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Developing clinically competent alcohol care teams

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Society for the Study of Addiction

Friday 6th November 2020

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Declarations, Funding & Grants:

- NHS England & Improvement
- NIHR-CDRF
- NIHR CRN Yorkshire & Humber

- NIHR Programme Grant
- Yorkshire and Humber Academic Health Science Network
- Office of the Police and Crime Commissioner
- Society for the Study of Addiction
- DH Alcohol Clinical Guidelines
- NHS England – ACT Working Group

Acknowledgements:

- Members of the Alcohol Care Team Clinical Competency Consensus Panel

University of Hull

- Dr Chao Huang & Amy Porter

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- Prof Simon Coulton

IOPPN, King's College London

- Prof Colin Drummond & Dr Emmert Roberts

University of Southampton

- Prof Julia Sinclair

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Aims

- Characterise the needs of patients hospitalised with alcohol use disorder
- Overview of the clinical competencies for Alcohol Care Teams

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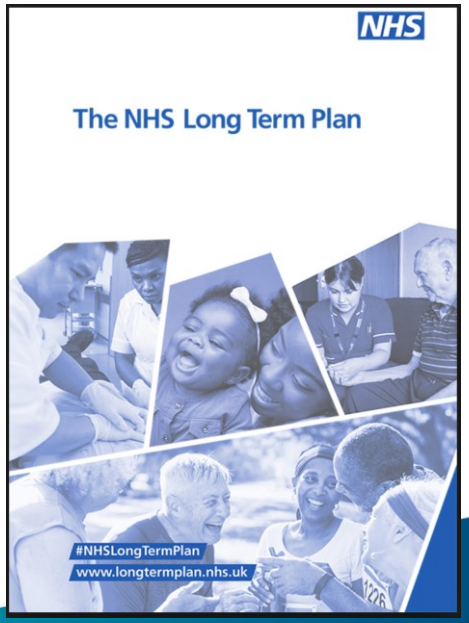
Alcohol Harm: Increasing priority

- **NHS Plan - Prevention Programme:** Over the next five years, those hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish ACTs



- 10 million people drinking **hazardous levels**
- Alcohol costs the NHS £3.5bn per annum
- Currently, 1.26million alcohol-related hospital admissions
- Average age of death: alcohol-specific causes 54.3 years

(DH, 2013; Burton et al, 2016)

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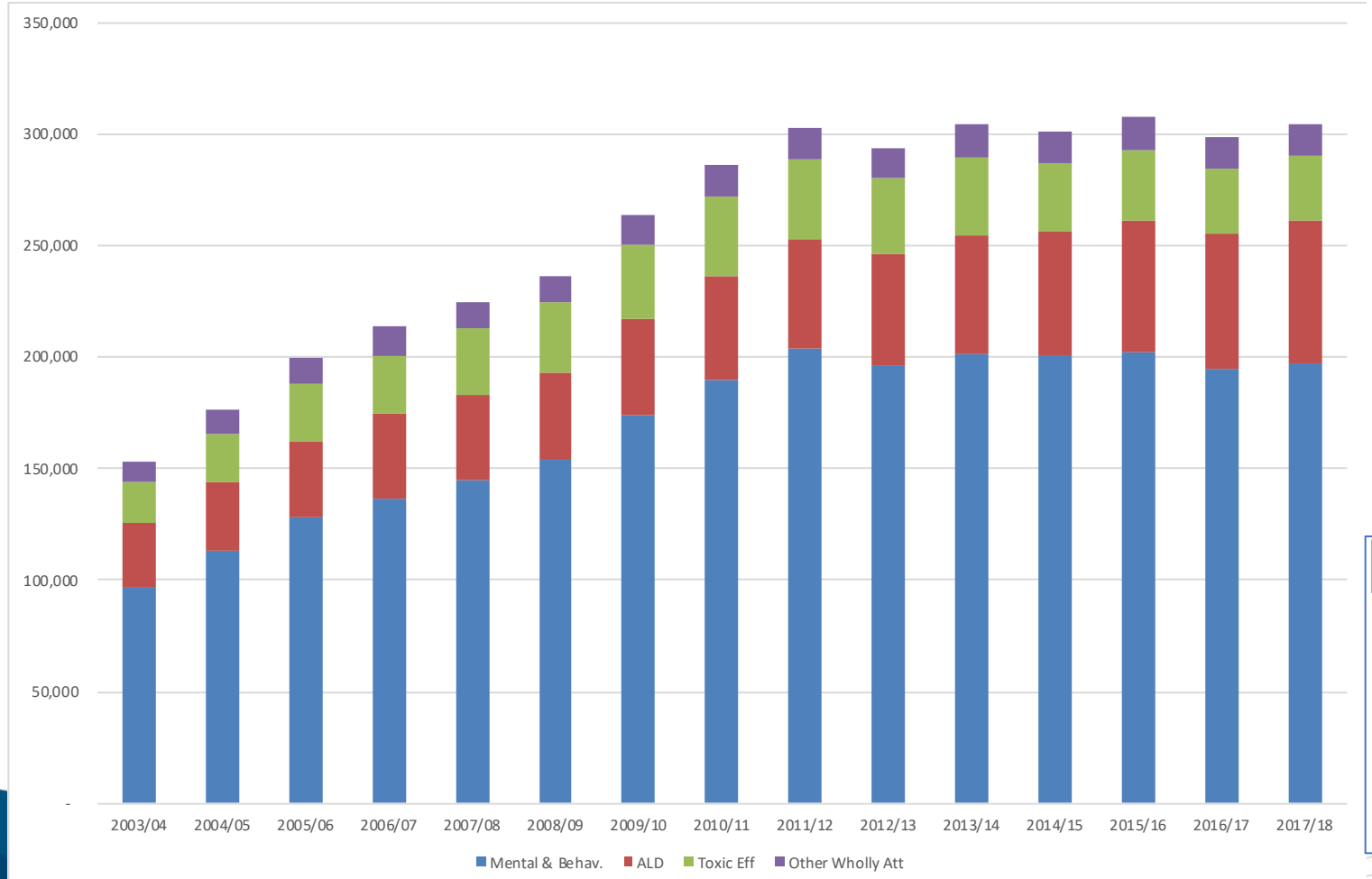
Wholly Alcohol-related admissions 2003-2018 (PHE, 2019)



Total Admissions: 300k

- 21% = K70 - ALD
- 66% = F10 Men. Bev. ETOH
  - Acute Intox. 20%
  - Harmful drinking 38%
  - Dependence 42%

ADDICTION
SSA SOCIETY FOR THE STUDY OF ADDICTION
REVIEW
doi:10.1111/add.14642

The prevalence of wholly attributable alcohol conditions in the United Kingdom hospital system: a systematic review, meta-analysis and meta-regression

Emmert Roberts[1], Rachel Morse[2], Sophie Epstein[3], Matthew Hotopf[4], David Leon[5] & Colin Drummond[1]

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Context

- Alcohol treatment system needs to be; *accessible*, *efficient* & *well resourced*
- Effective specialist treatment associated with improvements in liver morbidity and hospital admissions
- Health service use – individual and behavioural factors:
  - Individual's characteristics
  - Attitudes about health services
  - Ability to access care
  - Perceived and assessed need
- Unmet demand for treatment in one part of the system increases demand in another

(Babor, 2008; Rush & Urbanoski, 2019; Smart & Mann, 2000; Rautiainen 2019; Andersen, 1995; Ritter, 2019)

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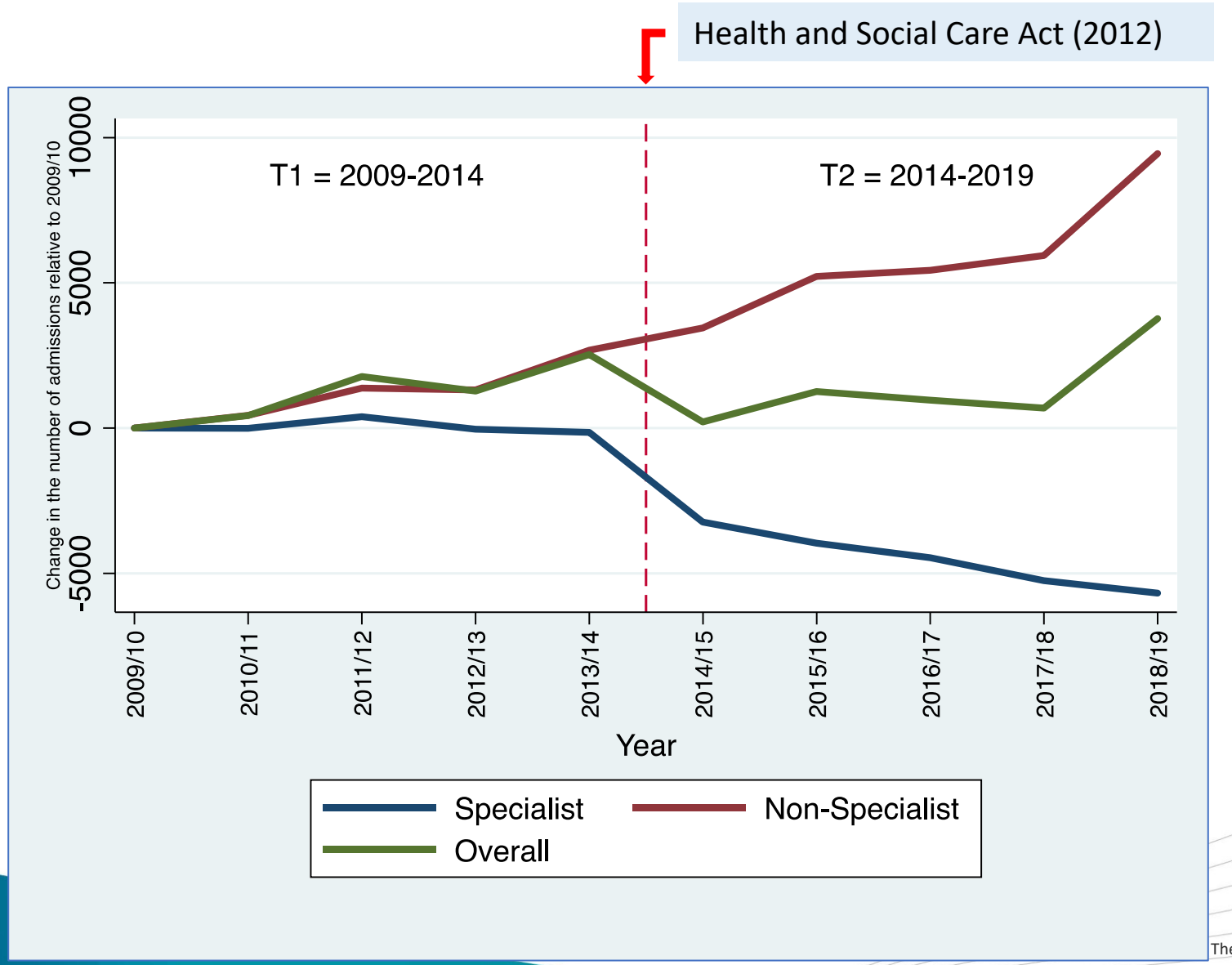
Annual changes in the number of alcohol withdrawal admissions by care setting relative to 2009/10 (Phillips et al, 2020)



r = - 0.93

Alcohol Alcohol, agaa086, https://doi.org/10.1093/alcalc/agaa086

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Characteristics

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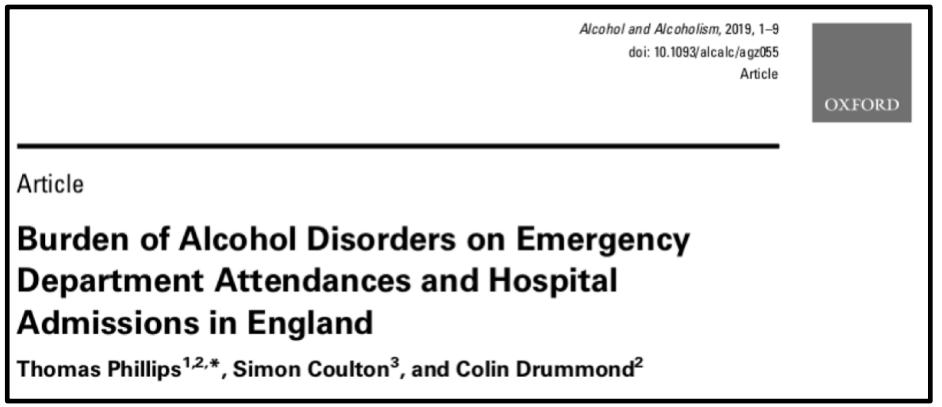
Defining the burden of AD on hospitals

- ED attendances and admission data were linked using Hospital Episode Statistics
- Groups identified:
  - a) no alcohol disorder (NAD)
  - b) acute alcohol disorder (AAD)
  - c) chronic alcohol disorder (CAD)
  - d) those with any alcohol disorder (AD) (b) and c) combined
- Associations between ED diagnosis and alcohol disorders
- Examining ED and hospital service use
- Cost differences by group using PMS


Alcohol and Alcoholism, 2019, 1–9
doi: 10.1093/alcalc/agz055
Article

Article

Burden of Alcohol Disorders on Emergency Department Attendances and Hospital Admissions in England

Thomas Phillips[1,2,*], Simon Coulton[3], and Colin Drummond[2]

Funded by: NIHR-CDRF

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Analysis of HES Emergency Admissions & Attendance data: Individual patient level

HES Inpatient Data 2009/10

N=6,563,447 Finished Consultant Episodes

Retained individuals: N=2,430,979

ICD-10 code – Wholly Alcohol Attributable Diagnosis (WAAD)

HES AED Data 2009/10

N= 13,284,470 Attendances

Retained individuals: N=7,810,689

AED "Diagnostic" code

Merged HES Inpatient & AED Data 2009/10

Matched: N=2,154,158

FINAL DATASET

Significant numbers of cases did not have any recorded AED conditions

Final dataset: N=1,209,760

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Distribution of demographic characteristics

	Total Sample	No Alcohol Disorder	Any Alcohol Disorder		Acute Alcohol Disorder	Chronic Alcohol Disorder
Totals: N (%)	1,209,760 (100)	1,128,502 (93.3)	81,258 (**6.7**)			
Age						
Mean age in years (95%CI)	58.3 (58.3–58.3)	**59.2** (59.2–59.3)	**45.5** (45.4–45.6)	*** <0.001*		
Sex						
Male:	47.5%	**46.1%**	**67.4%**	*** <0.001*		
Ethnic groups: N (%)						
Caucasian/Non-Caucasian %	83.7/16.3	**83.5**/16.5	**86.8**/13.2	***<0.001*		

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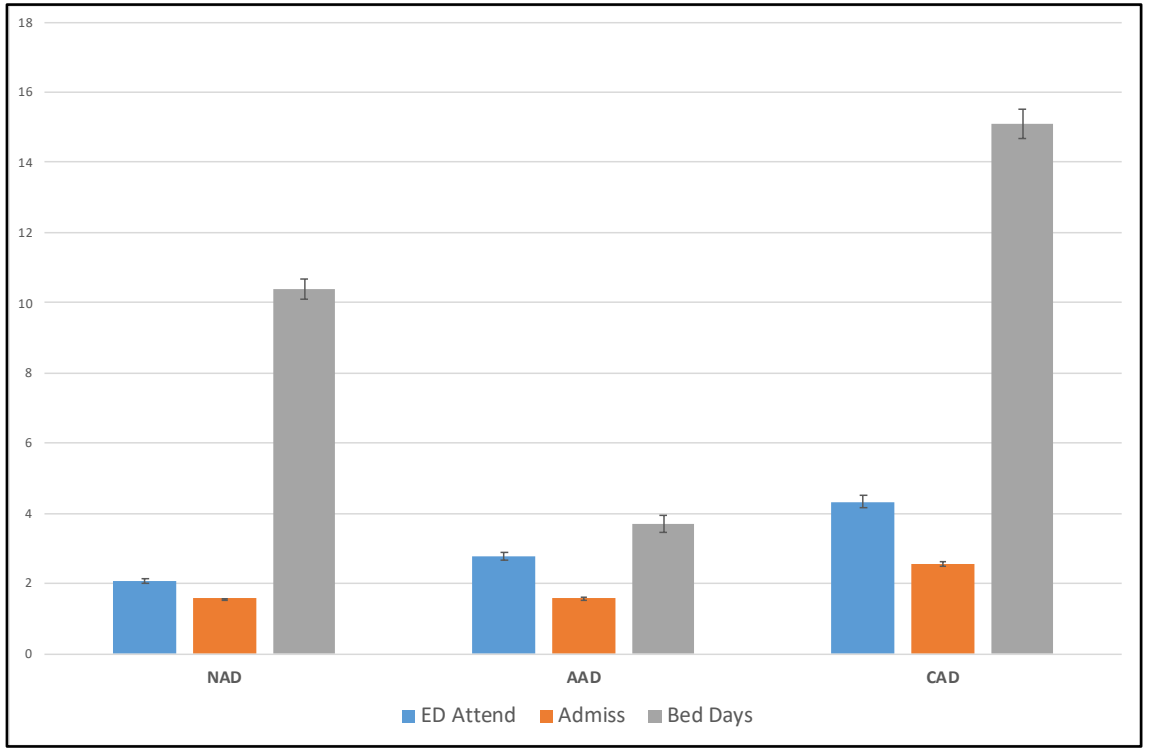
Mean annual number of ED attendances, admission and bed days by Alcohol Disorder (AD)

- Disproportionate ED attendances & Hospital Admissions
- Acute Alcohol Disorder:
  - Greater ED attendances (**2.78**; 95% CI 2.68–2.88)
- Chronic Alcohol Disorder:
  - Greater ED attendances **(4.33**; 95% CI. 4.14–4.52),
  - admissions (**2.56**; 95% CI. 2.50–2.63),
  - total bed days (**15.14**; 95% CI. 14.72–15.56).
- Majority admitted to General Medicine



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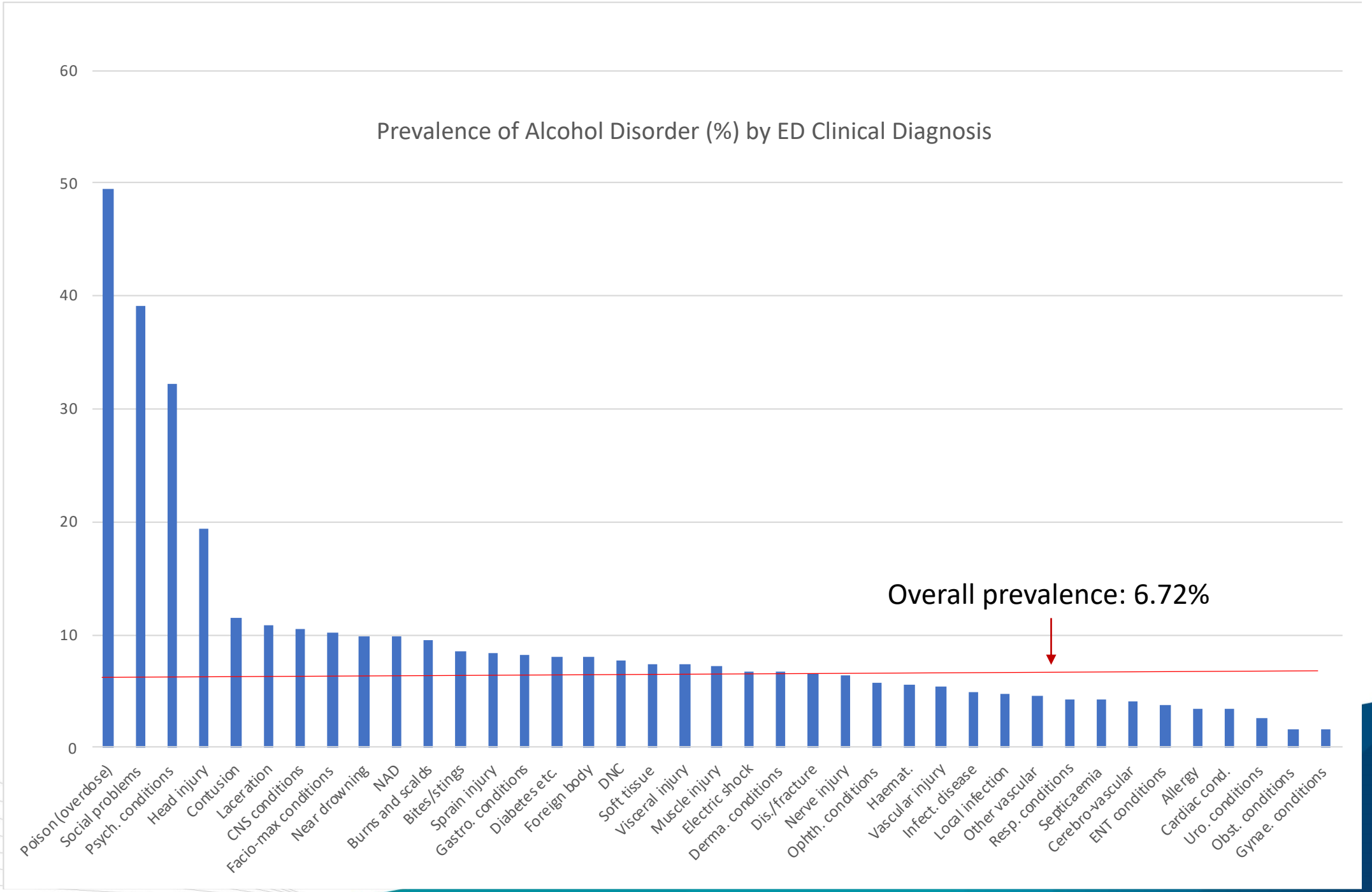

	ACUTE ALCOHOL DIS.		CHRONIC ALCOHOL DIS.	
ED Clinical "Diagnosis"	AOR	97.5% CI	AOR	97.5% CI
Poisoning (Inc. Overdose)	** **22.50**	(20.242; 25.010)	** 10.08	(9.179; 11.067)
Social problems (Inc. chronic alcohol. & home.)	** 8.51	(6.737; 10.743)	** **14.23**	(11.534; 17.552)
Psychiatric conditions	** 4.88	(4.141; 5.759)	** **5.92**	(5.295; 6.617)
Head injury	** **4.75**	(4.030; 5.602)	** 2.53	(2.282; 2.801)
Central nervous system conditions (ex. stroke)	–	–	** **2.27**	(2.095; 2.456)
Contusion / abrasion	** 1.69	(1.513; 1.897)	** 1.64	(1.491; 1.794)
Nothing Abnormal Detected	–	–	** **1.88**	(1.678; 2.109)
Laceration	** **1.76**	(1.481; 2.081)	** 1.32	(1.179; 1.481)
Diagnosis not classifiable	–	–	** **1.55**	(1.446; 1.660)
Diabetes and other endocrine conditions	–	–	** **1.59**	(1.426; 1.779)
Gastrointestinal conditions	–	–	** **1.89**	(1.777; 2.012)
Near drowning	–	–	* **1.70**	(1.114; 2.579)
Haematological conditions	–	–	* **1.23**	(1.030; 1.469)

Regression adjusted; hospital sites, age & gender. **<0.001; *<0.01

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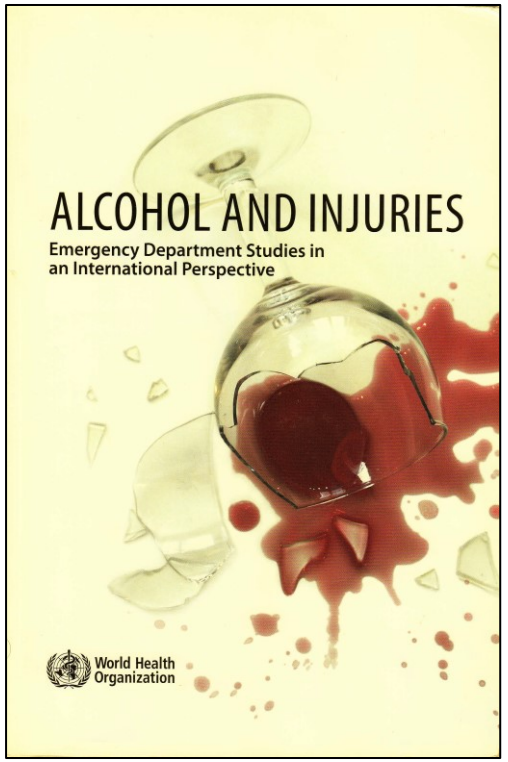
Characteristics ED & non-specialist admissions

- Male
- Not in a relationship
- Housing problems
- Attendance via ambulance
- Self-harm
- Accidents & injury (violence)
- Concurrent illicit drug use
- Chronic physical and mental health conditions (Pain)
- Tobacco use
- AUDs with chronic and excessive use greater morbidity
- Complexity and severity = **legitimate** admissions (Frequent)



(Cherpitel et al, 2009; Dent et al 2010, Jelinek, 2008; Parkman et al 2017; Roberts et al 2020**)**

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Competencies

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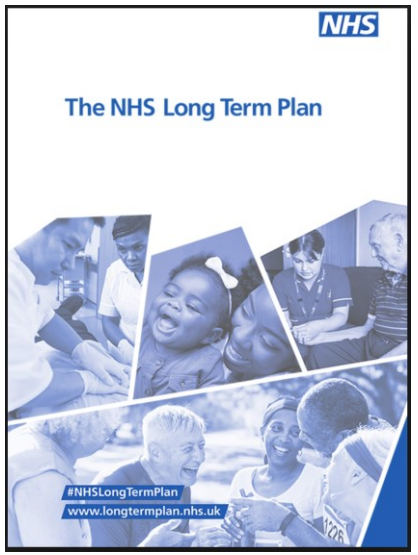
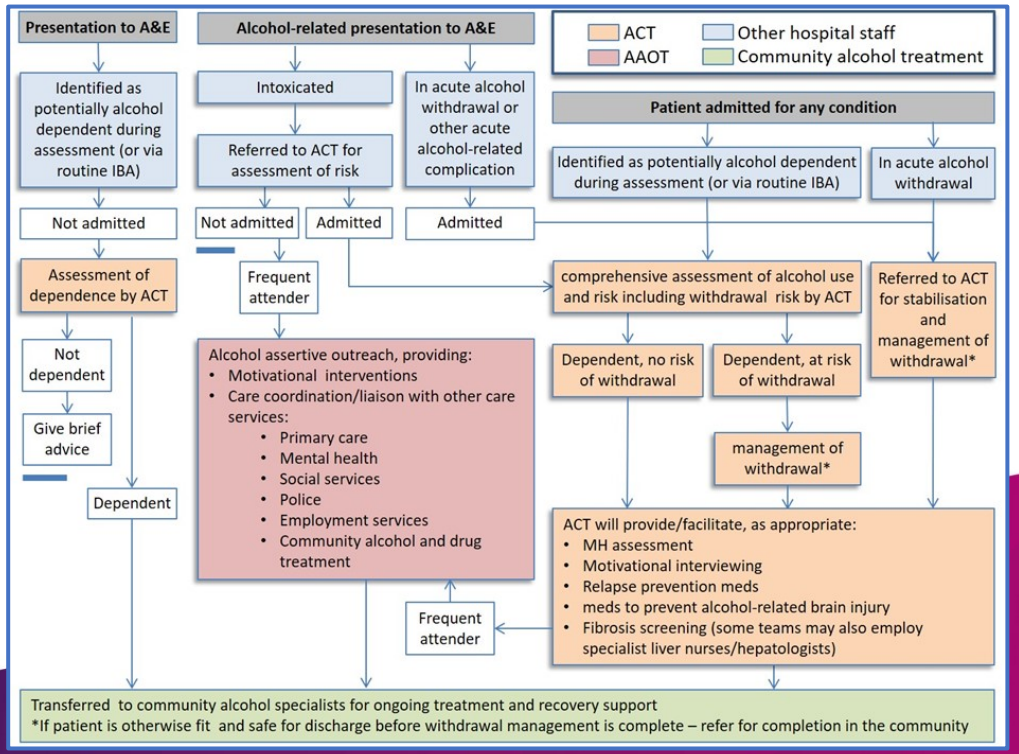
Alcohol Care Team

A multi-disciplinary ACT, 7 days/week based within Acute Hospital:

1. Screening and brief interventions
2. Carrying out comprehensive alcohol assessment
3. Specialist contribution to nursing and medical care
4. Management of medically-assisted alcohol withdrawal
5. Provision of psychosocial interventions
6. Planning safe discharge, including referral to community services
7. Senior clinician – leadership and strategic development
8. Provision of education and training in relation to alcohol.

(NHS, 2019; Moriarty, 2011 & 2020)





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Clinical Competencies Project

Alcohol and Alcoholism, 2020, 1–6
doi: 10.1093/alcalc/agaa024
Rapid Communication

Rapid Communication

Clinical Competencies for the Care of Hospitalized Patients with Alcohol Use Disorders

Thomas Phillips[1,*], Amy Porter[1], and Julia Sinclair[2]

Aim: Define clinical competencies common to ACTs

Methods: Three distinct phases:

- Review and synthesis of current literature:
  - Guidelines, publications, policy statements: ASAM, US; CCSA, Canada, CQC, UK; HIN London, Matua Raki, New Zealand, NCEPOD, NICE, POMH-UK; Royal Colleges, Skills for Health
  - Identified 555 competency statements (Refined to 98)
- Face-to-face expert panel consensus meeting:
  - 24 senior clinical alcohol practitioners, leaders and experts by experience drawn from all regions of England
  - Review initial list of competency statements: 112 statements
- Refinement of competency statements - 2 rounds of iterations
  - Voting software: Endorsing 4 or more included - Statement List

Funded: NHS England & Improvement

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Results: 72 Competency Statements

Components	(N=72)
Component 1 - Case Identification/alcohol identification and brief advice (IBA)	**1**
Component 2 - Comprehensive alcohol assessment	**2-12**
• Triage assessment	4
• Comprehensive assessment	2
• Goals & Care Planning	5
Component 3 - Specialist nursing and medical care planning	**13-32**
• Implementing Planned Care	2
• Advisory Roles and Functions	15
• Relapse Prevention	3
Component 4 - Management of medically-assisted alcohol withdrawal (MAAW)	**33-50**
Component 5 - Provision of psychosocial interventions	**51-56**
• Provision of MET	4
• Supporting Families	2
Component 6 - Planning safe discharge	**57-62**
Component 7- Clinical leadership	**63-68**
Component 8 - Provision of trust-wide education and training	**69-72**

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Examples: Higher level competency statements

Assessment Statement 7:

“Possesses the knowledge and skills to use and advise on the appropriate validated tools for the assessment and monitoring of patients with alcohol use disorder throughout their care”

Specialist care Statement 21:

“Differentiates the symptoms and signs of alcohol withdrawal from withdrawal from other drugs including prescription and over the counter (OTC) medications”

Specialist care Statement 22:

“Recognises and responds to over sedation and other complications associated with withdrawal medication”

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Challenges to be addressed

Issues of *access, effectiveness* and *resource*:

- Potential skills deficits – variability in professional backgrounds
- Lack of routine screening & case identification
- Organizational imperatives (i.e. LoS) v. comprehensive care
- Readmission:
  - Incomplete withdrawal programmes & Dx AMA
  - Socially disenfranchised groups
- Service user prioritization of needs
- Engagement of wider healthcare system – *collaborative/assertive care*

(Mitchell, 2012; Yedlapati & Stewart, 2018; Neighbors, 2018; Moriarty, 2019; Drummond, 2018)

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Conclusions

- Historic underinvestment in alcohol treatment
- Complex, high-need service users present to non-specialist settings often ill-equipped or resourced
- Competencies provide a template for clinical practice and the development of multidisciplinary ACTs
- Training and CPD for Alcohol Care Teams to be developed
- Health service and delivery research - impact and outcome of ACTs:
  - Effective training strategies for ACTs and Hospital Staff
  - Technology to support and guide withdrawal management
  - Transfer to ambulatory withdrawal programmes
  - Effective psychological interventions
  - Effectiveness of collaborative models of care

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