Delivering Healthy Ambitions
Better for Less

Overview.

We have higher than average levels of binge drinking, increasing risk and higher risk drinking in Yorkshire and the Humber.

This briefing identifies an integrated care pathway and describes four key evidence-based interventions that can impact on reducing alcohol related harm and admissions. Implemented together they have the potential to save £3.8m per PCT or £53m across our region.

The briefing intentionally only covers part of a stepped care model for alcohol care and should be seen as part of an agreed integrated care pathway locally.

What is the challenge?

Alcohol related conditions such as head and neck cancers, liver cancer, alcohol dependence syndrome, ischemic heart disease, hypertensive disease, and foetal alcohol syndrome contribute to morbidity and mortality rates.

The harm to the population and the cost and burden to local health economies has been well documented. In Yorkshire and the Humber:

- alcohol related admissions cost over £160m per year
- up to 35% of all A+E attendances and ambulance costs are alcohol-related
- 1 in 5 patients admitted to hospital for other reasons are drinking at increasing risk levels
- 1 patient in 5 presenting to primary health care are likely to be drinking at above lower risk levels, and based on the average list size, a GP will see over 360 such drinkers per year
- Problem drinkers consult their GP twice as often as the average patient.

A study by Yorkshire and Humber Public Health Observatory shows the cost of alcohol related hospital admissions for each GP practice in our region is on average £31 per person on a GP list with a maximum of £150 per person.

Figure 1.
Percentage cost of existing condition to alcohol attributable admissions in York & Humber.

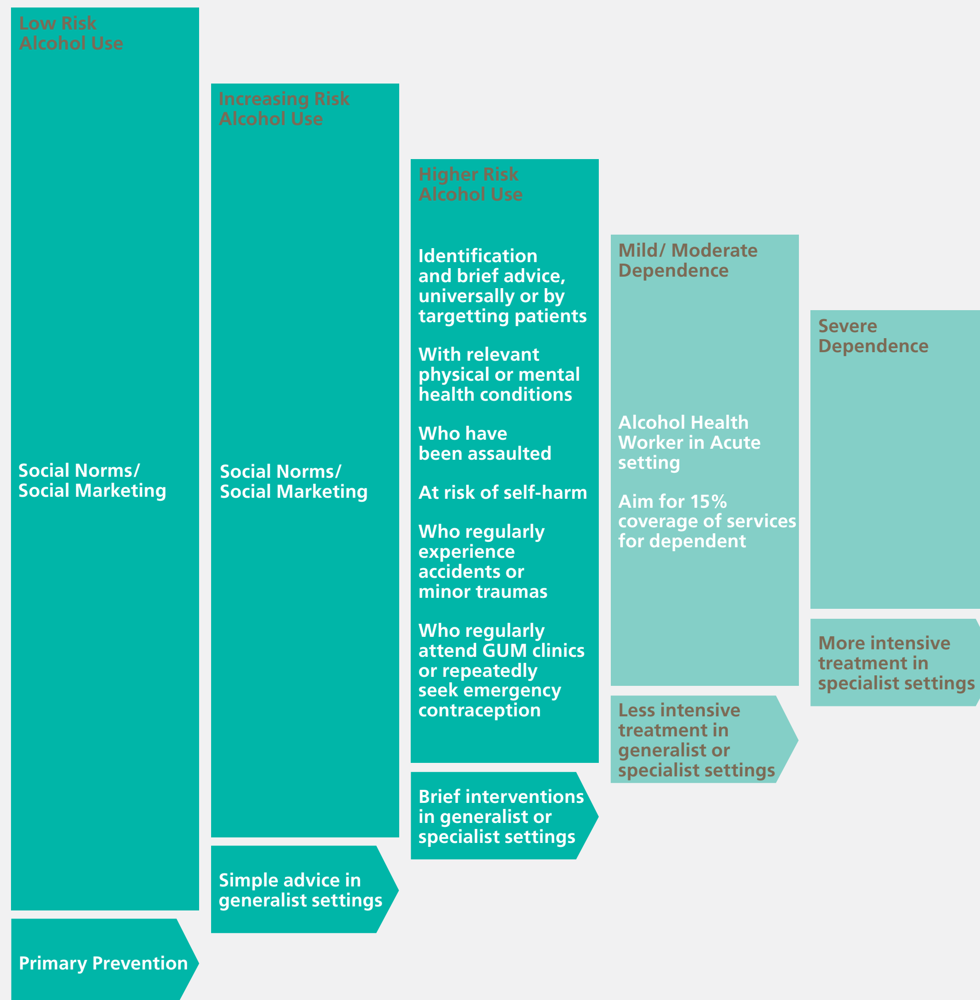
Condition	Alcohol Attributable Hosp. Admission	Cost % of all alcohol related hosp. admissions
Hypertensive	30,457	37
Cardiac Arrhythmias	15,005	23
Mental and behavioural	13,206	13

The care model

A stepped care model identifying people in primary care (through identification and brief interventions), in acute services (through Alcohol Health Workers) and through providing clinical pathways to specialist care will provide an effective model of care across localities.

The stepped care model enables people to reduce or discontinue their alcohol use, stabilise any long term conditions and have significant contribution to reducing unplanned hospital admissions and subsequent readmissions.

Figure 2.
How QIPP Better for Less Alcohol Prevention and Early Intervention approach fits with Stepped Care Model



How could we deliver a reducing alcohol related harm programme?

Evidence recommends a focus on the following four key areas, as part of an integrated care pathway:

- Identification and brief advice
- Alcohol Health Worker in an acute setting
- Improving services for dependent drinkers
- Behaviour change and social norms.

1. Identification and brief advice

Evidence shows that clinically significant reductions in drinking and alcohol-related problems can follow from brief interventions.

For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels. This compares favourably with smoking where only one in twenty will act on the advice given. As the evidence base is strong for brief interventions with alcohol and smoking and given that evidence suggests that 80% of dependent drinkers smoke, local consideration could be given to offer smoking cessation in alcohol services and for smoking cessation services to offer alcohol brief interventions, in areas where it would positively impact on their clients

Brief interventions are the subject of another Better for Less briefing published by NHS Yorkshire and the Humber, available here: www.healthyambitions.co.uk/betterforless

Patient Benefits

Evidence considered by NICE suggests that even very brief interventions may be effective in reducing alcohol-related negative outcomes. Patients who received an alcohol brief intervention in A&E made fewer visits to A&E during the following 12 months.

Financial Benefits

According to the World Health Organisation brief advice "heads the list of effective and cost–effective evidence based treatment methods."

Four studies provide evidence on the likely quality-adjusted life-year (QALY) gain associated with screening plus brief intervention for increasing risk and higher risk alcohol use. These studies estimate that the lifetime QALY gain due to screening plus brief intervention is likely to be in the region of 4–19 per 1000 compared to no intervention, depending on the intervention and whether it is repeated over time. If we assume brief interventions could reduce alcohol related admissions by 15% the regional saving to PCTs would be around £1.7m.

Figure 3.
Potential saving per PCT (assuming a 15% reduction in alcohol related admissions)

PCT	Cost of alcohol related admissions (£000s)	Potential saving: 15% reduction in cost of admissions (£000s)
Barnsley PCT	8,900	1,335
Bradford & Airedale Teaching PCT	17,000	2,550
Calderdale PCT	6,000	900
Doncaster PCT	11,700	1,755
East Riding of Yorkshire PCT	9,100	1,365
Hull Teaching PCT	7,500	1,125
Kirklees PCT	10,800	1,620
Leeds PCT	21,000	3,150
N.E. Lincolnshire Care Trust Plus	4,600	690
North Lincolnshire PCT	4,800	720
North Yorkshire & York PCT	23,800	3,570
Rotherham PCT	9,300	1,395
Sheffield PCT	18,100	2,715
Wakefield District PCT	9,100	1,365
NHS Yorkshire & The Humber	161,700	24,255
Average per PCT	11,550	1,733

Note: Calculation does not make any assessment of cost of implementing brief advice as is assumed to be part of ordinary service contacts. However some staff training may be required.

Implementation

Targeted widespread use of the NHS Yorkshire and Humber Making Every Contact Count Framework (available from nww.yorksandhumber.nhs.uk/toolkit_directory) for adults with existing medical conditions, in areas of deprivation or those in the high risk alcohol segmentation group post code areas, who have been identified via screening as drinking at increasing risk amounts of alcohol and who are attending NHS or NHS commissioned services, or services offered by other public institutions.

A new, free alcohol identification and brief advice e-learning tool for pharmacists is now available at: http://www.alcohollearningcentre.org.uk/eLearning/IBA/

According to NICE guidance brief advice should be:

- based on recognised, evidence-based resource
- based on FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy)
- take 5-15 minutes.

Professionals in the following areas should be trained (for example through the GP Certificate or the e-learning tool) to give structured brief advice on alcohol, as soon as initial screening occurs:

- Primary Healthcare
- Emergency Departments
- Other healthcare services (hospital wards, outpatients, occupational health, sexual health, needle and syringe exchanges, pharmacies, dental surgeries, antenatal clinics and those commissioned from the VCS and private sector)
- The Criminal Justice System
- Social Services
- Higher Education
- Other Public Services.

Consistent, accredited training is an essential factor in effective delivery of brief interventions. A free, short e-learning course on how to identify alcohol problems and offer simple brief advice in healthcare settings is available from e-Learning for Healthcare. The course is accredited by the Royal College of Nursing, see http://www.e-lfh.org.uk/projects/alcohol/index.html

It is also included in the Royal College of General Practitioners (RCGP) certificate for the management of alcohol in primary care. Visit http://www.rcgp.org.uk/practising_as_a_gp/substance_misuse/alcohol_certificate.aspx

Nurses are as effective as doctors in producing behaviour change and the most positive effects have been observed with adolescents, adults, older adults and pregnant women.

2. Alcohol Health Worker in an acute setting

Appointing an Alcohol Health Worker is one of the 'High Impact Changes' identified by the Department of Health. They offer an effective and efficient approach to case management and improving care for patients in the acute sector.

Bradford, North East Lincolnshire and Barnsley are amongst the areas to have appointed Alcohol Health Workers in acute settings.

An Alcohol Specialist Nurse Service in Liverpool has helped to reduce the average alcohol consumption of patients treated and reduce re-attendances. Over an 18 month period, the intensive care management and discharge planning delivered by an Alcohol Liaison Nurse in the Royal Liverpool Hospital was shown to prevent 258 admissions or re-admissions - about 15 admissions per month.

Financial Benefits

Economic analysis of a specialist Alcohol Health Worker appointment in a DGH suggested that the post saved ten times more in reducing repeat admission than it cost.

In Liverpool, in a 20-month period, the ASN's work saved at least £175,000 in hospital costs, solely through the earlier discharge of patients.

NICE state that implementing a specialist health worker should incur no additional implementation costs, although it may require an enhancement of existing services. Using a specialist health worker to implement the NICE clinical guideline should bring a reduction in the mean length of hospital stay for acute alcohol withdrawal by adopting a symptom-triggered regimen for drug treatment. This intervention has the potential to save £7m nationally, this equates to an average of £46k per PCT or approx £700,000 in Yorkshire and the Humber.

Implementation

A case finding approach should be considered in all local areas, with regular analysis of high intensity acute service users with alcohol related hospital admissions. Using appropriate, agreed and confidential information sharing protocols and multi-agency case reviews can enable more effective case management and secondary care for their clients.

3. Improving services for dependant alcohol users

A dependent drinker costs the NHS twice as much other drinkers. The largest and most immediate reduction in alcohol-related admissions can be delivered by intervening with this group through the provision of specialist treatment.

Patient Benefits

The NTA Review of the Effectiveness of Treatment for Alcohol Problems demonstrates there is a range of effective treatments to suit the variety of potential service users, with evidence indicating that those based on cognitive behavioural approaches offer the best chance of success. Whilst increasing risk and higher risk drinkers are likely to benefit from brief advice given by generic workers in almost any setting, dependent drinkers may require more intensive treatment given by specialist workers.

Treatment for dependent alcohol users can be life-saving and provide on-going improvements in patient's health and well being.

Financial Benefits

The UK Alcohol Treatment Trial (UKATT) shows that, over a 6-month period, specialist treatment delivered savings of nearly £1,138 per dependent drinker treated – nearly 40% of drinkers showed a 'much improved' outcome (reduction in problem by 2/3 or more). Achieving the DH ambition of specialist treatment for 15% of dependent drinkers in each PCT has the potential to save £21m across the region or £1.48m per PCT.

Nationally the Department of Health estimates that for every additional £1m invested in appropriate levels of accessible, evidence-based treatment, up to 1,200 alcohol-related hospital admissions, at a cost of £2.7m, could be averted, saving £1.7m.

Implementation

Department of Health guidance shows that in order to have the greatest impact local areas should: "ensure the provision and uptake of evidence based specialist treatment for at least 15% of the estimated dependent drinkers in the PCT area".

There is currently no national estimate of the percentage of dependent drinkers in treatment, but the North West PHO have attempted to estimate alcohol treatment figures in the recently updated Local Alcohol Profiles for England (LAPE) using population based estimates. These show that for 2008/09 Yorkshire and Humber region had 3.0% of its population aged 18-75 in treatment, which was slightly higher than the national figure of 2.7%. Whilst both Wakefield and Barnsley seemed to have the highest prevalence (5.5% and 5.4% respectively), Sheffield had the lowest at1.0%.

Estimates for the numbers of dependent drinkers across Yorkshire and Humber are to be reviewed quarterly through the Directors of Public Health.This will help us review progress towards the 15% ambition.

This intervention has the potential to save approximately £1,5m per PCT.

To help areas design a comprehensive approach to alcohol treatment Thomas Babor (2010) has updated a World Health Organisation evidenced based public health approach to tackling alcohol related harm which offers: cost saving opportunities, access to treatment within a population based approach. The following summarises the requirements of the programme:

- Attention to definition of cases
- Determination of the proportion of cases that will at any time seek and engage in treatment
- Treatment planning needs to take cognizance of natural history
- The treatment effectiveness question
- Economic benefits.

It is suggested that areas consider these aspects when developing care pathways, in order to ensure the most effective, quality care for patients.

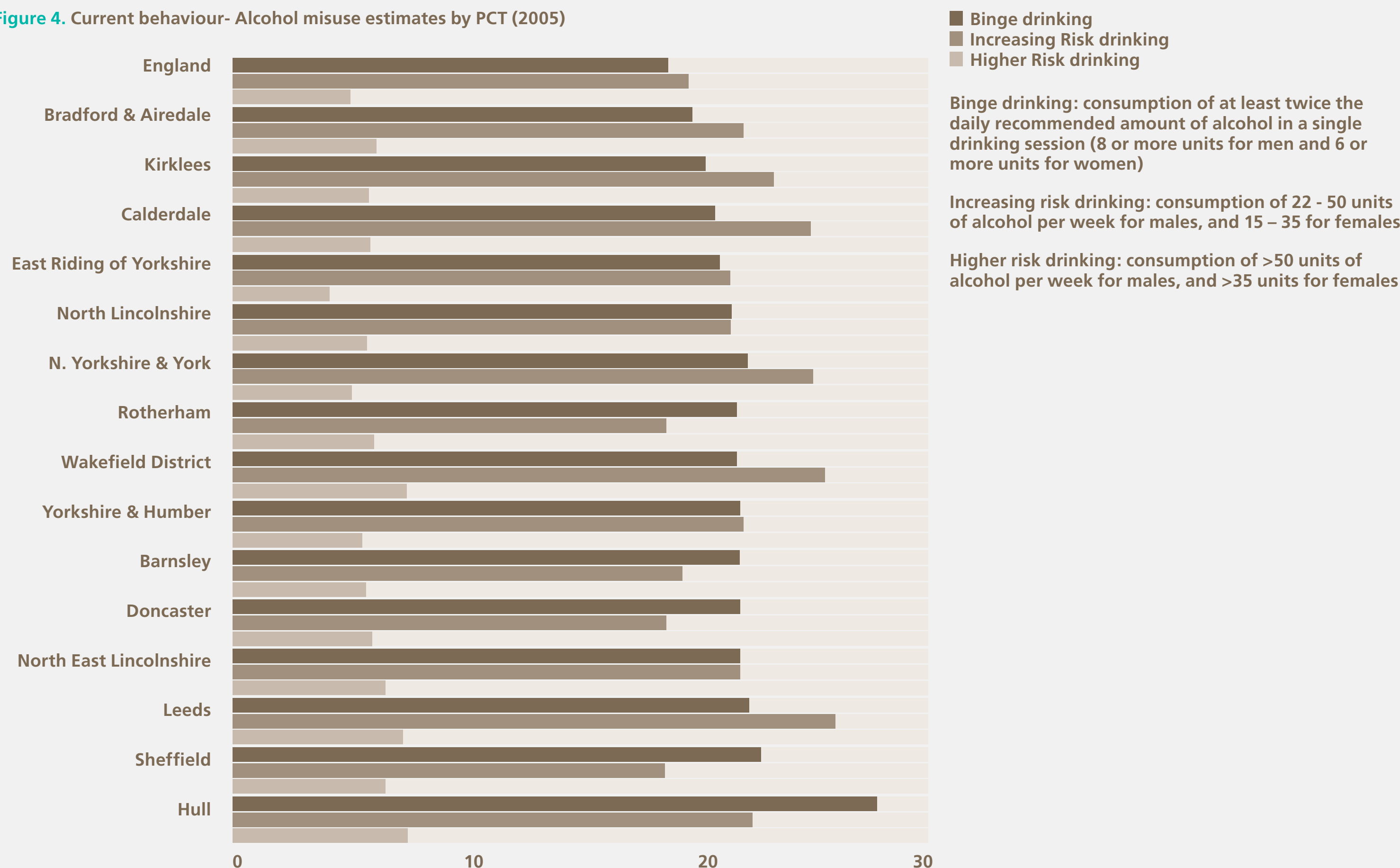
4. Behaviour Change and Social Norms

Behaviour change activity is sporadic and often lacks an evidence based approach. One well evidenced approach that has been shown to reduce alcohol use of those drinking at of those drinking above the lower risk limits is adopting a social norms approach to behaviour change.

Social norms strongly influence the way that people behave. They refer to the perceptions we have of how others behave, especially with regards to unhealthy behaviours such as drinking alcohol and smoking. Implementing a social norms approach which attempts to correct this misperception could help us harness the potential that we and our communities already have by establishing the correct norms, helping us lead healthy, productive and satisfying lives.

A social norms approach is embedded in localities, the smaller the community, the stronger that message helping create a more positive perception of health and well being in those neighbourhood and wards.

Figure 4. Current behaviour- Alcohol misuse estimates by PCT (2005)



Binge drinking: consumption of at least twice the daily recommended amount of alcohol in a single drinking session (8 or more units for men and 6 or more units for women)

Increasing risk drinking: consumption of 22 - 50 units of alcohol per week for males, and 15 – 35 for females

Higher risk drinking: consumption of >50 units of alcohol per week for males, and >35 units for females

Financial benefits

Studies in the US have found the approach to be cost effective, compared to traditional behaviour change approaches, but more UK focused research is needed.

If changing social norms resulted in a 5% reduction in the cost of alcohol related admissions the saving per PCT would be over £570,000 or £8m in the region.

Implementation

Consider an agreed approach to social marketing and behaviour change across partnerships and co-ordinate work across lifestyles issues.

Social norms approaches and interventions can be run cost effectively by using desktop research of existing surveys and segmentation to help define issues and through embedding the process in existing community engagement projects and perception work across neighbourhoods.

Remember the three key aspects: specific data, local involvement, and positive imagery.

To help produce a social norms approach locally, we have supported the development of guidelines by Bradford University, University of Leeds and the National Social Norms Institute: http://uksocialnorms.org

Conclusion

The four key recommendations identified in this briefing intentionally cover only part of a stepped care model for alcohol care and should be seen as part of an agreed integrated care pathway implemented in light of local circumstances.

The potential savings from addressing alcohol misuse are significant and whilst the modelling contained in this briefing is high level it attempts to give a sense of the potential savings that could be made by delivering better care for less. Taken collectively the four interventions outlined might offer the scale of savings identified in the table opposite, an average of over £3.8m per PCT.

Figure 5. Culmulative potential savings from interventions

PCT	Total Savings (£0s)
Barnsley PCT	3,314
Bradford & Airedale Teaching PCT	4,934
Calderdale PCT	2,734
Doncaster PCT	3,874
E. Riding of Yorkshire PCT	3,354
Hull Teaching PCT	3,034
Kirklees PCT	3,694
Leeds PCT	5,734
N.E. Lincolnshire Care Trust Plus	2,454
North Lincolnshire PCT	2,494
North Yorkshire and York PCT	6,294
Rotherham PCT	3,394
Sheffield PCT	5,154
Wakefield District PCT	3,354
NHS Yorkshire & The Humber	53,822
Average per PCT	3,844

References/ Resources

Regional Office for Europe of the World Health Organization (2009) Evidence for the effectiveness and cost–effectiveness of interventions to reduce alcohol-related harm.

Littleton et al. Smoking kills (alcoholics) Shouldn't we do something about it? Alcohol and alcoholism vol.42, No.3 pp167-173, 2007.

Department of Health (2009) Signs for Improvement Crown Copyright.

Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar Ed (2007) Effectiveness of brief interventions in primary care populations.

Moyer et al. (2002), Brief interventions for alcohol problems: a meta-analytical review Addiction Mar 97 (3)p279-92.

Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, et al Alcohol: no ordinary commodity – research and public policy. Oxford: Oxford University Press; 2010.

Institute Alcohol Studies (2007) Impact on the NHS http://www.ias.org.uk/resources/factsheets/nhs.pdf

Alcohol Profiles for England http://www.nwph.net/alcohol/lape/download.htm

Making Every Contact Count supporting resources http://nww.yorksandhumber.nhs.uk/toolkit_directory/

Royal college of GPs certificate for the management of alcohol in primary care http://www.rcgp.org.uk/practising_as_a_gp/substance_misuse/alcohol_certificate.aspx

NICE (2010) Alcohol use disorders – preventing the development of hazardous and harmful drinking.

NICE (2010) Alcohol use disorders – diagnosis and clinical management of alcohol related physical conditions.

Heather N & Kaner E, Brief Interventions against excessive alcohol consumption in Warrell DA, Cox TM Firth.

Royal College of Physicians (2001), Alcohol – can the NHS afford it? Recommendations for a coherent alcohol strategy in hospitals.

Making Every Contact Count NHS Yorkshire and the Humber Better for Less Briefing, 2010 http://www.healthyambitions.co.uk/betterforless

http://www.socialnorm.org/CaseStudies/alcohol.php

http://www.alcohollearningcentre.org.uk/Topics/Browse/SocialMarketing/SegmentationTool/

Key contacts

Policy

Dianne Draper
Health Policy Manager
dianne.draper@dh.gsi.gov.uk

Carol Massey
NHS Yorkshire and the Humber
carol.massey@yorksandhumber.nhs.uk

Strategy

Tim Barton, Strategy Lead
NHS Yorkshire and the Humber
tim.barton@yorksandhumber.nhs.uk

Economics

Helen Mercer
Economist
helen.mercer@yorksandhumber.nhs.uk

Better for Less briefings

All NHS Yorkshire and the Humber Better for Less briefings are available from:

www.healthyambitions.co.uk/betterforless