

Evaluation of the Hospital Alcohol Liaison Service (HALS) based at the Royal Lancaster Infirmary

Mike Leaf

INTRODUCTION

The purpose of this report is to:

- Provide commissioners and stakeholders with an insight into the quality and cost-effectiveness of the Hospital Alcohol Liaison Service (HALS) based in the Royal Lancaster Infirmary.
- Provide some background to the service, including the commissioning and implementation processes.
- Explore aspects of the service structure, delivery and outcomes.
- Draw conclusions about the quality and success of the service.
- Make recommendations for the future of the service.

The evaluation provides a brief policy background and the drivers for the business case. There is a narrative detailing actions undertaken during implementation and quantitative data illustrating outputs. Outcomes are explored to understand whether patients' behaviour has changed or healthcare utilisation has been affected. Finally, there are the results of a patient satisfaction survey and also some case studies to provide a holistic overview of the service.

BACKGROUND AND POLICY CONTEXT

The impact of excessive alcohol consumption on health care utilisation has been recognised for over a decade, with binge drinking and dependency resulting in increased usage of the NHS across primary, secondary and community service. In 2009 North West Acute Trust Chief Executives supported a case for change for the development of Hospital Alcohol Liaison and Assertive Outreach services. Evidence has illustrated that the implementation of HALS can reduce the length of time that alcohol dependant patients remain in hospital and reduce the likelihood of readmission by addressing their alcohol misuse. Evaluations suggest that the return on investment for effective HALS is between £3.50 and £3.85 per £1.00 invested.

THE BUSINESS CASE

In 2011/2012, there were 717 admissions for alcohol specific conditions for individuals living within the geographical footprint of NHS Lancashire North CCG. These admissions cost in excess of £1.5 million. A business case was developed to fund a HALS approach in the Royal Lancaster Infirmary based on an invest-to-save principle. Lancashire North CCG committed to investing £126,275 into the service. The service specification and KPIs were agreed in December 2013. The investment was to fund 2WTE band 7 specialist nurses and a 0.6 WTE band 2 administrator. This post is currently going through an agenda for change process to alter the banding to a Band 3, due to the data requirements of the role.

The outcomes to be achieved from the service are:

- A reduction in the number of alcohol specific hospital admissions, particularly in patients experiencing acute alcohol withdrawal and co morbid conditions.
- Improved physical and mental health as a result of reduced alcohol consumption and increased self-awareness and care.
- Increased knowledge, confidence and skills in the wider hospital workforce to enable referral and equitable management of patients.

The aims and objectives are:

Aims:

- To improve the effectiveness of the management of alcohol misuse, dependency and co-morbidity conditions by:
 - providing a specialist alcohol service at Royal Lancaster Infirmary where patients can receive alcohol assessment, support, treatment and referral.
 - providing effective pathways from acute to primary care, which will reduce alcohol-related hospital admissions for wholly and partly attributable alcohol-related health conditions.
 - optimising the medical management of alcohol-related conditions, thus reducing the necessity for hospital attendance and admission. Responsibility for individual medical episodes will be with the client's Physician.
- To increase the knowledge and skills of the workforce within the RLI to increase the availability of screening and brief interventions.

Objectives:

- To provide an alcohol screening, assessment, support and treatment service within the Royal Lancaster Infirmary to patients outlined in the four target populations below.
- To ensure that all clients from the target population with an AUDIT score of 16 and over (an AUDIT score of 20 and over indicates that the patient is at risk of dependency on alcohol) or with a raised index of suspicion for alcohol causality in disease receive a health and alcohol assessment and an appropriate package of care and aftercare.
- To develop and implement during the first 12 months of service delivery a procedure for managing acute alcohol withdrawal in hospital, including pharmacotherapy, psychosocial support and onward referral routes to community services and Tier 4 where

appropriate. This procedure will be in accordance with NICE clinical guideline 100 and 115.

- To provide brief and extended brief interventions for increasing and higher risk drinkers in accordance with NICE public health guideline 24 and NICE clinical guideline 115 for patients identified from the target population.
- To develop cost-effective treatment pathways, which are clinically evidence-based and developed in partnership with other alcohol service providers, general practice and other relevant generic services to ensure seamless transition across acute and primary/community settings through the Alcohol Liaison Nurse Service Group.
- To promote the dissemination of information on alcohol interventions to RLI staff in order to enhance knowledge in relation to social health and care in line with the Knowledge and Skills Framework and an equivalent input for relevant non-NHS staff.
- To increase the delivery of alcohol screening and identification by the RLI workforce to patients in the identified patient population enabling the assessment of people with alcohol problems and the onward referral of high risk drinkers through a comprehensive communications and training strategy.

IMPLEMENTATION OF SERVICE:

The service implemented a phased approach to developing the case load and became fully operational in October 2014. The service was commissioned to work across the organisation; line management is from the Acute Medicine Matron and clinical leadership is provided by the Consultant in Gastroenterology. Monthly implementation meetings between Public Health and HALS commenced as the staff were recruited, which aimed to ensure that implementation milestones were achieved.

A monthly steering group was established during June 2014 with attendance from staff across the site. This meeting was held to ensure that the service has a cross organisational presence. External community partners were also invited to support pathway development and implementation. With the support of the HALS team's Clinical Lead and Senior Management team, the transition from service conception through to service delivery has been a productive process.

Implementation achievements:

- The development, implementation and promotion of a specialist alcohol service that screens, identifies and provides support for people who drink alcohol to excess. The service is currently working with a majority of people that are alcohol dependant. Around 55% of the clients seen each month score 20+ on the audit assessment which suggests the client is highly likely to develop a dependency to alcohol.
- HALS has written and implemented a prescribing protocol for Assisted Alcohol Withdrawal, ensuring that inpatients are supported to withdraw from alcohol with a prescribing regimen that is NICE compliant. The team developed a training package for staff to

ensure that there was an understanding of the new ways of working.

- HALS intervention comments are transferred into GP discharge notes to raise awareness of alcohol consumption and provide information of the HALS intervention and impact of alcohol consumption on health conditions.
- HALS has developed strong links with the frequent attenders project and have lead the organisation of multi-disciplinary meetings for patients where alcohol was a strong contributing factor or the main cause of the repeat hospital attendances. From 2016 onwards, Frequent Attender and Hospital Alcohol Liaison Service Steering Group meetings will be amalgamated to improve information sharing and links.
- Pathways have been developed with mutual aid organisations such as AA. Pathways into community substance misuse services have been a focus of attention but have been challenging to implement due to incompatible models of delivery. A pilot project has been undertaken with Red Rose Recovery to provide asset based support through the allocation of coaches. The qualitative results are positive in terms of engagement. Funding for this pilot has been secured until December using CCG BCT funding.
- Training has been delivered to raise awareness of HALS and develop skills across site staff to undertake screening and referral. It became apparent that planned group training sessions were not effective due to barriers to staff release to attend. Therefore, HALS interacts with staff on a 1:1 basis to raise awareness, understanding and skills. The HALS team designed an audio training presentation that is being shown as part of the mandatory training days. All clinical staff across the Trust can also have access to this presentation via the HALS page on the Trust intranet site. This page has been developed by the team and contains useful information, training tools and clinical documentation.
- HALS have ongoing student doctor training placements to identify signs of alcohol dependency in patients by using AUDIT and Clinical Institute Withdrawal Assessment for alcohol (CIWA). The student doctors watch the HALS training presentation to reinforce the knowledge they have gained from their placement with the team. The student registrars are also provided with a training material pack so they have a point of reference should they require it at a later date and knowledge of the service's existence so they can make enquiries or referrals in the future.
- There are frequent discussions with regards to safeguarding issues including clients with parental responsibility, clients who are either subject to or perpetrators of domestic violence, clients who lack capacity due to alcohol related memory loss and clients who have a dual diagnosis of alcohol problems and mental health problems which can result in capacity issues linked to safeguarding.
- The HALS team have daily discussions with Mental Health Liaison in the hospital due to some clients'

shared problems. The team conduct face to face or phone referrals to Mental Health Liaison.

- The clients present to HALS with multi-faceted problems, which include not only their alcohol misuse but drug misuse, and also:
 - domestic abuse,
 - mental health issues,
 - learning disabilities,
 - frailty/adults over 65,
 - child care issues,
 - physical health issues/ comorbidity,
 - accommodation issues,
 - ethnic diversity challenges.

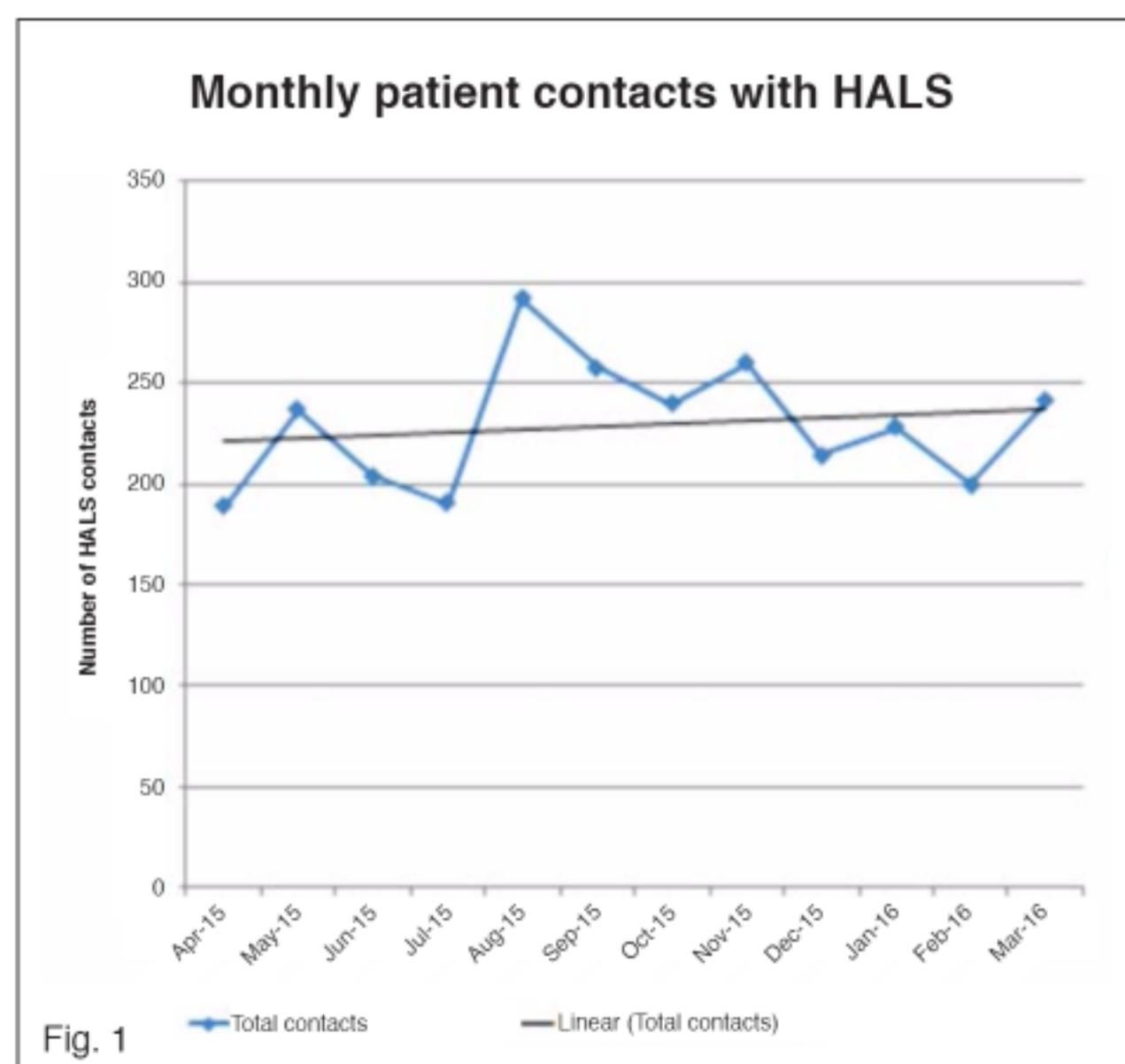
All these add to the complexity of each individual client the HALS team assess and support.

- The HALS team has developed a bespoke reporting system that enables report production to support and evidence monthly service performance statistics.

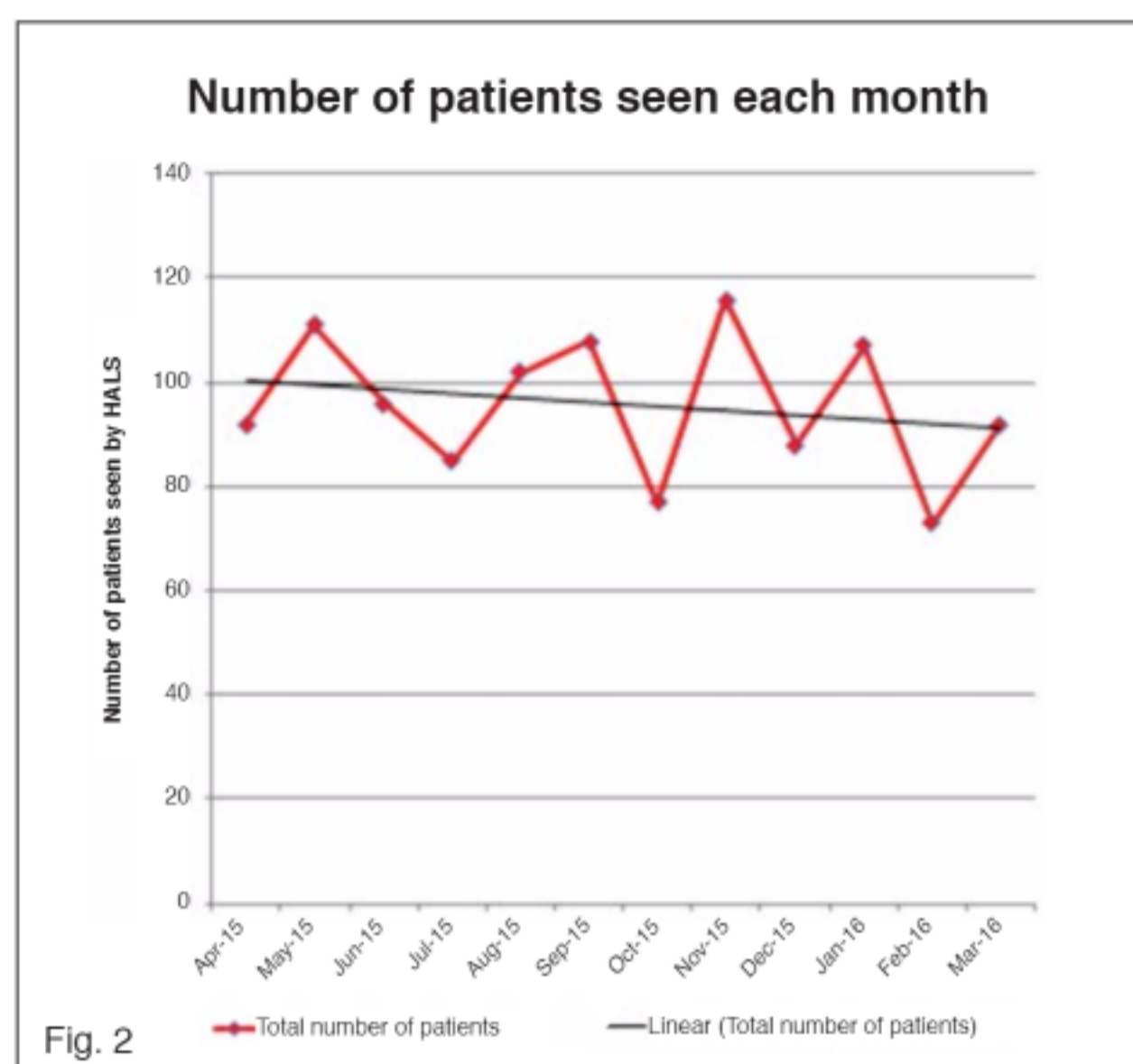
PERFORMANCE

The HALS team have been collecting a range of data since implementation in order to demonstrate outputs, outcomes and effectiveness.

Activity

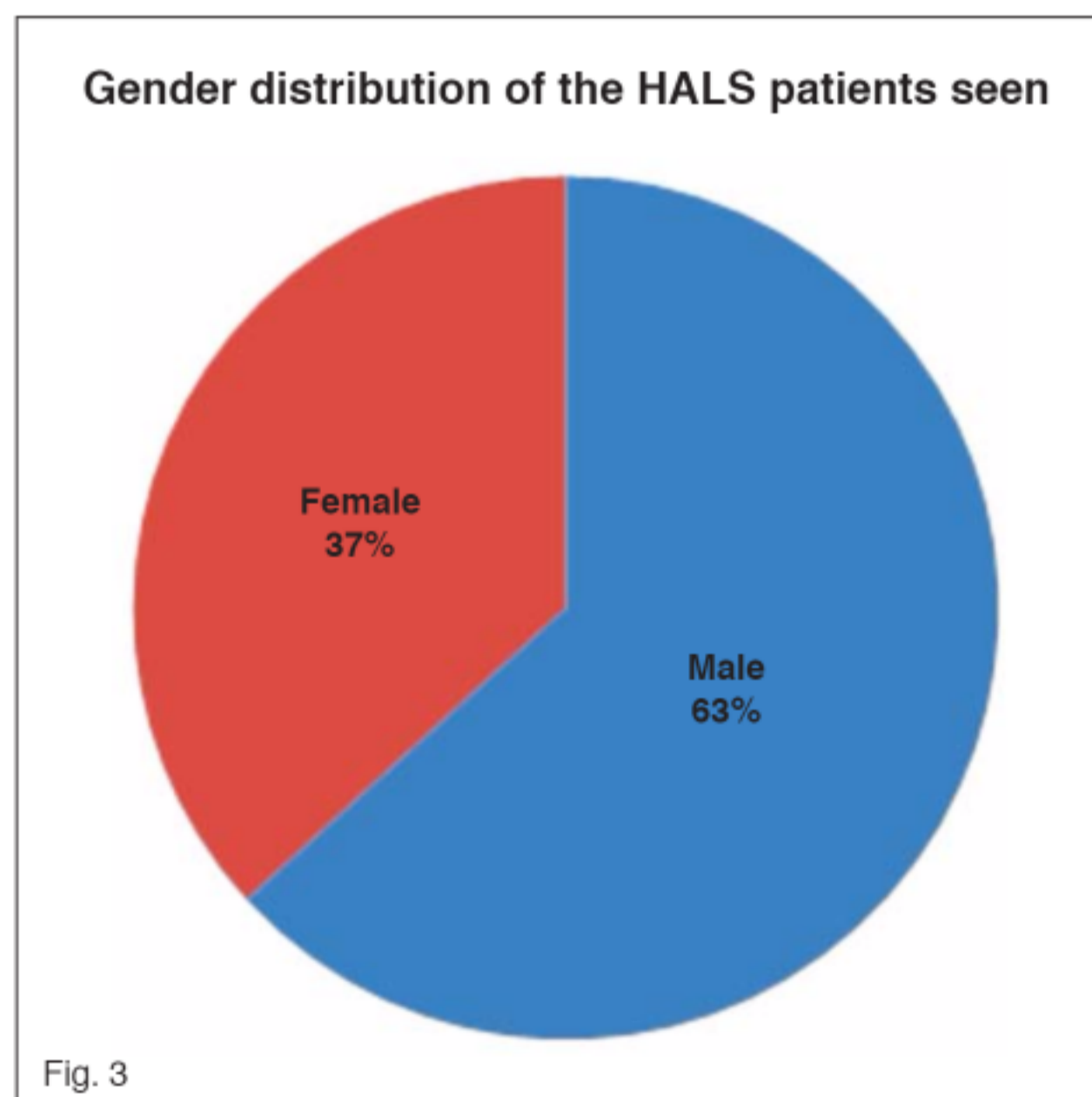


The monthly numbers of HALS contacts have shown a gradual increase since the start of the service, and peaking at 292 for August 2015. The average number of contacts Aug – October 2015 is 263; the service specification requires that there are 70 contacts each week (Fig. 1).



The service is seeing an average of 95 patients per month, with the highest number being 111 in May 2015. The average number of contacts per patient is 2.2, with the highest number of contacts being 23 for one patient. This shows that some patients require extended interventions by HALS (Fig. 2).

DEMOGRAPHICS



The service has been providing support to patients across all ages, although 86% are over the age of 35, with 20% over the age of 65. This coincides with intelligence from Alcohol Concern -(<https://www.alcoholconcern.org.uk/help-and-advice/statistics-on-alcohol/>)

“Older people tend to drink more frequently than younger people. The proportion of adults who drank every day increased with each group – just 1%

of 16-25 age group had drunk every day during the previous week, 4% in 25-44, 9% in 25-64 and 13% in 65+” (Fig. 4).

The support provided to the older age groups is also likely to reflect the incidence of alcohol specific and related conditions, which build up over time.

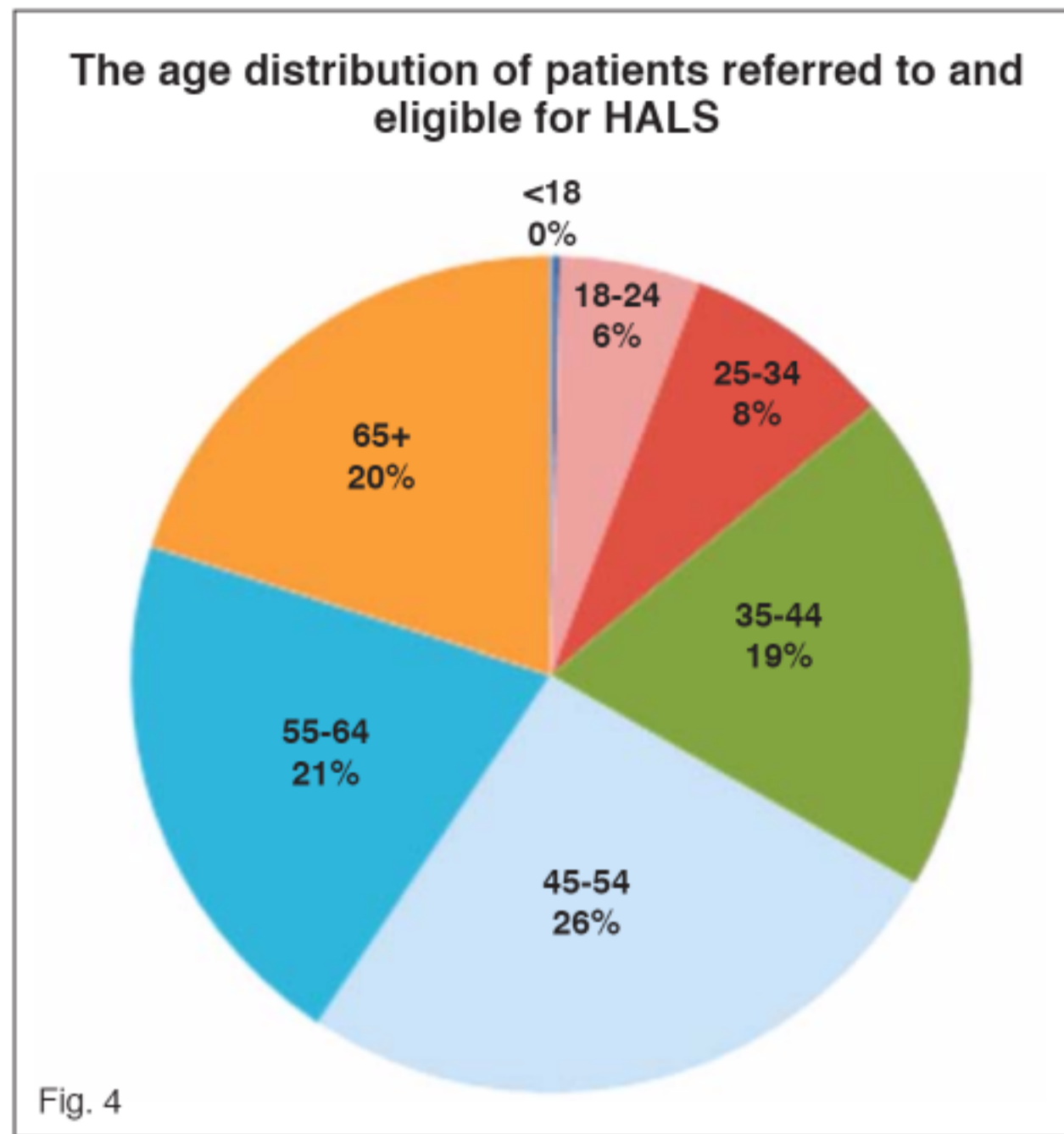


Fig. 4

The service was commissioned to provide interventions to patients living within the geographical boundaries of NHS Lancashire North CCG (Fig. 5).

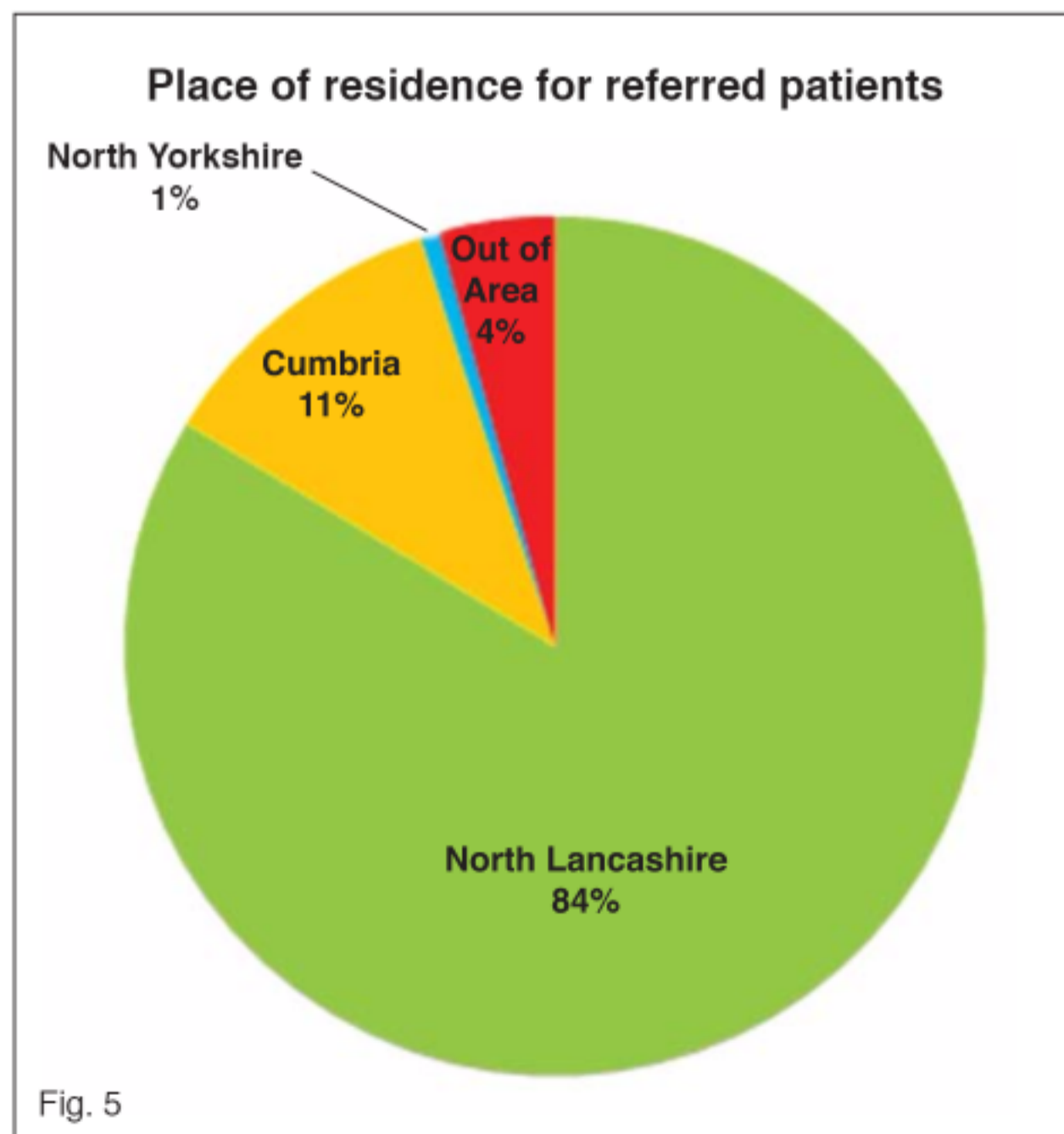


Fig. 5

84% of referred patients are from the Lancashire North area. However, 11% are from Cumbria, 1% from North Yorkshire and a further 4% are from out of area.

The first 4 digits of the postcodes for each geographical area have been analysed, as per the charts below (Fig. 6&7).

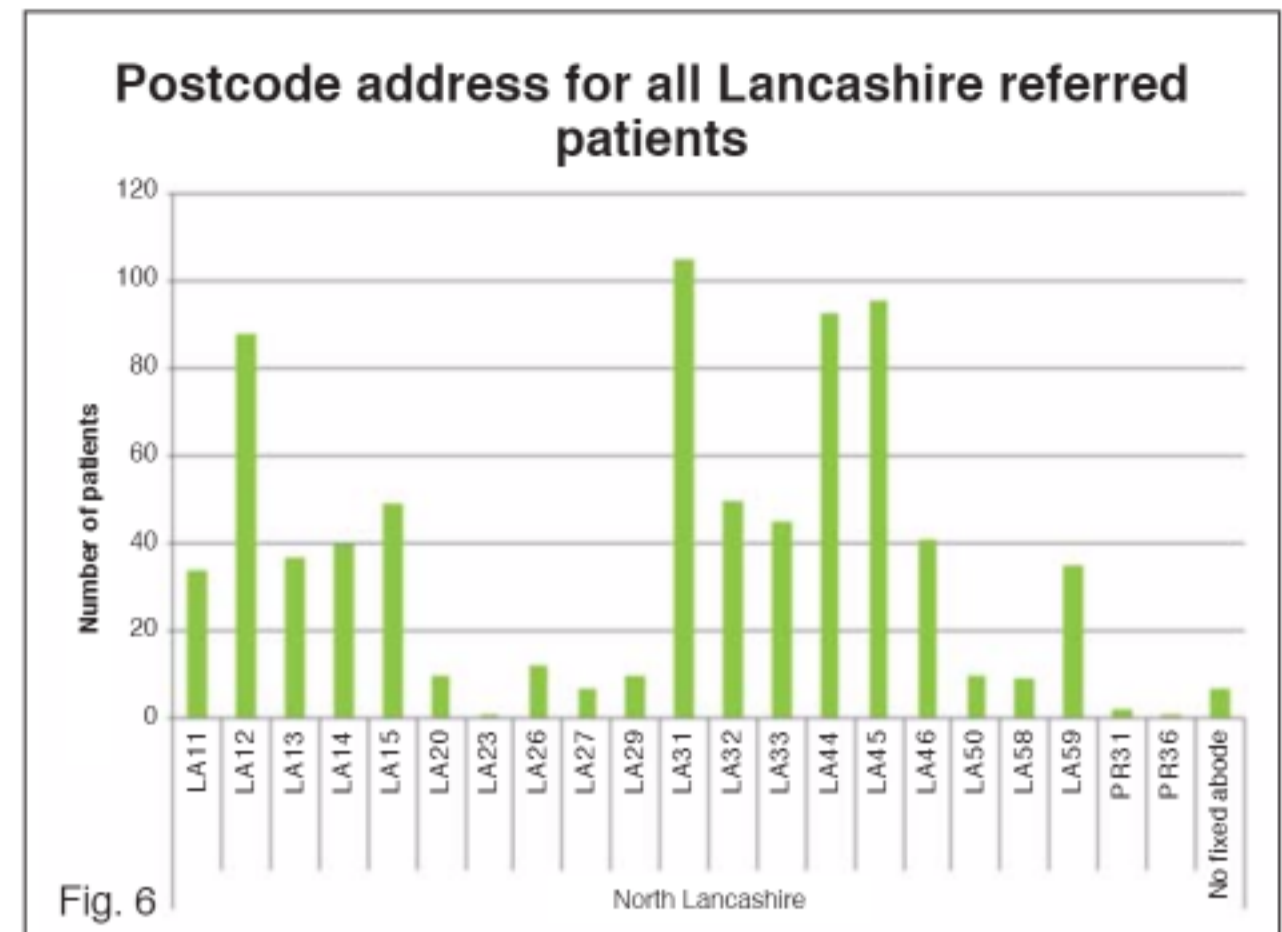


Fig. 6

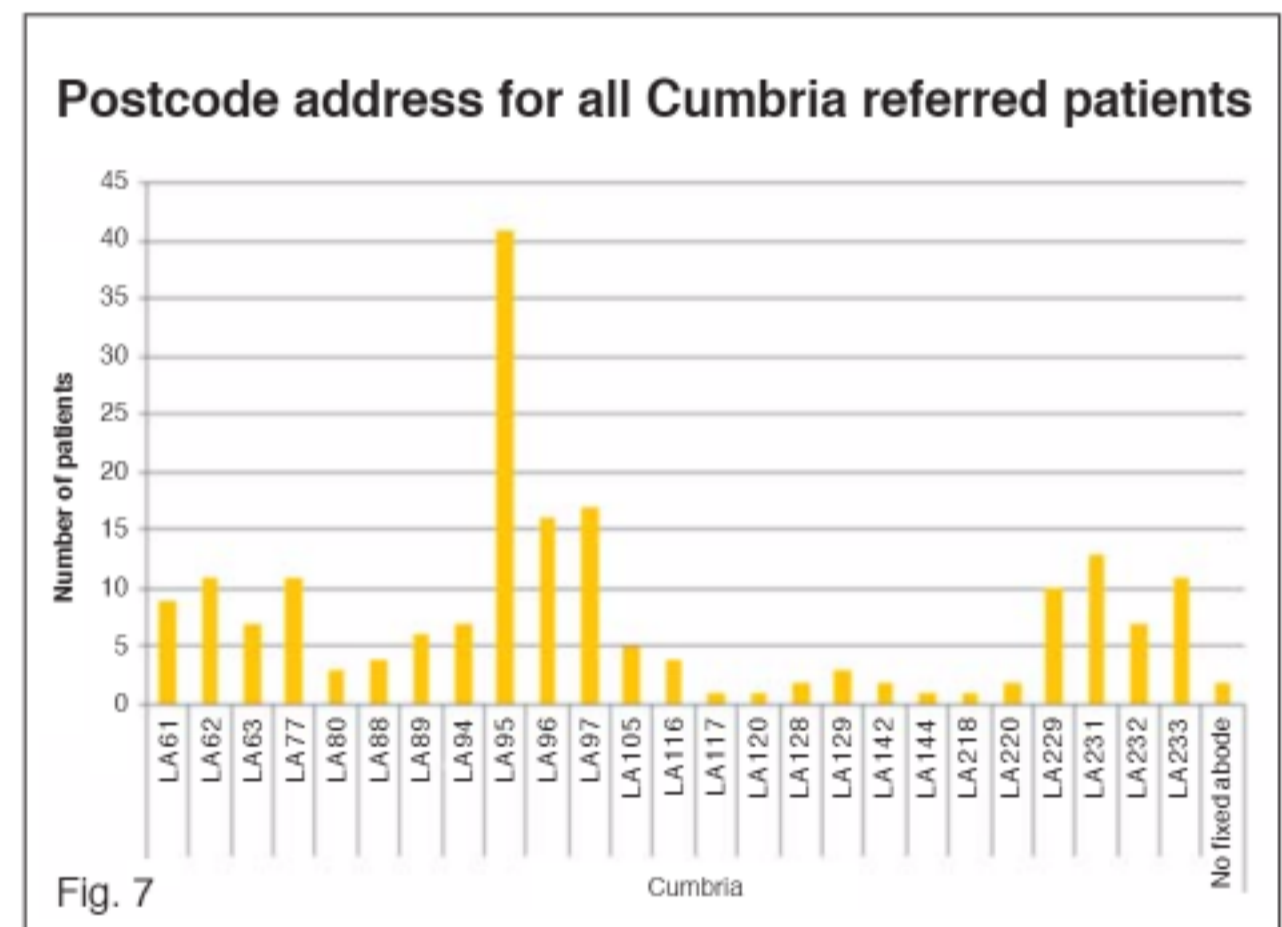


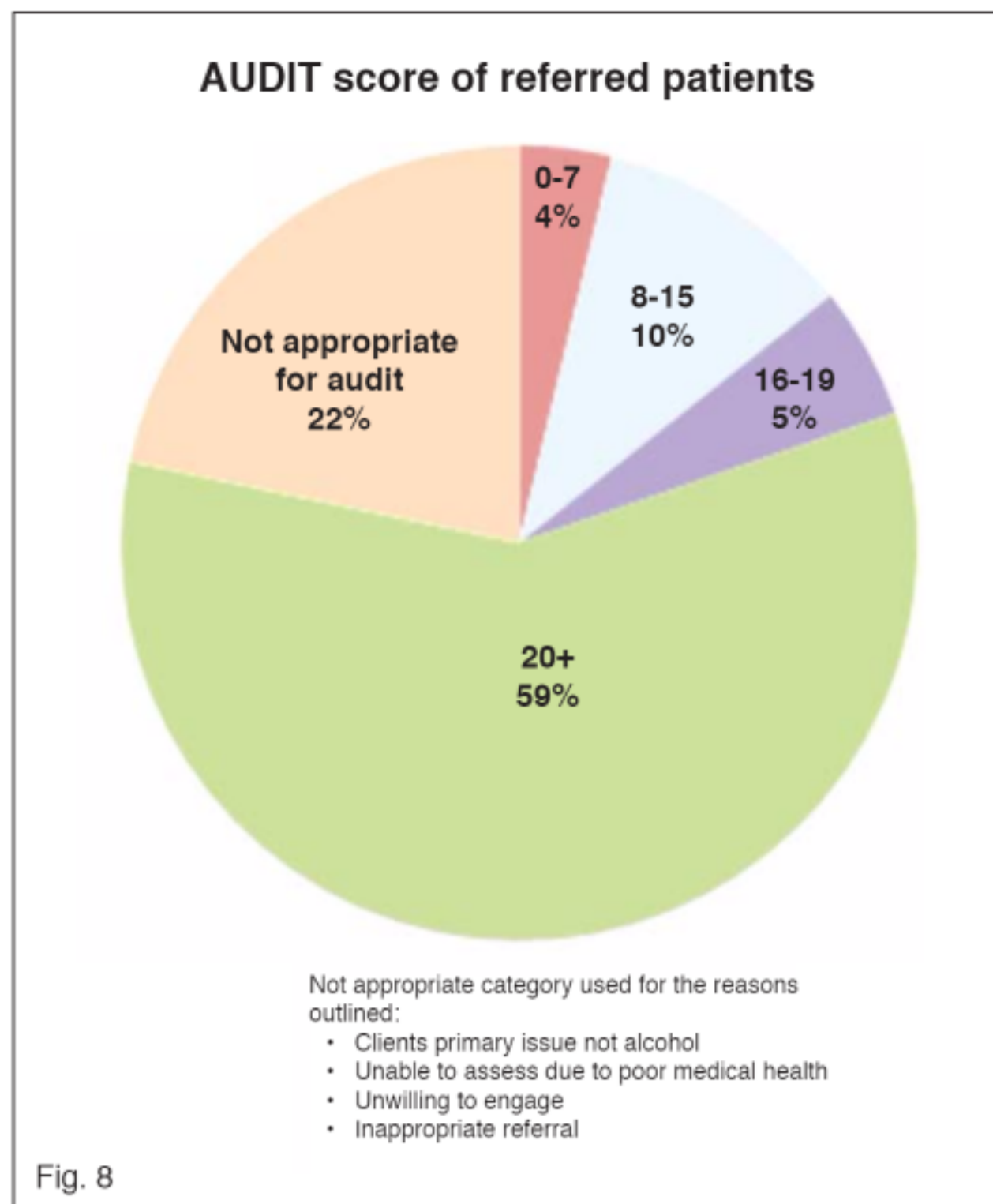
Fig. 7

The out of area postcodes span a range of postcodes, with the biggest number of patients coming from Preston area at 23%, followed by Blackpool at 13%, Carlisle at 11% and Manchester at 7%. There are examples of patients with no fixed abode attending the RLI with conditions associated with alcohol.

INTERVENTIONS

All patients referred to HALS are screened to assess their level of alcohol misuse using an evidence based sensitive and specific tool, AUDIT. Patients with an AUDIT score of 16 and over are eligible to receive an intervention from HALS as their alcohol consumption levels are likely to be damaging to their health. An AUDIT score of 20 and over indicates that the patient is at risk of dependency on alcohol and further tools can be used to understand the need for pharmaceutical intervention to manage the symptoms of withdrawal.

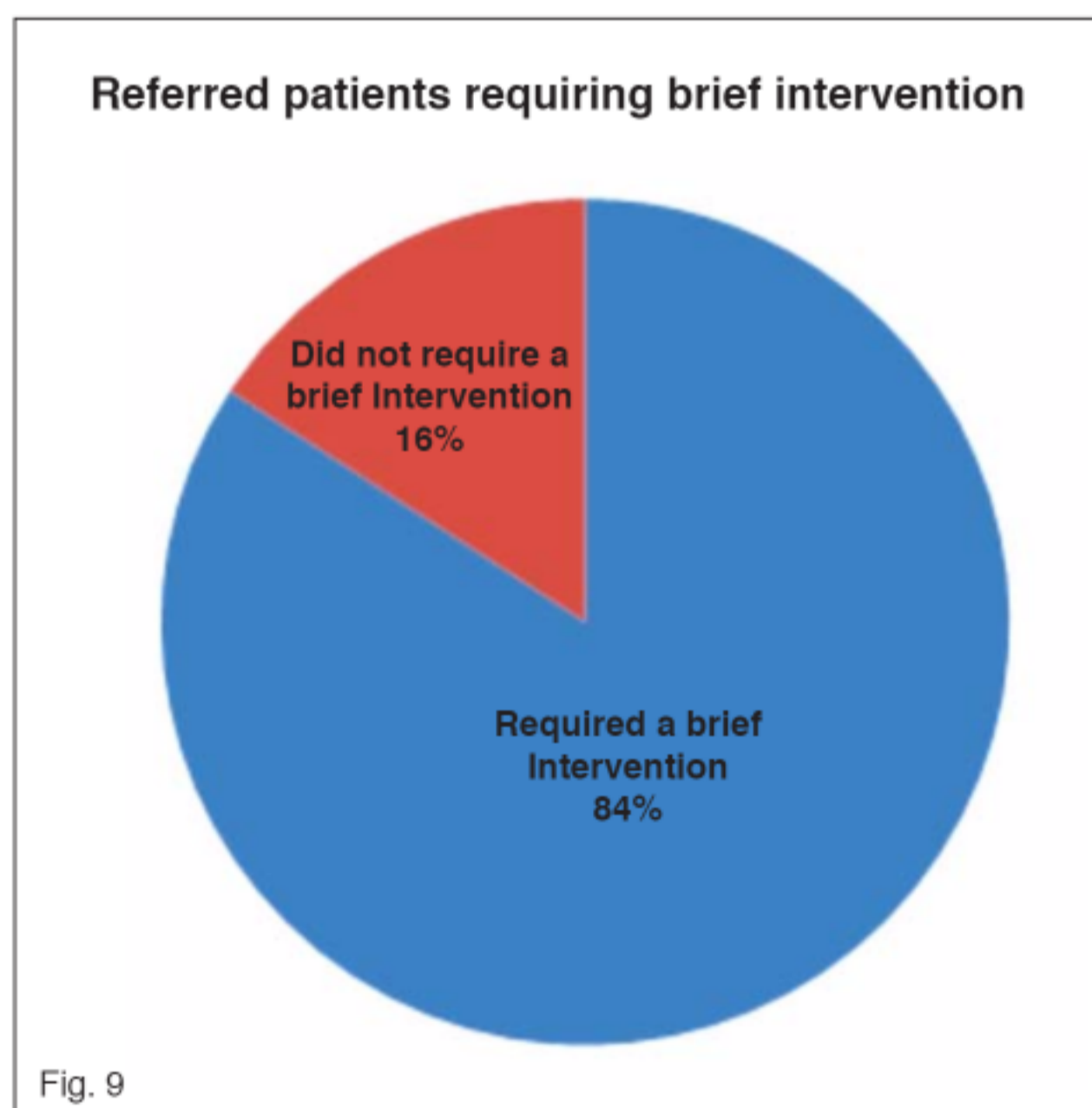
59% of referred patients had an AUDIT score of 20 and over, indicating risk of dependency and also reflecting the health impacts of excessive alcohol consumption. The expectation would be for the proportion of referrals to decrease as the AUDIT score decreases, but there is a higher than expected proportion of AUDIT score between 8 and 16. 22% of the referrals were deemed to be inappropriate by HALS.



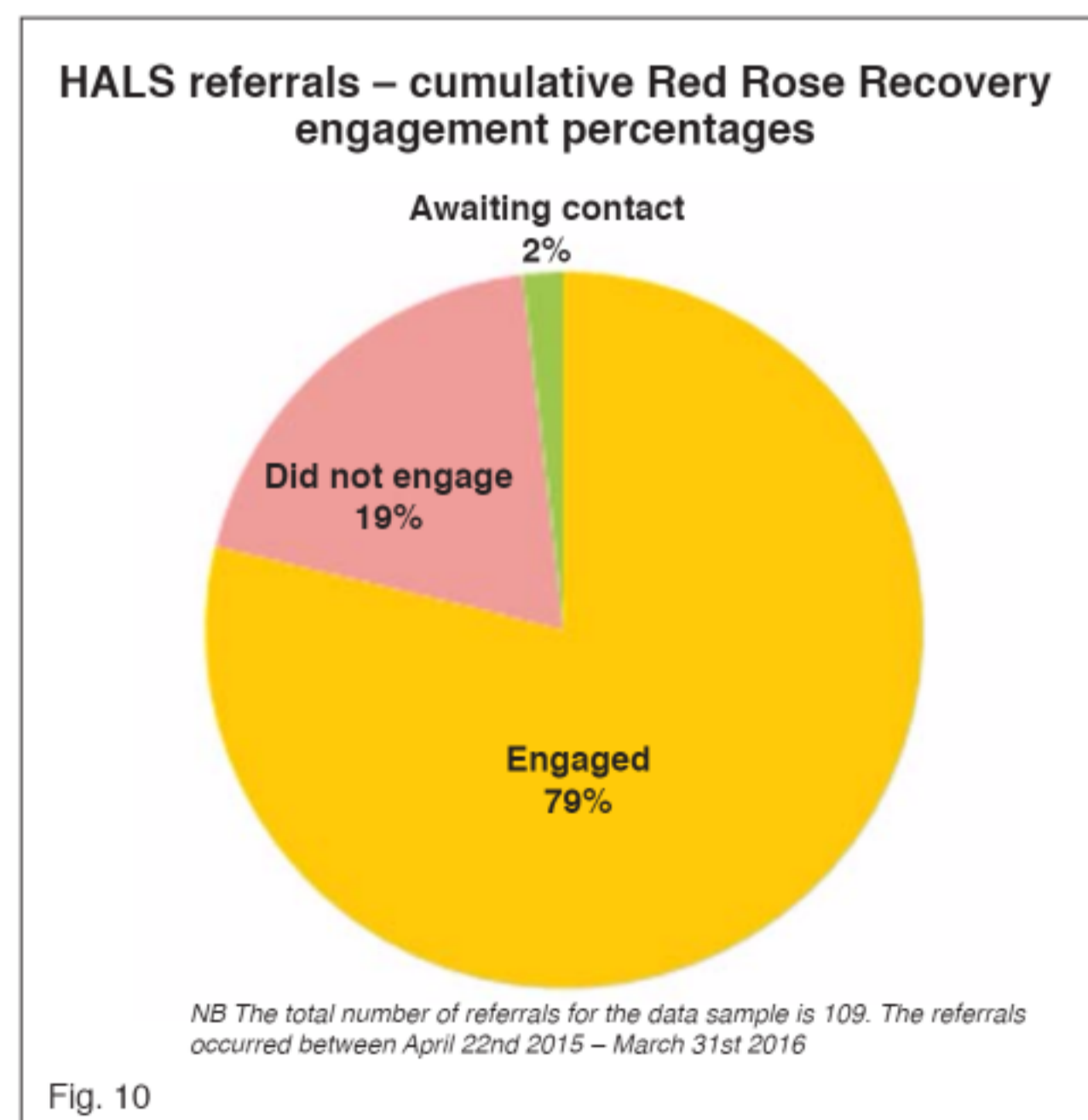
Some patients with an AUDIT score of over 20 will require pharmaceutical interventions to manage withdrawal symptoms.

A varying percentage of the clients will already be open to community alcohol services. There are clients that have tried community services but have declined further referral to these services as they found them to be unsuitable on an individual level. The client's autonomy is always respected but clients are regularly asked whether they want help to reduce their alcohol intake or to become abstinent and are given the option of community services if suitable. Information is provided to the client under these circumstances so that they know what to expect from a community referral. The motivation to seek help is encouraged by the ALN but clients choose whether they wish to seek support or not. A number of clients believe they can moderate or stop their alcohol consumption by themselves. The on-going pilot project with Red Rose Recovery will hopefully produce an increased referral rate to Inspire as they will be identifying and supporting clients to link in with Community Services, as appropriate to their needs. The HALS team have seen clients who have initially declined referral but, on recurring attendance, have later accepted and engaged.

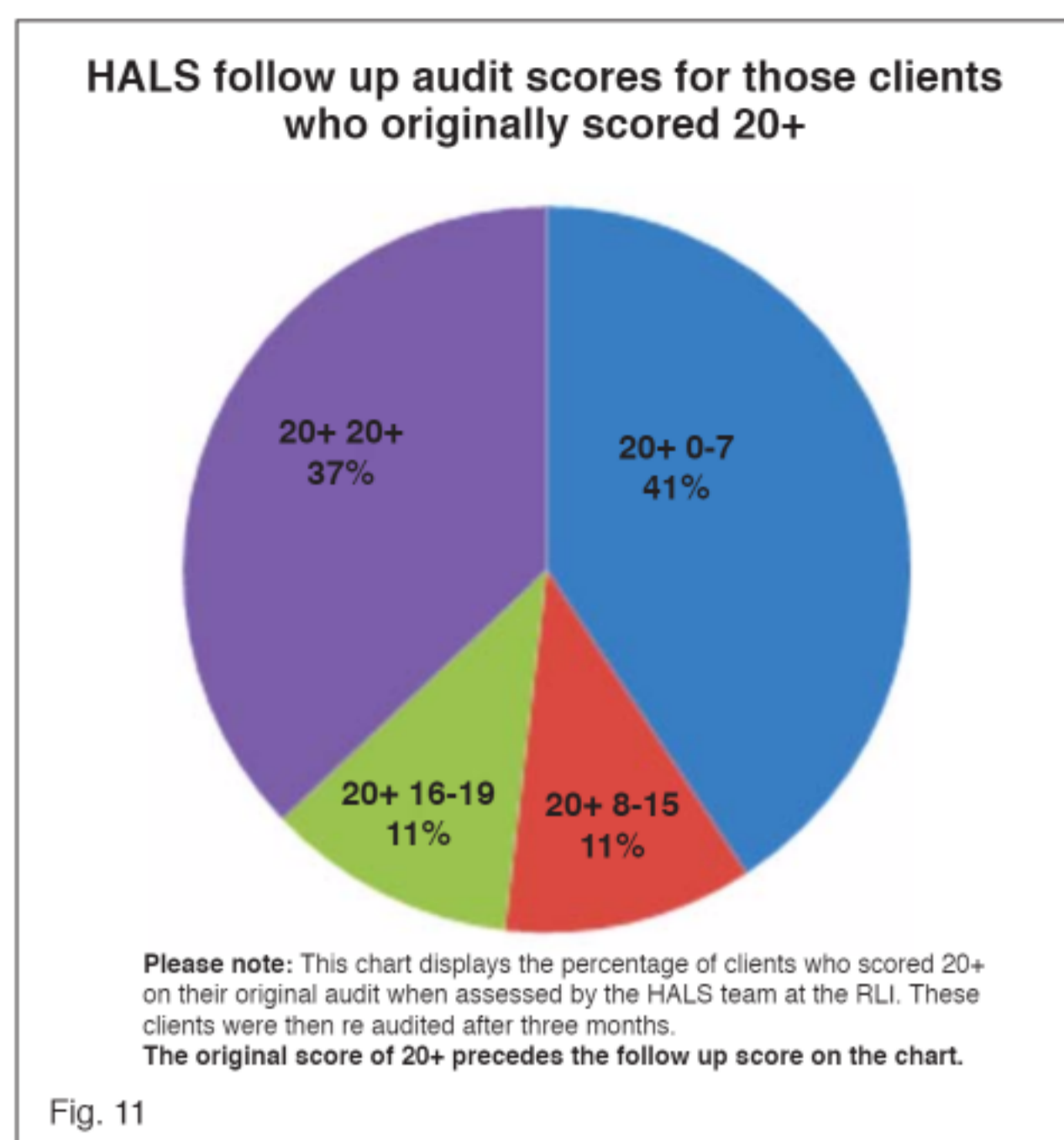
Red Rose statistical summary – Hospital Alcohol Liaison Service / Red Rose Recovery pilot project April 22nd 2015 – March 31st 2016 (Fig. 10)



Good practice recommends that individuals with an AUDIT score of 8 and over should receive a brief intervention. The intensity of intervention then increases with increasing AUDIT scores. The proportion of referred patients with an AUDIT score of over 8 is 73%, which correlates with the interventions provided (Fig. 8). However, brief interventions can be provided by all front line staff with an awareness of behaviour change and the impacts of alcohol on health. A wider delivery of brief intervention by front line staff across the Trust will facilitate HALS to provide a more specialist service (Fig. 9).



Alcohol Consumption 3 months post intervention. Three months after a patient has received an intervention from HALS, the team called up and repeated AUDIT to understand if there has been any change in the patient's levels of consumption.



The chart shows that 63% of the sample group has reduced their alcohol consumption as measured by AUDIT. 41% have reduced the AUDIT score to 0-7, indicating low risk. These outcomes are reliant on self reporting but are indicative of the positive impact of the service (Fig. 11).

The sample size of those re audited was 146 clients. Of those, 5% declined to engage and the remainder of 56% were unavailable either due to incorrect telephone contact details or not answering their phones.

SUMMARY

The first 13 months of service delivery has seen good progress against the aims and objectives and has made a strong impact. The outcomes data contained within this evaluation is very positive and needs to be further developed for the 12 month evaluation to demonstrate any causality.

RECOMMENDATIONS

The following recommendations are directed at both the commissioners of the services and the service providers.

Commissioning Recommendations:

1. The HALS services and associated support services including Inspire and Red Rose Recovery should continue to be commissioned from mainstream budgets. Explore the potential development of the Red Rose Recovery project to incorporate drug misuse referrals, this would require additional resources.
2. Explore the feasibility of expanding the service to include other forms of substance misuse.
3. Explore the development of a service to cover all sites within the Morecambe Bay area with Cumbria CCG.

Service Recommendations:

1. Explore opportunities for providing HALS services across the MBHT geography, involving Cumbria CCG.
2. Continue to collect and review data on the HALS service and Red Rose Recovery including insight into the socio-economic status of the patients.
3. Continue to raise awareness of the service eligibility criteria and encourage utilisation of AUDIT-C and AUDIT across the Trust to maximise efficiency.
4. Continue to develop and implement training and awareness raising programmes to increase skills and awareness of brief intervention. This training can be extended across other lifestyle issues which are known to cluster and cause or contribute to ill health (alcohol, tobacco, diet and physical activity).
5. Staff to be supported to incorporate the principles of Making Every Contact Count, understand local service pathways and community, support patients to address behavioural risk factors and adopt a self-care approach. This should be aligned to the work of the recovery community e.g. Red Rose Recovery.
6. The service continues to develop and improve the pathway into community services through collaborative practice with Inspire, and promote an emphasis on recovery e.g. Red Rose Recovery.
7. Continue to explore options for clinical support to analyse and interpret causes for healthcare utilisation in order to make recommendations for practice.
8. Continue to develop a multi-disciplinary approach through regular meetings with other relevant agencies e.g. Inspire, Red Rose Recovery.
9. Continue to expand the team's knowledge base and share this with the wider acute environment.
10. Continue to develop the solid working relationships the team have with the community service partners.
11. Develop mechanisms for effective audit, and link it to existing Lorenzo reporting systems.

Correspondence to:

Mike Leaf
 Director of Health Improvement
 Lancashire North Clinical Commissioning Group