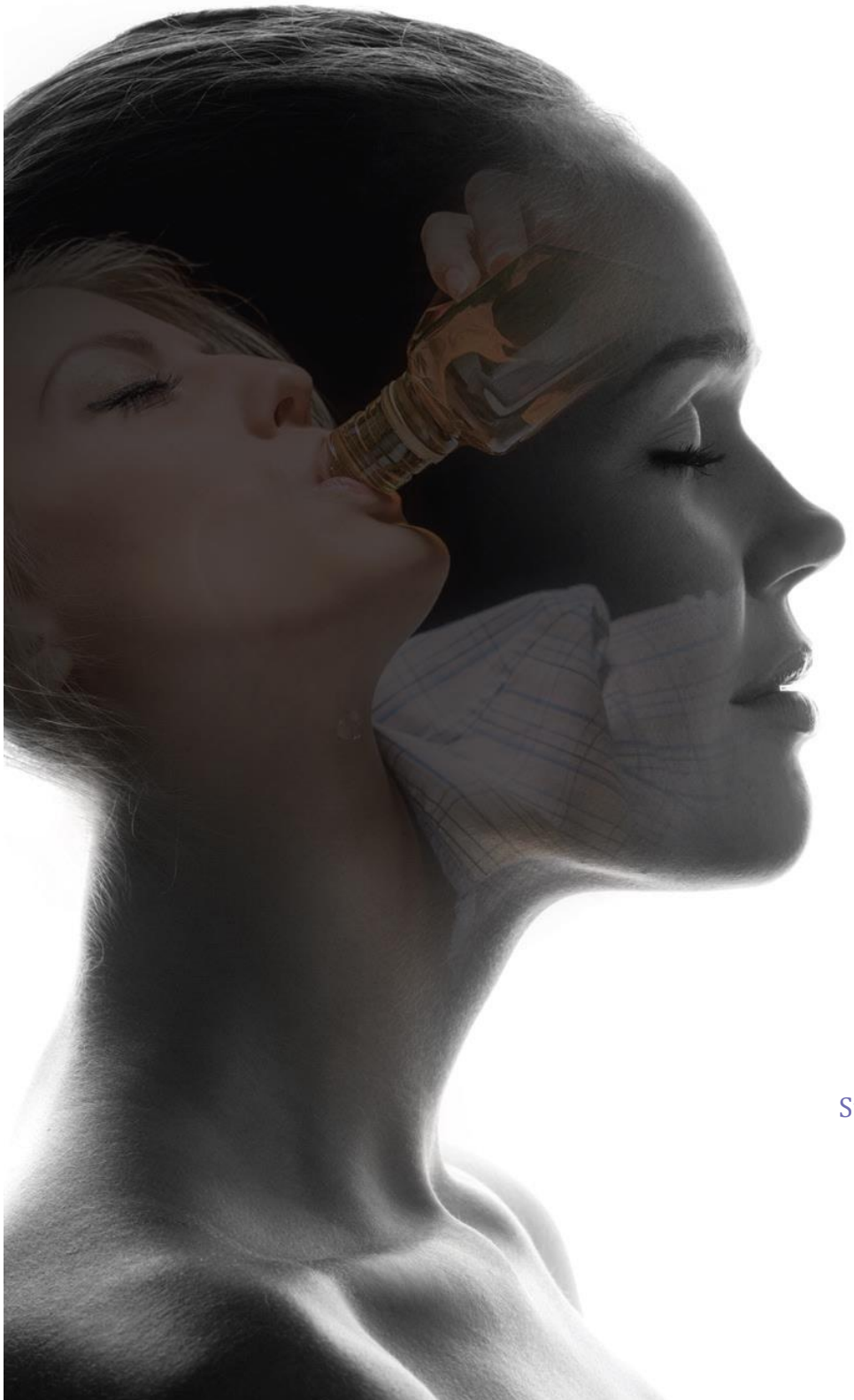
SUAB
Substance Use and Associated Behaviours Research at Man Met

Manchester Metropolitan University

Alcohol Care Teams
Summary of a Review for Manchester



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September 2022

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Acknowledgements

Special thanks go to Kieran Moriarty who gave his time to add the missing detail to the body of evidence referenced in this report.

1 METHODOLOGY

This summary reports on a review and research project that brings together evidence from policy guidance, research and evaluation literature and stakeholder testimony as relevant to the response to alcohol problems in acute secondary care settings with a particular focus on the role and operation of alcohol care teams. The main report includes research focused on the current and service needs for ACT and care pathway development and reduction in frequent attender burden. This report summarises the public domain evidence transferable to other service development in England.

1.1 Data collection

The collation of documentary evidence involved a series of literature searches using academic and generic search engines and included specific searches in specialised archives of organisations and institutions such as Public Health England (PHE), NICE, Department of Health and Social Care (DHSC). These searches were augmented by following up on further sources cited in included texts as needed.

Search terms used were guided by the focus of each of the sections of this report and included variations on the following:

- Reducing ambulance call-outs and alcohol
- Reducing repeat hospital admissions/attendances and alcohol
- Alcohol care teams and hospital
- Alcohol care teams – effectiveness
- Alcohol assertive outreach teams
- Alcohol and unmet need
- Frequent attenders in emergency care
- Alcohol and training
- Clinical management and policy, liver disease

Approximately 200 papers, reports or guidance documents were collated and reviewed.

Stakeholder evidence was obtained from a total of 28 individuals holding a range of roles across varied settings within the Greater Manchester area. Conversations with stakeholders were investigator led and guided by the foci of the project but conducted flexibly in line with the focus, reach and scope of the interviewee's role. We were unable to obtain service user perspectives.

Stakeholder and documentary evidence was further supplemented by the inclusion of notes from steering group meetings and relevant supporting papers, as well as consultation of various HSE and PHE/LAPE datasets.

As this is a summary of project findings for general use, specific details relating to Manchester health, social care and third sector services, not already available in the public domain, have been removed from this report.

1.2 Analysis

The approach to analysis was pragmatic, critically examining and extracting relevant findings from research and evaluation studies and bringing together the messages from guidance papers. Similarly, with stakeholder testimony, responses were interrogated for material which could inform the development and implementation ACTs with reference to areas of interest outlined by commissioners; existing arrangements, pathways, reducing frequent attendances/admissions, unmet needs and training.

1.3 Ethics considerations

The processes adopted for this consultation were approved by Manchester Metropolitan University Ethics Committee and included provision of full information about the study to prospective participants as well as the ways in which data would be handled and reported prior to interview.

2 BRIEF OVERVIEW OF CURRENT UK GUIDANCE AND GOOD PRACTICE FOR ALCOHOL CASE MANAGEMENT

2.1 UK Guidance

The NHS Long Term Plan (NHS, 2019) calls for more focus on alcohol harm prevention and, with further collaboration between NHS England Improvement (NHSEI) and Public Health England (PHE), makes specific recommendations to improve quality of alcohol-related care. These include the establishment of ACTs to reduce ED attendances, bed days, readmissions and ambulance callouts. Funding, it is suggested, could be used to establish these services, prioritising hospitals with the highest rate (top 25%) of alcohol dependence-related admissions which should establish ACTs and be working in partnership with local authority commissioners and substance use services. The Long-Term Plan cites evidence from good practice in Bolton, Salford, Nottingham, Liverpool, London and Portsmouth which demonstrate significant reductions in A&E attendance, bed days, re-admissions and ambulance callouts (NICE, 2014; NICE-QUIPP, 2016).

These recommendations build upon the government's alcohol strategy (HM Government, 2012), supporting evidence and expert commentary from The British Society of Gastroenterology, Alcohol Health Alliance UK and British Association for Study of the Liver (Moriarty et al., 2010), and listing the key functions recommended by the Royal College of Physicians (2013);

> *"Every acute hospital should have a specialist, multi-disciplinary alcohol care team tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions."*

The strategy stresses that this requires leadership, cross-departmental collaboration and partnership with primary care, specialist community alcohol services and patient groups and that there is good evidence that this can be achieved by the establishment of multi-disciplinary alcohol care teams. Much of the evidence for the functioning of ACTs has been developed from the Salford model of collaborative care championed by Kieran Moriarty, then consultant gastroenterologist at Royal Bolton Hospital who has developed the model since 1990 that made key recommendations for a consultant led multidisciplinary team approach, to enable hospital wide screening, brief interventions, protocols for detoxification, a readily available acute response for complex clinical management, staff training and liaison with psychiatry and primary care to facilitate holistic care (Moriarty et al, 2007; Moriarty, 2011). With more evidence to support the need for a whole systems approach to alcohol dependence that includes social care (LGA, 2018; 2019), current guidelines also emphasise strong community links.

In brief, the three main current guidance documents for ACTs (The Core Service Descriptor; Optimal ACTs; Developing Pathways) (PHE/NHS 2019a; 2019b; PHE, 2018a) indicate the core service components, operating principles and pathways recommendations in support of the development of ACTs within an effective whole system approach.

2.2 The core descriptor & optimal ACTS

The Core Service Descriptor details the service components and operating principles for both accident and emergency (A&E) and in-patients, specifically a multi-disciplinary Alcohol Care Team that delivers:

1. Case identification
2. Comprehensive alcohol assessment
3. Nursing and medical care planning
4. Medically assisted withdrawal management (MAW)
5. Provision of psychosocial interventions
6. Planning safe discharge with referral to community services
7. Senior clinical leadership
8. Trust-wide education and training.

Key to ACT functioning should be incorporation of ACT development with local authority and relevant partners, and an ACT that is co-ordinated with agencies for effective joint working across hospital and community support. This includes discharge pathways from hospital and hospital in-reach by community services. The Optimal Alcohol Care Teams (ACT) briefing sets out the case for establishing ACTs as per the Core Descriptor (included in 'The evidence' below).

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

1. reduce avoidable alcohol-related hospital admissions by reducing severe health risk among dependent drinkers
2. reduce the length of stay for inpatients by improving the management of withdrawal
3. provide appropriate, timely, meaningful education and support for those attending or being admitted with alcohol-related problems
4. facilitate integrated alcohol care between secondary, primary and community NHS England and NHS Improvement
5. provide psychosocial interventions to support dependent drinkers to sustain abstinence following discharge
6. improve compliance with the trust's alcohol withdrawal guidelines
7. educate staff on alcohol use disorder and its management
8. improve information sharing between services (e.g., secondary care, primary care and community services)
9. improve data collection and opportunities for analysis.

In short, the current guidance presents a plan for service improvement for dependent drinkers that provides a whole-systems integrated approach based on existing evidence, and which focuses on resource use and cost benefit. It presents a resource for commissioning groups and local authorities in developing a local response to alcohol-related admissions.

2.3 Care pathways

Public Health England guidelines for developing care pathways (PHE, 2018a) recommend steps for supporting treatment access following detection and brief intervention through care pathways between secondary and community care, indicating that '*pathways should be more than a travel itinerary*'. Caregivers should know how to refer and to whom, and to receive expected patients with all the relevant information to hand. Care providers should ideally understand the whole pathway and have the capacity to provide it. Provision should be regularly reviewed by all agencies, with partnership working to provide a seamless service. This suggests regular meetings, working groups and possibly audits to monitor the effectiveness of the pathway, identify barriers, missed opportunities and unmet need, and the means to problem-solve and instigate change.

The pathway guidance (see Figure 2.1) recommends Mental Health, Community and Acute Trusts should be identifying dependent drinkers through screening (using AUDIT or AUDIT-C) and refer to community alcohol services or mental health services, with use of assertive engagement services for high need, high-cost drinkers (usually referred to as frequent attenders).

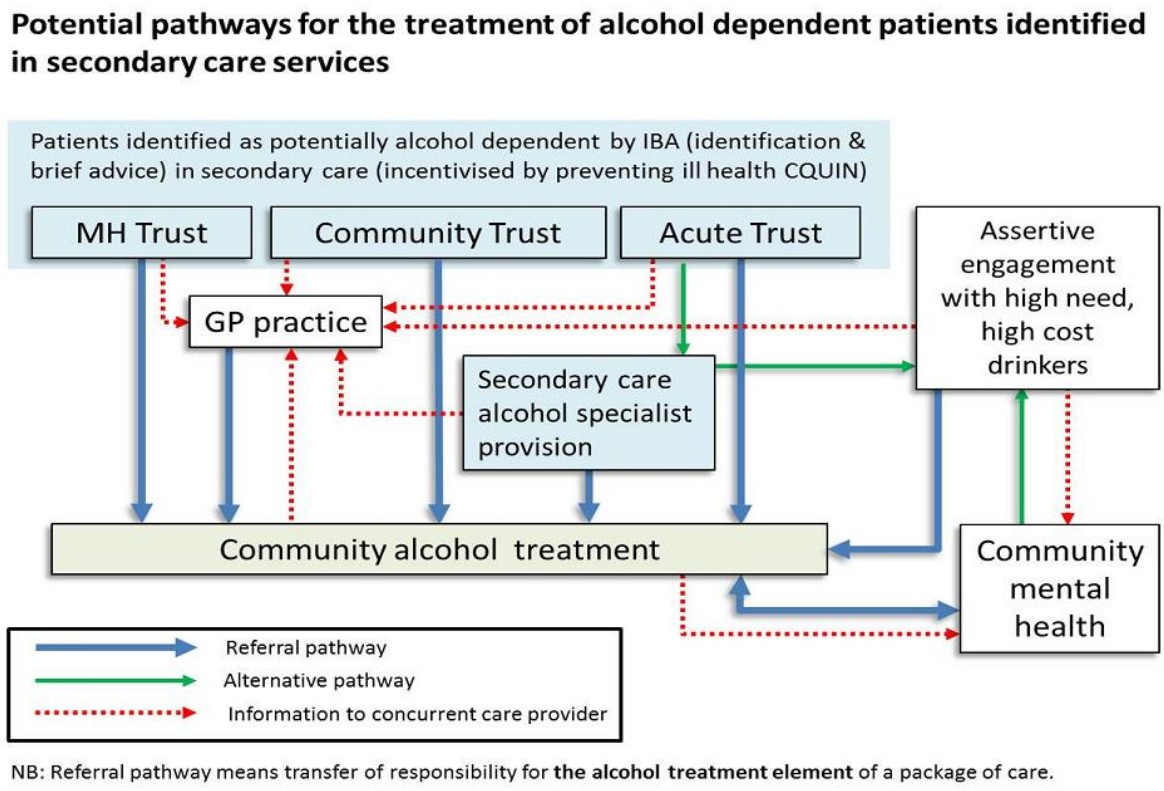

Figure 2.1: Alcohol dependent patients' referral pathways for secondary and community care services (PHE, 2018a).

Figure 2.2 further specifies the ways in which ACTs might facilitate efficient and effective care for this patient group.

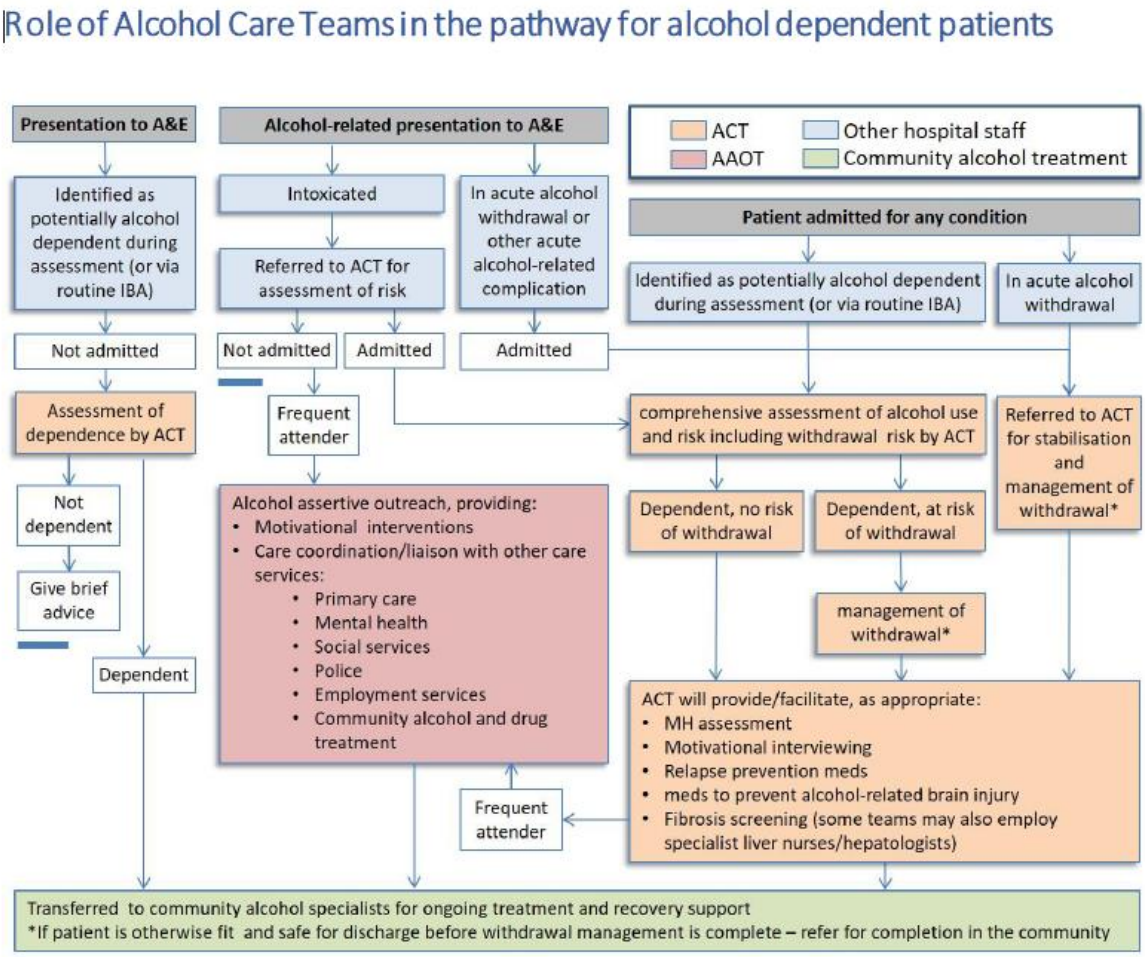

Figure 2.2: The role of ACTs in the pathway for alcohol dependent patients (PHE/NHS 2019a)

2.4 The evidence

2.4.1 Why focus on alcohol dependent adults

There were 1.26 million alcohol related hospital admissions in England in 2018/19, representing 7.4% of all admissions and 8% higher than the 2017/18 admissions (NHS Digital, 2020). This is part of a long-term upwards trend of heavier drinking by older adults (55-74). It is estimated that, in the UK hospital system, one in five patients uses alcohol harmfully, with one in ten alcohol dependent and most prevalent in A&E (Roberts et al, 2019).

An estimate of the burden of alcohol disorders on hospital inpatient and A&E services by Phillips et al (2019) demonstrates highly disproportionate rates of A&E attendance, admission and bed days for patients with chronic alcohol disorders (dependence or liver disease), in comparison with those with acute alcohol disorder or no alcohol disorder (at over 4 times for attendance, 2½ times admissions and over 15 more bed days). Estimated relative cost difference between patients with any alcohol disorder in A&E or admission, compared to patients with no alcohol disorder was £1,456.53, while chronic alcohol disorder admissions cost is 47% more than for patients with no alcohol disorder; a cost difference of £2,324.02 (Phillips et al, 2019). Overall, alcohol harm was estimated in 2011 to cost the NHS £3.5 billion per year (Scarborough et al, 2011) which is likely to have increased in parallel with the rising rate of alcohol-related hospital admissions to date.

Public Health England (PHE, 2021c) report an increase in unplanned admissions for alcohol-related liver disease since June 2020, which mirrors increased deaths from alcohol-related liver disease. A concern for PHE is that a Covid effect has increased drinking among those who are already heavy drinkers but has delayed contact with health services due to lockdowns and hospital avoidance. This may suggest an iceberg effect post-Covid as heavy drinkers later present with alcohol-related liver disease.

2.4.2 Alcohol Care Teams Models and Evidence of Effectiveness

Recommendations for the presence, structure and functioning of ACTs or similar provision in hospitals stem from a body of evidence informing the NICE Quality and Productivity Proven Case Study review, updated until 2016 and published by The British Society of Gastroenterology and Bolton NHS Foundation Trust (2016). The evidence supporting this and NICE/QUIPP is based on services in England that report evaluation results produced prior to 2011. Since these models and results were published, results from further case examples following similar models for alcohol management have been reported. Below we outline the evidence from the original sources where available.

2.4.3 Proven Case Study evidence

Nottingham produced a case study of a 5-year nurse-led hospital assessment service, providing AUDIT assessment, advice, weekly outpatient clinic and brief and extended brief advice (Ryder et al, 2010). This resulted in a two-thirds reduction in hospital admissions, saving 36 bed days per month. Also, clinical incidents of violence were reduced by 75%.

St Mary's Hospital, Paddington tested the use of the Paddington Alcohol Test (PAT) and brief advice for use in the Emergency Department (ED) (Touquet & Brown, 2009). Findings showed a 10-fold increase in referrals to an alcohol specialist and a 43% reduction in alcohol consumption, halving re-attendance within one year and increasing uptake of an alcohol clinic offer. Crucially, the evidence supports *immediate use* of the brief advice for best effectiveness. This suggests bedside intervention by department staff rather than referral to specialist teams when only a day service is available.

The Royal Liverpool Hospital extended the role of specialist alcohol nurses to include inpatient wards as well as the ED. Their data is no longer available, but the Nice Case Study report states they reduced 150 admissions over a year and have now rolled out the alcohol team to provide clinics throughout the city (as a form of outreach). No data on this impact is readily available. However, Liverpool Community Alcohol Service now provides community based self-referral or GP referral, and community detoxification.

The Queen Alexandra Hospital in Portsmouth assessed the use of 3 specialist nurses working with hepatologists and acute care medics in 2010, to roll out rapid assessment and management of alcohol dependent patients in acute care (Aspinall et al, 2011). They later developed a specialist alcohol team of 6 nurses and 1 administrator, and 4 liver specialist nurses. Providing support for bedside screening (using PAT), the team is estimated to have saved over 2000 bed days across the county in 2017. They are now delivering a 7-day service provided by specialist alcohol/liver nurses.

2.4.4 Further case study evidence

Alcohol Care Teams established in England are showing effectiveness in reducing admissions, re-admissions, bed days and mortality (NICE-QUIPP, 2016). As illustrated by the case studies below, specialist alcohol teams are developing and expanding from EDs to include inpatient wards and supportive links with community services. As reported by the NICE Case Study update (British Society of Gastroenterology & Bolton NHS Trust, 2016) Salford Royal has pioneered the alcohol assertive outreach team, and Royal Bolton Hospital has led the way on producing evidence in support of multi-disciplinary alcohol care teams that provide assessment, brief advice and outpatient follow up clinics, and support admissions and community discharge (Moriarty, 2011).

Bolton & Salford

The Salford Royal NHS Foundation Trust provide a 7-day ACT service comprising a lead consultant with a clinical and strategic role, multi-disciplinary clinical team and alcohol specialist nurses, linked to primary and community services. This consultant led, multidisciplinary model was shown to reduce length of stay from 8.0 days to 5.7 days, making a saving of more than 1000 bed days per year (Moriarty, 2011). The ACT at Salford Royal particularly targets A&E attendance and short-stay cases to deliver assessment, triage and brief intervention and advice. A multi-disciplinary Assertive Outreach Alcohol Service targets longer stay alcohol related patients (i.e., liver disease and detoxification cases) and the top 30 frequent attenders. This service is shown to significantly reduce admissions and A&E attendance (Hughes et al, 2013).

In this model, specialist nurses in alcohol, psychiatry and liver disease are seen as key cost-effective elements within the team, as is the need for a consultant lead with dedicated sessions, integrated alcohol treatment pathways between secondary and primary care, and the presence of a multi-disciplinary alcohol assertive outreach team. Additionally, there should be training for junior hospital staff, particularly in gastroenterology, acute medicine and psychiatry. Moriarty (2014) estimated that the cost of investing in specialist alcohol nurses at the Royal Bolton Hospital for £165,000 per year saves 2,000 bed days and frees 4-6 hospital beds, saving £636,000 and giving a return on investment of £3.85 for every £1.00 spent. The estimated cost effectiveness for the Salford ACT hospital model is an annual saving of £698,000, 400 fewer admissions and freeing up at least 2 hospital beds (NICE-QUIPP, 2016).

Sandwell and West Birmingham

Sandwell and West Birmingham Hospitals NHS Trust (SWBH) estimate a saving over 2 years of at least £570,000 and 1295 bed days following the inception of a 5-day/week short day ACT team that covers the two main general hospitals (Copeland & Bradbury, 2020). As these 2-year data include a first year focused on establishing the team and community networks, it is likely that larger benefits will accrue over future audit periods. Sandwell and West Birmingham Hospitals NHS Trust are now expanding the ACT team's function to provide a consultant-led 7-day service (8am – 8.30pm), with band 8 nurse leadership to co-ordinate research and development, FibroScan facilities and Commissioning for Quality and Innovation (CQUIN) monitoring, and to consider a 'step-down' facility for medically well detoxification.

South London and Maudsley

The ACT at King's College Hospital NHS Foundation Trust was established in November 2018 and over 3 months reported diverting 65% of A&E alcohol attendances to community services and reducing the average length of stay for admissions from 4.9 days to 4.2 days, which, they report, was 33% below national average for these patients with alcohol-attributable presentations. The ACT manages an estate with historically 55,000 alcohol-related hospital admissions. By October 2019, they reported reducing alcohol-related bed days from 6.3 days to 3.7 days, which is a saving of £536,000 per annum (King's Health Partners, 2019).

Wigan and Leigh

In 2013, Wigan Borough developed Integrated Neighbourhood Teams (INTs) as part of their Whole Systems Partnership to target people most at risk and those with complex health and social care needs, including people with chronic drug and alcohol needs (Whole System Partnership, 2016). The INTs include an Active Case Management team as part of Wigan and Leigh Drug & Alcohol Recovery Partnership, involving primary care, and an alcohol care pathway, both working closely with GPs, hospitals, A&E, dual diagnosis and mental health teams, community substance use services, Fire, Police, local Authority and multiple 3rd sector community providers. Within this network, the Extended Active Case Management Team (ACM) provides an assertive outreach and in-reach role, working across hospital and community providers, assisting with referrals from primary care, A&E and hospitals towards appropriate community and health support. The ACM team is comprised of specialist alcohol and liver disease nurses, operating within an Enhanced Alcohol Pathway, in effect functioning as an ACT.

Since the Enhanced Alcohol Pathway has been adopted in Wigan, alcohol-related hospital admission rates have reduced by approximately 25% with cost savings of approximately £672,000 in 2014/15 (Wigan Alcohol Care Team Evidence, 2015).

Northern Alliance
Evidence from interviews with clinical managers at Turning Point's ROAR (Rochdale and Oldham Recovery), indicates that Northern Alliance have a similar referral pathway arrangement with voluntary sector community substance use provider as currently exists at MFT, but report fewer barriers to liaison and communication due to having an information-sharing agreement between the Trust and Turning Point. This permits NHS staff to review Turning Point's patient information system but does not allow ROAR staff to access Trust records. This is reported to at least allow hospital staff to identify if patients are already in contact with services and review prescribed medication or other treatments.

2.4.5 Care pathways and referral networks

Patients with alcohol dependence or alcohol-related liver disease are also likely to have complex physical and mental health and social care needs which are not met in acute care and are therefore likely to need to return to hospital (Phillips et al, 2019) and require multi-agency and care pathways models to better meet their needs (Fleming et al, 2019). However, the gap between hospital and community alcohol services is commonly heightened by poor information sharing, lack of knowledge of services, service fragmentation and poor access to mental health services, all shown to reduce access to specialist community services (Roberts et al, 2020). The Local Government Association (LGA) and many clinical researchers report the need for sustained multi-agency and community interventions for chronic alcohol dependence and that hospital attendance and admission without this follow up is a missed opportunity to provide meaningful treatment and care (LGA, 2018; Drummond et al, 2016; PHE, 2014).

2.4.6 Assertive alcohol outreach and targeting of frequent attenders

Assertive outreach and in-reach for people with alcohol dependence and chronic alcohol-related disease is part of the alcohol care pathway approach for many services offering dedicated alcohol teams, but not all have integrated these teams within a whole systems approach to alcohol care. **Wigan Borough Council** have developed assertive outreach in all but name within their whole systems approach.

Blackpool Council have contracted Horizon (a community substance use agency) to provide assertive outreach for dependent drug and alcohol users who fail to engage in treatment services. Linking with hospitals and community service, the assertive outreach team also provide in-reach, providing psychosocial interventions and care pathway advice and monitoring (Blackpool Council, 2021).

Salford Royal Hospital provides an assertive outreach service and in 2012, this was shown to reduce admission rates of the top 30 frequent attenders by two-thirds (from 151 to 50) and A&E attendances by nearly two and a half (from 360 to 146) within 3 months of operation (Hughes et al, 2013). With an annual service cost at £300,000, This is estimated to produce £556,500 saving, representing a return on investment of £1.86 for every £1.00 spent (Moriarty, 2014).

The Institute of Psychiatry has also demonstrated the impact of alcohol assertive outreach in London by targeting 100 frequent users of health services, using intensive weekly contacts over 12 months. After 6 months of contacts, they demonstrated a 48% reduction in hospital bed days among targeted service users, in comparison with a matched group whose usage increased by 68% (a possible secular trend). Estimated net saving for the first year amounted to £10,500 per patient of inpatient costs alone (Drummond et al, 2016; Guy's & St. Thomas' Charity, 2018).

2.5 Summary of case studies

Alcohol care teams, enhanced pathways and targeting of frequent attenders are shown across several examples to be effective in reducing admissions, bed days and attendance rates, and to offer positive return on investment, especially following initial set up and development costs. Most models in the above examples follow the evidence guidelines to provide specialist liver and alcohol nurses, in-reach and outreach approaches to improve pathways between hospital, primary care and specialist community services. Most are using a 7-day service (but not 24-hour availability), with several adopting the Paddington Alcohol Test (i.e., St Mary's Paddington; Portsmouth) in emergency departments for cases where alcohol-related problem is detected, or AUDIT for routine screening. While case study models differ in several respects, all variants demonstrate clinical and cost effectiveness, indicating the robustness of the principle of alcohol care teams.

2.6 Contrasting evidence

It is important to note that all the evidence above comes from single site and local audit data measuring identified alcohol disorder patients, excluding unidentified cases. A study by Currie et al (2016) used national Hospital Episode Statistics of patients with anytime diagnosis of alcohol liver disease to compare rates of emergency department use between hospitals with ACTs (at 2013) and those without. They found no difference in re-admission/presentation rates between hospitals. However, this study only looked at emergency department activity and only at ACT presence, without examining the ACT system in place. By 2013 many of the examples given above appear to not comply with the recommendations given in the position paper by the British Society of Gastroenterology, Alcohol Health Alliance UK and the British Association for Study of the Liver (Moriarty, 2011) or for Bolton & Salford NHS Trust (i.e., co-ordinated policies for dedicated consultant lead, multi-disciplinary, assertive outreach and community pathways) (Moriarty, 2014). The evidence from the Currie study (Currie et al, 2016) may underline the need for a whole systems approach to ACTs.

2.7 Assessment of models

Public Health England (PHE, 2014) identified numerous models and approaches to providing alcohol care teams or liaison teams but report that the more successful models have consultant leads capable of strategic planning and management, with referral links to multi-agency community services and primary care, and a form of assertive outreach. These achieve the best returns on investment and patient outcomes. The contrasting evidence from Currie et al (2016) appears to confirm the importance of this whole systems approach. PHE (2014), NICE-QUIPP (2016) and the Health Innovation Network (2018) all recommend a

consultant led, 7-day hospital-based service with care pathways to community services that can provide meaningful follow-up for complex needs. A body of evidence for multi-disciplinary alcohol assertive outreach is also strongly indicating effectiveness for patient outcomes and return on investment, with recommendations for targeting frequent attenders with a 12-month period of weekly contacts that addresses social care needs such as housing, mental health, as well as physical and psychological interventions (i.e., Shumway et al, 2008; Larimer et al, 2009; Raven et al, 2011; Hughes et al. 2013; Moriarty, 2014; Drummond et al, 2016).

The use of High Intensity Use Services (NHS RightCare, 2021) to target all frequent attenders of A&E utilises a multi-disciplinary team that includes police, mental health services, primary care and social services. It currently lacks evidence of effectiveness in targeting alcohol-related presentations specifically, but does provide a model of structure and functioning where there are complex needs. There are currently no guidelines for the structure and functioning of assertive alcohol outreach teams. Different models currently work within a range of systems and may be dependent on the nature of the wider network locally. Guidelines have been suggested however from assertive outreach for mental health services that may provide a baseline to work from.

For the most complex needs where mental ill health is an issue, evidence from assertive outreach for severe mental illness indicates:

1. A maximum caseload of 15 patients per assertive outreach practitioner;
2. Input from a multidisciplinary team (including psychiatrists and substance misuse specialists);
3. Regular contact (minimum of once a week), with 50% of contacts occurring outside of the service;
4. Assertive engagement where there were persistent and repeated attempts to contact, and an emphasis on maintaining contact and building relationships;
5. A focus on both health and social care needs;
6. A flexible approach, focusing on the patient's goals even when these were peripheral to the alcohol dependence;
7. Prioritising practitioners' role both in care planning and in visits;
8. An ethos of 'going out of your way' and 'go the extra mile' for patients;
9. Extended care provided for a prolonged period of 1 year.

(Burns et al., 2000).

2.8 Summary

As indicated from the case study evidence above, the more effective management of alcohol-related hospital presentations involves an integrated approach that emphasises care pathways between secondary, primary and community care, reducing bed days, re-admissions and engagement with community services. Assertive outreach is demonstrated to be effective post-discharge in ensuring wraparound support, especially when deployed for the most frequent attenders.

3 EXISTING MANCHESTER ACT PROVISION & NEEDS

3.1.1 Increasing alcohol use and NHS burden

In England in 2019/20, there were 976,425 hospital admissions related to alcohol consumption, a rate 12% higher than in 2016/17 (PHE, 2021a). The Covid pandemic has increased unplanned hospital admissions for alcohol-related liver disease (up by 3.2%) but equally rates of alcohol-specific admissions have decreased by the same percentage. However, Greater Manchester rates were nearly all higher than the national rate (PHE, 2021a). Decreased rates may also be an artifice of the change in recording alcohol-related admissions by the Office for National Statistics (ONS) to be more sensitive to alcohol-*specific* conditions.

Further analysis by PHE (2021c) has revealed a sharp increase in alcohol specific deaths, both mental and behavioural and liver related since the onset of the Covid-19 pandemic. Trend data of mortality provides a more stable measure of alcohol burden and more likely to represent alcohol *specific* burden. In 2019 there were 7,565 deaths registered in the UK from alcohol *specific* causes, the second highest since the data time series began in 2001 (ONS, 2021). Provisional data for England and Wales show an annual 19.6% increase (7,423) in deaths from alcohol *specific* causes in 2020, the highest annual total since recording began in 2001.

3.1.2 Local need and the secondary care response to alcohol

A paper presented to Manchester's Health Scrutiny Committee in 2018 reported an estimated 9,528 adults are alcohol dependent in Manchester, a rate of 23.07 per 1,000 population, and higher than England's estimated national average of13.81. An estimated 28% of Manchester adults were binge drinkers by 2018, compared to 17% nationally, and 32% of adults in Manchester are estimated to drink hazardously (over 14 units/week) compared to 26% nationally (Manchester City Council, 2018).

The most up to date data on alcohol burden in Greater Manchester show that in 2019/20 hospital admissions attributable to alcohol were 6% higher (358,000 people) than 2017/18 and 19% higher than 2008/09 (NHS Digital, 2020). In the Manchester CCG area, in 2019/20 there were 4,095 alcohol specific hospital admission episodes which is 1,066 per 100,000 population and higher than the rate for the North West (891) and for England (644). In Greater Manchester, only Salford recorded higher rates of alcohol specific admissions (second highest in England) than Manchester at 1,613 per 100,000 population (PHE, 2021a). Manchester is now in the top 10 CCGs for alcohol related admissions (PHE, 2021a). The Greater Manchester Combined Authority review (GMCA, 2021) reports that to accommodate everyone who needs alcohol treatment requires a 'massively expanded treatment system'. The implication here is that Manchester only sees a tip of a large iceberg when measuring alcohol need by health service contacts.

The recent surveillance monitoring survey of practitioners and related professionals in Greater Manchester for *GM Trends* (GMCA/MMU, 2021) found a significant rise in alcohol treatment referrals, particularly for those aged over 40 who are new to treatment services. Many of these patients have self-referred or been referred following domestic violence incidents, hospital admissions or a mental health crisis. This appears to be a Covid-19

pandemic effect creating stress and heavier drinking behaviour. Of equal concern are the reports of relapse by people already known to services.

Of note in PHE reporting is the focus on the disproportionate concentration of alcohol related health harms in lower socio-economic groups, which is of particular importance in the context of Manchester which is one of the most deprived areas in England with life expectancy lower than average. Links between alcohol harms and deprivation are well known. Bloomfield (2020) explains the alcohol harm paradox, whereby lower socio-economic (SE) groups suffer greater health harms than those of higher SE status even though consumption may be the same or even lower. This is thought to be particularly true for mortality from chronic liver disease (Burton et al, 2017). Linked with this, Allan, Mooney and Ling's research has suggested that social deprivation and off-license density is the strongest predictor of the cumulative and health harms from alcohol (Allan et al., 2018).

In Greater Manchester, Rochdale, Salford, Oldham, Tameside and Bolton are all ranked in the worst deprived quintile (Ministry of Housing, Communities & Local Government, 2019). Central Manchester has the highest deprivation score in Greater Manchester at 40.0 in comparison with Salford at 34.2 and Trafford at 16.1 (ONS, 2020). The most deprived areas also have highest rates of alcohol dependency and alcohol specific deaths (PHE, 2016; ONS, 2021). As such, Manchester's hospitals fall within the criteria specified in the Long Term Plan (LTP) to qualify for support to implement (and further develop) Alcohol Care Teams in each of its three hospital sites.

3.2 Policy and priorities

The latest Manchester Alcohol Strategy found in the desk-top review was 2012-15 (Manchester City Council, 2012). The Greater Manchester Drug & Alcohol Strategy (GMHCB, 2021) aimed to reduce harm and offending, and increase recovery uptake. None of these targets appear to have been achieved.

4 EXISTING CARE PATHWAYS FOR ALCOHOL CARE IN CENTRAL MANCHESTER

It is clear from our evaluation that the smoothness and efficiency of care pathways and referral links for alcohol dependent service users between community, hospital and primary care across the Manchester Foundation Trust estate is determined by the existence of at least some ACT provision within the secondary care (Wythenshawe Hospital). There is a clear difference in pathway efficiency dependent on the presence or otherwise of an alcohol care team to centralise advice, provide liaison and early-stage assessment/interventions.

The substance use community care provision in Central Manchester (the MFT region) is provided by Change, Grow, Live (CGL), commissioned to provide community drug and alcohol treatment and support by MHCC. CGL provides holistic support (i.e., prescribing, psychosocial interventions, links to housing support, homeless services), outreach to street homeless and in-reach to the three MFT acute care hospitals. While in-reach was paused during the Covid-19 restrictions period, this service has re-commenced since September 2021. However, the service provided by CGL for secondary care is reliant on the quality and appropriateness of referrals received and the information exchanged.

4.1.1 The Street Engagement Hub

This is an initiative in central Manchester led by Manchester City Council and Greater Manchester Police, to target homelessness and street begging in Manchester. Located at the Mustard Tree, the Hub includes partners such as CGL, the Probation Service, Department for Work and Pensions, St John Ambulance, the Big Issue and local charities as well as providing a weekly multi-agency outreach service. The agencies at the Hub can provide for homeless people discharged from hospital where they need follow up first aid care, prescribing, Hepatitis C screening, housing and/or engagement with drug or alcohol services. It also provides liaison where clients need to be registered with a GP. CGL have recently commenced an assertive alcohol outreach team to be based at the Hub and provide follow up for drug or alcohol dependent clients when discharged from secondary care.

In relation to community care pathways, CGL, The Hub and Urban Village (GP services for homeless) have similar roles and provide similar referral linkages between hospital and community services, including a degree of in-reach and outreach, engagement work and, for Urban Village, training and advice to hospital staff.

Clients without a GP are encouraged and supported by the Hub to register at Urban Village, or may get the opportunity to be registered if they encounter Urban Village in-reach workers at the MRI.

4.1.2 Primary care services – Homeless Access Service

Beyond Urban Village, there is a wider initiative run by Manchester Primary Care Partnership to provide GP services to people with no or unstable housing. Several practices are included in the access service across the City of Manchester.

5 ADDRESSING UNMET NEED

5.1 Unmet need in Manchester

Against long term downward trends for people's reported drinking (House of Commons Library, 2020) evidence of drinking trends during the covid-19 pandemic has highlighted further areas of harmful drinking among heavier drinkers and increases in alcohol-related liver deaths (PHE, 2021c), suggesting a growing problem with alcohol dependent drinking. Data from the NDTMS additionally shows a 19% decline in the numbers of people entering alcohol-only treatment (PHE, 2018b), highlighting a growing national trend of current unmet need for alcohol treatment. Alongside this gap in need and alcohol treatment uptake is the high rate of alcohol related liver mortality and morbidity, made more challenging for intervention due to late presentation of decompensated liver disease (Thurz et al, 2019). Not only is it important to engage dependent drinkers in substance use treatment, but also to identify changes in liver function early for more effective intervention.

The higher prevalence rates of alcohol dependency are concentrated in the north of England. Almost half the people in treatment for alcohol *only* were living in areas ranked in the 30% most deprived areas. There were an estimated 586,797 adults with alcohol dependency in need of specialist treatment in 2017/2018 (the most recent estimate). Yet, an estimated 82% of adults in need of specialist treatment for alcohol are not receiving it (PHE, 2020).

Manchester had an estimated 8,671 adults with alcohol dependency in need of treatment in 2018/19 (a rate of 2.04 per 100 population). There were 792 adults in structured alcohol treatment (PHE, 2021a; PHE 2021b). According to the *GMCA review*, the 'gap' between estimated need for alcohol treatment and actual numbers in treatment services is so large that even a massively expanded treatment system would struggle to help all those people estimated to be in need (GMCA, 2021).

Survey evidence from Greater Manchester's clinical practitioners in the latest *GM Trends* report indicates increased alcohol use among patient groups, with a rise over the last year in the number of alcohol referrals experienced by practitioners, and specific concerns for those who have relapsed following treatment, older drinkers with no previous treatment episodes and those with mental health problems (GMCA/MMU, 2021).

The evidence above indicates that, pre-covid, there was a growing gap between people in need of treatment and those accessing treatment, which may be accelerated due to the effects of Covid lockdowns and subsequent economic and social impacts. At the same time, Manchester may be more vulnerable to increasing alcohol dependence than other locations due to the levels of deprivation in many wards and associated socio-economic factors.

5.2 Identifying unmet need

Local authorities and clinical commissioning groups are required to identify unmet need for social care and health provision, and adjust for identified unmet need. However, it is recognized that unmet need is hard to define and not an exact science for measurement. Additionally, some health needs are easier to define where they rely on bio-medical diagnosis, in comparison with complex and multi-factorial conditions such as alcohol misuse in which medical need overlaps with social care (Charles, 2016; Aragón et al., 2019). At the same time, unmet need for health services is also impacted by accessibility of care through rationing, waiting lists and prioritization (Robertson, 2016).

The current approach to resource allocation (RA) and unmet need estimation is population based, relying on a weighted formula based on the size of the population and adjusted to local area demographic profiles such as age, health inequalities, and additional proxy measures to adjust for unmet need (NHS England, 2014; 2016). It is recognized that this is not a robust approach to calculating unmet need (NHS England, 2014; 2016; Aragón et al., 2017), as it relies on observable data captured by or through contact with health and social care services. This clearly does not capture people who do not present to services, but will capture people such as frequent service users whose needs are inadequately met.

5.3 Tackling proxy variables in measuring unmet need

A comprehensive review of evidence for meeting unmet need by Aragón et al. (2017) provides a conceptual framework with which to understand unmet need for a specific population group and indicates existing evidence for how their need can best be measured, identifying relevant proxy measures. Their framework suggests firstly a method of understanding unmet need:

- Demand needs – where people are not accessing existing services
- Supply needs – in which services are not equipped to provide for needs
- Inadequately met needs – in which people can access services which do not adequately address their needs

People with alcohol dependence or at risk of dependence fall into all these categories: avoiding services or not having their needs detected, not receiving appropriate referral into treatment, and receiving acute care without addressing the underlying issues (see section 5.4 below).

Aragón et al (2017) identify and make recommendations for improved recognition of unmet need in populations, though not based on evidence specifically for substance use:

- **Population surveys**: while self-report surveys are not recommended, they suggest that community surveys that include bio-medical measures may provide more reliable data on which to base population estimates. For example, in Manchester, the roll out of community Fibroscan testing may provide sampling data from which to make estimates of prevalence.
- **Primary research**: They suggest that this is likely to be expensive when performed adequately, but local enquiry, especially making use of existing surveillance projects,

would give local-specific insights. For unmet alcohol need in Manchester for example, making use of the existing substance use surveillance programme for Greater Manchester (*GM Trends*) is likely to provide both quantitative and locally based qualitative data to inform on unmet needs.

- **Data linkage**: Aragón et al. suggest national data linkage as a potential source of proxy measures. However, improved data monitoring and administrative data collection by the ACTs (including recording of screening, brief advice and referral activity) and the development of HIVE (MANCHESTER FOUNDATION TRUST PATIENT RECORD SYSTEM), indicate potential data capture opportunities to improve identification of unmet need proxies.

Patient surveys and service activity data are also suggested by The Academy of Medical Sciences (2017), however with a caveat that surveys capture existing service users, and will need to be extended to capture those who do not access health services. For an alcohol dependent population in Manchester, data may be more representative if widened to include data from voluntary sector services including homeless, housing and substance use providers.

The Pathway organisation for homeless services has created a guide to needs assessment for medical respite service provision, which is similarly based on the strategies above. Focused on homelessness, the data may be a useful proxy for substance use. They include:

1. Collect data on homelessness and rough sleeping in the local area using the CHAIN database or the Autumn Street Count. They advise increasing findings by 20% to capture the 'hidden homeless' who may be sofa surfing or vulnerably housed. Estimates of alcohol dependence could be made from data on homelessness rates within Manchester City Centre. Data on homelessness may also be accessed from hospital and primary care administration data (numbers of patients registered as NFA).

Small scale interviews with key stakeholders such as homeless day centre providers, hospital discharge teams, addiction and mental health liaison and social services teams could also be used. However, these are already conducted as part of the *GM Trends* monitoring project for substance use which currently highlights underlying needs and change trends across Greater Manchester, including alcohol.

5.4 Summary

Calculating unmet need is recognised as not robust at present and is unlikely to identify alcohol dependent unmet need accurately based on the current system for CCGs to estimate local need for resource allocation. Identifying proxy measures is recommended in the literature, using surveys of existing evidence from service administration, patient record sampling, biomedical data collection opportunities (i.e., community Fibroscan testing), data linkage (especially where already collected such as *GM Trends* and homelessness data), and localised primary research sampling (also carried out in the *GM Trends* project).

6 REDUCING CALLOUTS AND REPEAT ADMISSIONS

6.1 Reducing frequent attenders and ambulance callouts

Blackwood et al (2020a) report that in the UK, people with repeated hospital admissions and A&E attendance due to alcohol are a high-cost, complex needs group of patients, representing over a quarter of the UK's alcohol admissions. Key reasons for repeat admissions, outlined by Blackwood et al., is the relapsing nature of dependence, associated physical and mental health needs, the injuries related to alcohol use and the poor self-care associated with dependence.

Green et al (2017) and the Royal College of Emergency Medicine (2017) estimate that anything from 1-2% to 7-9% of A&E attendance is by frequent attenders, with 7%-15% of those having an alcohol related need. Blackwood et al.'s study indicated that, on admission, alcohol-related frequent attenders in 2015 had an average hospital stay of 4.9 days and 10 days per year more than other non-alcohol-related frequent attenders (Blackwood et al., 2020a). They also found that length of stay increases for 5 years before someone becomes an alcohol-related frequent attender, suggesting decreasing health and growing complexity of need is not managed elsewhere. Their study detected a rapid reduction in attendance after a peak frequency year among this cohort which may indicate increasing mortality rates by this stage of attendance.

6.2 Characteristics of alcohol-related frequent attenders

Frequent attenders of A&E with alcohol related diagnoses are reported to be majority male with traumatic injuries or psychiatric issues (Parkinson et al, 2015). However, this research highlights the large number of intoxication cases rather than cases of alcohol withdrawal or alcohol-related chronic health problems, such as liver disease. Phillips et al (2019) report that the largest burden on services among all alcohol related disorder cases are those with chronic alcohol dependence or use, with social, psychiatric or alcohol associated medical conditions. They also report that demographically, those with chronic alcohol dependence or liver disease in their mid-40s present the greatest burden through repeated and longer hospital admissions.

The recent British Red Cross report on frequent attenders (British Red Cross, 2021) includes qualitative evidence suggesting a negative feedback loop of service use when underlying needs are not met. They suggest that a belief that no one can help and dissatisfaction with the hospital experience leads to a revolving door of help-seeking when causative factors of need are not addressed. These are often chronic social and mental health needs among substance users that acute services are not equipped to deal with. This report also highlights that substance using frequent attenders are more likely than other frequent attenders to have multiple diagnoses (such as mental illness) but less likely to be admitted.

Phillips et al (2019) also report that frequent attenders with an acute alcohol disorder (i.e., intoxication or withdrawal) tend to have fewer admissions and fewer days in hospital than

those with other alcohol-related diagnosis and may represent the 'revolving door' presentations to A&E. Cases of chronic alcohol disorder, (i.e., alcohol dependence, liver disease) were the most frequent alcohol-related attenders with the highest rate of admissions and bed days of all alcohol diagnoses cases.

The evidence from profiles of alcohol-related frequent attenders indicates that underlying needs that contribute to their reasons for presentation are not met, and these are likely to be associated with mental illness. Smith et al (2021) found a high proportion of people targeted by assertive alcohol outreach teams in London had severe mental health problems as well as drug or alcohol addiction. These clients often had a history of non-engagement with mental health services and presented complex diagnostic challenges due to their dual diagnosis. The evidence above suggests that involvement of mental health services and joint-working with mental health assertive outreach for care planning via a frequent attender team approach is a way forward.

6.3 Current practice and evidence

Substance users with unstable housing also present late and reluctantly to services for care needs and may self-discharge before follow-on care can be arranged. This may be due to previous negative experiences such as stigmatising secondary care (Lewer et al, 2021). This indicates a training need for general staff receiving and treating this patient group. These patients also have practical difficulties in admission: they have nowhere to store their possessions if living on the street, cannot travel to a hospital and feel ashamed if they are unclean. They may also not know what alternative services are available in their area (Homeless Health Network, 2020). Evidence from the ACT consultation underlines the issues of negative experiences for this patient group due to staff attitudes and stigmatisation, making presentation to general health care services an off-putting experience. There appears to be more success in engagement through street-level, easy access engagement with health and other wraparound services within the community.

Homeless patients in hospital in the UK are 2½ times as likely to have an emergency re-admission than housed patients, and over 2½ times as likely to present at A&E than housed patients (Lewer et al, 2021). However, these unplanned presentations are not necessarily linked to having more health problems than housed patients, but are often long-term conditions that are poorly managed (Lewer et al, 2021). This indicates that homeless people are not accessing the community supports for complex and long-term conditions that others have access to, and represent the inadequately met needs group referred to by Aragón et al. (2017). Manchester Homeless Health Needs Audit (MHHN, 2016) reported that 70% of attendees at Urban Village Medical Practice considered they had at least one long-term condition, and 71% reported drinking or using drugs, with 23% drinking daily (MHHN, 2016). This evidence is supported by a US study into the Street Medicine Model by Raven et al (2011) who showed a reduction in admissions and health costs, and an increase in community health engagement when targeting frequent and high-risk service users (homeless substance users) with integrated and assertive outreach care.

One cause for frequent re-admissions and presentations to A&E is difficulty in registering with a primary care practice and lack of integrated follow-on care after discharge (MHHN, 2016), which supports findings from our ACT Manchester consultations.

The Mpath (Manchester Pathway) commenced in 2013 providing in-reach to Manchester Royal Infirmary for homeless patients and providing links to multi-disciplinary primary care for continuing health support, and assertive outreach to frequent attenders (Mpath, 2013). This 'Pathway Model' service recorded that the majority of homeless hospital patients were admitted for alcohol-related problems, with over 70% being alcohol dependent. The six-month impact evaluation showed that providing linkage to primary care services on discharge reduced the number of admissions and attendances by 49%, bed days by 39% and reduced 28-day readmissions by 59%. In the same timeframe, 89% engaged with Mpath services and 82% registered with their GP services. These results were followed by significant positive changes in socio-economic capital and 63% received an alcohol intervention. Of the 29 frequent attenders, 21 did not re-attend A&E within 3 months.

Homelessness in Manchester city centre is currently being tackled by the city's Homelessness Strategy (2018-23) (Manchester Homelessness Partnership, 2019), the Greater Manchester Mayor's projects (A Bed Every Night; Housing First) and PHE funding, among other initiatives. This has resulted in projects such as Mpath, the Street Engagement Hub (Homeless multi-agency support hub) and the establishment of alcohol outreach workers that mirrors the Street Medicine Model. Current evidence of effectiveness indicates that both the Pathway Model (integrated hospital - primary care services) and Street Medicine (Integrated Assertive Outreach) have an impact on frequent admissions, health service burden and improved community engagement, but evidence for cost effectiveness as a whole system may still be required (Luchenski et al, 2018). However, the Pathway Model is shown to be cost effective in use of community health in homeless-mental health pathway working (Khan et al, 2020).

The combination of a pathway and street medicine approach (also termed medical respite) offers a bi-directional pathway link across primary, community and secondary care. Key elements of their function appear to be the provision of hospital discharge support – for follow-up care – and reduced risk of re-admission (Dorney-Smith et al., 2019). There are now several models established as pilots in the UK, all showing cost effectiveness, reduced hospital usage and improved health outcomes. However, Dorney-Smith et al.'s review highlights problems with siloed funding and a need for joint commissioning.

6.4 Assertive outreach (AAOT) and targeting frequent attenders

There is also evidence of effectiveness for alcohol assertive outreach teams (AAOT) to reduce hospital admissions and emergency department presentations among frequent attender dependent drinkers with complex needs. In Salford, Hughes et al (2013) demonstrated that a team comprising consultants in emergency medicine and substance use, specialist nurses and social workers improved health outcomes and reduced admissions and A&E presentations within a 3-month period, with an estimated cost saving in the period of £607,000 within six months (Moriarty, 2014). A randomised control trial in South London (Drummond et al., 2018) estimates that AAOT present a net saving of £10,569 per patient from hospital admissions. Salford NHS Foundation Trust's Assertive Outreach Alcohol Service targets the 20 highest frequent attenders with an estimated 15% reduction in A&E attendance and admission (NICE-QUIPP, 2016).

Alcohol assertive outreach has also been trialled in Rochdale and Oldham, and currently ROAR (Rochdale and Oldham Active Recovery) provides some AAOT activity that is targeting frequent attenders.

[While a focus on homeless is effective] our consultation evidence from clinicians indicates that housed alcohol dependents can often present the most complex case management challenges but often remain 'under the radar' until admitted to hospital.

Alcohol assertive outreach teams (AAOTs) linked to Alcohol Care Teams do have the capacity to target frequent attenders regardless of housing status, and therefore present a cost-effective option specifically for reducing hospital usage.

Alcohol assertive outreach teams are not included in the core descriptors for ACTs, but where integrated local care is the long-term whole system aim, linkage between ACTs, AAOTs and community-based street services would ideally be established.

For the most effective use of integrated community-based street care, Raven et al (2011) suggest that:

- Care is coordinated and responsive to specific patient needs.
- Care does not end at hospital discharge, but continues into the community.
- Integrated, multidisciplinary services and provider teams are necessary to care for the whole patient.
- Care teams must serve patients where they are, both physically and mentally.
- Data sharing and adequate communication among team members is essential for care coordination and tracking patients' progress.

6.5 Ambulance callouts

Alcohol-related ambulance callouts are estimated to represent approximately 16% of all callouts and 18% at weekends in Scotland, or between 6%-10% in Northern England - with such variability due more to definition of alcohol-related callouts rather than geographical differences in alcohol use (Manca et al., 2021). Alcohol-related callouts reported for England are mainly behaviour-related due to intoxication (violence, domestic violence, 'feeling unwell', injuries and overdose) and a smaller proportion due to withdrawal fits, with 71% of callouts resulting in hospital attendance (Martin et al., 2012; Parkinson et al., 2016). Alcohol-related cases expose ambulance and A&E staff to a high degree of abuse and violence and are estimated to take up 25% of total A&E consultant time (Institute of Alcohol Studies, 2015).

Pre-hospital practitioners are found to be an effective resource for reducing avoidable transport to A&E when able to deliver appropriate care and advice out of hospital (Knowles et al., 2020). This is also acceptable to patients and carers and reduces costs. However, the evidence applies generally to a range of patient needs including frail elderly, care home callouts and mental health needs. Several ambulance services have adopted strategies to divert cases from hospital transportation using specialist community response, specialist units, urgent care community practitioners, and provision of training and advice to high-risk groups (i.e., care homes) (Knowles et al., 2020).

London Ambulance Service reports that substance use and dependency, as well as a lack of engagement with primary care services, are two of the profiles for frequent callers to the service, among a range of other chronic health and vulnerability needs (London Ambulance Service, n.d.). Models of care targeting frequent users are used by several services that include flagging frequent callers and having frequent caller protocols or care plans, diversion or referral to GP services, working jointly with social care and primary care services and case management by a multi-disciplinary team (Snooks et al., 2019; London Ambulance Service, n.d.).

6.6 Summary

The evidence indicates that reducing demand on hospital services from frequent presentations and re-admissions requires joint working between hospital ACTs and community services that can provide follow-up support following discharge, assertive outreach and diversion or alternative community-based provision, and, specifically, targeted multi-disciplinary and multi-agency interventions for those identified as frequent attenders. Targeting of frequent attenders by a hospital-led MDT that includes key stakeholders, including ambulance, police and social services, as well as primary and community services, is a model shown to be effective in identifying underlying needs of frequent attenders and providing more wraparound support that reduces burden on acute and emergency services.

7 TRAINING

7.1 National and local policy and guidance

The topic of training is mentioned numerous times in the ACT documentation and in related policy and evaluation literature. However, the documentation is often rather vague about of what that training should comprise and how, when and to whom, it should be delivered.

There are three sets of NICE guidance (2010; 2011; 2014) on working with alcohol-related problems:

- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence
  Clinical guideline [CG115] Published: 23 February 2011 last checked July 2019
- Alcohol-use disorders: prevention
  Public health guideline [PH24] Published: 02 June 2014 last checked July 2019 and being updated
- Alcohol-use disorders: diagnosis and management of physical complications
  Clinical guideline [CG100] Published: 02 June 2010 Last updated: 12 April 2017. Checked in January 2019 and being updated

These guidance papers present a high level of detail concerning the ways in which various aspects of alcohol related problems should be managed in clinical settings but, again, on the whole say little about training people to undertake these tasks. The NICE guideline CG115 (NICE, 2011 (last checked July 2019) emphasises that

> *Staff working in services provided and funded by the NHS who care for people who potentially misuse alcohol should be competent to identify harmful drinking (high-risk drinking) and alcohol dependence. They should be competent to initially assess the need for an intervention or, if they are not competent, they should refer people who misuse alcohol to a service that can provide an assessment of need. P7*

Given that almost anyone using NHS services may potentially misuse alcohol, the implication of this statement is that ALL staff should be competent to make that initial assessment and know what to do to follow up. Further the CG115 guidance stipulates that all interventions should be delivered by 'appropriately trained and competent staff' and that 'pharmacological interventions should be administered by competent specialist staff' (p8). There is, therefore, a need to identify the knowledge, skills and attitudes which staff will need to have or develop in order to be able to administer or deliver the various types of care packages that may be needed.

7.2 Alcohol in training curricula

Clearly some aspects of treatment will require the involvement of specialists, but in 2012 the Academy of Medical Royal Colleges and the Royal College of Psychiatrists voiced concern about the lack of attention to alcohol (and other drugs) during medical training, particularly the lack of consistency across medical colleges with regard to post-graduate

education. They produced a set of ***core alcohol competencies*** spanning the knowledge, skills and attitudes that **all doctors** should possess. This is wide-ranging and includes not just awareness of addiction and associated physical harms or the ability to identify problematic use, but also interventions and impact of addiction on others. Further, all doctors should be able to recognise conditions in which alcohol may be relevant, to effectively assess use and to provide brief advice or management/referral for further interventions. All of this should be in a context of medical staff being comfortable discussing substance use and doing so in an empathic and non-judgemental way. While the ambition had been that these competencies would be embedded into post-graduate medical training, the extent to which this has happened evenly across colleges is questionable.

The General Medical Council's Core Medical Curriculum (2017) does include a section on drug and alcohol dependence, but this is, as stated by one of our consultants, almost entirely focused on recognising and recalling the physical effects of alcohol on the body – and knowing local protocols for referral. There is also a competence framework for nursing on Caring for People with Liver Disease produced by the Royal College of Nursing (2015). Although this resource does highlight how all nurses in all settings have a role to play in identification and brief advice, in itself, it is a very detailed listing of competencies at different levels of experience and is very focused on nurses working with patients with known liver disease.

References to alcohol in general nurse training standards occur just twice and do so in fairly generic contexts, focused on health promotion rather than interventions, although motivational interviewing skills are mentioned as relevant in some contexts (NMC, 2018). Even within mental health nursing, in a rapid scan of course curricula in England, King's College, London was the only one to include content on substance misuse.

From the literature and curricula examined, it seems less likely that nurses who are not liver or alcohol specialists will have had specific training on working with substance use as part of their core training. Nevertheless, all of the recent guidance stresses the need for **all** frontline health and social care workers to be able to identify hazardous or high risk drinking and provide brief advice, raising the question of how such competencies are to be developed and how staff may need to be supported in this. Thus, in summary, medical staff *should* possess core competencies – but it is uncertain that all will have had the opportunity to develop these.

7.3 The role of ACTs in developing and delivering training to staff in secondary care

The training remit of an ACT is mentioned at three different points in the Core Descriptor document, and as can be seen in Table 6.1 below, the requirements are quite wide ranging but, for the most part, also quite vague.

Table 7-1: Areas of training relevant to acute settings

Types of alcohol related training relevant to acute settings	Source
Core ACT guidance documents:	
Improving compliance with the trust's alcohol withdrawal guidelines and 'educating staff on alcohol use disorder and its management'.	Aims of the optimal ACT
Provision of trust-wide education and training in relation to alcohol.	Core service components
[Alcohol] IBA skills - and the skills necessary to train other staff in provision of IBA (identification & brief advice). Trust wide role in raising awareness of alcohol related conditions and provision of training in withdrawal management.	The knowledge and skills requirements of ACT staff
Training areas identified in other documentation	
Onward pathways and referral mechanisms	Drummond et al (2013)
Staff attitudes, stigma and suicide risk	Moriarty et al (2010), Kings Health Partners (2020)
Responding to negative service user behaviour	NICE 2014 (PH24)
Extended brief interventions where appropriate	NICE 2014 (PH24)
Ethnicity and cultural competence	RCP (2018)
Alcohol and older people	RCP (2018)
Impact on children and families	Commission on Alcohol Harm (2020)
Alcohol exposed pregnancies	Commission on Alcohol Harm (2020)
Multi-disciplinary joint training for psychiatry, gastroenterology, hepatology, acute care physicians and alcohol and MH nurses	Moriarty (2011)
Dual diagnosis training	RCP (2018)

7.4 Training whom?

There is clearly a role for ACTs in providing training to hospital staff. PHE guidance indicates that ACTs should facilitate the training of staff in all clinical areas. Emergency departments, gastroenterology and acute medicine clearly feature highly in this, but other evidence has highlighted that there should be training for those working with children and families and those working in midwifery and family planning, for example Commission on Alcohol Harm (2020). Further, there are known links between alcohol and a variety of other 'partially attributable' conditions where timely identification and brief advice (IBA) may serve a preventative or early intervention role.

Encouraging site-wide use of screening does however require that all staff are comfortable with using the tools and confident that they will be able to follow up. McGeehan et al.'s evaluation of ACT activities (2015) suggested that staff not wishing/feeling able to deliver brief interventions may instead 'exaggerate' screening tool scores in order to trigger a referral to the ACT for follow up (McGeehan et al 2015), adding unnecessary workload to the ACT – or indeed avoid asking the initial questions.

Parkman et al.'s (2017) study of service user experience found that people with complex drink problems who frequently attend A&E felt that the staff only wanted to help with non-drinking related problems. They suggest that if those staff were knowledgeable and up to date about pathway options for support services, and ideally familiar with those services

and the people providing them, this may encourage those patients to use the community and other services on the pathway.

One potentially important area is that of substance use among older people. *Our invisible addicts* (RCP, 2018) identified increasing numbers of older people coming to the attention of services. Indeed, one of the consultants to this report recognised this in their community treatment service, and it was mentioned by an acute care practitioner as an overlooked population because of assumptions that falls among the elderly are not due to alcohol. This raises a number of issues around adequate identification and response for what is often a different cohort of people with different needs. It also emphasises the need to ensure that adequate links are in place for gerontology, palliative and end of life care, and for those services locally to be fully informed about managing alcohol use in older age.

Although ACT services are largely focused on adult (over 18) dependent drinkers, the training role is wider than this and there are also questions about the response to those who are drinking at risky or hazardous levels without dependence, and those who are under 18.

7.5 The training requirements of the core descriptors

The ACT core service descriptor only indicates that ACTs should educate staff on alcohol use disorder and its management. However, it requires that inpatients should be referred to the ACTs following identification of alcohol dependence from routine screening. Therefore, training to all relevant clinical hospital staff should include identification and brief advice (IBA). Further to that, general education should include:

Basic understanding of bio-psychosocial factors of alcohol dependence
Referral pathways and mechanisms
Signs and symptoms of withdrawal and requirements for medically assisted withdrawal (MAW)
Prophylactic treatment for brain injury (thiamine/Pabrinex)
Psychosocial interventions such as motivational interviewing.

Emergency and acute care staff will additionally benefit from:

Alcohol care planning
MAW regimen advice
Mental health assessment for dual diagnosis and co-morbidities
Medications to support sustained abstinence and consumption reduction

All relevant clinical staff may also benefit from education for:

Alcohol dependence in pregnancy, older people, children and young people
Alcohol dependence and end of life care, and poly substance use.

7.6 Barriers to training

Much of the literature focuses on ACTs providing or supporting the roll-out of IBA training and the important element in this appears to be that the training occurs in all clinical areas (PHE, 2014). It is worth noting that the ambition is for all adult patients or ED attenders to be screened using AUDIT-C, and brief intervention provided as needed for those drinking at high risk or increasing risk levels. This early intervention approach sits alongside the role of ACTs in supporting the management of alcohol dependence and withdrawal. Indeed, Wythenshawe ACT's vision statement reveals that training of other staff in alcohol awareness is a core part of the team's purpose, in particular training that 'promotes respectful, non-judgmental care of people who misuse alcohol'.

The team's objectives in relation to training is specified as the 'provision of teaching and training to MFT staff to deliver brief advice to those drinking at increasing and higher risk levels.' However, research has identified a string of barriers to implementing IBA across health settings in both the UK and elsewhere in the world (PHE, 2016b; Systematic review evidence underlying NICE guidance PH24, 2010). These include:

- [lack of] time, training and financial incentives;
- feeling awkward asking questions about alcohol, lack of training in counselling skills;
- belief that patients would not act on advice;
- healthcare professionals focussing on dependence and not hazardous drinking;
- [lack of] practitioner familiarity with screening tools and brief intervention content;
- some locations possibly being unsuitable for alcohol screening and intervention;
- some nurses preferring a holistic approach while others prioritise care of injuries over health promotion.

The tackling substance misuse resource pack (Health Innovation Network, 2018) reiterates the limited focus on alcohol use in training programmes for health professionals, that alcohol misuse can be seen as 'one task too many' in busy working environments and that alcohol patients can be stigmatised and viewed as 'only having themselves to blame for their health problems' (section 1.4).

Almost all the above barriers were noted in our consultation evidence.

7.7 Knowledge and skills required of ACT staff

Before leaving this section on training and in thinking about the formation of ACTs in Manchester's hospitals, it is important to consider the staff skill mix that is needed and what training and support ACT staff may require. Phillips and colleagues (2020) have recently reported on a Delphi panel study which aimed to identify the competencies required of ACT staff in order to deliver the services expected by the guidance. In relation to training they identify four key competencies:

- To develop educational materials on alcohol use to support both prevention and recovery
- To provide ongoing support, implementation and training of systematic screening and brief interventions for frontline employees, as well as providing a referral route for more complex cases
- To liaise with and support frontline staff caring for inpatient and emergency department attendees in the appropriate, NICE-compliant management of patients with alcohol use disorders
- To provide training and support to appropriate NHS professionals in assessment and monitoring of patients experiencing acute alcohol withdrawal; ensuring protocols are widely available and using evidence-based tools as an adjunct to clinical judgement.

Thus, within the ACT there needs to be educational and communication skills as well as clinical competence. Moriarty (2020) further suggests that alcohol specialist nurses should be trained to establish clinical and community networks, and provide clinical leadership, mentoring, live video and digital communication - with regular visits to support healthcare leads in their communities. It will be important for ACTs to evidence their training input and impact, and this should be built into the metrics that are collated on ACT activity.

7.8 Best practice

Kerry Lyons has written about Tameside Hospital's nurse-led team and the training programme they have developed (Lyons, 2016). They have a monthly rolling education programme which is described as 'multigrade'. They have also trained alcohol champions to promote best practice in every clinical area in the hospital and have 'GP and student nurse training spokes for alcohol intervention'.

The NICE proven case study (NICE-QUIPP, 2011 and 2016) describes how, after 12 months of a 7/7 service, more than 600 healthcare staff had been trained in IBA. The team had also trained a network of 50 trust alcohol link workers and run an alcohol and liver disease course for staff. Sandwell and Birmingham mention that one member of the ACT took on the role of education lead (Copeland & Bradbury, 2020).

7.9 Summary

Overall, it is clear that whilst all clinical staff should have some preparation for working with people who are drinking, this is likely to be limited and at the very least will need to be updated periodically. For the training role to be successful in the context of busy practice environments, the relevance of effective working with alcohol use will need to be recognised and supported by senior staff within sites and departments. Moreover, the content, format and frequency of any such training will need to be negotiated against other training needs and workload considerations. This is perhaps particularly true in relation to the roll out of routine IBA.

ACTS will need to reflect on how best to meet the training needs of all staff groups and ensure that they are not only equipped with knowledge about processes and procedures, but also have the opportunity to develop the skills, attitudes and understanding that will instil confidence in engaging with this area of work. This includes what needs to be learned by whom and how often. There may be mileage in considering offering basic awareness training at least to auxiliary and support staff who have regular contact with patients (such as reception and security staff and porters for example). This will help to target attitude change and improve engagement experiences for patients.

It will be important to engage with other service and training providers who may be able to contribute to, or in some cases certainly should be part of, the training offer in order that frontline staff can develop a good sense of the services to which they are referring.

Discussions with local education providers [or specialist services] may increase the routine input at undergraduate level. ACTs may consider training ward or department based 'alcohol champions' who can support other staff in their development of expertise.

Commissioners and other service providers will need to be involved in the planning for the development of a training package to ensure that service specifications meet the requirements and that there is a comprehensive, coherent training package on offer across sites which neither duplicates nor leaves gaps.

In terms of evidencing training inputs and impacts, ACTs will need to find a way to record what training is being delivered to whom. It may be worth exploring ways of capturing training undertaken in individual staff members' personnel records. There will also be a need to ensure that as training takes off and referrals to both ACT and community services likely increase, that neither are overloaded.

8 IMPLEMENTATION PLAN AND DATA REPORTING RECOMMENDATIONS

8.1 Summary of findings

There are many existing strengths in the ACT and alcohol care pathway provision due to established informal and local arrangements in Manchester, and good use of current local service provision and initiatives such as RADAR [detoxification unit] and initiatives for homeless inclusion in the city. Also, the existing ACT arrangement at Wythenshawe Hospital has established a workable model and tested what works for the locality.

The evidence of impact from co-ordinated and targeted services within and around an ACT is clear in relation to reducing re-admissions and bed days and engaging complex alcohol dependent patients with wraparound services. Effective whole system approaches to in-hospital alcohol teams, assertive alcohol outreach and targeting of frequent attenders is shown significantly reduce costs and improve patient outcomes.

ACT descriptors detail the minimum provision and allow flexibility for local arrangements and initiatives, and do not include key evidenced approaches that can enhance provision in a locale.

8.1.1 Monitoring and data collection

The recommended data collection from the core service descriptors for monitoring and evaluation purposes clearly mirror the key aims of the core and optimal descriptors targeting improvements in frequency and quality of screening and early detection, and acute care management (withdrawal management). It is also recommended in the core descriptors that impact of the ACT and care pathway implementation should target evaluating rates of referral to community services, reduction in bed days and length of stay, re-admissions and emergency service use, cost-benefit (see Table 8-1). Additional monitoring and evaluation recommendations from the core descriptors should also include regular patient surveys for improvement in service experience. Our findings indicate that any additional data would include monitoring of any key additional ACT activity that is incorporated into the ACT role. This is likely to include training events, outpatient clinic contacts and destination of referrals. This would capture pathway flow and services used or underused.

8.1.2 Staff Training

Training of staff requires frequent updating to accommodate staff rotations and staff turnover. Training needs to target: screening and assessing procedures, withdrawal management, managing and responding to dual diagnosis patients, referral pathways and available advice, staff attitude and morale when managing alcohol-dependent patients, and

short-term psychosocial interventions such as identification and brief advice (IBA). Suggestions include incorporating alcohol management into induction for junior doctors on rotation and new staff, MDT training for specific teams (avoiding the medic/nurse split), and identification of 'champions' - department-based link practitioners to provide and disseminate advice and expertise.

While training should be part of the ACT remit, it is useful to engage training from other providers with oversight and monitoring by the ACT. In that way, frontline staff can also develop understanding of such services and build relationships.

Training data need to be captured centrally by the ACT to identify what is delivered, by whom, to whom, with records of trainee evaluation of the training received. It is also suggested that alcohol training could be captured in individual staff members' personnel records to identify coverage and need for updates.

8.1.3 Assertive Outreach

While AAOTs are not currently part of the core descriptors, the evidence from models in England demonstrate their cost effectiveness in reducing frequent admissions and bed days. ACTs could effectively target the two vulnerable patient groups with the most impact on hospital resources: 1. acute, short stay, frequent attender patients; 2. chronic long stay patients. The AAOT service would enable follow-up care after discharge particularly for those with no registered GP, insecure housing, chronic mental health problems.

8.1.4 Frequent attender MDT

There are several models for frequent attender management which all show effectiveness in reducing repeat presentations and re-admissions.

An effective approach may be a MDT led by emergency care consultants and include the ACT, alcohol assertive outreach team and community and primary care representatives including as permanent or guest members among the police, probation and other stakeholders, as relevant. The MDT would review a 'most frequent attender' list monthly, rotating cases by need and inviting relevant stakeholder agencies. The MDT would establish a care plan for each case and review every 6 months-12 months.

8.1.5 Information-sharing

One of the core descriptor aims is to improve information-sharing between services (e.g., secondary care, primary care and community services). This can be problematic if the key

agency providing community services is non-NHS. This means that patient records cannot be shared throughout the pathway and creates barriers between secondary and community services, especially when community services are engaged to prescribe medications.

Information-sharing agreements may overcome barriers for follow-up discharges and identification of frequent attenders, for instance, if non-NHS agencies remain key elements to the care pathway. It will be important that information sharing arrangements allow for identification of patients already receiving medications, and that consents are embedded into information-sharing.

8.2 Overall implementation

8.2.1 Recommendations (service-specific recommendations for the City of Manchester are not included in this summary)

The evidence indicates that best practice for ACT and care pathway functioning is to follow the recommendations from the British Society of Gastroenterology and Bolton NHS Foundation Trust (2016), NICE (2014; NICE-QUIPP, 2016) and Bolton & Salford model (Moriarty, 2014), with adjustments to new evidence. This would constitute:

1. Adoption of consultant leadership, with a clear role description for the ACT as source of advice, liaison and training, and complex assessments, but not routine bedside working.
2. Adoption of frequent attender MDT meetings led by the emergency care team (ED and could include AMU) and includes community services, primary care, ambulance, police, and social service representatives as minimum.
3. Establish assertive alcohol outreach team to work from secondary services and work jointly with the frequent attender MDT.
4. Ensure information agreements across hospitals and community services.
5. Staff training and support for using referral pathways, especially use of RADAR, ACTs and CGL in-reach. Include alcohol withdrawal management and referral in induction training for rotating and new staff.
6. Ensure AUDIT-C is on electronic record systems for screening. In addition to CQUINS, have in-house incentives specifically for AUDIT-C.
7. Provide training for screening, holistic assessments and IBA for generalist staff to avoid reliance on ACTs to adopt this role.
8. Clear boundaries of role for ACTs (to avoid mission creep). Careful balance between having a presence on the ward to doing the job of the ward staff. ACTs should be adding something, not replacing something.
9. Use of [third sector] for assertive outreach links.
10. Consider capacity building for detoxification and mental health teams.

8.2.2 Short-term approaches (12 -18 months)

Rollout ACT recruitment and identify a medical consultant for the team overall – must have time allocated for the role. The current recommendation for 0.2 WTE is unlikely to be adequate for [large multi-sites]. Ensure ACT numbers not only comply with minimum core descriptor algorithm but take into account sickness, holidays, maternity leave, slippage (gap between staff leaving and recruitment). Could implement Salford's model of approach in using locum cover for this. Administration support will be essential for the ACTs to fulfil the monitoring and evaluation tasks.

Ensure information sharing between hospitals and [third sector providers].

Establish ACT roles at the outset. It is important that each hospital ACT has a clear remit. There is a danger of mission creep in that a) they are used to replace department staff in bedside screening and routine management, and b) they become a pathway bottleneck as patients await assessment by ACT when routine management could otherwise be carried out by trained department staff.

Create MDT teams to liaise with ACTs regarding training, sources of advice and referral pathways. The MDT should include representatives from existing providers: A&E and acute leadership, Gastroenterology and hepatology teams, mental health teams, and third sector and local authority providers.

Ensure AUDIT-C is on electronic record systems for screening and is recorded. Some staff may not consistently record CQUINs as the target is too high, therefore in-house incentives for recording screening may be a better approach to encouraging compliance. Provide generalist staff training for screening using AUDIT-C, conducting holistic assessments and BIA. It is important that ACT is not used for routine screening and brief intervention and advice.

Establish a data collection and monitoring system that can collect the minimum measures advised in the core descriptors, for both monitoring and evaluation purposes. This will require at least the minimum administration staff as recommended by the core descriptors, (0.8) per team, preferably at band 3 to ensure consistency of staffing and capabilities to conduct auditing.

Establish audit goals for each element of the team to measure effectiveness and impact in the short term: referrals to the ACT, other services, number of admissions and re-admissions, length of stay. Also, record when an AUDIT-C is performed, and where the patient is referred. It may not be possible to collect all the core descriptor metrics until services are using electronic recording systems.

Ensure more use of underused services. Any service shown to be currently underused in a whole-system or integrated system should be identified and incorporated into ACT pathways.

8.2.3 Medium-term approaches (18 months – 3 years)

Frequent attender MDT monthly meetings. Once ACTs are established and functioning, a frequent attender MDT should be established to target reduction of re-admissions,

ambulance call outs and bed days. These may function effectively with a core group from the ACT and emergency care, mental health services and social services, and an outer group of multi-agency representatives. The precise make up of these groups are best decided locally within each hospital and ACT.

Alcohol assertive outreach teams (AAOTs). The evidence for effective alcohol assertive outreach teams is robust and shows good cost-effectiveness. Some models of AAOTs commission community services to provide assertive outreach (i.e., Blackpool) but better evidence supports in-house teams that function in addition to ACTs and are linked in with the frequent attender MDT. NHS-led AAOTs will be able to access patient records but also liaise with community services and other relevant 3rd sector providers. The evidence supports targeting of frequent attenders with a 12-month period of weekly contacts to address social care needs as well as mental, physical and psychological interventions.

Monitoring and evaluation may be more consistent and practical if electronic records systems are in place. The metrics recommended may then be more achievable (see Table 8-1).

Staff training should be rolled out once the ACT is established. This should target *emergency and acute care and gastroenterology*, but also *general wards and departments* to deliver training to medical, nursing and allied professional staff. Arrangements should also be made to ensure alcohol training is included in the induction training for *new staff and rotational* staff. Training will need to include screening and assessment, brief intervention and brief advice, management of withdrawal and prophylactic treatment (i.e., Pabrinex), data recording and referral options, as well as the role of the ACT. Additional and more specialist/targeted training could also be provided for those regularly managing pregnant drinkers, dual diagnosis patients and those with highly complex needs.

Consideration could be given to also engaging other providers to deliver training in order to highlight their role in the care pathway and establish relationships with other services. Training needs to be supported by senior clinical staff in order to give staff time to attend training sessions. Insight training should also be rolled out to auxiliary hospital staff such as receptionists, porters and volunteers to target attitude change.

Co-ordination of planning and commissioning may reduce any existing piecemeal service planning and funding that creates gaps and overlaps in provision.

Review use of AUDIT-C and consider uptake of Paddington Alcohol Test (PAT) for emergency department use. The core service descriptors indicate the need to routinely screen inpatients for alcohol dependence using AUDIT or AUDIT-C and thence referral to the ACT. However, several of the best practice models use the PAT in the emergency departments which is found to aid assessing clinicians to both prioritise and deliver brief advice, and guides the clinician to appropriate alcohol-related acute care (See Touquet & Brown, 2009). It is specifically designed to be used in the emergency department setting, is similar to the AUDIT test, but where AUDIT is recommended for general alcohol screening, the PAT is recommended to be used in the ED for suspected alcohol cases only as screening generally is suggested to be unfeasible in this setting (Patton et al, 2004).

8.2.4 Long-term approaches (3 years +)

Integrated Care Systems may offer opportunities to develop integrated care for alcohol within a whole system approach. Development of ACTs and smoother care pathways may provide a model of approach in integrated care, but may need to adapt to wider strategic changes as integrated care is rolled out across a broader range of public health programmes. Changes to commissioning to accommodate integrated care systems may provide smoother planning by reducing funding ring-fencing, competing priorities and postcode barriers.

Table 8-1: Core Descriptor Recommended Metrics

	Period	Indicator	Definition	Analysis
1	Short Term	Number of patients screened throughout the hospital using AUDIT/Audit-C	Total No of patients screened by any member of staff in any inpatient or outpatient department	Indicates the total number of patients screened
2	Short Term	Number of patients screened positive for possible dependence (AUDIT>19, AUDIT-C >10)	Total No 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	Short Term	Number of referrals to the ACT, including referral source	No of patients referred to the ACT from each department of the hospital	Percentage of eligible patients (2) referred to ACT. Highlights pathway weaknesses
4	Short Term	Number of patients commencing MAW	No of patients commencing MAW under the supervision of ACT	Percentage of referrals (3) where MAW is required
5	Short Term	Number of patients completing MAW in the hospital	No of patients completing MAW in hospital under the supervision of ACT	Percentage of commenced MAWs (4) completed in the hospital
6	Short Term	Number of referrals to community alcohol services	No of patients formally referred to continue treatment in community alcohol services	Percentage of referrals to ACT (3) referred to community alcohol treatment
7	Short Term	Number of patients referred to community services to complete a MAW commenced in the hospital	No 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
8	Short Term	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	Short Term	Readmissions for patients with alcohol dependence related conditions (broad measure)	No of readmissions for alcohol dependence related conditions (broad measure)	A downward trend is positive
10	Medium Term	Averted emergency admissions	No of instances where ACT intervention has prevented an admission	An upward trend is positive
11	Short/ Medium term	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	Medium Term	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	Long Term	Cost of service	Revenue cost of the ACT	Baseline for return on investment
14	Long Term	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	Long Term	Savings from bed days saved by averted admissions from A&E	Estimated No 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	Long Term	Savings from reduced length of stay	No of bed days saved due to discharge prior to the documented planned discharge date	= bed days saved x average bed day cost

9 HORIZON SCANNING: POTENTIAL TRENDS IN THE NEXT 5-10 YEARS

9.1 Rising burden of alcohol-related liver disease

Public Health England (PHE, 2021c) report an increase in unplanned admissions for alcohol-related liver disease since June 2020, which mirrors increased deaths from alcohol-related liver disease. A concern for PHE is that a Covid effect has increased drinking among those who are already heavy drinkers but delayed contact with health services due to lockdowns and fear of hospitals. This may suggest an iceberg effect post-Covid as heavy drinkers who later present with alcohol-related liver disease. PHE (2021c) stresses the importance for Local Authorities to continue to focus on alcohol. This emphasises a whole systems approach that includes health and social care, policing and licencing. Additionally, planning for improved services for earlier detection, treatment and prevention may be working with a secular trend of rising need. This needs to be taken into account, not only for service planning, but for monitoring of effectiveness, whilst controlling for background effects of rising need and delayed presentations due to Covid.

9.2 Integrated care systems

Integrated Care Systems (ICSs) are being introduced in England to integrate NHS and local authority providers and commissioners within geographical areas and facilitate the planning of health and care services based on local need. This means joining up hospital and community/primary care services to improve comprehensive and joined-up care covering physical, mental and social care.

The NHS England and NHS Improvement (NHSEI, 2020) described the core purposes of an ICS as being to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Strategically, care will be organised around neighbourhoods, places and systems. This requires a change in commissioning arrangements with one Provider Federation Board bringing together acute and mental health trusts, and the Primary Care Board. Formalised governance for integrated care will require a shared budget, negating the current silo funding that exists between different commissioners.

9.3 Additional evidence for ACTs

The National Institute for Health Research (NIHR) is in the process of allocating funding for research into the impact of Alcohol Care Teams on admissions and patient outcomes. These projects are due to report findings within the next four years, providing more robust evidence from randomised control trials and comparison studies for the effectiveness and

functioning of ACTs. We can anticipate further evidence of cost effectiveness, patient outcomes and effective structures and functioning of ACTs for optimum impact.

There is also a randomised control trial being carried out by Blackwood et al (2020b) to examine the impact of intensive assertive alcohol outreach on clinical outcomes and acute care resource use for frequent attenders across five trusts in London. This study will improve the evidence base for assertive outreach from currently relying on single service evidence.

9.4 Early detection of and targeted specialist treatment for liver disease

It is recognised that liver disease presents a high death rate among people admitted to acute care, but that treatment is most commonly delivered by generalist practitioners rather than specialists. Where specialist treatment is available, the mortality rate is improved (National Confidential Enquiry into Patient Outcome and Death, 2013). This division is particularly linked to stigmatisation of alcohol dependent patients (Williams et al, 2014). The establishment of liver units at district hospital level, and the increase in early detection in primary care aims to ensure improved prevention and access to specialist treatment. However, there are concerns that there will be a shortage of hepatologists and specialist gastroenterologists (Williams et al, 2021).

The recommended model for regional liver centres is for a local liver specialist lead in order to develop community services for liver patients, and to work jointly with alcohol care teams and alcohol assertive outreach teams (Williams et al, 2021). Joint working is considered to improve knowledge and skills for both liver specialist and alcohol care team staff, and deliver greater integration of pathways between community, primary, secondary and tertiary care.

NICE guidelines recommend FibroScan use in primary care for confirmed or suspected cirrhosis patients - particularly those who have Hepatitis B or C, misuse alcohol or are obese - performed by GPs or specialist nurses who receive training and supervision in its use (NICE, 2020).

There is a non-comparison study evidence to support the impact of targeting high risk patients in primary care in reducing progression to cirrhosis (NICE, 2020; Williams et al, 2021). However, this evidence is based on specialist nurse or GP assessments with targeted patient groups, as per NICE recommendations that reduce unnecessary referrals (Williams et al, 2021). Concerns have been expressed by clinicians from our stakeholders that FibroScan readings are sensitive to multiple factors (i.e., a recent meal) that produce high positive sensitivity (identification of false positives) and therefore unnecessary referrals to specialist services. This would suggest careful deployment is needed to avoid inappropriate use of FibroScan technology. Use of FibroScan technology may however be effective for use in community health settings when used by staff trained in its use and able to take account of inaccurate measures.

9.5 Government's new 10-year drug strategy

The Government's forthcoming 10-year drug strategy indicates greater focus on public health responses to increasing problem drug use and drug-related deaths, as recommended by Dame Carol Black's report (DHSC, 2021). Reportedly there will be approximately £300 million spent on law enforcement but, crucially, approximately £530 million available for increased spending on treatment. This public health focus is likely to impact on services delivering targeted drug treatment interventions, including tertiary and community services, most of which in Manchester and elsewhere also deliver services for alcohol dependence. Diversion from prison to treatment for drug users will put increased demand on current services, requiring expansion, new commissioning contracts and further staff training needs. This may present either an opportunity or a challenge for alcohol care teams and care pathways. The increased emphasis on drug treatment may require an upscaling of community services that currently provide for both alcohol and drug dependence. This may provide more provision and treatment options, or create a diversion of resources towards drug dependence at the expense of alcohol dependence. However, there may be an opportunity to capitalize on the increased funding through economies of scale by bringing alcohol and drug services more closely together. This better captures the needs of those who use both alcohol and drugs problematically (as many drug users do), creates more opportunities for service efficiency in using the same pathways with enlarged resources, and improves the skills mix of staff along the care pathway.

It remains to be seen how the additional funding will be offered to localities, but is it likely to pose additional commissioning need to existing arrangements.

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