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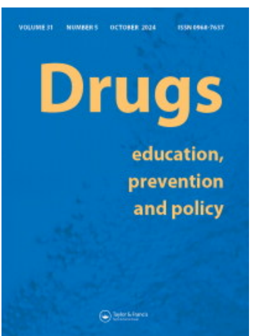

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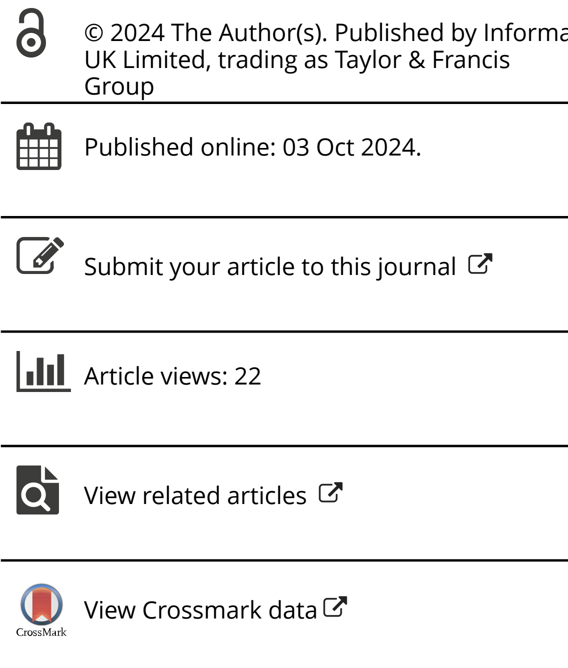

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OPEN ACCESS

Tackling hospital service burden of alcohol dependence in England: a service evaluation of alcohol care teams (ACTs) and care pathways for integrated care

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ABSTRACT

Background: Chronic alcohol disorder hospital admissions are increasing in England and present a huge cost to England's health and social care costs. Hospital-based alcohol care teams (ACTs) aim to better meet these patients' complex needs through assessment and targeted referral. This has the potential to work effectively within England's newly established integrated care system.
Methods: The aim of this project was to identify in what ways ACTs can be effective in improving care pathways for complex care in a whole-system health and social care setting. We conducted semi-structured, tailored interviews with practitioners, managers and commissioners, across three hospital and community settings in one large urban region in England, comparing ACT working with non-ACT working.
Results: Effective pathways were enabled by the presence of an ACT, multi-agency community initiatives, assertive alcohol outreach and frequent-attender team meetings. Identified barriers were lack of systemic funding and commissioning, poor communication between agencies, lack of information-sharing and insufficient staff training.
Conclusion: Community outreach and in-reach between hospitals and community services enable effective care pathways when ACTs provide the point of contact. A well-resourced ACT with clear operational remit can create links between diverse agencies and enables improved wraparound care for alcohol dependent patients.

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Alcohol care team; pathways; alcohol dependence; frequent attenders; acute care

Introduction

Harmful alcohol consumption, dependence and alcohol-related deaths increased worldwide during and post Covid-19 (Kilian et al., 2022; NIH, 2023; NIH & NIAAA, 2021), particularly among those already engaging in hazardous drinking (Carver et al., 2023; Matone et al., 2022; PHE., 2021). Notwithstanding a Covid effect, Oxtoby (2022) reports English hospital admissions for alcohol among the over 50s has increased by 22% since 2017, with an 80% increase of people aged over 65 seeking alcohol addiction treatment. Pre-Covid, Roberts et al. (2019) estimated one in ten patients in UK (United Kingdom) Emergency Departments (ED) to be alcohol-dependent, and Phillips et al. (2019) estimated chronic alcohol disorders to be over four times more prevalent among English ED attendance than acute or non-alcohol cases, over twice as likely to be admitted, and taking up 15 more hospital bed days. They estimated a cost difference of over £2000 per patient between chronic alcohol and non-alcohol patients.

A particular issue associated with alcohol-related presentations to hospital is repeat and frequent attendance. Alcohol-related frequent attender hospital stays are found to be 10 days per year more than non-alcohol-related frequent attenders (Blackwood et al., 2021). These patients are also likely to present with high-cost complex needs. Blackwood et al. (2021) report that repeated admissions are due to relapse of alcohol use, enduring physical and mental health problems and the physical injuries and poor self-care linked to alcohol dependence.

Such patients also commonly have complex needs such as mental ill health, physical co-morbidities and social care problems which cannot be met by acute care services, resulting in repeated hospital presentations. This flags a requirement for combined agency referral pathways similar to the complex care management (CCM) approach adopted in the US (Hong et al., 2014). This involves interdisciplinary teams from health and social care to address physical, mental and socio-economic issues concurrently (Fleming et al., 2019). Such systems reduce costs and provide customized care, and are based on local resources and needs (Hong et al., 2014). Such systems require good co-ordination between services (Hong et al., 2014), however, Roberts et al. (2020) report that pathway gaps between hospitals and community services in England are typified by barriers to information-sharing, lack of knowledge about services, disparate services, and problems accessing specialist care. The UK's Local Government Association (LGA) calls for an established multi-agency approach for chronic alcohol dependence to address such service gaps. Along with

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policy-makers, they suggest that a lack of community follow-up is a missed opportunity to provide the care alcohol dependent patients need (LGA, 2018, 2019; PHE, 2014).

The UK's National Health Service (NHS) Long Term Plan (NHS, 2019) makes specific recommendations to set up alcohol care teams (ACTs) in acute secondary care settings to reduce burden on hospital services from alcohol-related cases; reduce avoidable hospital admissions and length of stay and improve care between hospitals, primary care and community care (PHE/NHS, 2019a). ACTs are defined as multi-disciplinary clinical teams with integrated pathways that span primary, secondary and community care, with direct access to specialists in gastroenterology and hepatology, addiction, psychiatry and social care services, supported by local alcohol policies for emergency and acute care services (Moriarty, 2020). Funding for ACTs is allocated to English secondary care providers with the highest rates of alcohol-dependent attendance (the top 25%), and focused on intoxicated, alcohol-dependent and alcohol-complications patients in emergency and acute care departments across the hospital (PHE/NHS, 2019a).

Evidence for ACTs stems from the Salford model which demonstrates the effectiveness of a consultant-led ACT multi-disciplinary team (MDT) consisting of medical and nursing specialists, supporting hospital screening, staff training, brief interventions, referral pathways and complex case management advice (Hughes et al., 2013; Moriarty, 2011; Moriarty et al., 2007). The development of ACTs in targeted English NHS commissioning regions follows recommendations from guidance documents for ACTs (PHE, 2018; PHE/NHS 2019a, NHS, 2019b) to deliver an effective whole system approach that addresses both health and social care needs. Care pathways for alcohol case management in England would need to be able to extend across Trust and service commissioning boundaries, incorporate health, social care and NFP care services in a multi-agency coordinated system. This is compatible with the Integrated Care Systems (ICSs) approach (NHS Confederation, 2022) newly introduced in England to provide integrated health and social care to ensure wraparound services that meet local needs.

This project sought to conduct a service evaluation within one large urban English exemplar in order to identify system needs for integrated care for this patient group.

Aim

The overall project aim was to identify the system elements required to enable ACTs in delivering effective integrated alcohol care pathways within complex care systems.

Our objectives were:

- Identification of key service burdens and barriers to effective care delivery and referral
- Identification and evaluation of effective processes, strategies and good practice in ACT and pathway procedures
- Identify factors within systems structures that can improve alcohol care pathways and effective care delivery.

Method

We adopted a qualitative approach to investigating the real-world experiences of key stakeholders from practice, policy and management levels of delivery, across relevant health and social care services. Semi structured interviews, tailored to the stakeholder's role in the pathway or policy-making, focused specifically on exploring how the establishment of ACTs could best operate within referral pathways in order to provide whole-system care.

A documentary review of research, policy and evaluation evidence (forthcoming) informed interview topics, and the existing ACT practice guidelines (PHE, 2018; PHE/NHS 2019a, NHS, 2019b) provided *a priori* themes for exploration.

Setting

We conducted our evaluation in a large city in the north of England, a region with one of the highest rates of alcohol deaths in England and increasing since 2019 (ONS, 2022). The city district consists of several general and specialist hospitals within one of the largest integrated health partnerships in the UK. Health and social care services are delivered in a wider administrative region by multiple health Trusts, with overlapping borders between hospitals, primary care, mental health and local authority services, with addiction services provided by different commissioned not-for-profit (NFP) agencies. Not-for-profit substance use services in England are commissioned in their own right to provide treatment and recovery support alongside and in partnership to statutory health and social care services. Therefore, the services support each other. There are three different NFPs for the region, with geographical boundaries overlapping Trust and local authority catchment areas. This can result in two or three NFPs serving one hospital, depending on where hospital patients live. At least one NFP provided in-reach to two hospitals; practitioners providing a presence in the acute care service areas and providing links to follow-up services on discharge. In-reach was also provided in one hospital for homeless patients by a primary care service.

We focused on three main city general hospitals, termed here 'East', 'West', 'Central'. 'West' hospital had a limited ACT in place, that provided hospital-wide assessment, advice, referral and staff training. The existing ACT consisted of a nurse-led team; a charge nurse and two staff nurses, with gastro-hepatology consultant availability, based in acute care, and providing weekday coverage. The other two hospitals had no ACTs. At the time of this study, the ACT funding was transitioning from local support from one hospital to Public Health England funding for a fully commissioned ACT working across all three hospitals. This study was part of an evaluation of ACT working to establish a wider ACT and pathways. The existence of one ACT provided the study with a degree of contrast between hospitals and pathways. The evaluation was carried out post-Covid when processes of referral and communication had returned to normal practices.

Stakeholder consultations

Stakeholder testimonies were obtained via interview from 28 individuals across areas serving the three hospitals within a relevant care delivery area. These included ACT, community

mental health, community nursing, midwifery, specialist addiction social workers, acute and emergency medicine consultants and specialist practitioners, consultants from gastro-hepatology, psychiatry, primary care, practitioners and managers from NFP substance use services, and local and regional health commissioners. Stakeholders were recruited from the researchers' extensive networks in the area. Consultations were investigator-led following a semi-structured format that was formulated to each interviewee's role. Interviews were carried out online using Microsoft Teams, lasting between 30-60 minutes. Microsoft Teams transcriptions were used to record the interviews, and contemporaneous field notes taken.

Analysis

The approach to analysis was guided by the project objectives to identify care pathways, and the efficiencies and barriers in working across a multi-agency system. Evidence of key barriers and facilitators from the documentary review and the practice and policy guidelines were used as *a priori* themes, but researchers remained open to identifying emergent findings. Collective reflective synthesis was performed to act as a form of inter-rater reliability by the research team.

Stakeholder testimonies were analysed using the *a priori* and emergent themes related to the functioning of ACTs and ACT objectives. We particularly focused on current practice for alcohol dependent patients; key service burdens, strategies to reduce frequent attendance and admissions, unmet needs, care pathway functioning, and staff training. We also conducted a care pathway mapping exercise based on interviews to identify gaps and facilitators of effective pathway referral.

Ethics

Our approach for this consultation was approved by the university ethics committee (EthOS Reference Number: 34343). Health Research Authority (HRA) exemption from research ethics was obtained for this project.

Findings

Objective 1: Identification of key service burdens and barriers to effective care delivery

Frequent attenders

It was clear from the review that alcohol-related frequent attenders represent significant burdens upon hospital acute care services. Practitioner stakeholders reported finding this patient group challenging and also frustrating to work with:

> And it's not just alcohol, people often also have problems with other drugs, homelessness, unstable accommodation, family dynamics etc. Daily presentation to [ED] becomes part of the daily routine. (Emergency Care Consultant #1, East)

The more vulnerable patients are also shown in our study to represent the 'revolving door' presentations to ED:

> You get this kind of revolving door potentially where people are living in very poor conditions, become unwell, get admitted. They often have … a lot of very high intensity, often ITU-type treatments: they get a bit better and then they go back. And then if you're not careful, the cycle just repeats itself. (General Practitioner, Central)

Unmet need and screening

Testimonies from stakeholders indicate that emergency and acute services are not equipped to address the needs of chronic alcohol users without further support, especially if they require alcohol detoxification, which is likely to contribute to admissions and extended bed days:

> They [patients] tend to come in anything but office hours, which makes management of the acute phase quite tricky and a lot of them end up being admitted to hospital because it's the only safe way to manage them. (ED consultant #1, East)

This also suggested there were gaps in knowledge about the NFP sector and existing detoxification services as it was clear these patients were not being referred to such services, but emergency care practitioners also considered acute care not the place to screen patients for alcohol misuse:

> And then you caught up for hours sorting out somebody, you know, and you're like,
>
> I haven't got time for this, really not when I've got 120 people in the department… (ED Consultant #2, East)

Our stakeholders highlight how frequent attenders with substance use problems are more likely to present with co-morbidities such as mental illness and social problems:

> Clients who were very vulnerable [are] revolving door alcohol clients. (NFP in-reach practitioner, Central)
>
> It's the other things that come with the alcohol, isn't it? So, it's the mental health side of things. The homelessness aspect. [] and also then there's the trauma aspect, There's been some domestic violence, you know, all that kind of trauma is kind of a big umbrella, isn't it? (ED Consultant, Central)

Homelessness

Homelessness and unstable housing was an emergent theme from our analysis and shown to be a problem for referral. Our practitioners stated they found difficulties providing any signposting or referral for homeless patients:

> And those people who come out with no fixed abode and they don't have stable accommodation. They're sofa surfing, so you can't follow-up with those. (NFP in-reach practitioner, Central)
>
> Actually, homeless people [] regularly end up in hospital, you know, in very poor condition. Sometimes they're discharged or they discharge themselves fairly precipitously. (Homeless in-reach General Practitioner, Central)

One problem associated with frequent attendance and re-admissions is not being registered to a general practitioner (GP), so the usual route for community referral follow-up is missing (MHHN, 2016). This reflects the findings from our stakeholders:

> …what tends to happen in primary care, with people [who] are homeless is they just disappear - you know… one of the things that inhibits [GPs] with registering people is that people turn up,

they've got any number of issues, they've got no support… they can just appear to have loads and loads of intractable problems. (General Practitioner, Central)

Social care stakeholders indicated that their clients often report negative attitudes from hospital staff, both clinical and administrative, which suggests a need for training for all hospital staff working with this patient group:

We have a lot of people saying 'I'm not going to hospital, they'll just turn me away' and you know, they're actually right, they're, correct. (Substance use social worker, Central)

Practitioners underlined the issues of negative experiences which may partly explain self-discharge or admission refusal:

You can have [] an attitude that feels like it [alcohol dependence] is not anything you can do anything about, which of course the patient picks up on (ED Consultant #1, East)

Staff skills, time, and training

The need for staff training features in the ACT policy and evaluation literature, and this was highlighted by stakeholders, both for improving referrals and in managing patients more effectively:

{Training is needed for practitioners] to develop more knowledge of services, more knowledge of alcohol. …it can be [otherwise] a more medical model which was, 'the patient scored for alcohol dependence, well they need to go and do a detox …. And then they'll be OK'. (General Practitioner, West)

I think there's a sort of mystique [around alcohol] where we've got 'well that needs a specialist to deal with it' … The alcohol in many ways complicates [the problem,] people's beliefs are that it should be complicated. (Substance misuse social worker, East)

The ACT guidance is not specific on what training should be provided, or for whom. However, as alcohol use is ubiquitous, it is fair to suggest that all relevant staff should have some training in conducting assessments and referral, as stakeholders recognized:

…there's a real need on the wards, because it's often an area there isn't generally, part of the medical curriculum. (General Practitioner, Central)

Our clinical stakeholders, however, found that time was the main barrier to using the AUDIT-C screening tool, and then not using it for early identification:

It doesn't always get done. [] obviously for the alcohol patients it gets done, but you're never going to discover anything new till you ask the question really…. (ED consultant #2, East)

If we do that as the medical team as part of our clerking in the patient because our AUDIT-C was plunked at the front door, the nurses do [the clerking] and they don't have time. [] But I don't think [we need] more steps into the front door processes because we're under massive pressure to get people seen through so it just slows everything down. (ED Consultant #2, East)

Where there was no ACT in place, practitioners appeared to struggle to manage alcohol dependent patients, especially in understanding care needs and referrals. This was attributed to lack of basic training:

…medical students [] get one morning in their whole five years with an alcohol addiction psychiatrist. so [] you learn it through the prism of Liver disease. [] All the hard things are about the treatments for withdrawal. The tests you would do. And then obviously the simple message that you should [deliver]: 'Actually, you should stop drinking mate, it's not good for you'. (Consultant addictions psychiatrist)

Where an ACT exists and delivers training, emergency staff were happy with their role and information-giving:

(Q: what are the strengths of the ACT system?) Good, nursing and doctors are well aware of risks and signs of withdrawal and the need for brief intervention. (ED Nurse, West)

Pathway barriers

It was clear from the consultations and pathway mapping that care pathways between hospitals, community and primary care were more or less efficient depending on the presence of an ACT in the hospital. Where the ACT was present, advice was centralized and early intervention initiated.

The pathway to tertiary care (in-patient detoxification) was also facilitated by the ACT:

That's actually … the front door for the acute Trusts, [] because they are then sending their patients through to us… (Consultant addictions psychiatrist)

Where no ACT existed, opportunities for early intervention could often be missed, referral pathways poorly understood or dysfunctional, and discharge likely to be unsupported in the community. Information-sharing with community care was also inadequate:

(Interviewer question to two consultants): Do you have any links into the [named community center] or is that just strictly a city center agency?

(Response to colleague): Should we? (ED consultant #1, East),

'Really, yeah…. Nurses might know…' (ED consultant #2, East).

Our consultation found very local arrangements for primary care and substance use in-reach, and highly reliant on informal networks and relationships between staff:

Quite often I will just give [a known contact] a ring. To be honest, we work with them on and off for many years. It would be like giving somebody a ring and you know, so it's just 'we've got such-and such in here'. (Specialist substance use social worker, East)

Community follow-up care was reliant on the quality and appropriateness of referrals received:

So, the frustrations are around some of the agencies referring in. So, things like police, will often [refer to us] without [patient] consent. Or, you know, [the information is] just 'this person needs to stop drinking'. 'Right, well, I'll just sort that out shall I'? (Specialist substance use social worker, East)

Referral problems can arise within the commissioning area, if patients do not have a GP or the GP letter does not flag up the alcohol concern:

For [every patient] leaving [acute care] an alert is emailed to their GP – but this only identifies the presenting problem, so a lot of

people are missed re alcohol since their main reason for attending [hospital] might be a broken ankle – but they broke their ankle because they were drunk. (ED Nurse, West)

Central hospital is serviced by one NFP, but the wider region is provisioned by three different NFP services that overlap East and West general hospital footprints. All provide prescribing, psychosocial interventions, links to housing support, community outreach and hospital in-reach. The links between the secondary, primary and NFP providers make up the key structure of the care pathway network, however, we found NHS staff would not know a patient's recent medical history if prescribing is managed by the NFP service. Equally, they could not easily follow-up a patient:

And for somebody who's pitched up in the hospital for alcohol, potentially you could have 10 different ways of referring into that [correct NFP] service. And it's complicated and a problem. (Emergency care consultant #1, East)

It was apparent that commissioning of specific services consisted of different funding streams that created confusion:

it's very piece meal. Isn't it? Sort of comes with pots [of money] and some of it wanting the same thing…. I wish it was a bit more strategic and coordinated in terms of the way that's commissioned. (Consultant Addiction Psychiatrist)

Referral difficulties also arose for patients residing outside the commissioning area, often because staff did not know which NFP service covered which area, or could not easily determine where a patient lived. One stakeholder suggested deciding it was dependent *'on which local authority collected their bins'*. (NFP *service clinical practitioner, East*)

… you've also got the lottery of post codes …Where we can, we refer it onto the appropriate services, it's just if there's any issues with consent. … if a referral is received over the phone, then you can, you know, say that this isn't the right place, but sometimes it comes in from an email and it's a staff nurse on then you've got no chance of going back and finding that nurse [to advise]. NFP service manager, Central & West)

Where an ACT was in place, our informants all reported good working relationships based on the ACT visibility on wards and departments and the availability of the team. The ACT had established good referral links with community services including social workers, NFP providers, and in-patient detoxification within mental health services:

We almost entirely refer through our alcohol team, so it would be [named person] and her colleagues and they're often quite a visible presence on our ward. Everybody would recognize them and if they had a patient, would be making sure – 'you know about the man in bed 7 over there'. So, we've got a good relationship with our ACT and [named person] is really good. (ED Consultant, West)

So, we do need the alcohol care teams. They're often the main referrers, and that's probably right because they are the ones who can do the assessments properly. (Consultant addictions Psychiatrist, detoxification in-patient unit)

The ACT also assisted with smoother hospital admissions:

[For reluctant clients] we call ACT to say 'such and such is coming in' and 'can you make sure they screen properly? There are concerns around their health' … (Specialist substance use social worker, West)

Recently, I had a gentleman with very serious self-neglect and very significant financial abuse. He's in hospital … safe and undergoing a detox… I am fairly certain without that care team being in the hospital he would have been discharged straight away. (Specialist substance use social worker, West)

An area that most clinical stakeholders reported as problematic was contacting and referring to mental health services. However, the existing ACT was reported to be developing a referral pathway with the dual diagnosis team:

[We] Have had a few referrals from [West] – needed advice about how to approach MH services – there is an alcohol nurse [there] who keeps in touch. (Mental health practitioner, dual diagnosis team)

Communication barriers

There was also a communication issue where NHS and NFP services cannot share confidential patient information. Our clinical practitioner informants reported not being able to follow up patients, not knowing if they were already receiving treatment for dependence, and being unable to communicate patient consent to the referral:

The other issue is probably 'cause we're not NHS. There's some information sharing issues that we have to look at from a governance point of view. (NFP substance use service, East)

Sometimes we get quite a lot of information, sometimes literally. [Sometimes] we don't even know if we've got consent to contact them, which can prove a problem. (NFP substance use service, Central)

Managerial level meetings set up during Covid-19 included NFP service providers which proved effective in understanding different needs, resources and ideas. These continued post-Covid, with attendees reporting it to be an effective forum to support inter-agency working:

This is, uh, got even better during COVID, they are willing to share information. (NFP service manager, Central)

And this has improved actually during COVID. Since the Covid, [] the [NFP sector] is being included in those meetings as well, which they're finding really, really useful. I can't see any good reason not to carry on with it. (Regional Health Commissioner #1)

Covid pandemic strategies for maintaining communication reduced silo working and have also continued for case management across agencies. This appeared particularly effective for pathways between statutory and NFP agencies:

So, think post pandemic. That's one of the positive things that we can continue to do. We've done the same with social services, they've been attending (complex case meetings) as well so that we can do more of a joint working and everybody knows what each other is doing so that we can have a combined approach rather than working separately. (NFP substance use service manager, East)

Objective 2: Effective processes, strategies and good practice

Assertive alcohol outreach and in-reach

The working of in-reach and outreach was an emergent theme in our analysis. We found the assertive alcohol outreach team (AAOT) was provided by the 'Central' NFP service and focused on those who do not engage with discharge follow-up. This AAOT works with a community homeless engagement center in the city to identify recently discharged patients as well as identifying alcohol-dependent people in the community not in contact with services. Not-for-profit services and primary care also offered hospital in-reach, for substance use and homelessness respectively, with in-reach and outreach coordinating quite effectively:

> In-reach and [] outreach [are important] because the minute somebody leaves the doors of the hospital there needs to be somebody to pick that up because they're very complex people who are dependent drinkers. And so I saw that work quite well (Regional Health Commissioner #1)

> The [AAOT] team are very experienced and [] quite a lot of the members in the team are experienced and they get to know a lot of the clients that are in [the City] and so they know what a lot of them look like. (NFP service manager, Central)

Focusing on the homeless however is unlikely to address the engagement needs for alcohol dependents recognized officially as 'housed'. This group of patients may present the most complex case management challenges but often remain 'under the radar' until admitted to hospital:

> He said he was homeless, [but] turned out his address was in [out of area] you know, and he was still technically married so he had a right to go back to his house that he lived in with his wife. But then the tenancy had been dissolved, Honest to God, it just got really big and complicated. (ED Consultant #2, East)

Assertive alcohol outreach teams are not included in the core descriptors for ACTs but, where integrated care systems are in place, linkage between ACTs, AAOTs and community-based street services could be established. It was also suggested that AAOTs could also work with the dual diagnosis team:

> I think there's something in there; that crossover between dual diagnosis teams and the alcohol assertive outreach teams and ACTs. (Regional Health Commissioner #1)

Frequent attender meetings

Targeting of frequent attenders by a hospital-led MDT that includes whole-system stakeholders is a model shown to be effective in identifying their underlying needs and providing more wraparound support that reduces burden on acute and emergency services (Mpath, 2013; NICE-QUIPP, 2016). The hospital in the research area with an ACT conducts frequent attender MDTs that includes ambulance, police, social services, and primary and community services, and have found the improved communication useful:

> *ACT are following regular attenders up, we've had a success story, I mentioned [during the MDT meeting] that we hadn't seen a certain patient and learned that the ACT had engaged community alcohol services and the GP and he was being better supported in the community. (ED Nurse, West)*

Staff training and ACTs

Alcohol Care Teams are recommended to also provide staff training on alcohol (NICE-QUIPP, 2016). From our consultations it is clear that training of staff requires frequent updating to accommodate staff rotations and staff turnover:

> Hospital staff turnover is high and alcohol is just one of the presenting issues that staff come across so it's important for us … having a presence in the hospital and keep looking at ways [] we can disseminate the information about the pathways to keep it up to date and relevant and so that they know how to refer. (NFP in-reach practitioner, Central)

Our findings show that training can be provided by other agencies such as NFP and community services. In that way, acute care staff can also develop understanding of such services and build pathway relationships. We found piecemeal training offered by other agencies, but suggest this could be coordinated by the ACT.

Objective 3: Recommendations for systems structures to improve alcohol care pathways and ACT functioning

Communication

Communication issues was an emergent theme. One of the ACT core aims is to improve information-sharing between services. We found this problematic as the key agency providing substance use community services is non-NHS – a common arrangement across the UK. This means confidential patient records cannot be shared throughout the care pathway and creates barriers between secondary and community services. This is especially problematic when community services are prescribing medications. This also presents a barrier to patient consents for information-sharing between services:

> And then you might see the client. Then, you know, you'd prepare them for detox and then it just comes up in conversation and they say, 'Oh well, I did go to [ED] a few weeks ago' and information kind of comes out that way sometimes. (NFP service practitioner, Central)

Information-sharing agreements would need to overcome barriers for follow-up discharges and identification of frequent attenders if non-NHS agencies remain key elements to the care pathway. It will be important that this allows identification of patients already receiving medications, and that consents are embedded into information-sharing – the two key barriers identified through the consultations with clinical staff:

> But if we can share that information, they can tell us who the top ten (frequent attenders) are. We can then look [and see if] we're already working with them… (NFP service practitioner, Central)

Community hubs

This form of secondary, primary and community care reflects the area's Integrated Care System (ICS):

> A footprint response, so across the whole of the Trust, I think that's really… that would happen on an ICS footprint … in terms of the health and social care. (Regional Health Commissioner #2)

This would also support the creation of multiple pathways to and from secondary care:

> I think [the 'no wrong door' approach,] that's a big issue actually. 'cause obviously, for patients who are trying to get help, especially when they're very desperate or relatives or trying to get help, it can be really difficult. …whatever the front door is, it needs to be easy to open. (Consultant addictions psychiatrist)

The role of ACTs

The guideline documents for the ACTs emphasize the need for a specialist team based in secondary care, and particularly available to acute care services to provide appropriate support and responses for this patient group. However, operationally, the precise role of the ACTs is to be determined locally. One concern for commissioners and practitioners was that the ACT should add more to the system rather than replace other roles:

> [a patient] needs an assessment, actually those staff on the wards should be equipped with the [skills] so they shouldn't be pulling away from the critical work of the ACT which is, you know, first-hand responding and supporting that work. (Regional Health Commissioner #2)

> … this is one of the worries, that the ACTs become actually a bottleneck rather than… a facilitator … shouldn't necessarily be at the bedside all the time. They should be supporting everyone else who is at the bedside. (ACT practitioner, West)

> It's not just about being at the bedside and doing the assessments, it's about making sure everyone is better at dealing with alcohol. (Consultant addictions psychiatrist)

Problems for commissioners was funding an ACT 24/7 service. The existing ACT was a 9–5 weekday service but clinicians felt that was problematic:

> Patients are [arriving] during overnight hours, patients fall through the net (ED Consultant #2, East)

Frequent attender meetings

Frequent attender MDTs can be effective in reducing burden on acute care (Sousa et al., 2019), and 'West' hospital was in the process of re-commencing these post-Covid. One consultant had experienced these elsewhere and felt they were very effective:

> We used to review the top 20 … we'd all the necessary stakeholders there, the police …social services, probation services and alcohol services, GP representation. So, everybody [] could actually contribute to the management of the patients. Every month we tended to look at a different group, just to make sure the plans in place were working for the patients and… look to the things that had worked and how well… That worked quite well. (AMU consultant, West)

One NFP service was also attending similar MDTs in their neighboring area, which suggests NFP sector attendance would be an important element for the frequent attender meetings, made easier post-Covid:

> I think Teams meetings have helped a lot with that because [] people don't have to leave their place of work to attend a meeting. (NFP service manager, East)

Summary

Our findings show that practitioners and service managers reflect the concerns regarding repeat attenders to hospital acute settings, but highlight also that operational policy and practice systems present barriers to meeting the complex needs of this patient group. One could argue that acute care is not the place for dealing with complex health and social needs, but it could and should be one of the 'no wrong door' entries into care. It is clear that an effective ACT available to acute care can facilitate an appropriate care pathway to meet their complex needs.

Discussion

Our findings show that ACTs can facilitate improved care pathways within and between agencies within a whole-system approach to care. If a key aim for ACTs is to reduce demand on hospital services from frequent presentations and re-admissions it will require structured joint working between hospital ACTs and primary and community services. We suggest also that assertive outreach can improve follow-up and reduce re-admissions, and targeting of frequent attenders by a hospital-led MDT which includes all key stakeholders (i.e. acute and emergency care, gastro-hepatology, addictions psychiatry, social services and in-reach or outreach practitioners) can be effective in identifying underlying needs and providing wraparound support.

Key service burdens and barriers to effective care and referral

Frequent attenders and complex needs

Patients with chronic alcohol dependence and complex needs present the largest alcohol-related burden on services in England (Phillips et al., 2019). A British Red Cross report (British Red Cross, 2021) suggests that repeat ED presentations occur because patients believe no one can help them in the long term. Without underlying complex needs being addressed, they continue to present repeatedly with consequent immediate needs. Our findings indicate that acute services are unable to be responsive to longer-term and complex needs for these patients and may lack clear referral pathways and knowledgeable staff without an ACT presence.

Unmet need

Profiles of alcohol-related frequent attenders indicates that a host of complex socio-economic and health needs contribute to their reasons for presentation (Roberts et al., 2020), and these needs are likely to go unmet. Smith et al. (2021) found a high proportion of people targeted by AAOTs had severe mental health problems as well as drug or alcohol addiction. They often had a history of non-engagement with mental health services and present complex diagnostic challenges. While pathways often exist between acute care and

gastro-hepatology (Williams et al., 2021), the same arrangements are not often present for mental health. Our findings suggest that involvement of mental health services and joint-working with mental health assertive outreach for care planning via a frequent attender team approach may be a way forward. A dedicated pathway between alcohol services and mental health may reduce the waiting times currently existing for referrals to mental health services in England (NHS England, 2024) and reduce the contacts required in routine mental health referral pathways. Arguably, such patients' conditions are likely to deteriorate with long waiting times (Rethink, 2024). This notion of creating such a pathway is reflected in plans in the region we examined to develop closer links between the ACT and the dual diagnosis team.

One concern arising from treatment access evidence is that patients from deprived areas have additional needs currently not serviced by health and social care. Public Health England data indicates disproportionate percentages of women, housed, and over 40s entering alcohol treatment in 2019 (PHE., 2020), which may reflect a population who find access to treatment pathways easier. Public Health England also report the majority entering treatment were self-referred, with only 10% from general practitioners, and only 3% of referrals made from hospitals. Currie et al. (2016) found that that the introduction of ACTs did not impact on the number of service users, but did increase the proportion of patients from the most deprived areas. This suggests an increased targeting of most need through the adoption of ACTs, and poor pathways into support and treatment without ACTs. The ACT role of identifying dependent drinkers and managed onto a treatment pathway may be a more effective approach to tackling unmet need than relying on the general practitioner or self-referral for this group. It is also important to point out that the ACTs are likely to be able to refer more holistically, taking into account a patient's level of motivation and priority of need and support. A recovery pathway is not just about detoxification and abstinence but may require more focus on building 'recovery capital' (Granfield & Cloud, 1999) such as housing, social or financial support. A whole-system health and social care approach with knowledgeable referral pathways offers more flexible avenues into behaviour change.

Homelessness and substance use stigma

Problems arising from homelessness was an emergent finding from our research. According to Lewer et al. (2021), the UK's homeless patients are more than twice as likely to be admitted to hospital via acute care than those with stable housing, and twice as likely to present to ED than housed patients. Repeated presentations are not, according to Lewer et al, necessarily due to having more health problems, but associated with unmanaged chronic conditions.

This patient group often only present to services at a late stage, and often reluctantly, and, as reported by our acute clinical stakeholders, can discharge themselves before any follow-up care can be organized. Lewer et al. (2021) and our informants suggest this is because they have experienced stigmatised attitudes on previous visits. Van Boekel et al. (2013) highlight that health professionals' stigmatizing attitudes can stem from perceived threat of violence and poor motivation, and lack of empathy. In addition to stigma, these patients can face practical difficulties in accessing care. For instance, the Homeless Health Network (2020) reports that homeless people may feel ashamed at being dirty, may have nowhere to put their possessions or are not aware of services in the area. They present challenges to care pathway management because establishing their home catchment area provider proves difficult, but our study shows that in-reach and outreach can be effective care pathway facilitators for this group.

Staff skills, time and training

The ACT guidelines support the need to ensure all clinical staff receive identification and brief advice (IBA) training (PHE, 2014). Our informants however repeatedly reported lack of skills among general acute nursing and medical staff. The policy ambition is that all adult patients are screened using AUDIT-C (Alcohol Use Disorders Identification Test-Concise) (Bradley et al., 2003), and offered brief intervention and advice as a motivational, opportunistic health promotion opportunity (PHE., 2019). Regardless of debatable evidence for the effectiveness of IBA in secondary care settings (Kaner et al., 2018), initiating early intervention is part of the ACT role, to support staff to include this in their own 'bedside' role. The role of ACTs should be supporting staff through training, advice and assisting in the management of alcohol dependence and withdrawal. Our informants expressed concern for ACT 'mission creep': a gradually expanding role that could result in ACTs delivering hands-on interventions rather than supporting existing services to do so. This would result in the ACT being seen as a first intervention specialism rather than being an adjunct to the acute care function.

Skills deficit in acute care, however, may present a barrier to effective identification and health promotion in acute care. Frequent ED attenders report feeling that the staff only focused on the immediate non-alcohol issue (Parkman et al. (2017). In order to support alcohol screening, staff will need to feel competent using the tools and feel able to enact follow-up. McGeechan et al. (2016) ACT evaluation showed hospital staff lacked confidence in delivering brief intervention and advice. Their study suggested that staff may exaggerate problems in order to refer on to the ACT. This adds to the ACT workload and produces the 'mission creep' effect.

The Health Innovation Network's Tackling Substance Misuse Resource Pack (2018) identifies a lack of training programs for practitioners on alcohol. They report that alcohol misuse is seen as 'one task too many' for busy staff, and such patients can be viewed as 'only having themselves to blame for their health problems' (section 1.4).

We identified multiple barriers to screening and delivering brief intervention in the literature (NICE, 2014; PHE, 2016; Van Boekel et al., 2013) including:

- Lack of time and no training in counselling or communication skills
- No financial incentive for the department
- Lack of confidence in asking and talking about drinking

- Belief that people would not act on advice
- Focusing only on dependence
- Staff not trained in screening or brief intervention
- Poor environment to conduct sensitive interventions
- Prioritizing physical and immediate health issues over health promotion

Concerns for 'mission creep' and lack of skills in acute care both highlight the importance of the ACT training role, and should be prioritized over hands-on clinical intervention.

Pathway and communication barriers

We found many existing strengths in the existing ACT and alcohol care pathway provision due to established informal and local arrangements, and good use of current local service provision and initiatives such as use of detoxification services and homeless initiatives. Also, the existing ACT arrangement had established a workable model and tested what works for the locality. This underlines the principle of place-based commissioning and service planning as services can be responsive and flexible in accommodating local initiatives. However, the *ad hoc* approach tended to create a reliance on local knowledge, experience and personal relationship-building with other agency colleagues, creating quite narrow and haphazard opportunities to refer accurately. One issue highlighted with the existing link to primary care was focusing on the single presenting problem rather than having an alcohol-specific route to follow-up care. With several hospitals and providers across a large region, a need for a multi-site ACT and a whole system care pathway may become unsustainable if reliant on personally-built communication routes.

One of the core descriptor aims is to improve information-sharing between services (PHE/NHS (2019a). This may be problematic if Integrated Care Systems in England are relying on NFP community services with no information-sharing agreements. 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. This also presents a barrier to patient consents for information-sharing between services.

Theme summary

It is clear that acute care staff experience challenges when managing alcohol-related patients with complex needs and, without specialist support, struggle to address unmet needs. Understandably, they do not feel it is part of their remit. The ACT role, however, shows promise in being able to co-ordinate care to meet these additional needs, and able to facilitate the care pathway to appropriate care.

Effective processes, strategies and good practice

Assertive alcohol outreach and frequent attender meetings

Our findings and literature evidence indicate an important role for AAOT within the alcohol care pathway. Assertive alcohol outreach teams (AAOT) can reduce hospital admissions and ED presentations among frequent attender dependent drinkers with complex needs. In Salford, Hughes et al. (2013) demonstrated that a team of consultants in emergency medicine with specialist substance misuse nurses and social workers improved health outcomes and reduced admissions and ED presentations within a 3-month period, with an estimated cost saving of £607,000 within six months (Moriarty, 2014). A randomized control trial in South London (Drummond et al., 2018) targeted frequent users of services with intensive weekly contacts over 12 months. They estimate a net saving of £10,569 per patient from hospital admissions, and a 48% reduction in hospital bed days. Salford's AAOT targets the 20 highest frequent attenders, resulting in an estimated 15% reduction in ED attendance and admission (NICE-QUIPP, 2016).

Assertive alcohol outreach teams linked to ACTs do have the capacity to target frequent attenders regardless of housing status, and therefore present a cost-effective option specifically for reducing hospital usage. The Pathway Model and Street Medicine approaches (Khan et al., 2020; Raven et al., 2011) also provide continuity of care following discharge, and capture a wider range of health needs including drug use, mental health and safeguarding.

Staff training

In order to comply with ACT guidelines, training needs to target: screening and assessing procedures, withdrawal management, managing and responding to dual diagnosis patients, referral pathways and advice, staff attitude and morale, and short-term psychosocial interventions such as identification and brief advice (IBA). A way forward could be incorporating alcohol management into induction for junior doctors on rotation and all new staff, MDT training for specific teams, and identification of 'champions' - department-based link practitioners to provide and disseminate advice and expertise. Sandwell and Birmingham Trust in the English Midlands nominate one member of the ACT to take on the role of education lead (Copeland & Bradbury, 2020), and ACT staff in our consultation suggested the training of alcohol link workers or 'champions' within hospital departments to promote awareness and staff confidence. Lyon (2016) reports on her hospital's nurse-led team and the training programme they have developed in England. They have a monthly rolling education programme which is described as 'multigrade' to provide different levels of training for different roles. 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.

Recommendations for systems and structures

Communication

Information-sharing agreements would need to 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 this allows for identification of patients already receiving medications, and consents are embedded into information-sharing – the two key barriers identified through the consultations with clinical staff.

Community hubs

One reported cause for frequent attendance and re-admissions to ED is difficulty in registering with a primary care practice and lack of integrated follow-on care after discharge (MHHN, 2016), which supports our findings. Manchester's 'pathway model' was set up as a homelessness health inclusion pathway incorporating primary care with and in-reach links to hospitals and community services such as housing and substance use NFP services. Their impact evaluation showed linkage to primary care services following hospital discharge reduced hospital admissions and attendances by 49%, bed days by 39% and 28-day readmissions by 59%. In the same timeframe, 82% of service users registered with the hub's primary care services. These results were followed by significant positive changes to clients' socio-economic capital, and increased uptake of alcohol interventions (Mpath, 2013). Such a service mirrors the US Street Medicine Model (Raven et al., 2011), a coordinated community and hospital-based management system, which showed a reduction in admissions and health costs, and an increase in community health engagement when utilizing an AAOT.

Role of ACTs

Our findings underline the usefulness of ACTs to ensuring good care pathways. Where absent, there was un-coordinated or weak structures for community follow up. Dorey et al. (2021) similarly reported poor or absent community follow-up where no hospital-based alcohol specialist nurse was available. Our findings also indicate the importance of a 24/7 ACT service in order to ensure coverage of nights and weekends, and highlight the importance of setting clear role boundaries for ACT staff to protect against 'mission creep'.

Frequent attender meetings

Evidence and our findings both support that regular inter-disciplinary and inter-agency meetings are effective in targeting the neediest patients, reducing burden on services from repeat presentations and admissions, and, at the same time, ensuring that patients receive the support and referral they need. An alcohol-specific pathway would respond better to patients' needs and signpost to the services best suited to provide follow-up.

Conclusion

Public Health England report ACT models that achieve the best returns on investment and patient outcomes have consultant leads capable of strategic planning and management, referral links to multi-agency community services and primary care, and a form of assertive outreach (PHE, 2014). Integrated Care Systems offer opportunities to develop holistic care for alcohol within a whole system approach that engages social as well as health care. Development of ACTs and smoother care pathways across organisations and agencies 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 programs. The adoption of integrated care boards which can commission services may provide smoother planning by eliminating silo funding and postcode barriers.

Of relevance to care pathways, integrated care systems offer opportunities to reduce the identified pathway barriers occurring between commissioner group borders, and introduce more consistent service commissioning and collaboration between NHS, local authority services and NFP sector providers.

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Data for this project is not available due to funder restrictions.

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