Reducing alcohol harm in Nottingham City

Introduction

Alcohol harm represents a significant public health burden in Nottingham City, with a statistically significantly higher prevalence of dependent drinkers (2.2% compared to 1.4% in England). Nottingham City has some of the worst outcomes for alcohol-related harm in England. There are significantly more years of life lost due to alcohol-related conditions (843 per 100,000 compared to 624 per 100,000 in England) and more alcohol-related road traffic accidents (51.6 per 1,000 compared to 26.5 per 1,000 in England). Additionally, there are high rates of claimants of benefits due to alcoholism (264.9 per 100,000 compared to 132.8 per 100,000 for England)[2].

Nottingham City has statistically significantly higher rates of admissions for alcohol-related conditions (1,000 per 100,000 compared to 647 per 100,000 for England), for alcohol-specific mortality (19.2 per 100,000 compared to 10.4 per 100,000 for England) and significantly higher rates of admission episodes in men for alcoholic liver disease (418.8 per 100,000 in Nottingham City, compared to 160.6 per 100,000 for England)[1].

A recent deep-dive analysis of alcohol-related hospital admissions for 2015/16 in Nottingham City reported the following:

1,404 people had 2,463 alcohol-specific admissions (admissions that are wholly attributable to alcohol – for example alcohol-induced chronic pancreatitis). In addition, 5,174 people contributed to 2,539.16 alcohol-related admissions (admissions that are partially attributable to alcohol, but not wholly attributable – for example oesophageal cancer).

Mental and behavioural disorders due to alcohol were the most frequently recorded reason for admission for an alcohol-specific cause (e.g. acute intoxication, harmful use).

15% of patients admitted for an alcohol-specific reason were readmitted for an alcohol-specific reason within 28 days, showing readmission is a common occurrence.

People admitted to hospital for an alcohol-specific reason are often also admitted to hospital for other reasons. In 2015/16, patients with alcohol-specific admissions had an average of 2.45 emergency department (ED) attendances compared with 0.45 attendances per year in the wider population.

The estimated total cost of alcohol-related admissions in Nottingham City was £4.72m. This cost was based on a conservative estimate whereby an average bed day cost was estimated at £200 per day for patients admitted overnight and at £100 for those discharged on the same day. The cost does not take into account costs for some alcohol-specific admissions, ED attendances, East Midlands Ambulance Service, primary care, social care and the wider system.

Areas of focus

A report to the STP Leadership Board in August 2018 set out eight areas of focus for tackling the rising burden associated with alcohol. The consensus was that these areas should be considered when service planning and, where appropriate, in commissioning intentions.

Increase population level understanding of risk and harm

Only an estimated 1 in 10 of the population have a good grasp of current alcohol guidelines and levels of understanding of the wider harms of alcohol, such as risk of developing some cancers, is low[3].

Nottingham City Public Health is working to address this in part with Public Health England through the development and agreement of a campaign around alcohol harm in pregnancy.

Preventing alcohol harm through wider related national and local policy

Alcohol consumption is driven by a number of factors including acceptability, accessibility and affordability. Locally, alcohol licensing provides opportunities to influence accessibility. Alcohol licensing is a statutory duty of the Local Authority and since 2013, Directors of Public Health have been responsible authorities under the Licensing Act 2003. This provides opportunities to influence policy and to make or support representations in relation to licensing applications. This is a relatively new role for public health but there are examples of good practice as well as guidance available to develop this area of work[4]. Affordability is a major issue and there is good evidence to suggest that increasing price leads to reduced consumption and harm[5]. Price related interventions such as Minimum Unit Pricing do though require a change of national policy. There is however, a role for the Health and Wellbeing Board and STP in influencing national policy, and this is particularly timely as a national alcohol strategy is currently under development.

A systematic approach to Alcohol Identification and Brief Advice (IBA)

Alcohol IBA is a simple and brief intervention that aims to motivate at-risk drinkers to reduce their consumption and so their risk of harm. It is estimated that for every eight people who receive alcohol IBA in key settings including primary care, one will reduce their consumption to lower risk levels[6]. On a population level, this offers significant opportunity for change.

Identification of 'alcohol champions' in key organisations across the system

To upskill staff and embed interventions like alcohol IBA into routine practice, organisations should identify an appropriate senior member of staff to be the key point of contact for alcohol related issues and to have oversight of the organisation's work to reduce alcohol related harm.

Including alcohol as a priority for employee health and wellbeing

The workforce engaged in the Health and Wellbeing Board is large and diverse. This provides opportunities for developing and delivering consistent messages around harm reduction as well as ensuring that managers and staff across the partnership know how to access support and treatment.

Better communication of identified alcohol risk between some key parts of the system

Communication is currently variable, with inconsistent communication between ED and primary care where alcohol misuse/risk has been identified, limiting the opportunity for primary care to intervene.

Case management in ED of High Volume Service Users (HVSU)

A significant proportion of HVSU in the ED setting will have a significant alcohol misuse issue. Identifying these service users and then facilitating access to intensive case management has been shown to be associated with reduced use of services and a range of positive outcomes, including reduced attendance at ED and fewer emergency admissions[7].

Agreeing and embedding pathways for service users with co-existing mental health and substance misuse issues

Service users with coexisting mental health and substance misuse issues are particularly vulnerable and can experience difficulty accessing services[8].

Progress against the areas of focus

Work to understand the problem as it currently stands is complete. Locally monitored indicators as well as emerging published evidence and grey literature are used to identify and respond to any changes in the local picture.

There is considerable progress at an STP level; including the development of population level alcohol indicators as well as agreement on key priorities and the eight areas for focus that are outlined above.

There is some progress towards embedding pathways for service users with co-existing mental health and substance misuse issues through the co-location of an IAPT provider with the Nottingham City substance misuse service.

The systematic approach to IBA has progressed in some parts of the system. The Preventing Ill Health CQUIN has been a driver of progress in the inpatient setting, where work is ongoing to embed IBA into routine practice and raise the profile of alcohol harm. The Alcohol Pathways Group led progress in the ED, where alcohol screening questions now form part of routine patient contact.

Opportunities to further progress the eight areas of focus

Local system-level progress to increase population level understanding of alcohol harm is currently isolated to alcohol and pregnancy within specific areas of the city. There exists an opportunity to increase population level understanding in other specific groups as well as the general population.

The Health and Wellbeing Board and its member organisations have the opportunity to include alcohol as a priority in employee health and wellbeing, and to influence other local employers to follow suit. Whilst it is acknowledged that alcohol may already be a part of employer health and wellbeing initiatives, the nature and variation between employers remains largely unclear. Public Health England's employers' toolkit could be a useful resource for developing and standardising activity[9].

Alcohol IBA is currently being delivered inconsistently across the system and intra-organisational high-level commitment is required to develop and embed this effectively. Substance misuse services currently deliver the IBA training available to staff and, considering this service has experienced funding reductions, the way in which increased demand for training can be met needs to be agreed. The impact of effective IBA delivery by trained staff would be an increase in identification of people who would benefit from alcohol treatment programmes and a similar increase in demand for access to these programmes. Whilst a positive output of IBA in terms of reducing alcohol harm, consideration must be given to the ability of substance misuse services to meet this increased demand.

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