduced the AUDIT C Alcohol Questionnaire and educated and trained 600 staff in Identification and delivering Brief Advice (IBA) for alcohol problems. All inpatients are routinely screened for alcohol consumption, facilitating identification of dependent, harmful and hazardous drinkers and of patients with previously undiagnosed liver disease.
- Access to Brief Interventions within 24 hours of detection of alcohol-related problems. This structured advice lasts for 20-40 minutes and involves individualised personalised feedback to the patient about their level of health risk due to alcohol, with practical advice about reducing their alcohol intake.
- Health promotion and educational updates, in diverse hospital and community settings, to improve awareness and engagement. Accessibility is paramount, overcoming any barriers.
- Partnership with Link/Community workers to overcome the alcohol stigma in Asian and ethnic minority communities.
- Transparent, No-blame Clinical Governance Meetings.
- Collaborative working with local Liver Clinical Networks and Liver Transplant Units.
- Partnership with Public Health, council, local authority, GP commissioners, mental health, social services, patient groups and other key stakeholders. The Bolton Integrated Alcohol and Liver Group of key commissioners and providers meets regularly to integrate local and national alcohol and liver disease strategy, care and treatment pathways.

**Moriarty K.J. Collaborative Liver and Psychiatry care in the Royal Bolton Hospital for people with alcohol-related disease. Frontline Gastroenterology 2011; 2:77-81.**

## Appendix 3

### Acute Hospital Model for an Alcohol Care Team

- A consultant-led, multidisciplinary, patient-centred Alcohol Care Team to be integrated across primary and secondary care
- A 7 day Alcohol Specialist Nurse Service
- Coordinated policies for the Emergency Department and Acute Medical Units
- A Rapid Assessment, Interface and Discharge (RAID) Liaison Psychiatry Service
- An Alcohol Assertive Outreach Team for frequent attenders to hospital
- Formal links with Local Authority, Clinical Commissioning Groups, Public Health and other stakeholders

Please see Williams, Aspinall, Bellis et al (2014) in 'Contacts and resources'.