Public Health England

NHS

Alcohol Care Teams: Core Service Descriptor

This resource has been jointly developed by NHS England and NHS Improvement and Public Health England, based on the evidence for effectiveness of alcohol care teams in acute hospital settings.

Equality and Health Inequalities Statement
Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

November 2019

Purpose of this resource

This resource is for NHS commissioners, acute trusts and their local partners wishing to implement or improve alcohol care teams (ACTs) in order to deliver the optimal benefits in helping patients reduce alcohol-related harm. This guideline provides the best available evidence on how an alcohol care team should be configured. Local areas are asked to reflect on their current provision and use this resource to help improve services. Sections of the document can be used directly as in-service specifications or adapted as needed.

Background

Alcohol causes a wide range of conditions including cardiovascular disease, cancers and liver disease, as well as contributing to harm from accidents, violence and self-harm. Over 1.1 million hospital admissions each year have alcohol as a causal factor in the patient's diagnosis.

Dependent drinkers are at the highest risk of alcohol-related conditions. Baseline data for the preventing ill health CQUIN indicates that around 4% of inpatients screen positive for alcohol dependence versus 1.4% in the general population.

A NICE evidence based case study provides good evidence that ACTs that provide specialist interventions to alcohol-dependent inpatients, reduce avoidable bed days and readmissions. The NHS Long Term Plan makes a commitment to support those hospitals with the highest rate of alcohol dependence-related admissions to establish ACTs in line with the core service model.

Aims of the optimal ACT

ACTs are teams of alcohol specialist clinicians, based in acute hospitals which provide specialist support, predominantly to alcohol-dependent patients. They aim to:

- reduce avoidable alcohol-related hospital admissions by reducing severe health risk among dependent drinkers
- reduce the length of stay for inpatients by improving the management of withdrawal
- provide appropriate, timely, meaningful education and support for those attending or being admitted with alcohol-related problems
- facilitate integrated alcohol care between secondary, primary and community

care providers

- provide psychosocial interventions to support dependent drinkers to sustain abstinence following discharge
- improve compliance with the trust's alcohol withdrawal guidelines
- educate staff on alcohol use disorder and its management
- improve information sharing between services (e.g. secondary care, primary care and community services)
- improve data collection and opportunities for analysis.

Core service components

A multi-disciplinary ACT should be able to provide packages of care that include:

- case identification/alcohol identification and brief advice (IBA)
- comprehensive alcohol assessment
- specialist nursing and medical care planning
- management of medically-assisted alcohol withdrawal (MAW)
- provision of psychosocial interventions
- planning safe discharge, including referral to community services
- clinical leadership by a senior clinician with dedicated time for the team
- provision of trust-wide education and training in relation to alcohol.

Key operating principles of the ACT

A&E presentations

The ACT will assess patients presenting to A&E with acute intoxication, in acute alcohol withdrawal or with alcohol-related complications (see NICE CG100).

Patients not ready to be fully assessed e.g. intoxicated should receive an initial assessment for risk that would require immediate admission. See NICE CG115 – 1.2.2.5.

Patients in acute withdrawal will be admitted and the ACT will stabilise their condition and manage MAW as appropriate to their needs. Patients presenting with other alcohol-related complications will be assessed by the ACT, who will contribute to their care plan.

Inpatients

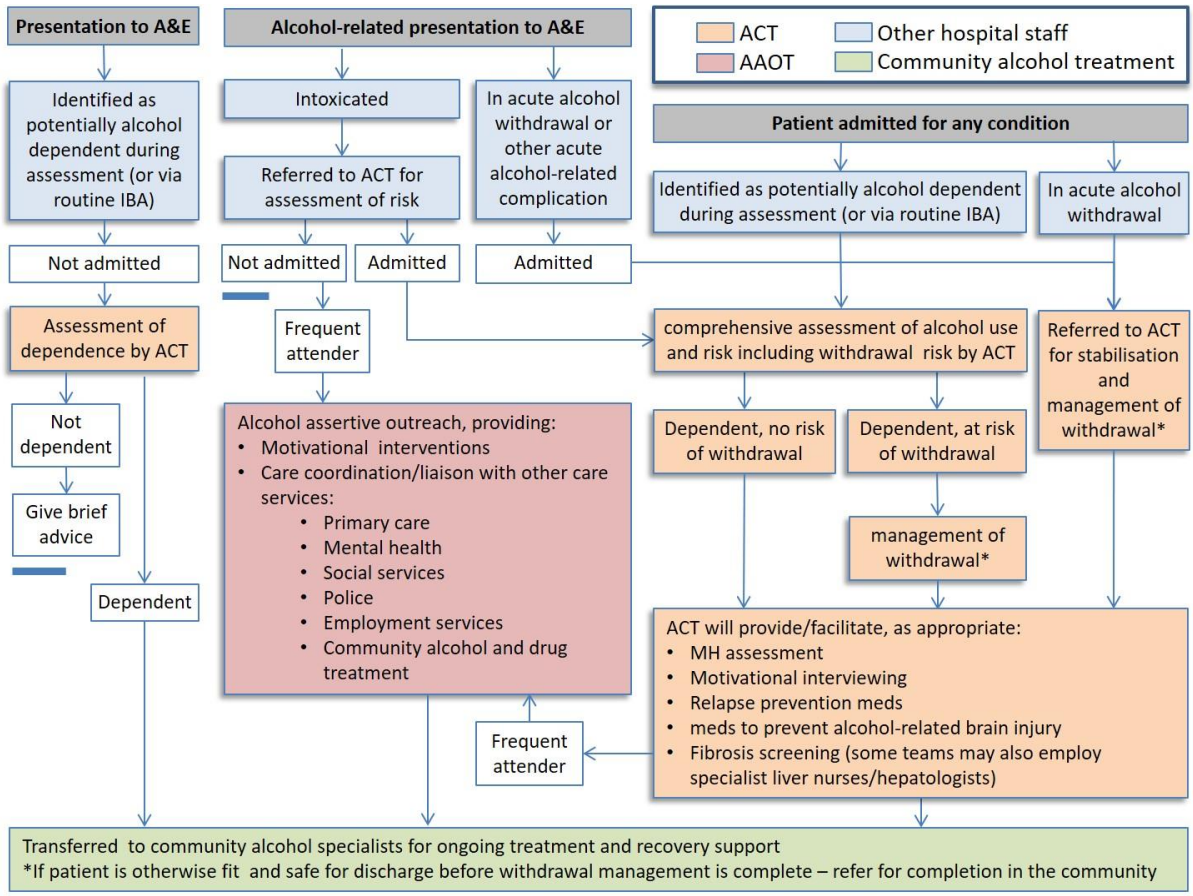
Inpatients admitted for any condition who are identified as possibly alcohol-dependent via routine screening will be referred to the ACT to undertake a comprehensive alcohol assessment. See NICE CG115 – 1.2.2.6.

Based on the assessment outcome, the ACT will contribute an alcohol care plan, integrated with the care plan for any other presenting condition. An alcohol care plan may include:

- a medication regimen to support MAW (see NICE CG100)
- medication to support sustained abstinence or consumption reduction (see NICE CG115)
- Thiamine to reduce risk of alcohol related brain injury (see NICE CG100)
- screening for liver fibrosis (see NICE NG50)
- specialist mental health assessment
- psychosocial interventions to support engagement with community alcohol treatment (see NICE CG115 -1.3).

All alcohol-dependent patients will be referred to specialist alcohol support in the community for continuation of alcohol treatment on discharge. When patients are medically fit for discharge before their MAW is complete, the ACT will advise on the appropriateness of completion of MAW in the community on a case by case basis, based on comprehensive assessment.

Role of Alcohol Care Teams in the pathway for alcohol dependent patients



Establishing the ACT within the local alcohol harm reduction system

To have the best chance of abstaining from alcohol, patients identified as alcohol-dependent need to receive coordinated, seamless support from the health and social care system. To facilitate seamless care, the ACT needs to be part of an integrated system of alcohol interventions across primary and secondary care and the community.

Any break in support is likely to lead to unsuccessful attempts to sustain abstinence and related ill health (see developing pathways for referring patients from secondary care to specialist alcohol treatment).

To ensure integration:

- ACTs should be planned jointly with local authority and other relevant partners
- ACT staff should develop and operate within a well-coordinated joint working

programme with services providing ongoing community support for dependent drinkers

- ACT team leaders should work closely with community alcohol services to agree on discharge pathways, so that patients transfer seamlessly to specialist support to sustain abstinence
- community alcohol services should in-reach into the hospital to prepare patients for transfer
- joint governance and oversight with clear lines for escalation for any clinical/service issues should be in place.

Defined relationships with the following teams are advised:

Acute	Community	Primary Care	Voluntary sector
A&E Complex discharge Mental health Primary care Social services Smoking cessation support Substance misuse	Alcohol treatment services Mental health	GP	Alcohol specific charities Homeless charities Mental health charities

Staffing

To achieve the improvements in patient care and reductions in demand on services, specialist alcohol care should be available for patients who need it in every inpatient ward and emergency department in the trust, 7 days per week, with robust pathways in place to support other departments outside business hours. Evidence suggests that to achieve this level of coverage, teams will require a minimum of three whole-time-equivalent (WTE) alcohol specialist staff.

Evidence from sites providing an optimal service would suggest that one staff member is needed for every 500 inpatient discharges per month[1]. Therefore, sites/trusts with greater than 1,500 discharges per month are likely to require one additional (WTE) alcohol specialist staff member for every additional 500 discharges. The overall number of discharges in the sites to be covered by the team should be used when thinking about the number of staff needed to operate a seven-day service.

[1] Adult inpatient discharges from most recent Secondary Uses Service (SUS) dataset – NHS Digital

Where a trust has multiple sites, additional consideration should be given to ensure staffing is deployed, so that a seven-day service can be provided across all relevant sites.

At least one of the specialist clinicians should be a senior alcohol specialist nurse (ASN), to support complex cases and manage the team. The service should also receive support from:

- 0.2 WTE consultant grade clinical lead per trust
- 0.8 team admin per trust (additional support may be required where higher patient throughput requires additional clinical staff).

Knowledge and skills: ACT clinical staff:

ACT staff need expertise in:

- Medical management of alcohol withdrawal
- Comprehensive alcohol assessment
- Mental health assessment
- Substance use disorder
- Psychosocial interventions
- IBA and skills to train other staff in provision of IBA.

Knowledge and skills: Trust level

ACT staff raise awareness of alcohol-related conditions and train other staff on alcohol IBA and alcohol withdrawal management. Clinical leads have an important role in both clinical governance and championing the ACT throughout the Trust.

Leadership

Consultant leadership is recommended, with clinical input to the team, responsibility for raising the profile of the service at a trust level and maintaining political capital.

Proposed metrics

For clinical planning, improvement of the service and to demonstrate the impact and value of the service, the following data should be collected and analysed.

Clinical management data:

	Indicator	Definition	Analysis
1	Number of patients screened throughout the hospital using AUDIT/Audit-C	Total № of patients screened by any member of staff in any inpatient or outpatient department	Indicates the total number of patients screened
2	Number of patients screened positive for possible dependence (AUDIT>19, AUDIT-C >10)	Total № of patients screened positive for possible dependence by any member of staff in any inpatient or outpatient department	Percentage of screened patients (1) appropriate for referral to ACT
3	Number of referrals to the ACT, including referral source	№ of patients referred to the ACT from each department of the hospital	Percentage of eligible patients (2) referred to ACT. Highlights pathway weaknesses
4	Number of patients commencing MAW	№ of patients commencing MAW under the supervision of ACT	Percentage of referrals (3) where MAW is required
5	Number of patients completing MAW in the hospital	№ of patients completing MAW in hospital under the supervision of ACT	Percentage of commenced MAWs (4) completed in the hospital
6	Number of referrals to community alcohol services	№ of patients formally referred to continue treatment in community alcohol services	Percentage of referrals to ACT (3) referred to community alcohol treatment
7	Number of patients referred to community services to complete a MAW commenced in the hospital	№ of patients discharged and referred to community alcohol service for completion of MAW in the community	Percentage of commenced MAWs (4) referred for completion in the community

To support delivery of person-centred care and keep the experience of the patient at the core of service improvement, a patient survey should be routinely conducted and reflected upon. The results and qualitative feedback should be used to make service improvements. To provide for effective evaluation of the impact and value of the service, the following should also be recorded by the trust at baseline and as the service develops, to fully demonstrate improvements.

	Indicator	Definition	Analysis
8	Alcohol-specific admissions	Rate of admissions to the hospital for conditions wholly attributable to alcohol	A downward trend is positive, although trusts should be aware of the potential for initial upward trend as training improves the quality of coding
9	Readmissions for patients with alcohol dependence related conditions (broad measure)	№ of readmissions for alcohol dependence related conditions (broad measure)	A downward trend is positive
10	Averted emergency admissions	№ of instances where ACT intervention has prevented an admission	An upward trend is positive
11	A&E attendances for those with multiple alcohol-specific admissions	A&E attendances for patients who have had two or more alcohol-specific admissions in the last year	A downward trend for alcohol-related frequent attendance at A&E might be expected in services that provide assertive outreach
12	Ambulance call-outs for those with multiple alcohol specific admissions	Ambulance call-outs for patients who have had two or more alcohol-specific admissions in the last year	A downward trend for alcohol-related frequent ambulance call-outs might be expected in services that provide assertive outreach
13	Cost of service	Revenue cost of the ACT	Baseline for return on investment
14	Income from service interventions	Income from procedures provided as a result of the ACT intervention	Income from procedures that are alternative to admission (offsets the cost of service (13)
15	Savings from bed days saved by averted admissions from A&E	Estimated № of bed days saved from emergency admissions averted by ACT (10)	= averted admissions x average length of stay for alcohol admissions x average bed day cost
16	Savings from reduced length of stay	№ of bed days saved due to discharge prior to the documented planned discharge date	= bed days saved x average bed day cost

Levers and incentives

- Alcohol and tobacco harm reduction CQUIN 19/20
- Making Every Contact Count (MECC) 19/20
- Standard contract 8.8 19/20
- CCG Health inequalities funding supplement.

Resources

- Sandwell & West Birmingham Hospitals case study
- IBA resources provided for the alcohol and tobacco brief interventions CQUIN