Collaborative liver and psychiatry care in the Royal Bolton Hospital for people with alcohol-related disease

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Since 1990, the Royal Bolton Hospital has been evolving a patient-centred, collaborative, seamless, holistic, gastroenterology, psychiatry, community model of alcohol care, team working, governance, research, training, education and health promotion. The aim is to deliver an accessible, responsive, cost-effective, rolled-out service. Consultant gastroenterologists, a specialist liaison psychiatrist, psychiatric alcohol liaison nurse, gastroenterology-based liver nurse practitioner and ward nurses provide joint inpatient and outpatient care for people with alcohol misuse, especially alcohol-related liver disease. A ward based, consultant-led, multidisciplinary team, with a dedicated social worker, meets daily to discuss all inpatients, unify treatment and facilitate discharges. On Monday–Friday, the two alcohol specialist nurses assess, triage and give brief advice to all alcohol-related medical admissions, liaise with consultants about admission or arrange outpatient appointments with the community alcohol team. This has reduced the average length of stay from 8.0 days to 5.7 days, saving the Trust more than 1000 bed days annually. This highlights the need for a 7 day alcohol specialist nurse service, one of 11 key recommendations in a recent position paper by the British Society of Gastroenterology, Alcohol Health Alliance UK and British Association for Study of the Liver on future alcohol care required in British district general hospitals. Other key recommendations include a hospital ‘alcohol care team’, with a lead clinician, coordinated policies in accident and emergency, with an outreach service, psychiatry input, adequate consultant numbers and integrated alcohol treatment pathways between primary and secondary care.

Introduction

Alcohol misuse and alcohol-related problems, especially binge drinking and alcohol-related liver disease, are major public health concerns. Rising alcohol

consumption and increasing incidence of cirrhosis are seen across all ages and sections of society.

In 2008, in England, there were 9031 deaths directly related to alcohol.¹ The majority die from alcohol-related liver disease (ALD). Given the historical inaccurate coding and underreporting of alcohol-related deaths, these figures are probably a gross underestimate. In England, liver cirrhosis mortality approximately trebled between 1970 and 1998. In the 35–44 year age group, the death rate increased eightfold in men and almost sevenfold in women, while there was a fourfold increase in those aged 25–34 years.²

In 2006–2007, the National Health Service (NHS) expenditure on alcohol services was £2.7 billion.³ In 2008, over 78% of costs were incurred as hospital-based care, including both outpatient and inpatient costs. Inpatient NHS costs alone were responsible for ~45% of the £2.7 billion.⁴ In 2007, the National Social Marketing Centre estimated the total annual societal cost of alcohol misuse in England to be £55.1 billion.⁵

Collaborative alcohol care

Historically, alcohol care has been fragmented between hospital departments and the community, with no continuing care or health promotion and a lack of dedicated alcohol workers. Our vision was to change that.

Collaborative care is a multidisciplinary team approach to assessing, planning, implementing and evaluating care, in collaboration with the patient, and is developed around an anticipated length of stay or episode of care. Patients are empowered to make lifestyle changes. Since 1990, the Royal Bolton Hospital has been evolving a patient-centred, collaborative, seamless, holistic,

gastroenterology, psychiatry, community model of alcohol care, team working, governance, research, training, education and health promotion.^{6,7} The aim is to deliver an accessible, responsive, cost-effective, rolled-out service.

Following the introduction of this model, 80–95% of the ward nurses and therapy team were better able to detect alcohol misuse and more confident in caring for, and communicating with, patients, carers and families. Patients and carers also expressed their improved satisfaction in receiving one stop, joined-up care. The essentials of our care include:

- Consultant gastroenterologists and a liaison psychiatrist, with a special interest in substance and alcohol misuse, provide joint inpatient and outpatient care.
- A psychiatric alcohol liaison nurse (PLN) and a gastroenterology-based, liver nurse practitioner (LNP) work in close partnership, together with the specialised gastroenterology ward nurses and the consultants, who supervise them.
- A multidisciplinary team, which meets daily to discuss all inpatients and any outpatient or service issues. The meeting is consultant-led, together with the ward doctors, nurses and specialist nurses, social worker, dietician, physiotherapist and occupational therapist. All healthcare professionals write in the same notes. The team working ethos makes everyone feel valued and optimises and unifies patient-centred, collaborative care.
- A dedicated social worker greatly influences length of stay and facilitates discharge to a suitable environment. Discharge and ongoing care of inpatients, who are out-of-area, may be problematic, and the daily involvement of the appropriate social worker is vital. There is particular difficulty in providing care for the homeless and rough sleepers. There are increasing numbers, particularly of young men, with alcohol-related dementia, including Wernicke–Korsakoff syndrome, for whom there is a major shortage of suitable long term care.
- Daily consultant gastroenterology input into the acute medical receiving unit facilitates the rapid triage and clinical and endoscopic management of gastroenterology emergencies and their transfer to the gastroenterology ward or critical care area.
- Close working with local liver centres.
- Joint outpatient clinics by a multidisciplinary medical, nursing and psychiatric team enable joint medical and psychiatric care at one visit, reducing ‘did not attend’ rates.
- Telephone hotline; rapid access is provided to patients, their families and carers, either directly to the LNP or PLN, or via the secretaries or ward, where a close relationship has developed.
- Unified primary, secondary and community alcohol care, including nurse-supervised home detoxifications, often commenced in hospital.
- Given the intensity of nursing patients with alcohol-related diseases, it is vital that the nursing establishment

is adequate, especially out of hours, when most clinical incidents occur. This leads to increased staff sickness, damaged morale and sometimes to the loss of dedicated skilled gastroenterology nurses.

- Clinical Governance Meetings. These discuss all deaths, lessons learnt, end of life care, infections, complaints, risk management and disease coding to provide accurate data on disease prevalence and facilitate payment by results. They are transparent, confidential and conducted in a ‘no blame’ culture.
- A seamless flow for a patient from tier 1 (general practice) to tier 4 (hospital) care, and back again, using tier 3 (community alcohol team (CAT)) and tier 2 (drug and alcohol action team), as appropriate.
- A close working relationship with liaison psychiatrists, who provide inpatient psychiatric care in residential settings.
- The establishment of an integrated, multi-agency alcohol strategy with public health, the council, commissioners, the local authority, voluntary agencies, health promotion, police, social workers and other stakeholders has had considerable mutual benefits. This approach helped persuade the Department of Health Team for Health Inequalities to make Bolton one of the 20 early implementers of the National Alcohol Strategy. The benefits of extra funding to similar socially deprived, high alcohol disease prevalence areas will be rolled out nationally.

Joint liver and psychiatry alcohol nursing

In the Royal Bolton Hospital, the LNP partners the PLN. On Monday–Friday, at 08:00, they go to the acute medical receiving unit and jointly triage all alcohol-related admissions. They undertake an immediate and brief intervention with patients in need, initiate care plans and arrange rapid outpatient appointments with the CAT. This has reduced the average length of stay from 8.0 days to 5.7 days, saving the Trust more than 1000 bed days annually.⁷

Similar savings by specialist nurses have previously been reported in the Royal Liverpool Hospital.⁸ The average daily cost for treating patients, with alcohol specialist nurse (ASN) supervision, across all NHS Trusts in England and Wales, is around £219 for an inpatient and £271 in an accident and emergency observation ward.⁹

The LNP inputs daily into the gastroenterology ward, enhancing both risk management, by supervising detoxifications, and quality of care, especially for very sick patients. The LNP also ensures adherence to the British Society of Gastroenterology guidelines for managing the complications of ALD and facilitates discharges.

The LNP and PLN assess and treat patients with alcohol-related problems in all clinical areas. They have a major teaching, training and educational role, for both staff and patients. They have established patient support groups and a network of over 50 alcohol link

workers throughout the Trust. In combination with patient advocates, the police and social services, they run fora for, and are having an impact on, problem drinkers, aged 9–15 years.

The benefit of employing ASNs, rather than alcohol specialist workers, without nursing skills, is that nurses can manage patients with decompensated liver disease and other comorbidities. Moreover, nurse consultants can oversee ASNs and prescribe detoxification medication. A model nurse consultant job description, illustrating the key clinical, educational, audit, research and general aspects of the post has been described.¹⁰

A successful business case for ASNs in Liverpool (courtesy of Lynn Owens) is provided (see supplementary material, document 3, available online only).

Need for a 7 day ASN service

The dramatic impact of ASNs during a 5 day working week highlights the need for a 7 day ASN input into our hospitals, especially since such a large proportion of binge drinking, alcohol-related problems present out of hours, particularly at weekends. The human and financial resources required to provide such a service are described.¹¹ ASNs pay for themselves many times over, in terms of improved detection of alcohol misuse, accessibility, waiting times, did not attend rates, reduced inpatient detoxifications and length of stay, thus achieving 4 h trolley waits and relieving bed pressures.

Patient and family support

Patients, families, carers and friends most often turn to the ASN, with whom they have established a close bond, for continuing care, in relapse and other crises, and for support, in all its forms. When a consultant or nurse has cared for a patient with an alcohol-use disorder for many years, one of the most difficult decisions is when to gradually withdraw active treatment and commence end of life care. Many years of devoted care may be forgotten if families feel let down in these situations. It is here that sensitivity and compassion are most needed in helping patients to die in peace and with dignity, and in supporting families in making extremely difficult decisions.

Importance of philosophy of care

A non-judgmental approach helps to remove the concept of alcohol misuse as a 'self-inflicted disease'. The stigma is especially prevalent in the Asian community where it can result in exclusion from a community or place of worship. For men, alcohol misuse is a taboo subject, which can make them very loathe to confide in a female ASN. Link workers play a crucial role in patient care, as vital members of the multidisciplinary team and in all clinical areas. A close partnership with link and community workers helps overcome the stigma and barriers to alcohol care.

Current management of people admitted to hospital with alcohol-related problems

Accident and emergency

Most hospital admissions for alcohol-related problems occur acutely via the accident and emergency department. Evidence of alcohol-related harm may be missed or ignored. Doctors and other health professionals should use the 1 min Paddington Alcohol Test¹² to screen for alcohol misuse. Early identification and brief advice (that is, 1–2 min use of 'The Teachable Moment') by any trained healthcare professional, to relate drinking to accident and emergency attendance, should be combined with the offer of a brief intervention, which is a 20–40 min consultation with an ASN.¹³

Acute alcohol withdrawal

A coordinated, hospital-led Assertive Outreach Alcohol Service (AOAS) can avoid many admissions for detoxification. Patients may be admitted for a planned or unplanned alcohol withdrawal.¹⁴ The staff on all wards should be trained in assessing and monitoring symptoms and signs in patients with acute alcohol withdrawal.¹⁴ Management is usually commenced on an acute medical unit, with subsequent transfer to a gastroenterology/hepatology ward.

Detection and management of underlying psychiatric illness

Liaison psychiatry

There should be a consultant-led liaison psychiatry service in all clinical areas, especially accident and emergency, acute medicine, gastroenterology and hepatology wards. A consultant psychiatrist should liaise closely with the lead alcohol clinicians in the accident and emergency department and acute medical units to ensure that all patients are assessed for possible psychiatric illness, especially depression and suicidal ideation.

This will involve staff training and collaboration between accident and emergency department doctors and nurses, the Mental Health Crisis Team and ASNs, particularly psychiatric liaison nurses, together with the CAT. The hospital psychiatry alcohol lead should ensure that there are clear mechanisms and pathways for rapid referral to a psychiatrist specialising in alcohol dependency.

Choice of ward

At present, management tends to be partial, depending on the ward to which the patient is admitted. Patients perceived as medical admissions are usually managed on hepatology/gastroenterology wards. Conversely, psychosocial interventions are usually commenced during admission to psychiatry wards.

Optimal specialist inpatient alcohol care

Dual diagnosis, comorbidity, mental health disorders and social problems are common. Joint initial triage

and assessment of all alcohol-related admissions to an acute medical unit, on the morning after admission, by a LNP and PLN, followed by structured multidisciplinary management, would be far superior and more cost-effective than the current patchwork approach in most hospitals.

The LNP is frequently the first to recognise the severity of underlying liver disease in patients admitted to acute medical units. By informing the liver specialist, rapid assessment, prompt treatment and transfer to a gastroenterology, hepatology or critical care ward is facilitated.

Psychosocial interventions involve group work and one to one key working sessions, addressing psychosocial issues. These depend on local facilities and the availability, if any, of addiction or liaison psychiatrists specialising in alcohol misuse. Adjunctive pharmacological therapy, with acamprosate or disulfiram, may be commenced.

Alcohol-related disease: future care

In 2010, the British Society of Gastroenterology, Alcohol Health Alliance UK and the British Association for Study of the Liver published a joint position paper focusing particularly, but not exclusively, on secondary alcohol care.¹¹

Key recommendations

In a typical British district general hospital, serving a population of 250 000, there should be:

1. A multidisciplinary 'alcohol care team', led by a consultant, with dedicated sessions, who will also collaborate with public health, primary care trusts, patient groups and key stakeholders to develop and implement a district alcohol strategy.
2. Coordinated policies on detection and management of alcohol-use disorders in accident and emergency departments and acute medical units, with access to brief interventions and appropriate services within 24 h of diagnosis.
3. A 7 day alcohol specialist nurse service and alcohol link workers' network, consisting of a lead healthcare professional in every clinical area.
4. Liaison and addiction psychiatrists, specialising in alcohol, with specific responsibility for screening for depression and other psychiatric disorders, to provide an integrated acute hospital service, via membership of the 'alcohol care team'.
5. Establishment of a hospital-led, multi-agency Assertive Outreach Alcohol Service, including an emergency physician, acute physician, psychiatric crisis team member, ASN, drug and alcohol action team member, hospital/community manager and primary care trust alcohol commissioner, with links to local authority, social services and third sector agencies and charities.
6. Multidisciplinary, person-centred care, which is holistic, timely, non-judgmental and responsive to the needs and views of patients and their families.

7. Integrated alcohol treatment pathways between primary and secondary care, with progressive movement towards management in primary care.
8. Adequate provision of consultants in gastroenterology and hepatology to deliver specialist care to patients with ALD.
9. National indicators and quality metrics, including alcohol-related admissions, readmissions and deaths, against which hospitals should be audited.
10. Integrated modular training in alcohol and addiction, available for ASNs and trainees in gastroenterology and hepatology, acute medicine, accident and emergency medicine and psychiatry.
11. Targeted funding for research into detection, prevention and treatment strategies and outcomes for people with alcohol-use disorders.

Conclusion

Currently, alcohol treatment services are not adequately equipped to cope with the nation's alcohol problem. However, there are hopeful signs. Two of the three National Institute for Health and Clinical Excellence (NICE) guidelines on alcohol-use disorders have been published in 2010,^{14 15} and the third will be published in 2011. Together with the National Plan for Liver Services 2009, they emphasise public health, prevention and treatment measures and the need for a specialist alcohol workforce, especially for consultants in gastroenterology and hepatology and ASNs.

Reports from the All Party Parliamentary Group on Alcohol Misuse,¹⁶ the House of Commons Public Accounts Committee¹⁷ and the House of Commons Health Select Committee⁵ have highlighted the gaps in our alcohol services and the urgent need for the development of cost-effective pathways of alcohol care. Implementation of our key recommendations will achieve this.

Moreover, specialist alcohol care can pull people back from the brink of the most devastating consequences of alcohol misuse, especially alcohol-related liver disease, give them back their self-respect and restore them to their families and communities. The development of high quality, integrated prevention and treatment services for people with alcohol-related disease will prove to be a wise investment for the future health of our nation, especially that of our young people.

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