A REVIEW OF ALCOHOL SERVICES IN SCOTLAND'S ACUTE HOSPITALS

Summary report prepared for Scottish Health Action on Alcohol Problems

FIGURE 8
CONSULTANCY SERVICES LTD

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The Research

Scottish Health Action on Alcohol Problems (SHAAP) commissioned Figure 8 Consultancy (Dundee) in May 2022 to conduct a comprehensive review of alcohol services in acute hospitals in Scotland, with particular focus on people with Alcohol-related Liver Disease [ArLD], to identify areas that SHAAP and others may be able to support improvement.

Research Objectives

1. To understand the service provision for patients admitted to Scottish hospitals with ArLD, in relation to Alcohol Use Disorder (AUD).
2. To use this information to advise on how to improve such services and support (possibly in the form of a 'toolkit').

In addition to these two overarching objectives, the research project also provided observations for SHAAP's own use regarding their current and future role in supporting acute hospitals in relation to people with ArLD.

Research Methodology

1. **Online Survey:** Figure 8, in collaboration with SHAAP's Project Advisory Group, designed an online survey for a physician treating patients with ArLD and/or an alcohol liaison/addictions nurse from each acute hospital in Scotland to complete. The survey was designed to establish the level of provision and gaps in hospital-based alcohol services.

2. **Extended semi-structured interviews:** Figure 8 targeted interviewees from: (a) as many Health Boards as possible; (b) a mix of key roles (Gastroenterologists, , Hepatologists, General Physicians, Alcohol or Addiction Liaison Nurses, Nurse Specialists in Hepatology, and Liaison and Addiction Psychiatrists); and (c) a mix of the hospitals from a self-identified four-tier categorisation of alcohol services in acute hospitals as indicated below.

What would a full hospital Alcohol Care Team look like?

'It would mean that any of the generic wards, whatever their nature, once they realise that underlying, presumably someone's admission, is alcohol, that they can draw on some skills or experience to then...'

Tier 1: A hospital with a formally designated Alcohol Care Team [ACT].

Tier 2: A hospital with an established service specifically targeting problem drinkers which has not been formally designated an Alcohol Care Team.

Tier 3: A hospital with a limited/occasional/ intermittent/ad hoc service for problem drinkers.

Tier 4: A hospital with no service specifically for problem drinkers.

Results – Online Survey

Responses to the online survey were received from 20 of the 32 acute hospitals that were invited to take part in the study. These responses were received from 12 out of the 14 Scottish Health Board areas. There was roughly an even split of respondents between Hepatologists (n=6), Gastroenterologists (n=6), Gastroenterologists with liver interest (n=5), and General Physicians (n=4). The remaining responses came from two Alcohol Liaison Nurses, and one Geriatrician.

Of the 20 hospitals that participated in the survey:

- **Three** identified themselves as **Tier 1**
- **Six** identified themselves as **Tier 2**
- **Eight** identified themselves as **Tier 3**
- **Three** identified themselves as **Tier 4**

Tier category	% of total responses	Number	Hospitals
We have a formally designated Alcohol Care Team [ACT].	15%	3	• Ninewells • Royal Infirmary of Edinburgh • University Hospital Ayr
We have an established service specifically targeting problem drinkers which has not been formally designated as an ACT.	30%	6	• Aberdeen Royal Infirmary • Forth Valley Royal Hospital • Glasgow Royal Infirmary • St. John's Hospital • University Hospital Hairmyres • Victoria Hospital
We have a limited/occasional/ intermittent/ad hoc service for problem drinkers.	40%	8	• Borders General Hospital • Caithness General Hospital • Dumfries & Galloway Royal Hospital • Lorn and Islands Hospital • Mackinnon Memorial Hospital • Raigmore Hospital • The Balfour • Western General Hospital
We have no service specifically for problem drinkers.	15%	3	• Belford Hospital • Dr. Gray's Hospital • Perth Royal Infirmary

When asked to indicate ...

... **how their alcohol services are managed**, there was an even split between 'medical' and 'nursing'.

... **the responsible speciality for their alcohol service**, 10 respondents (59%) indicated 'psychiatry', 2 'acute medicine', and one each 'gastroenterology/ hepatology' and 'joint hepatology/ psychiatry'.

... from a list of options **how their alcohol service is funded**, just over half indicated that they have secured funding through their local Alcohol and Drugs Partnership, with the remaining hospitals having their funding split between a variety of secondary care budgets.

... **if their hospital has a designated alcohol lead**, only 4 out of 17 (24%) who answered the question indicated that they do have a designated alcohol lead.

... **if their hospital has any local documentation outlining the management of Alcohol Use Disorders** [AUD], of the 17 respondents who answered, 6 said 'yes', 7 said 'no' and 4 'did not know'. All of the hospitals who reported that they have a designated alcohol lead also noted that they have a local document outlining the management of AUDs.

... from a list of options **how patients are referred to their hospital's alcohol service (where one exists – see above)**, only one respondent reported that all patients at their hospital with a positive AUD screen are 'automatically referred'. 9 respondents stated that nursing staff from the alcohol service visit potential sites around the hospital to actively seek patients with an alcohol problem. A majority of respondents (n=14) stated that medical or nursing staff refer patients who are noted to have an alcohol problem.

... **how many of each type of staff in their hospital manage patients with AUD**, across the 16 hospitals who responded, the majority of staff noted as managing AUD patients are gastroenterologists and/or hepatologists with a total of 59 reported. Additionally, there were a total of 21 psychiatrists (addiction or liaison), 19 GI/Liver Nurse specialists, and a total of 30 Addiction/Alcohol Liaison/other Alcohol Nurse Specialists.

When looking only at the 9 hospitals surveyed that each have over 100 beds, and ignoring the one such hospital which has no specialist alcohol nurse provision, the ratio of whole time equivalent (WTE) alcohol nurses to the total number of hospital beds was calculated as a crude indicator of staffing levels. The mean ratio was 1:266, ranging from 1:1053 (low) to 1:113 (high).

HOSPITAL (colour-coded as per tier categories above)	WTE	No. of staffed beds	Ratio WTE/beds
Borders General Hospital	2	227	1:113
Aberdeen Royal Infirmary	4	678	1:169
Royal Infirmary of Edinburgh	4.4	904	1:205
Forth Valley Royal Hospital	2.4	647	1:270
University Hospital Hairmyres	1.4	434	1:310
Glasgow Royal Infirmary	2.5	929	1:372
Ninewells Hospital	1.5	785	1:523
Dumfries & Galloway Royal Hospital	0.3	316	1:1053

When asked to indicate ...

... from a list of options **how alcohol intake is recorded in their hospital**, the majority (n=16) noted that their hospital employs descriptive (including units quantification) methods. A further 4 stated that their unit uses descriptive (without units quantification) recording methods. Six use either the AUDIT or FAST recognised alcohol screening tools. Three recorded that they used other methods.

... **whether their hospital routinely screens patients for AUD**, there was an even split between those responding 'yes' and those responding 'no' (6 each). A further 7 respondents stated that they do not know.

... **what action is triggered when screening identifies a patient with AUD**, of the 8 respondents one noted 'an automatic referral to alcohol service', 3 noted 'advised referral to alcohol service', one noted 'other', and 3 noted 'none'.

... **if an alcohol screening test is routinely administered prior to, or as a requirement of, referral to a GI/Liver unit**, one respondent said 'always', 3 'usually' 5 'sometimes', 5 'rarely' and 4 'never'.

... **if an alcohol screening test is routinely administered by staff within their GI/Liver unit**, only one respondent stated 'always', 3 'usually' 3 'often', 4 'sometimes', 3 'rarely' administered, and stated that they are 'never' administered. The same one respondent as above did not know.

... **if patients under the care of the local addiction services are routinely screened for liver disease**, 6 answered 'yes', 5 answered 'no', and 8 were 'not sure'.

Available treatments for patients with AUD.

When asked to indicate...

... from a list of options, **any/all alcohol treatments that are provided in their hospital**, the following responses were provided, suggesting that brief interventions (for non-dependent drinkers) and protocols for prevention/management of alcohol withdrawal syndrome are widely available but more specialised treatments for alcohol dependency are not.

Treatment	Count
Brief Interventions	15
Symptom-triggered Management of Alcohol Withdrawal Syndrome	15
Signposting	11
Neuroprotective Pharmacological Treatment	10
Motivational Interviewing	7
Pharmacological Relapse Prevention	7

Available treatments for patients with AUD (continued).

When asked to indicate...

...from a list of options, **how doctors looking after patients with ArLD manage AUD**, the responses varied widely:

Doctors treat patients themselves	5
Referrals to hospital-based Alcohol Nurses	5
Patients are actively referred to community alcohol services	4
Patients are provided with information and encouraged to self-refer	3
Patients are managed by liver nurse specialists	1
GPs are asked to refer or treat patients	1

... **how often follow up plans are routinely completed and reviewed for those being discharged who have ArLD**, there was an even spread with 3 saying 'always', 5 'usually', 3 'often' and 5 'rarely'.

'Plans formulated and enacted by hospital alcohol liaison nurses.'

'These patients are usually already under the care of specialist services. If we suspect a new patient they get referred as an in-patient for further work-up and assessment prior to discharge.'

'For those who also get seen by hepatology yes, for the ones with no sign of liver disease, I am not sure and at present have no way of finding out.'

'Variable - person dependent - no SOP agreed locally.'

'No communication between addictions team and referring physician regarding progress post discharge in my experience.'

'Random dependent on responsible consultant.'

...**whether their hospital-based specialist nurse continues to follow-up patients with AUD following discharge**, the majority did not, with none saying 'always', only 5 saying 'usually' or 'often' and 11 saying 'rarely' or 'never'.

Key findings from the survey responses

The following high-level key findings have emerged from the analysis of survey responses:

Disparity in screening and management of harmful, hazardous, and dependent alcohol use	a) The reported practices for screening for, referral and management of AUD in both patients in general and in those with ArLD varied widely.
	b) The variety in approaches observed, points towards a lack of standardisation across the country and even within Health Boards.
Inconsistent follow-up	a) Inconsistencies were identified in post-discharge follow-up practices, especially regarding specialist nurses' engagement.
Reliance upon community-based alcohol services	a) A reliance upon community-based alcohol services for post-discharge management was noted but not necessarily with clear patient pathways into these services.
Challenges unveiled	a) Qualitative insights from survey responses revealed staffing shortages and infrastructure issues.

Summary and implications of the survey findings

The survey found heterogeneity in the management and treatment of AUD across Scotland's acute hospitals. This variance may reflect resource availability, hospital priorities, regional prevalence of AUD and differing perspectives on the best approaches to care.

The survey revealed inconsistency in post-discharge follow-up, with an absence of follow-up from specialist nurses in most hospitals.

The heavy reliance upon community-based alcohol services, whilst beneficial for supporting people and their health once back at home/in a community setting, also underscores a potential gap in hospital-based post-care services. Depending on the robustness and efficacy of these community services and how well integrated they are with hospital services, this could either be a positive approach to care or a potential pitfall. Furthermore, the qualitative insights from the survey shed light on the broader challenges in treating patients with AUD. Whilst some hospitals have made strides in establishing specialised teams, others are hamstrung by staffing shortages or lack the necessary infrastructure and/or leadership.

Results – Semi-Structured Interviews

The evaluation team undertook **22** qualitative semi-structured interviews with **24** professionals between December 2022 and June 2023, representing **12** of the **14** Scottish Health Boards.

	Interviewee role	Number
Doctors (17)	Gastroenterologist	4
	Gastroenterologist with liver interest	1
	Gastroenterologist/Hepatologist	2
	Hepatologist	2
	General Physician	2
	Consultant Addiction Psychiatrist	4
	General Liaison Psychiatrist	2
Nurses (6)	Alcohol/Addictions Liaison Nurse	4
	Clinical/Liver Nurse Specialist	2
Social Worker (1)	ARBD Team Leader (Social Work)	1

[Interviewer] What would a full hospital alcohol care team look like?

[Respondent] I think you're absolutely right. It would mean that any of the generic wards, whatever their nature, once they realise that underlying, presumably someone's admission, is alcohol, that they can draw on some skills or experience to then…'

'… I know how to take an alcohol history, I know how to recognise features of alcohol misuse and dependence, but it's not the same as if there is a bigger picture of how we're managing this within our Trust. So I think it's highlighting the lack of knowledge and the lack of a clear pathway for those patients, and that has been really helpful.'

The key theme to emerge from across the interview cohort was the disparity of experience (i.e. differences regarding funding; roles of individuals; nature and extent of services for alcohol; and use of guidance) and context (i.e. geographical locations and hospital size).

Detailed analysis indicates that these disparities are split into messages that were:

1. either consistent or frequent,
2. less frequent but considered worthy of note.

Consistent or frequent messages		
Emergency Departments (ED or A&E)	Issue	Inconsistencies in policy development and practice in ED regarding alcohol-related provision.
	Variation	Inconsistencies are notably visible between larger hospitals with more developed alcohol service provision (e.g., Aberdeen and Edinburgh Royal Infirmaries) and other hospitals.
	Interventions	Consideration for universal alcohol-use screening for all ED patients was observed as a potential best practice.
Psychiatry	Disparity	Notable differences in service provision between hospitals with addiction psychiatry specialists and those reliant on general liaison psychiatry.
	Specialist need	Highlight the value and need for specialist and liaison psychiatry services for alcohol.
	Challenges	Care for patients with Alcohol Related Brain Damage (ARBD) and interconnectedness with psychiatric interventions and alcohol were noted.
Provision and practice disparities	Fragmentation	Practices are often reliant upon specific individuals rather than a systematic approach, leading to variances in provision from hospital to hospital.
	Nomenclature	Variation in local terminologies and acronyms impacts uniform understanding and documentation.
	Inconsistencies	There appears to be a lack of consistency at regional and hospital levels regarding specific alcohol provisions, such as fibro-scanning and care for people with ARBD.
Staff support	Importance of supervision	Instances were noted where lead consultants provided pivotal support and supervision.
	Peer networking	Different forums and groups facilitated peer support and knowledge exchange, though accessibility and awareness of these forums varied, with staff in smaller, more remote, hospital settings being the least likely to be involved in such networking. At the same time these staff would potentially benefit most from such networking.
Struggle for prioritisation	Competing demands	Alcohol care provision is often in competition with other medical and procedural demands, hindering focused attention and prioritisation.
	Policy struggle	Alcohol care in hospitals has to compete at a policy level with a whole range of other considerations, with ArLD often finding itself lower down the priority list.

'...but I often get referred these patients on day three, day four, and then because of bed pressures, these patients then get discharged, without anything in the community, so it's just a revolving door...'

'...it would be useful to see what other substance use liaison nurses are doing because I could be missing a lot.'

'I think that one of the issues is that there's now screening for so many different things when you admit a patient to hospital and I remember we've had the redesign of our medical admissions document twice or three times since I've been a consultant in NHS xxx and the amount of stuff that people have wanted put in it and then the concern about how much stuff there is to fill in and how many boxes you have to tick is a constant battle.'

Infrequent messages worth noting		
Screening tools	Non-universality	An evident lack of standardised alcohol screening across hospitals.
	Varied practice	Use of different tools and often reliance on open conversations and clinical judgement for alcohol history documentation.
Medication use	Limited mentions	Specific references to drugs and medication used in treatment were scarcely made during interviews.
	Prescribing dilemma	There was some debate about the prescribing of benzodiazepines, because of potential "benzo-seeking" behaviours among patients.
Alcohol versus drugs	Prioritisation	Alcohol treatment was often viewed as being 'neglected' when amalgamated with substance use teams, where drug use treatment frequently dominates the agenda.

Summary and implications of the interview findings

The findings from the qualitative data illuminates the intricacies and variations in alcohol-related healthcare provision across Scotland. The findings expose:

- Gaps in policies and practices across various hospitals.
- The fragmentation in alcohol-related healthcare provision and disparities in quality and accessibility.
- The value in developing a unified approach, possibly through a toolkit and other guidance, aimed at standardising and enhancing alcohol-related care.

Conclusions

This survey of alcohol services in acute hospitals in Scotland reveals wide variation in their nature and capacity. Most hospitals have alcohol nurses to provide specialised input to in-patients identified with AUD. However how such patients are identified is rarely systematic, the nature of the care usually includes brief interventions and a symptom-driven approach to alcohol withdrawal syndrome, and some offer specific interventions for treatment of dependency, but few provide on-going AUD treatment after discharge, even for those with liver disease. There are inconsistencies in how the services are funded and in their capacity, and a lack of clarity on leadership with wide variation in the ratio of nurses to hospital beds.

Next steps

SHAAP will act on the findings of this report with a view to improving the provision and effectiveness of services. This is likely to include:

- Aligning the findings with the approach to the UK Alcohol Treatment Guidelines that the Scottish Government takes to improve services.
- Establishing a network or other way to support individuals working within alcohol services in hospitals to share information, guidance and other support.
- Advocating for a clear commitment from Scottish Government and Health Boards (with ADPs) to establish leadership on alcohol care in hospitals as the first step towards developing ACTs where these are not in place.

Dr Alastair MacGilchrist, Chair, SHAAP

"Over 100 patients are admitted to Scottish hospitals every day due to the direct health effects of alcohol use. In addition many patients admitted with illnesses not directly caused by alcohol are drinking in a hazardous or harmful manner. For all these patients, hospital admission is an ideal opportunity to address the alcohol issue and reduce the health and wider problems it causes for each person, and the effectiveness of Alcohol Care Teams has been known for over a decade. Unfortunately, this survey shows that in Scotland whether that opportunity is grasped is a classic 'post code lottery' with alcohol services in hospitals revealed to vary from suboptimal to non-existent and with no consistent approach to funding or practice. There is a clear need for an agreed consistent approach which will require national and local commitment and clarity of responsibility for planning and delivery. This can only happen with increased and more transparent funding. Such an approach will reap benefits not only to those patients with health problems resulting from alcohol use but also, through reduced readmissions, to an overall easing of the financial burden placed on the NHS. SHAAP is committed to do whatever it can, via the steps outlined above, to help achieve these aims."

SHAAP

SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS
www.shaap.org.uk

Scottish Health Action on Alcohol Problems (SHAAP) is a partnership of the Medical Royal Colleges in Scotland and the Faculty of Public Health and is based at the Royal College of Physicians of Edinburgh (RCPE). SHAAP provides the authoritative medical and clinical voice on the need to reduce the impact of alcohol-related harm on the health and wellbeing of people in Scotland and the evidence-based approaches to achieve this.

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