Newcastle Alcohol Care and Treatment Service

Margaret Orange
Treatment Effectiveness and Governance Manager
Up to 2009 Newcastle had one of the highest ARHA in England.
ARHA data

• 47 codes

• 13 - Wholly attributable to alcohol

• Remaining – Partially attributable

• National data set – NWPHO

• National Indicator – NI39
Analysing the data

• Hospital Admissions Only – Requested data set

• Postcode/ GP / NHS number

• up to 7 identified codes accepted

• Wholly attributable to alcohol (main focus)

K70 – Alcohol liver cirrhosis
F10 – Mental and Behavioural disorder due to alcohol
T51 – Alcohol intoxication
Analysing the data

- 1411 admissions - (707) patients
- Costs = £2.5m
- 943/1411 readmissions (66.8%)
- 239/707 patients readmitted (33.8%)
- 153 males & 86 females
- 468/707 patients admitted once (66.2%)
- age breakdown
Newcastle

Proportion of population in each age group. Newcastle population as a whole and Newcastle admissions 1/4/07 - 31/3/09

Newcastle population

- <15: 0.0%
- 15-24: 10.0%
- 25-34: 20.0%
- 35-44: 30.0%
- 45-54: 40.0%
- 55-64: 50.0%
- 65-74: 60.0%
- 75-84: 70.0%
- 85+: 80.0%

Newcastle admissions

- <15: 75.4%
- 15-24: 10.0%
- 25-34: 9.0%
- 35-44: 4.0%
- 45-54: 2.0%
- 55-64: 1.0%
- 65-74: 0.0%
- 75-84: 0.0%
- 85+: 0.0%
Segmentation - understanding the patient layers

• Patients admitted to hospital for 1 day or less (no overnight stay)
• Patients admitted only once
• Patients admitted once for intoxication / patients re-admitted for intoxication
• Patients with multiple re-admissions for alcohol-related harm (harmful and dependent drinkers)
• Patients with chaotic lifestyles accessing hospital services across the 3 PCT/Local Authority areas
• Patients with severe ongoing/end stage illness
Phase 1

Initial target groups

- Patients **re-admitted for intoxication**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle</td>
<td>44</td>
<td>49</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Northumberland</td>
<td>17</td>
<td>25</td>
</tr>
</tbody>
</table>

- Patients with **multiple re-admissions** for alcohol-related harm (harmful and dependent drinkers)

**20% of patients using over 70% of the costs**

- Patients with **chaotic lifestyles** accessing hospital services across the 3 PCT/Local Authority areas

**North of Tyne 12**
## Example of a re-admission record

<table>
<thead>
<tr>
<th>Codes listed</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K703 (primary diagnosis)</td>
<td>Diseases of the liver</td>
</tr>
<tr>
<td>F102</td>
<td>Dependence syndrome</td>
</tr>
<tr>
<td>I10X</td>
<td>Hypertensive diseases</td>
</tr>
<tr>
<td>J459</td>
<td>Chronic lower respiratory diseases</td>
</tr>
<tr>
<td>R18X</td>
<td>Symptoms and signs involving the digestive system and abdomen</td>
</tr>
<tr>
<td>Z720</td>
<td>Persons encountering health services in other circumstances</td>
</tr>
<tr>
<td>Z867</td>
<td>Persons with potential health hazards related to family and personal history and certain conditions influencing health status</td>
</tr>
</tbody>
</table>
### Example of an Intoxication Record

<table>
<thead>
<tr>
<th>Codes listed</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T40 (primary diagnosis)</td>
<td>poisoning by drugs, medicaments and biological substances</td>
</tr>
<tr>
<td>X620</td>
<td>intentional self harm</td>
</tr>
<tr>
<td>T51</td>
<td>intoxication/toxic effects of substances non medicinal as to source</td>
</tr>
<tr>
<td>S099</td>
<td>injuries to head</td>
</tr>
<tr>
<td>W19</td>
<td>fall</td>
</tr>
<tr>
<td>F101</td>
<td>harmful use</td>
</tr>
</tbody>
</table>
Needs Assessment

- Support the tier 3 specialist service
- Build capacity in tier 1 services
- Assessment, clinical interventions, care coordination
- Community/home detox where appropriate
- Alternatives to hospital admission
- Facilitate earlier, planned & coordinated discharge

- Address the NI 39 indicator
Reducing hospital admissions

- Hospital admissions only
- Wholly attributable fraction
- “frequent fliers”
- Outcome improvement likely
- Reduction in admissions likely

No direct referral route
The role of ACTs

A partnership approach to;

• Identify alcohol admissions
• Multi agency care planning meetings
• Care coordination
• Provide alternatives to hospital admission
Multi-agency approach

- Primary Care
  Treatment Effectiveness Manager
  Community Matron
  Alcohol Nurse Specialist (Primary Care)
- Mental Health Trust
  Alcohol Nurse Specialist (Mental Health)
- Acute Hospitals Trust
  Alcohol Nurse Specialist (Acute Services)
- Tyneside Cyrenians
  X4.5 Assertive Outreach Workers
Acts Philosophy

- Long term condition philosophy
- Community Matron Model
- Advanced clinical skills
- Medicines management
- Innovative case management (MAMs)
- IBA Strategy
Community Matrons

Community Matrons promote and provide care at home with the aim of avoiding, where at all possible repeated hospital admissions.

Community matrons work with patients who are:

• Experiencing long term illnesses
• Over 18
• May benefit from early hospital discharge
• Have had repeated hospital admissions

Your GP may ask the Community Matron to contact you to offer you support if any of these issues apply to you.

They can:

• Meet with you and find out how they can help you to be as well as possible.
• Make plans with you to achieve this. Involve your family or carer if you would like this.
• As part of the plan liaise with others involved with your care.
Newcastle Alcohol Care and Treatment Service

Imelda O’Mahony
Community Matron
Background

- Pre – acts
  - 7 ARHA in 7 months

- Codes
  - T51 intoxication
  - F10 harmful use
  - K70 alcoholic liver disease
Challenges

- Ambivalent use of alcohol
- Mental health history
- Social anxiety
- Deteriorating physical health
- Family/relationship difficulties
Acts involvement

- Assessed at GP practice
- Multi-agency meetings
- Seen 3x per week
- Exploration of ambivalence
- Monitor physical health
- Props referral
- Mental health referral
- Introduction to recovery services
Current Situation

• Continued ambivalence
• Ongoing support
  – Physical wellbeing
  – Attendance at hospital appointments
  – Psychotherapeutic support
• Considering the use of rehab

• 6 ARHA in 14 months
Newcastle Alcohol Care and Treatment Service

Lorraine Hussain
Alcohol Nurse Specialist
Background

• Pre – acts
  – 4 ARHA in 14 months
  – Drinking 4 litres of 7.5% cider (30 units daily)

• Codes
  – F10 harmful use
  – K70 alcoholic liver disease
Challenges

• Significant health issues
  – Requires hip replacement
  – Oesophageal Varisces
• Lives alone
• Vulnerability
ACTS INVOLVEMENT

• GP liaison
• Multi-agency meetings
• Seen three times a week by team.
• Slow reduction planning with intensive support
• Psychotherapeutic work
• Referral to Occupational Therapy
• Referral to Physiotherapy
• Referral to recovery centre
• Physical activity
• Social support
  – Money management
  – Appointment attendance
Current Situation

- Current consumption - 1 pint of 7.5% daily
- Fear of sobriety
- Triggers
  - Sport
  - Family
- Awaiting surgery (6 months)
- Vulnerable adult

- 1 ARHA in 6 months
Up to 2009 Newcastle had one of the highest ARHA in England.
2009-10 - 2010/11 Q1-Q4 and 2009/10
Quarterly change in alcohol related hospital admission
Actual rate of ARHA:

<table>
<thead>
<tr>
<th>Year</th>
<th>Newcastle</th>
<th>North East</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002/03</td>
<td>1,843</td>
<td>1,216</td>
<td>925</td>
</tr>
<tr>
<td>2003/04</td>
<td>2,003</td>
<td>1,535</td>
<td>1,022</td>
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<tr>
<td>2004/05</td>
<td>2,016</td>
<td>1,555</td>
<td>1,144</td>
</tr>
<tr>
<td>2005/06</td>
<td>2,244</td>
<td>2,244</td>
<td>1,749</td>
</tr>
<tr>
<td>2006/07</td>
<td>2,465</td>
<td>1,898</td>
<td>1,384</td>
</tr>
<tr>
<td>2007/08</td>
<td>2,615</td>
<td>2,597</td>
<td>1,473</td>
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<tr>
<td>2008/09</td>
<td>2,748</td>
<td>2,251</td>
<td>1,743</td>
</tr>
<tr>
<td>2009/10</td>
<td>2,805</td>
<td>2,466</td>
<td>1,743</td>
</tr>
<tr>
<td>2010/11</td>
<td>2,578</td>
<td>2,507</td>
<td>1,664</td>
</tr>
<tr>
<td>Age</td>
<td>Admissions pre-ACTs</td>
<td>Admissions post-ACTs</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------</td>
<td>--------------------------------------</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>22 admissions over 24 months</td>
<td>1 admission over 3 months</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>17 admissions over 23 months</td>
<td>1 admission over 6 months</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>6 admissions over 18 months</td>
<td>0 admissions over 14 months</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>30 admissions over 24 months</td>
<td>0 admissions over 3 months</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>4 admissions over 12 months</td>
<td>4 admissions over 19 months</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>4 admissions over 14 months</td>
<td>1 admission over 6 months</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>12 admissions over 16 months</td>
<td>0 admissions over 8 months</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>30 admissions over 24 months</td>
<td>0 admissions over 3 months</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>12 admissions over 24 months</td>
<td>6 admissions over 21 months</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>2 admissions over 18 months</td>
<td>4 admissions over 9 months</td>
<td></td>
</tr>
</tbody>
</table>
So Why does it work?

• The Service
  – Philosophy
  – Flexibility
  – Skill base

• The client
  – Relationship
  – Coordination of care
  – Skill base

To come: formal evaluation and research