ALCOHOL-RELATED DISEASE

Meeting the challenge of improved quality of care and better use of resources

Lead Author
KIERAN J. MORIARTY

Co-Authors
Paul Cassidy
David Dalton
Michael Farrell
Ian Gilmore
Christopher Hawkey
Francis Keane

Kevin Moore
Lynn Owens
Jonathan Rhodes
Don Shenko
Nick Sheron

A Joint Position Paper on behalf of the

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

The full report can be accessed at
www.bsg.org.uk/clinical/general/publications.html
# Key Recommendations

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

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

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

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

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

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

Recommendations

Our principal recommendation is for a multidisciplinary “Alcohol Care Team” in each District Hospital, led by a Consultant, with dedicated sessions, who will also collaborate with Public Health, Primary Care Trusts, patient groups and key stakeholders, to develop and implement a district alcohol strategy.

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

Each health district should establish a hospital-led, multi-agency “Assertive Outreach Alcohol Service (AOAS)” to move the most frequent attenders and biggest consumers of hospital resources into a more
appropriate, supported, community environment. The AOAS team might include an emergency physician, acute physician, psychiatric crisis team member, alcohol specialist nurse, Drug and Alcohol Action Team member, hospital/community manager and Primary Care Trust Alcohol Commissioner, with links to local authority, social services and third sector agencies and charities.

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

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

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

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

In order to facilitate this, training modules should be established, run jointly for psychiatrists and physicians, including hepatologists, gastroenterologists, A & E and acute physicians and for alcohol and mental health specialist nurses. They would focus on the assessment and treatment of both the psychiatric and medical aspects of alcohol-related problems, substance and drug misuse and addiction. Accreditation of competencies at a national level should be developed for clinicians, nurses and for Units treating people with alcohol-related disease.
There needs to be targeted research into the causes, prevention and treatment of alcohol-use disorders, especially liver disease, as well as educational initiatives to maximise the effectiveness of public awareness and deterrence and bring about a change in social attitudes and our drinking culture. Clinical trials are needed to assess the efficacy of pharmacological and psychosocial interventions, which may assist abstinence. Cost-effective alcohol strategies, including the Department of Health “High Impact Changes,” should be implemented, with sharing of model practice via the National Treatment Agency for Substance Misuse and the Department of Health Alcohol Learning Centre.

**Future Care**

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

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

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

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

1 Kieran Moriarty. Consultant Gastroenterologist, Royal Bolton Hospital, British Society of Gastroenterology (BSG) Alcohol Lead, Member of Alcohol Health Alliance UK (AHA UK).
2 Paul Cassidy. GP Associate Medical Director, NHS South Tyne and Wear.
3 David Dalton. Chief Executive, Salford Royal NHS Foundation Trust.
4 Mike Farrell. Chair, Faculty of Addictions, Royal College of Psychiatrists, Reader in Psychiatry, Institute of Psychiatry, London, Member AHA UK.
5 Ian Gilmore. President of the Royal College of Physicians of London, Chair AHA UK.
6 Chris Hawkey. Professor of Gastroenterology, University of Nottingham, BSG President (2009-10).
7 Francis Keaney. Consultant Addiction Psychiatrist, Institute of Psychiatry, King’s College London, Member AHA UK.
8 Kevin Moore. Professor of Hepatology, Royal Free Hospital, London.
9 Lynn Owens. Nurse Consultant, University of Liverpool, Clinical Lead for Alcohol Services, Liverpool PCT.
10 Jonathan Rhodes. Professor of Medicine, University of Liverpool, BSG President (2010-12).
11 Don Shenker. Chief Executive, Alcohol Concern.
12 Nick Sheron. Consultant Hepatologist, University of Southampton, Vice Chair AHA UK.
14 Wendy Darling. Consultant Psychiatrist in Alcohol and Substance Misuse, Royal Bolton Hospital.
15 Chris Day. Professor of Hepatology, Newcastle University Hospitals.
16 Department of Health North West. Alison Wheeler, Regional Alcohol Programme Manager and Hazel Parsons, Head of Advocacy & Communications.
17 Dipak Fatania. Asian Link Worker, Royal Bolton Hospital.
18 Jan Freeman. Consultant Gastroenterologist, Derby City General Hospital, Chair Liver Section of the BSG.
19 Richard Gardner and Surinder Gill. Luther Pendragon Communications.
20 Peter Hayes. Professor of Hepatology, Edinburgh, President British Association for Study of the Liver (BASL).
21 Mike Hellier. Past-President, BSG, Author BSG Strategy Document.
22 Ruth Hussey. Department of Health and NHS North West Regional Director of Public Health/Senior Medical Director.
23 Rajiv Jalan. Consultant Hepatologist, University College, London, Secretary of BASL.
24 Eileen Kaner. Professor of Public Health Research, Newcastle University.
25 Stephen Liversedge. Chair Professional Executive Committee, NHS Bolton, Lead Local Enhanced Service for Alcohol.
26 Duncan Loft. Consultant Gastroenterologist, University Hospital, Coventry, Chair Clinical Services and Standards Committee, BSG.
27 Gerald Prescott. Patient Representative.
28 Alison Rogers. Chief Executive, British Liver Trust.
29 Royal Bolton Hospital and Bolton Community Alcohol Nursing Team – Sandra Crompton, Emma Dermody, Julie Aulton.
30 Stephen Ryder. Consultant Hepatologist, University Hospital, Nottingham, Secretary Liver Section of the BSG.
31 Jonathan Shepherd. Professor of Oral and Maxillofacial Surgery, Director Violence Research Group, Cardiff University.
32 Ajith Siriwadena. Professor of Hepatopancreatobiliary Surgery, Central Manchester Hospitals.
34 Tom Smith. Chief Executive, BSG.
35 Patricia Suarez. Senior Policy Adviser, NHS Confederation.
36 David Thompson. Professor of Gastroenterology, Salford Royal NHS Foundation Trust.
37 Robin Touquet. Professor of Accident & Emergency Medicine, St Mary’s Hospital, London.
38 Lynda Waters. Patient Representative, British Liver Trust.
39 John Williams. Professor of Health Sciences Research, Swansea University School of Medicine.
40 Members of Council and Executive of the BSG, AHA UK and BASL.
**British Society of Gastroenterology, Alcohol Health Alliance UK and the British Association for Study of the Liver**

The British Society of Gastroenterology (BSG) is a professional society, with a multidisciplinary membership, focused on the promotion of high standards in clinical services, research and education in gastroenterology and hepatology within the UK. [www.bsg.org.uk](http://www.bsg.org.uk)

The Alcohol Health Alliance UK (AHA UK) is a group of 25 organisations (see list below), whose mission is to reduce damage caused to health by alcohol misuse. [www.rcplondon.ac.uk/professional-issues/public-health/pages/alcohol.aspx](http://www.rcplondon.ac.uk/professional-issues/public-health/pages/alcohol.aspx)

The British Association for Study of the Liver (BASL) is the primary organisation for hepatologists and scientists working in hepatology within the UK, and works closely with the BSG. [www.basl.org.uk/](http://www.basl.org.uk/)

Members of the Alcohol Health Alliance UK

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

**ACKNOWLEDGEMENT**

To Alison Addis for her patience and forbearance in typing this paper.
Trends in Standard Death Rates for major diseases since 1970. Data are from the World Health Organisation Health for All Database. Death rates normalised to 100% in 1970 (courtesy of Dr. Nick Sheron). www.euro.who.int/HFADB