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# Setting up an Alcohol Care Team

## (Working In Partnership to Tackle Drug and Substance Misuse 2023)

Recovery near you

Birmingham and Solihull Mental Health NHS Foundation Trust

The Royal Wolverhampton NHS Trust

# Aims for this session

- Brief history of the problem local and national
- Key components in setting up an our ACT
- Welcome to our world, ‘a day in the life’

## History
## The National Plan for Liver Services in 2009

- Liver disease deaths continue to rise, average age of death 59 years and falling
- Hepatology services are patchy
- The infrastructure to run a liver service is not in place outside liver units, with significant shortages in radiology, pathology, alcohol support services and multidisciplinary meetings.

# History
# Chief Medical Officer annual report 2011

"Liver disease has emerged as a key theme from international comparisons which show that this is the only major cause of mortality and morbidity which is on the increase in England whilst decreasing among our European neighbours."

- Among the causes of the increasing numbers of people with liver disease are

1. obesity,
2. undiagnosed hepatitis infection, and increasingly,
3. harmful alcohol use.

# History
# NCEPOD 2013

National Confidential Enquiry into Patient Outcome and Death

## Measuring the Units

### A review of patients who died with alcohol-related liver disease

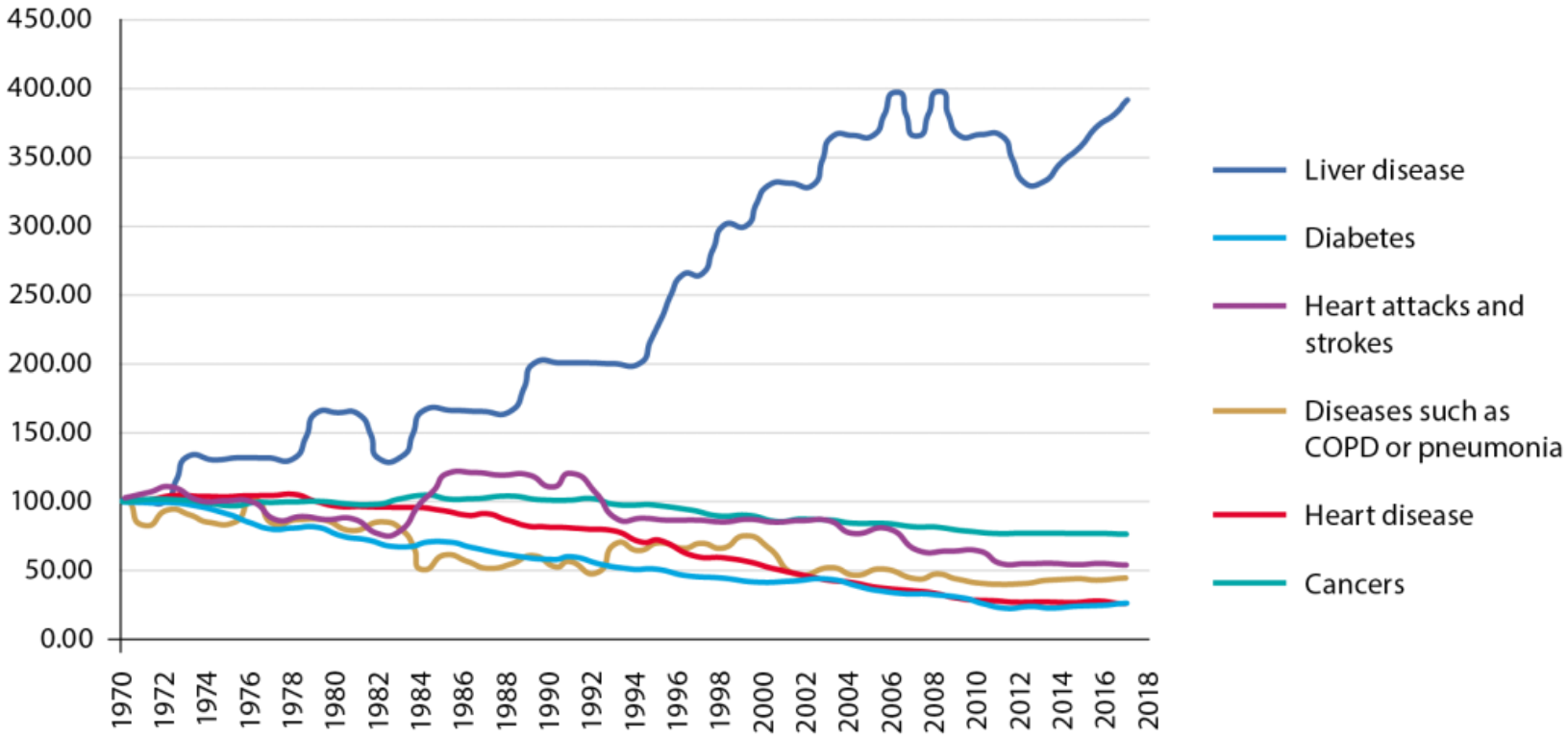
NCEPOD principal recommendations

1. All patients presenting to hospital services should be screened for alcohol misuse.
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.
3. Each hospital should have a 7-day Alcohol Specialist Nurse Service
4. A multidisciplinary Alcohol Care Team, led by a consultant with dedicated sessions, should be established in each acute hospital

NCEPOD

# History
# British Liver Trust

The rise in deaths from liver disease compared with other major diseases




Standardised UK Mortality Rate Data – All Ages

# Local
# Alcohol related hospital admissions. LAPE data
# (We win 6th prize nationally!) pipped by Kingston upon Hull, Middlesborough, Stoke on Trent, Salford, Knowsley,

**9.01 - Admission episodes for alcohol-related conditions (Broad)** 2016/17 — Directly standardised rate - per 100,000

| Area | Recent Trend | Neighbour Rank | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|---|
| England | – | - | 1,135,709 | 2,185 | 2,181 | 2,189 |
| Wolverhampton | – | - | 6,405 | 2,791 | 2,723 | 2,861 |
| Sandwell | – | 1 | 7,362 | 2,661 | 2,600 | 2,723 |
| Walsall | – | 2 | 6,722 | 2,626 | 2,563 | 2,690 |
| Kingston upon Hull | – | 3 | 7,232 | 3,222 | 3,147 | 3,298 |
| Rochdale | – | 4 | 5,220 | 2,684 | 2,611 | 2,759 |
| Middlesbrough | – | 5 | 4,060 | 3,253 | 3,153 | 3,355 |
| Stoke-on-Trent | – | 6 | 6,902 | 2,990 | 2,919 | 3,061 |
| Derby | – | 7 | 5,694 | 2,526 | 2,460 | 2,593 |
| Salford | – | 8 | 7,331 | 3,497 | 3,417 | 3,580 |
| Knowsley | – | 9 | 4,222 | 3,008 | 2,916 | 3,101 |
| Oldham | – | 10 | 5,157 | 2,535 | 2,466 | 2,606 |
| Coventry | – | 11 | 7,640 | 2,743 | 2,681 | 2,806 |
| Bolton | – | 12 | 6,550 | 2,530 | 2,469 | 2,592 |
| Nottingham | – | 13 | - | * | - | - |
| Gateshead | – | 14 | 5,319 | 2,689 | 2,617 | 2,763 |
| Rotherham | – | 15 | 6,284 | 2,447 | 2,386 | 2,508 |

*Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.*

# Local
# Alcohol related deaths LAPE data
# (we win 1st prize nationally!)

"The mortality rate was highest in the North East region (20.0 per 100,000 population) and lowest in the East of England region (9.2).

The mortality rate at upper-tier local authority level varied from 29.3 in Wolverhampton to 5.5 in Richmond upon Thames."

Local Alcohol Profiles for England: short statistical commentary, December 2021 - GOV.UK (www.gov.uk)

# Key components in setting up our ACT

- Use national guidance and data to advise the service set up, but consider local issues and need (its probably not a ‘one size fits all’)
- Get hospital buy-in. Especially around local need. Local department s such as ED will have different needs to maternity for example.
- Involve service user feedback. Engage people with lived experience
- Create guidelines and protocols early – so the hospital know what’s expected
- Create information about the team early so the hospital knows what to expect
- Train the staff and set up supervision and support
- Start data collection immediately
- IBA – Set screening and referral pathways to the team
- Training, training, training! Anywhere and everywhere that will have you
- Health Promotion events

## Admission criteria for ED for patients in acute alcohol withdrawal

Consider admission into hospital in line with NICE Guidelines CG100:

- Alcohol withdrawal seizures or delirium tremens present
- Lower threshold for people with vulnerabilities—safeguarding, consider frailty, cognitive capacity, learning difficulties and lack of social support
- Other emergency physical / mental health, that would precipitate admission anyway
- Young people under 16

Options:

- Refer to community addiction teams – who have a budget for community and specialist inpatient detox
- Ambulatory detox
- For people who are alcohol dependent but not admitted to hospital, offer advice to avoid a sudden reduction in alcohol intake. Note that a sudden reduction in alcohol intake can result in severe withdrawal in dependent drinkers

# IBA – Set screening and referral pathways to the team

Not all patients are easily identifiable

Alcohol screening is essential

# AUDIT-C screening tool

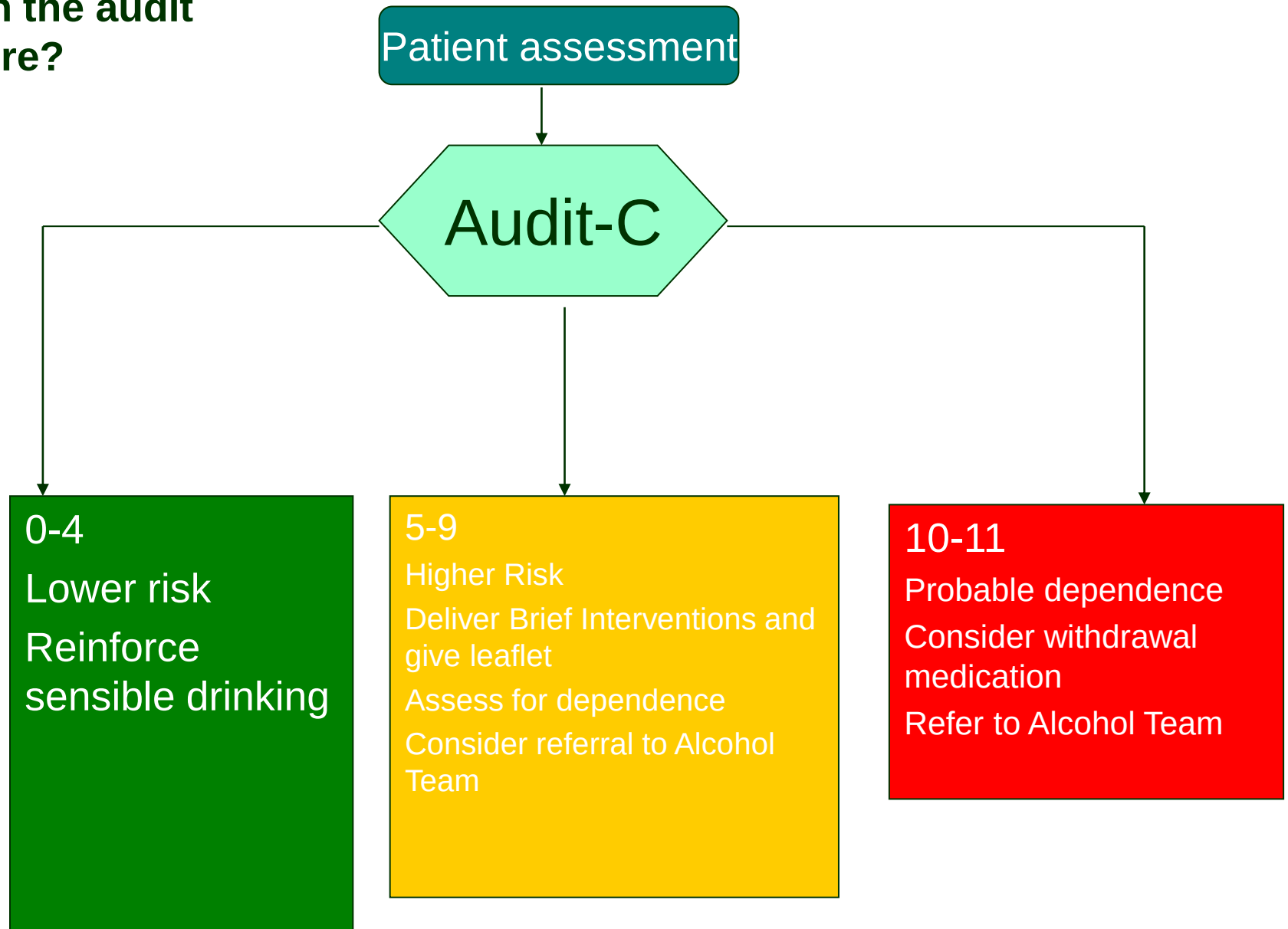
## Drinks containing more than One UNIT


## AUDIT – C

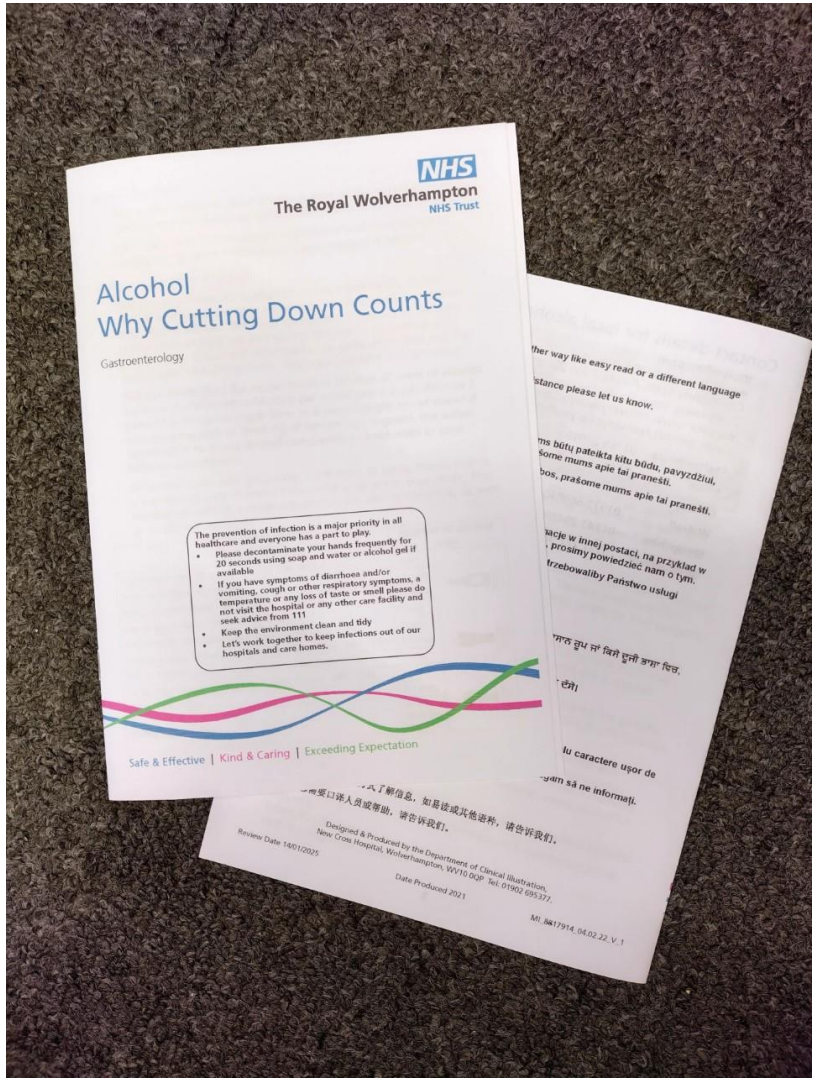
| Questions | Scoring system | | | | | Your score |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week | |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ | |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |

**Scoring:**
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

## What can you do with the audit score?



# Brief intervention tool



# Other local projects

Maternity service

- Integrated safeguarding protocol, following the death of Daniel Jones
- Monthly table top review of all pregnant women
- Vulnerable midwives team, ACT nurses, health visitors, mental health nurse and community alcohol team

Lived experience

- In-house SMART group – self management and recovery training (paused during lock down)
- Recovery champions – volunteer from our local service user involvement team (SUIT) who work with the hospital team, visiting patients, representing the visible face of recovery.

# Other local projects

Outpatients

- Initially supporting the hepatology consultant in his clinic once a week
- Developing into 2 added nurse led clinics for ACT only, for patients who will not easily transfer to local community alcohol service or are out of county and 1 clinic for sick liver/alcohol patients jointly ran with liver consultant and ACT nurse
- ACT fibroscan clinic, one ACT nurse trained to offer fibroscans as part of the CQUIN, giving us another forum to deliver specialist brief interventions

Pre-op project

- Developing service with planned surgery
- Training to consultants and pre-op screening team
- Referral pathway from pre-op appointment, support over the phone, assessment and breathalyser on day of surgery

# Other local projects

Training and health promotion

- Training courses for ED and AMU staff on a rolling programme
- Training for all wards and departments, inc pharmacy, social care etc
- Training on nurse induction and preceptorship
- Training for new doctors
- Health promotion events 3 x year eg Alcohol Awareness Day, Dry January

Early discharge and continuation of detox

- Once assessed as no longer meeting criteria for admission
- Either referred to community alcohol team who will continue detox the following day
- Ambulatory detox with the ACT if unable to attend the local alcohol service
- Appointment is given daily for detox monitoring with ACT nurse and / or home visits with ACT nurse and outreach support worker

# A day in the life

07:30 Down to pre-op ward to meet patient, male age 55, coming in today for surgical excision oropharyngeal squamous cell carcinoma. On initial referral 3 weeks ago, drinking 4-6 cans strong lager 18-27 units per day. Drinking increased when lost wife to cancer 8 years ago. Hasn't worked since lockdown and is socially isolated. Phone support and reduction plan during last 3 weeks in preparation for admission. Now drinking 2 cans daily = 9 units and had no alcohol yesterday. Breathalysed 0.00mg/l, no evidence of withdrawals. Congratulations and support given, further engagement and relationship building session. We will follow his progress during his stay and discuss aftercare nearer discharge.

08:15 Morning alcohol team meeting – 5 new referrals overnight, 15 inpatients for review from assessments earlier in the week, With a team of 4 nurses, 1 nurse delivering training to ED staff 2 nurses available to see patients, 1 off as worked the weekend. Prioritising and planning the day.

09:00 Assessment female age 32 recent admission to ICU following variceal bleed. Intubated and sedated for 24 hours. Background ALD, and is known to the team. 9 year old son currently staying with patients mother. Previous domestic abuse was the trigger for drinking. Patient very poorly, discloses relapse following period of abstinence, feeling ashamed and frightened. Detox complicated by ALD, safeguarding concerns as patient divulges her mother has started drinking with the stress of it all. Detox organised and discussion with ICU staff. Phone call to social worker to discuss care of son. Referral to community team to offer support to mother.

11:00 On way to Gastro ward to review a patient, -Bleeped to ED to assess male 35, suicidal and in alcohol, withdrawals, wife present. Had 4 seizures in ED, wife insists he doesn't drink that much and never before work. She is terrified by the seizures and believed he was going to die. He reports he is drinking 20cl whisky before work and 2 further 35cl whisky after work and overnight = 7.5 + 13 + 13 = 33.5 units daily. Breathalysed at 0.80mg/l which is over 2 x drink drive limit. Is driving most days for work. Medication organised for patient, support given to wife. Drink drive leaflet discussed with both. Advised admission due to ongoing seizures. Will be fully assessed when sober. Wife given information and psychosocial session, will be offered ongoing support

13:00 LUNCH

# A day in the life

14:00 Review on Gastro ward, male age 40, no previous support for alcohol use or contact with any services. Drinking half a bottle spirits daily up to admission, lost job as a chef 2 years ago due to drinking. Underweight at 55kg height 6ft. Very low in mood, very ambivalent about change, little self confidence. Lives alone with some contact from sister once a week. 3rd session with client, detox now finished. Referred to dietician. Motivational interviewing session and looking at options re anti craving medication and referral on. Very uncertain and declines referral to local community alcohol team. Booked follow up in ACT nurse led clinic, for further engagement and repeat bloods for anti-craving medication

15:00 Phone call from client, distressed. 45 yr old female police officer. Initially assessed in ED a few months ago. Initial trigger for drinking PTSD. Declined referral to community alcohol team as she was fearful of meeting people she would know/meet at work. No alcohol now for 3 months, but increased stress at work is causing severe cravings. Motivational interviewing session on the phone looking at benefits and losses of returning to drinking, longer term life goals and follow up booked for ACT outpatients

16:00 Time to go home ansa machine on, what will tomorrow bring?

# Thanks for Listening!