

# Alcohol Care Teams:

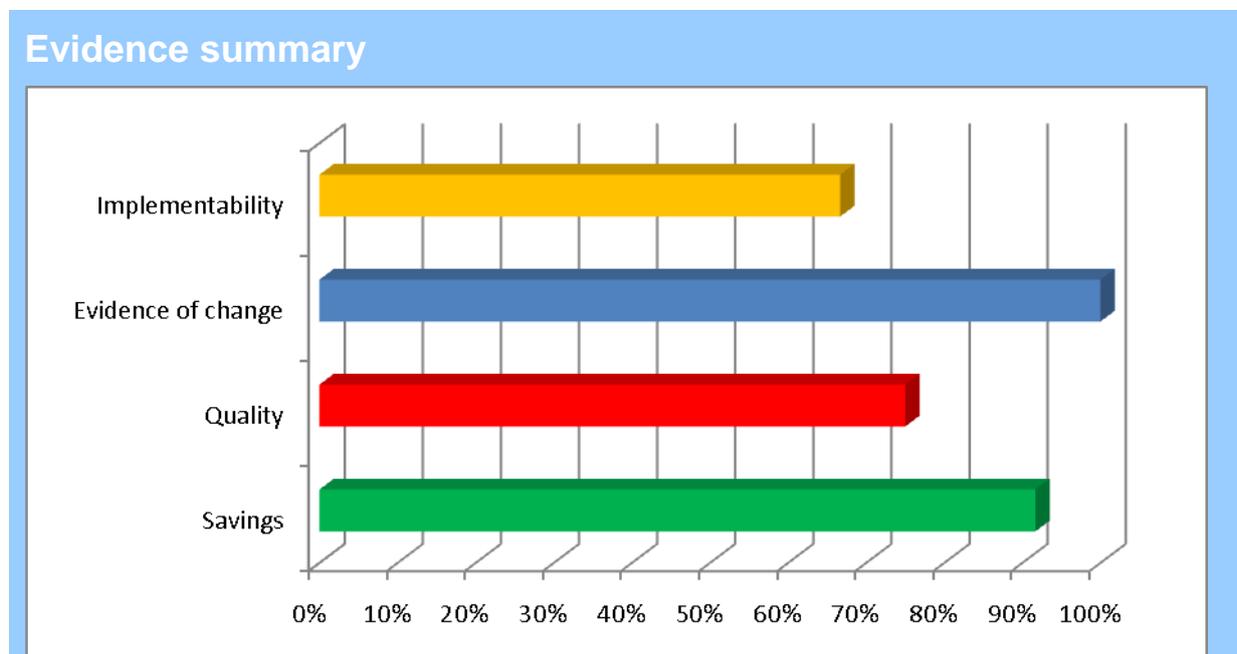
## to reduce acute hospital admissions and improve quality of care

Provided by: **The British Society of Gastroenterology and the Royal Bolton Hospital NHS Foundation Trust**

Publication type: **Quality and productivity example**

QIPP Evidence 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 QIPP criteria of savings, quality, evidence and implementability; each criterion is given a score, which is then combined to give an overall score. The overall score is used to identify the best examples, which are then shown on NHS Evidence as 'recommended' or 'highly recommended'.

Our assessment of the degree to which this particular case study meets the criteria is represented in the evidence summary graphic below.



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## Details of initiative

### Purpose

To reduce acute alcohol- related hospital admissions and readmissions, which currently costs the NHS £2.7 billion annually. A significant proportion of this spending is avoidable and alcohol services could be significantly 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. There are very few dedicated alcohol teams in the NHS. Hence, there are few strategies to care for frequent admissions and readmissions.

Coordinated policies are essential and we need integrated Alcohol Treatment Pathways developed between primary and secondary care, particularly in the light of recent proposals from the Health Secretary to suggest that hospitals will not be paid for people readmitted within 30 days of discharge. This policy would have a huge impact on alcohol care, where there are a large number of "frequent attenders". This highlights the urgent need for commissioners, chief executives and clinicians to better manage pathways of alcohol care between hospitals and the community.

There are substantial savings to be made, as well as an opportunity to improve quality of care, both at a population and individual level. The savings arise from (i) reduced admissions for detoxification ("drying out") and (ii) reduced readmissions consequent on better management of alcohol addiction and mental health problems, such as, secondary prevention.

### Description (including scope)

Very few hospitals have dedicated alcohol services, and a 2009 survey showed that only 42% of acute hospitals had any alcohol specialist nurse support (D Ward, et al, 2009).

The principal recommendation 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. The evidence in this document is not only for the team, but for a variety of actions, including Brief Interventions, specialist alcohol nurses and ways of reaching out to patients.

Alcohol Care Teams coordinate policies of care across acute departments, including A&E. They provide access to Brief Interventions within 24 hours of detection of alcohol-related problems. Structured advice lasts for 20-40 minutes and involves personalised feedback to individuals about their level of

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health risk due to alcohol, practical advice about reducing alcohol consumption, with a range of options for change, and written information to support the advice.

Hospitals have coordinated policies of care for patients with alcohol-related problems in Accident and Emergency and Acute Medicine departments, including a 7 day Alcohol Specialist Nurse Service, a Mental Health Crisis Team and Alcohol Link Workers' Network. These provide access to Brief Interventions or advice and appropriate services within 24 hours of detection of an alcohol-related problem.

Each health area can establish a hospital-led, multi-agency "Assertive Outreach Alcohol Service" to move the most frequent attenders and biggest consumers of hospital resources into a more appropriate, supported, community environment. These initiatives may require a degree of "pump-priming" to get them up and running.

Examples are provided in Gate 3 'Evidence of effectiveness'.

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## Topic

Acute / urgent care, mental health, long term conditions, primary care, right care, safer care and clinical rationalisation.

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## Other information

In 2006/7, alcohol misuse cost the UK economy £25 billion, of which the NHS expenditure was £2.7 billion (DH, 2008). Of this amount, 78% of the costs were incurred as hospital-based care. Inpatient costs alone were responsible for 45% of this spend (NHS Confederation and Royal College of Physicians, 2010).

Alcohol-related problems are a major and growing problem in the UK, when compared to the incidence and cost in other countries (J Jewell et al, 2010). Rising alcohol consumption and increasing incidence of cirrhosis are seen across all ages and sections of society. In 2008, there were 9,031 deaths directly related to alcohol, mostly from alcohol-related liver disease (ALD).

In England, liver cirrhosis mortality approximately trebled between 1970 and 1998, with the death rate for men in the 35-44 age group increasing eight-fold and seven-fold for women. There was a four-fold increase in 25-34 year olds (DH,2001). Both this and a second seminal report (Royal College of Physicians, 2001), highlighted the problem and set the alcohol agenda for the decade.

While much attention is given to alcohol as a social policy concern, there is an additional need to provide care for a large and growing group of alcohol-related health problems, where national quality standards are lacking and the absence of coordinated policies means that care is imperfect and spending is poorly targeted and ineffective.

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A recent paper, which focuses particularly, but not exclusively on secondary care, makes 11 key recommendations, relevant to a typical British District General Hospital, for future alcohol care (K.J. Moriarty, 2010).

## NORTH WEST CHIEF EXECUTIVES' CHALLENGE

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

The review identifies two principal patient cohorts and determines that organised service intervention could result in a 5% reduction in National Indicator Set 39 admissions. The first cohort is patients staying in hospital for 0-1 day. They constituted 50% of alcohol-related admissions to Salford Royal. The solution modelled would be to establish a 7-day Alcohol Specialist Nurse Service to screen, triage and provide brief interventions. The service cost would be £279,000, liberating 2 hospital beds, saving £698,000 annually. There would be 400 fewer admissions per year, equating to 133 NI 39s and a 1% reduction in alcohol-related admissions.

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

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

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

The combined cost for the two initiatives would equate to £660,000 and a potential reduction of 5% in alcohol-related admissions to a district general hospital serving a 250,000 population. The case is predicated on the commissioner and

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provider agreeing to share the cost benefits of bed reduction and tariff avoidance. These cost benefits amount to a potential £1.6 million per locality, equating to an annual saving to the overall UK economy of £393 million. However, the potential savings in the North West, where there is a high alcohol-related disease prevalence, may not be applicable to other regions with a lower disease prevalence.

Salford Royal NHS Foundation Trust has recently established a hospital-led AOAS, as part of a "Healthy Hospital Project". Of the 20 most frequent A & E attenders, 19 had an alcohol-related problem. Following implementation of their AOAS, preliminary data suggest a 15% reduction in both A & E attendances and admissions for this patient cohort during the 6 month pilot, compared with the preceding 6 month period.

## 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 5 dedicated sessions weekly, who will also collaborate with Public Health, Primary Care Trusts, patient groups and key stakeholders to develop and implement a district alcohol strategy.

Each District General Hospital should appoint an "Alcohol Care Team". This would be a formalised group of individuals, with an overall Lead Clinician. It would include a Lead from hepatology, gastroenterology, psychiatry, accident and emergency and acute medicine, other key specialist Leads, the Lead alcohol specialist nurse and an executive member of the Trust Board, with a locally appropriate balance of representatives from primary care and patient groups.

The Alcohol Care Team should work closely with Public Health, Primary Care Trusts, key stakeholders and patient groups to develop and deliver a strategy for reducing alcohol-related problems in the district.

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

The Lead Clinician would have shared responsibility, with Public Health and primary care, for delivering timely and responsive high quality support services and achieving targeted 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.

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The Lead Clinician would usually be a hepatologist, gastroenterologist or liaison psychiatrist, but could be an acute medicine physician or accident and emergency consultant, or a doctoral level nurse consultant. The Lead Clinician would identify individuals responsible for alcohol policy, with a dedicated clinical session, in key clinical areas.

The Lead Clinician requires the skills and knowledge to be able to develop, implement, monitor and evaluate effective treatment pathways across disciplines and services and the ability to provide clinical supervision and support to a range of care providers of different professional groups and specialties. The Lead will also provide clinical expertise to policy makers at local, regional and national level.

## Gate 1: Savings delivered / anticipated

<b>Amount of savings delivered / anticipated</b>	<p>£1.6 million savings for a District General Hospital serving a 250, 000 population. This equates to £640,000 per 100,000 population.</p> <p>Based on national indicators and length of stay costs:</p> <ul style="list-style-type: none"><li>- on average, an alcohol-related admission costs a PCT £1824</li><li>- on average, an alcohol-related A&amp;E attendance costs a PCT £80</li><li>- on average, each avoided admission will save a provider £300.</li></ul>
<b>Type of saving</b>	<p>Real cash savings will be achieved through reduced expenditure. 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>The cost of change is an estimated £660,000 for a population of 250,000.</p>
<b>Programme budget</b>	<p>Problems of the gastrointestinal system and potentially numerous others, given impact of alcohol on many systems and services.</p>
<b>Details supporting Gate 1</b>	<p>Nationally, 13-20% of all hospital admissions are alcohol-related. This figure is undoubtedly an underestimate, since coding of alcohol-use disorders is notoriously inaccurate. Moreover, patients with alcohol-related problems are often very ill. Hence, they constitute at least 20% of the overall Consultant Direct Clinical Care (DCC) workload.</p> <p>It is difficult to single out a programme budget above, since there are around 70 diseases and injuries, where alcohol contributes to</p>

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causation. We have opted for problems of the gastrointestinal system. Most hospital admissions for alcohol-related problems come through A&E (where, without intervention, evidence of alcohol-related problems may be missed or ignored). The top ten presentations are: fall, collapse, head injury, assault, accident, 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.

There were 863,000 alcohol-related hospital admissions in 2007/8 (accounting for 6% of all admissions), compared to 510,000 in 2002/3. However, these figures are a gross underestimate, since coding for alcohol-use disorders has been notoriously inaccurate.

Approximately 35% of all A&E attendances are alcohol-related, which increases to 70% at weekends (Prime Minister's Strategy Unit, 2003). A 2009 audit at St James' Hospital, Leeds observed that 21.4% of general medical admissions via A&E were alcohol-related (NHS Confederation and Royal College of Physicians, 2010).

There is a need for initiatives to be coordinated. Brief Interventions are most effective if they are organised systematically and with a clear pathway. This requires a hospital team with links to an area alcohol team.

Robin Touquet and colleagues in the Emergency department at St Mary's Hospital, London 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 (AHW). The AHW gave brief intervention and education, which resulted in a reduction of 43% in alcohol consumption. Every two referrals to the AHW resulted in one fewer reattendance during the following year. If patients are offered an appointment with the AHW on the same day, almost two-thirds attend. If the appointment is delayed for longer than 48 hours, only 28% attend. Hence, the intervention needs to be immediate (R Touquet et al, 2009).

A Cochrane review by Kaner et al found that Brief Interventions lowered alcohol consumption in one year of follow up.

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## Gate 2: Quality outcomes

### Impact on clinical quality

Clinical quality is expected to improve as the alcohol team will allow time to be freed up from reducing admissions and readmissions. It would be reasonable to expect that the targeted alcohol work would also improve outcomes for individual patients.

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<b>Impact on patient safety</b>	Treatment by a specialist alcohol team will mean that patients' problems are addressed more effectively and hence this may reduce future adverse events for individual patients.
<b>Impact on patient and carer experience</b>	Avoidance of admission or readmission to hospital will theoretically improve 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 re-admissions and be placed on a clinical pathway, whereas at present, many are frequent flyers and discharged without their underlying problems being addressed (See Contacts and resources section).

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## Gate 3: Evidence of effectiveness

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<b>Evidence base for initiative</b>	Based on NHS Evidence accredited guidance. NICE Guideline on 'alcohol-use disorders: preventing harmful drinking' (see Contacts and resources for link)
<b>Evidence of deliverable from implementation</b>	Example is based on experience in one or more organisations that have had systematic follow up and reporting of results. See below for details.
<b>Where implemented</b>	<p>NHS England. Various NHS hospitals have adopted different ways of introducing a specialist alcohol team. In many cases, schemes have been piloted and proved to make savings before being introduced. Examples follow. Please see Contacts and resources section for evidence.</p> <p>The Royal Bolton Hospital NHS Foundation Trust has a very well developed alcohol team, which systematically uses Brief Interventions and has strong links to community teams. The Royal Bolton Hospital collaborative care for alcohol- related liver disease and harm is a multidisciplinary team that consists of a Consultant Gastroenterologist, Liaison Psychiatrist, Psychiatric Alcohol Liaison Nurse, Liver Nurse Practitioner and all relevant health care professionals, including the dedicated social worker (K. J. Moriarty, 2010).</p> <p>The alcohol specialist nurses (ASNs), on a daily basis, jointly assess all alcohol-related admissions, provide brief advice to patients and initiate care plans. Patients are offered rapid outpatient appointments with the Community Alcohol Team, and/or detoxification starting in the hospital. A dedicated social worker greatly influences the average length of stay and facilitates discharge of the patient into a suitable environment. The nurses run their own liver disease course for staff and a network of 50 alcohol link workers throughout the Trust has been established.</p> <p>Inpatient detoxifications have been reduced, saving the Trust more than 1,000 bed days annually, equating to £250,000 in reduced admissions alone. Allied to this, the two ASNs supervise and optimise</p>

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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. In the 6 month pilot, this innovation has facilitated 541 discharges from the gastroenterology ward, compared to 355 in the comparable period last year, a 52% increase.

The annual cost to the Royal Bolton Trust, including all add-on-costs, of the two Band 6 nurses, with secretarial support, is £90,500. Therefore, the 2 ASNs, by reducing admissions and facilitating discharges, save the Trust around £350,000 annually.

This 5-day ASN service is therefore producing savings very similar to those predicted in the North West Chief Executives' Challenge, which proposes a 7-day ASN service. This would mean that nurses would continue to supervise the care of inpatients, but would now also see patients presenting to Accident and Emergency Units, a particular priority at week-ends. Clearly, this will reduce admissions and readmissions and enhance quality of care out-of-hours.

**New Way of Working.** In order to cope with the large numbers of inpatients with alcohol-related problems, the 4 Gastroenterology Consultants now work 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. This has had a dramatic effect. There has been a 52% increase in ward discharges, length of stay has fallen from 8 days to 5.7 days, and mortality from 11.9% to 8%. The downside has been that, during these two weeks, the consultant on the ward loses 10 endoscopy and out-patient clinic sessions.

The implementation of such an enhanced, consultant-led, clinical "Alcohol Care Team" clearly requires consultant gastroenterology and hepatology expansion to disseminate this quality initiative to improve health outcomes and patient-centred care.

Robin Touquet and colleagues at St Mary's Hospital, London have engaged and trained staff to use the Paddington Alcohol Test 2009 (PAT) to give Brief Intervention, education, audit and feedback to patients presenting to A&E.

Brief Intervention packs have been developed at Newcastle.

The Royal Liverpool Hospital has pioneered an extension of the role of Alcohol Specialist Nurses from A&E to inpatient care, preventing 150 admissions per year. The role of ASNs in Liverpool has since been further developed into a Nurse-led Alcohol Services Lifestyle Team, with daily clinics in different locations in the city. They provide access for GPs to refer patients to the service (see the DH Alcohol Learning

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Centre [www.hubcapp.org.uk/TUL3](http://www.hubcapp.org.uk/TUL3) for more details).

An Alcohol Specialist Nurse was appointed at the United Bristol Healthcare Trust in 2006. A part-time pilot in the hepatology unit proved cost-effective, through a reduction in readmission rates and it also led to positive health outcomes for the patients. The ASN has been implementing AUDIT into six targeted wards: hepatology, medical gastroenterology, surgical gastroenterology, surgical and trauma/orthopaedics. The ASN also organised the first UBHT Alcohol Awareness Day in 2006 and further consolidated linkages with alcohol services throughout Bristol. The ASN works closely with an Alcoholics Anonymous (AA) link worker in the hospital, with AA meetings being held every Monday.

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

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

## NEED FOR A 7-DAY ALCOHOL SPECIALIST NURSE SERVICE

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

A 7-day ASN service is not a 168 hour/week service, which would be neither appropriate, nor financially viable. The nurses would provide access to brief interventions and appropriate services within 24 hours of diagnosis, usually the morning after admission, when engagement with the patient is possible. In the Emergency Department, the primary aim of the attending doctor is to deal with the patient's presenting problem. Where indicated, the doctor then performs the 1-minute Paddington Alcohol Test. If an alcohol-related problem is detected, an appointment with an alcohol specialist nurse is arranged within 24 hours.

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A hospital requires a minimum of 4 Alcohol Specialist Nurses to provide a 7-day rota. It suits some nurses, with family commitments, to work at week-ends. In essence, it would involve a clinic on a Saturday and Sunday morning to see the A & E attenders, followed by a review of admissions to the Acute Medical Unit.

The nurses would require a skill mix of mental health, liver and accident and emergency experience, and the competencies to recognise liver disease and psychiatric disorders, especially depression, at an early stage. Where appropriate, two hospitals might provide a combined rota, or a combined hospital and community nurse service could be developed, as in Liverpool.

The 7-day Alcohol Specialist Nurse Service cares for the patient cohort staying in hospital for 0-1 day. However, specialist nurses also supervise inpatient care and reduce length of stay. Moreover, liver nurse practitioners play a major role in the care of hepatology patients, both in hospital and following discharge. The nurse job description should include health education and promotion for patients, families and an alcohol link workers' network, which they should establish throughout the Trust.

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## Degree to which the actual benefits matched assumptions

Implementation of an ASN 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 (S.D.Ryder, 2010).

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. Nurse- led follow-up attendance was high in both groups (see Appendix 1 ).

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## If initiative has been replicated how frequently / widely has it been replicated

Different elements of an alcohol team approach have been introduced in different places, as outlined above. What is needed is for these to be brought together into coherent local care management pathways.

The three NICE guidelines offer hope for improving alcohol care services, but a push is needed to ensure that best practice is adopted.

Salford Royal NHS Foundation Trust is piloting their "Assertive Outreach Alcohol Service". This has already resulted in a 15% reduction in alcohol-related hospital admissions and readmissions.

There is also evidence to support a positive role for Alcohol Specialist Nurses in inpatient care. Pioneered at the Royal Liverpool Hospital, the appointment resulted in:

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- a reduction in the average alcohol consumption of patients treated
- earlier patient discharge
- reduced re-attendances
- improved staff attitudes and knowledge.

The report found that an Alcohol Specialist Nurse saved £175k of hospitals' costs over 20 months, preventing 150 admissions per year. Preventing the admission of 30 patients covers the salary of one ASN for one year.

The NICE Guidance on 'alcohol-use disorders: preventing harmful drinking' contains many examples of cost savings and cost-effectiveness. The real impact of these changes will be made if they are introduced in concert - using Brief Interventions systematically and creating a cross-sector pathway between hospital and community. Critically, there is a need for leadership and a team taking responsibility for managing alcohol problems.

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## Supporting evidence for Gate 3

The report " Alcohol-related Disease: Meeting the challenge of improved quality of care and better use of resources" sets out a detailed plan for the management of people admitted to hospital with alcohol-related problems and is available at <http://www.bsg.org.uk/clinical/publications/alcohol-related-disease-2010.html>

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## Gate 4: Details of implementation

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### Implementation details

Using the latest healthcare economic modelling techniques, this management initiative, strongly supported by commissioners, clinicians, social services and the voluntary sector, was convinced of the major cost benefits, in terms of reduced admissions and readmissions and enhanced quality of care, if dedicated alcohol teams were established. This is being borne out by the Salford Royal pilot.

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### Time taken to implement

Can be achieved in the medium term: 3 months - 1 year. Pilot implemented all stages in 6 months.

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### Ease of implementation

Affects a whole organisation across a number of teams or departments. The whole of the hospitals or PCT are affected.

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### Level of support and commitment

Many Trusts recognise that addressing alcohol-related admissions and disease is their Number One priority. This is particularly evidenced by the recent DH funding for Reablement, linked to hospital discharge.

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### Barriers to

Leadership and partnership between clinicians, chief executives

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<b>implementation</b>	and commissioners are critical in establishing alcohol teams and ensuring their success.  Time is also needed to allow all stakeholders to focus on cost-cutting problems, which will need to be recognised within job plans.
<b>Risks</b>	The main risks are the resource of the team members. Reticence to deploy these differently has been overcome by pilots, which have demonstrated cost savings.
<b>Supporting evidence for Gate 4</b>	No further information provided

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## Further evidence

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<b>Dependencies</b>	There has been a reluctance to use Brief Interventions systematically, due to the lack of targeted funding. However, for every eight people who receive simple alcohol advice, one will reduce their drinking to within lower risk levels. This compares favourably with smoking, where only one in twenty will act on the advice given. Brief Interventions work well (DH, 2005)
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## Contacts and resources

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<b>Contacts and resources</b>	<p>If you require any further information please email: <a href="mailto:contactus@evidence.nhs.uk">contactus@evidence.nhs.uk</a> and we will forward your enquiry and contact details to the provider of this case study. Please quote QIPP reference 10/0021 in your email.</p> <p>NICE Guideline on 'alcohol-use disorders: preventing harmful drinking' <a href="http://guidance.nice.org.uk/PHG/Wave15/1">http://guidance.nice.org.uk/PHG/Wave15/1</a> D Ward, N Murch, G Agarwal, D Bell. A multicentre survey of inpatient pharmacological management strategies for alcohol withdrawal. QJM 2009; 102(11): 773-780 DH. The cost of alcohol harm to the NHS in England: an update to the Cabinet Office 2003 Study. London: 2008 NHS Confederation and Royal College of Physicians. Too much of the hard stuff: what alcohol costs the NHS. London: 2010 J Jewell, N Sheron. Trends in European liver death rates. Implications for alcohol policy. Clinical Medicine 2010; Vol 10, No 3: 259-263 <a href="http://www.statistics.gov.uk/pdfdir/ghs.0110.pdf">http://www.statistics.gov.uk/pdfdir/ghs.0110.pdf</a> DH. The Annual Report of the Chief Medical Officer of the Department of Health. London: 2001 Royal College of Physicians. Alcohol – can the NHS afford it? Recommendations for a coherent alcohol strategy in hospitals. London: Royal College of Physicians, 2001 K.J. Moriarty. Alcohol-Related Disease: meeting the challenge of improved quality of care and better use of resources. 2010. A Joint</p>
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Position Paper on behalf of the British Society of Gastroenterology, Alcohol Health Alliance UK & British Association for Study of the Liver. [http://www.bsg.org.uk/images/stories/docs/clinical/publications/bsg\\_alc\\_disease\\_10.pdf](http://www.bsg.org.uk/images/stories/docs/clinical/publications/bsg_alc_disease_10.pdf) )

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R Touquet, A Brown. Revisions to the Paddington Alcohol Test for early identification of alcohol misuse and brief advice to reduce emergency department re-attendance. *Alcohol & Alcoholism* 2009; 44(3): 284-6

EF Kaner, HO Dickinson, FT Beyer, et al. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews* 2007, Issue 2

K. J. Moriarty. Collaborative liver and psychiatry care in the Royal Bolton Hospital for people with alcohol-related disease. *Frontline Gastroenterol* Published Online First: 23 December 2010 doi:10.1136/fg.2010.002105.

Brief intervention pack, Newcastle example, <http://ncl.ac.uk/ihs/enterprise/>

AA intervention, [www.hubcapp.org.uk/QAM2](http://www.hubcapp.org.uk/QAM2)

S.D.Ryder, G.P.Aithal, M.Holmes, M. Burrows, N.R.Wright. Effectiveness of a nurse-led alcohol liaison service in a secondary care medical unit. *Clin Med* 2010; 10(9):435-40.

DH. Alcohol Needs Assessment Research Project (ANARP): the 2004 national alcohol needs assessment for England. London: 2005

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ID: 10/0021

Published: February 2011

Review due: February 2012

## Appendix 1: Figures 1 and 2

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

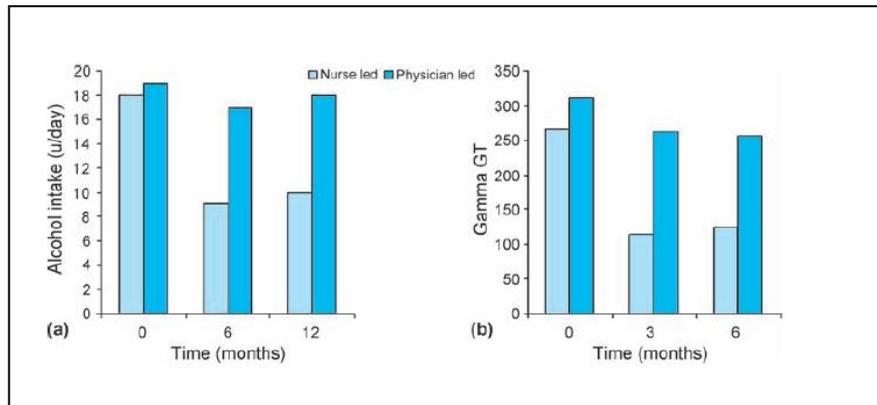


Figure 2: Impact of Nurse-led Alcohol Care Team on admissions to hospital for alcohol withdrawal. The service was introduced in Q2. (Q1 etc refer to 3-month periods from 2002). Ryder et al, 2010

