EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO: **BOARD OF DIRECTORS MEETING**

DATE: **29 JANUARY 2015**

SUBJECT: **ALCOHOL: NCEPOD SELF-ASSESSMENT FOR EKHUFT**

REPORT FROM: **MEDICAL DIRECTOR**

PURPOSE: **Decision**

CONTEXT / REVIEW HISTORY / STAKEHOLDER ENGAGEMENT

Alcohol is an increasing public health problem incurring significant and potentially avoidable health economy expenditure. Alcohol-related disease has been a priority for public health for several years and implementation of proposed solutions requires a whole health economy approach.

SUMMARY:

The NCEPOD report 'Measuring the Units: A review of patients who died with alcohol-related liver disease' was published in 2013. The attached paper details the key recommendations from the report and a self-assessment against the key NCEPOD recommendations prepared by Dr Anne Ballinger, Consultant Gastroenterologist.

RECOMMENDATIONS:

Development of a comprehensive alcohol related disease service is required within the Trust. This service should link with the Kent Community Alcohol Partnerships (KCAPs) and other relevant services within the community.

NEXT STEPS:

Complete a gap analysis of alcohol related disease services across the Trust to inform how the service should be structured and how each site will link into community services.

IMPACT ON TRUST'S STRATEGIC OBJECTIVES:

Reduction in readmissions related to alcohol related disease

LINKS TO BOARD ASSURANCE FRAMEWORK:

AO1: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care

AO6: Drive increased efficiency and effectiveness of Trust corporate led services and through the implementation of major infrastructure projects A08: Information: Engage with the divisions to develop and provide clinical information to support strategic decision making.
IDENTIFIED RISKS AND RISK MANAGEMENT ACTIONS:
FINANCIAL AND RESOURCE IMPLICATIONS: To be determined
LEGAL IMPLICATIONS / IMPACT ON THE PUBLIC SECTOR EQUALITY DUTY:
PROFESSIONAL ADVICE TAKEN ON ANY NOVEL OR CONTENTIOUS ISSUES
ACTION REQUIRED: Discuss and agree recommendation.
CONSEQUENCES OF NOT TAKING ACTION: Continued increase in alcohol related disease length of stay and continued increased standardised readmission ratio for alcohol related disease

Introduction

Alcohol misuse encompasses alcohol related illness and injuries together with significant social impacts such as crime, violence, teenage pregnancy, loss of workplace productivity and homelessness. Excessive drinking is a major cause of disease, accounting for 9.2% of disability-adjusted life years (DALYs) worldwide with only tobacco smoking and high blood pressure as higher risk factors.

Health inequalities are clearly evident as a result of alcohol-related harm; alcohol-related death rates are about 45% higher in areas of high deprivation, and liver disease represents one of the few diseases where the inequalities gap is increasing.

Nationally alcohol misuse is estimated to cost £22 billion overall, £3.5 billion on health costs, £11 billion on crime and £7.3 billion on lost productivity. In England alcohol causes 1.1million hospital admissions, and contributes to 1.2million incidents of violent crime a year, 40% of domestic violence cases, and 6% of all road causalities.

Costs to the NHS of alcohol harm is predominantly born by acute hospital care (78.3%) followed by ambulance services (13.8%) and primary care (4.1%), while specialist alcohol services account for just 2.0% of the total cost.

Liver disease is the 5th largest cause of death in the UK. The average age of death from liver disease is 59 years, compared to 82-84 years for heart & lung disease or stroke, with a 5-fold increase in the development of cirrhosis in 35-55 year olds over the last 10 years (Moriarty, 2010). Effective prevention strategies or treatments are available for alcohol misuse, which is one of the three main causes of liver disease; these strategies decrease the risk of developing cirrhosis, liver cancer and their associated mortality.

Kent Data

1. Kent County Council have estimated health costs (actual and modelled data that includes diagnosis codes for wholly/partially attributable admissions, primary care consultations, emergency admissions, ambulance costs, prescribing, treatment services) for South Kent Coast at £15.76 million per year which equates to £96 per person per year (16+ population) and for Thanet at £11.49 million per year, £100 per person.
2. In 2010-11 the equivalent of 1,543 people per 100,000 population in Kent were admitted to hospital for alcohol related harm (approximately 22,620 people).
3. Between month 6 2013-14 to month 6 2014-15 the average length of stay for emergency admission following alcoholic liver disease in EKHUFT has increased from 8.2 days to 11.0 days, the standardised ratio of emergency readmissions is 119.2%.
4. 23.1% of the population over 16 years old are estimated to be at increasing or higher risk of drinking across Kent, higher than the England average of 22.3% and equating to 272,258 people.
5. In Kent, it is estimated that 173,410 people binge drink, increasing their risk of acute health harms including accidents, and contributing to other social harms in the local community
6. All areas of East Kent have high levels of indicators of alcohol misuse in comparison with the rest of the country, Thanet is the district that has the highest levels for all indicators and is the area with the greatest level of alcohol misuse. Thanet is the sixth worst local authority in England for chronic liver mortality.

What Works?

Evidence based high impact changes are recommended by the Department of Health to reduce hospital admissions for alcohol-related harm. The most appropriate intervention recommended for dependent drinkers is structured psychosocial intervention with inpatient or community detoxification if also required. Increasing risk and higher risk drinkers benefit from brief advice given by generic workers in almost any setting. A Cochrane Collaboration review (Kaner et al., 2007) showed substantial evidence for identification and brief advice (IBA) effectiveness. A study by Moyer et al (2002) showed that for every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels. NICE recommend identification of increasing risk drinkers is made using AUDIT, initially a simple 3 question tool (AUDIT-C) to identify patterns and levels of drinking. A draft report by Public Health (2014 – 2016) on alcohol services describes working with commissioners to industrialise routine delivery of IBA across all health, community and social care settings.

The Substance Misuse Team at QEQM, Margate

Kent County Council have invested in a 2 year pilot study at QEQM based on the data shown for the national, and specifically Thanet, problem of alcohol misuse. The funding also covered substance misuse but only alcohol is referred to in this summary.

The pilot study began in February 2014. Funding was provided for 1 x band 7 nurse and 3 x band 6 nurses to form a Substance Misuse Team based at QEQM. The team has senior nursing input from Sally Moore (Senior Matron for Medicine) and clinical input from Dr Anne Ballinger (Consultant Gastroenterologist).

The aim of the pilot specifically in relation to alcohol is to implement AUDIT screen of all patients (irrespective of age or speciality) attending QEQM, provide brief advice for those misusing alcohol and to link with community services (Turning Point) for ongoing and outpatient care.

The implementation of AUDIT across all specialities has required training at many levels and alteration of pathway documents to include AUDIT. The team have also developed a protocol for outpatient detoxification of patients who are admitted with alcohol withdrawal and have provided specialty advice for patients admitted with complicated alcohol related problems such as alcoholic hepatitis.

Data collection began in April 2014 after some initial staff training and pathway development. The data described is for the period April – December 2014:

1. 457 patients seen by Substance Misuse Team
2. 382 Brief interventions delivered
3. 108 patients referred to Turning Point (for comparison, in the year before this pilot study only 9 patients were referred to Turning Point across the whole Trust).

Routine AUDIT-C screen of every patient has been achieved in endoscopy, maternity and surgical admissions.

AUDIT-C forms part of the admission booklet in medicine and by education and teaching completion of AUDIT-C is becoming more wide spread.

Routine AUDIT-C screen has been difficult to achieve in A+E where the need is greatest.

Kent Alcohol Strategy 2014-2016

The Kent Alcohol strategy details a 6 point pledge for reducing alcohol related harm in Kent:

1. Improve Prevention and Identification
2. Improve the Quality of Treatment
3. Co-ordinate Enforcement and Responsibility
4. Tailor the plan to the local community
5. Target Vulnerable groups and Tackle Health Inequalities
6. Protect Children and Young People

The report identifies areas where improvement is needed, particular areas of overlap with EKHUFT services include screening and brief interventions for hazardous and harmful drinkers in non-alcohol-specialist settings such as A & E, better communication and public awareness, and identification of the additional needs of adults and young people presenting at A & E who are misusing alcohol.

Self-assessment Against Key Recommendations From NCEPOD

1. All patients presenting to hospital services should be screened for alcohol misuse. An alcohol history indicating the number of units drunk weekly, drinking patterns, recent drinking behaviour, time of last drink, indicators of dependence and risk of withdrawal should be documented.

   Barely met, the AUDIT score is in the admission booklet for medical patients only and not other specialities e.g. surgery. AUDIT is actually completed only 25% of the time (audit data QEQM) and the AE staff (QEQM) have at times refused to complete it. Audits to assess compliance have not been completed on other sites.

2. All patients presenting to acute services with a history of potentially harmful drinking, should be referred to alcohol support services for a comprehensive physical and mental assessment. The referral and outcomes should be documented in the notes and communicated to the patient's general practitioner.

   Not met, this requires a team set up as described with dedicated and funded sessions

3. Each hospital should have a 7-day Alcohol Specialist Nurse Service, with a skill mix of liver specialist and psychiatry liaison nurses to provide comprehensive physical and mental assessments, Brief Interventions and access to services within 24 hours of admission

   Partially met, the alcohol specialist nurse team need to be funded on each site with sufficient staff to provide 7 day week cover.

4. A multidisciplinary Alcohol Care Team, led by a consultant with dedicated sessions, should be established in each acute hospital and integrated across primary and secondary care.

   Not met, this requires a team set up as described with dedicated and funded sessions.

5. All patients admitted with decompensated alcohol related liver disease should be seen by a specialist gastroenterologist / hepatologist at the earliest opportunity after admission. This should be within 24 hours and no longer than 72 hours after admission to hospital.

Largely met, due to a ward/speciality based system patients with alcohol related liver disease are taken over by the gastroenterology team within 24 hours for most and by 72 hours at weekends.

6. Escalation of care should be actively pursued for patients with alcohol-related liver disease who deteriorate acutely and whose background functional status is good. There should be close liaison between the medical and critical care teams when making escalation decisions.

   This is best met at QEQM where patients admitted with alcohol related liver disease are taken over by a gastroenterologist and an alcohol specialist nurse and community services (Turning Point in reach) review them on the ward. This does not happen on the other two sites.

Conclusion and Recommendations

Alcohol-related disease is a major burden for the health economy and East Kent has a particular problem in comparison with the rest of the country.

Self-assessment against key NCEPOD criteria indicates a clear need for the development of an alcohol related disease service within the Trust. This service should be of a level to meet the key recommendations in the NCEPOD report and link with the Kent Community Alcohol Partnerships (KCAPs) and other relevant services within the community in order to reduce admissions, reduce length of stay and improve outcomes from alcohol-related disease.

References

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Measuring the Units: A review of patients who died with alcohol-related liver disease. A report by the National Confidential Enquiry into Patient Outcome and Death (2013).

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Moyer A, Finney JW, Swearingen CE, Vergun P. (2002) Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. Addiction. Mar;97(3):279-92