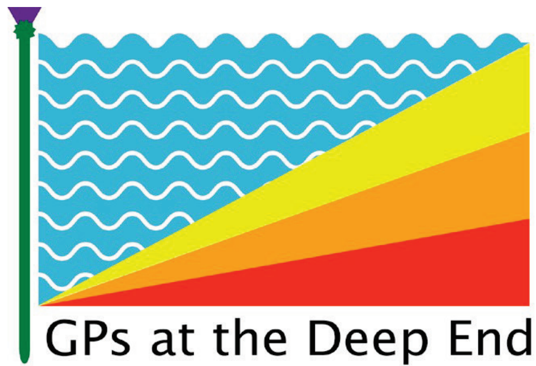

Deep End Report 31

Attached Alcohol Nurse Deep End Pilot (July 2015–2016): final report

December 2016

SUMMARY

- The Attached Alcohol Nurse Deep End Pilot (July 2015-2016) tested a service model of partnership working by bringing specialist community services into Deep End general practice settings.
- Its aim was to address the needs of people with problem alcohol use who are in contact with their general practices but who have not previously engaged well with addiction services.
- Two FTE specialist Band 6 addiction nurses were attached to six Deep End practices in NW Glasgow working in partnership with the general practice team.
- 132 patients were referred, 71% of those agreed to be seen, and 82 patients had specialist alcohol assessment and treatment in the pilot.
- The profile of the patients in the pilot bore a striking to resemblance to the profile of people described in a recent in-depth study of alcohol related deaths in Glasgow.
- Associations of improved outcomes beyond engagement in alcohol care were not feasible due to the short time scale and size of the pilot.
- All professionals involved in the pilot were unanimous – it was welcomed and successful.
- The theory of change was:
    - The team relationship and function that built up between the GP practices and attached alcohol nurses. Vital to this was informal discussion and recording in GP notes.
    - The engagement strategies the nurses used with patients – described as responsiveness, ‘stickability’ and flexibility.
- Recommendations for the future are:
    - The pilot should be repeated at scale in Deep End practices for a period of three years with a programme evaluation resourced and embedded in service delivery which will include feedback from patients.
    - This should be delivered by specialist senior alcohol nurses embedded in general practices providing the full range of alcohol treatment services using GP recording systems and with a team working approach.
    - Delivery of care should be characterised by these key ingredients for patient engagement – responsiveness, ‘stickability’ and flexibility.

“General Practitioners at the Deep End” *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.*

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INTRODUCTION

The Attached Alcohol Nurse Deep End Pilot tested a service model of partnership working by bringing specialist community services into Deep End general practice settings. The aim was to address the needs of people with problem alcohol use who are in contact with their general practices but who have not previously engaged with addiction services.

The pilot took place in 6 Deep End practices in the Possilpark Milton area of North West Glasgow from July 2015 to July 2016, funded by the Glasgow City Alcohol and Drug Partnership.

The report describes why we undertook this pilot; what was achieved, including its key ingredients; how the pilot compared to usual care in the community addiction team; the outcomes measured; and two case studies illustrating the pilot's context. The report concludes with recommendations for future service delivery.

BACKGROUND

General Practitioners at the Deep End serve the 100 most deprived general practice populations in Scotland. They welcomed the current political determination to address alcohol related harms through public health measures in Scotland, but also sought an associated improvement in service provision for people with problem alcohol use living in deprived areas[1].

People living in deprived communities in Glasgow experience the highest levels of alcohol related deaths, with an *increase* in inequalities in alcohol related deaths in the last three decades. In 1981 alcohol related deaths in the most deprived areas were 2 times greater (a 2-fold difference) than in least deprived areas, but by 2007/11 there was a 5-fold difference[2]. Also the rate of alcohol-related general acute hospital discharges in 2014/15 is 8 times greater for patients living in the most deprived areas compared to those living in the least deprived areas[3]. In the northwest of Glasgow this accounts for around 4% of hospital admissions in 2012/13[4].

At the start of the pilot it was accepted that the caseload of Glasgow Alcohol and Drug Recovery Services (GADRS) in Glasgow, included around 40% of people with alcohol problems with the other 60% using other services including general practice[1]. For example, in 2012/13 458 patients admitted to hospital and assessed by the Addictions Acute Liaison Service as having dependent alcohol use, *declined* referral to GADRS for support. 41 of these patients had 4 or more hospital admissions over a 12 month period, costing the health service around £110,000. It is estimated that the remainder of these patients had between one and four admissions per year. A reduction in these hospital admissions by one per patient would provide a potential saving for the NHS of approximately £300,000 per year[5].

This pilot by recognising the intrinsic strengths of general practice 'patient contact, population coverage [almost 100%], continuity, flexibility, cumulative knowledge, long term relationships and trust'[6] capitalised on by other Deep End initiatives (Link workers, Govan SHIP project), aimed to provide GP practices in deprived areas with appropriate support to meet this unmet need in alcohol services provision and start to challenge the statistical trends.

It was judged essential that help and support was made as accessible as possible- to address this aspect of the inverse care law. 'If the NHS is not at its best where needs are greatest, inequalities will continue to widen'[7]. This utilises the principle of 'proportionate universalism' where health provision is universal, but the depth of provision correlates directly with the level of need within a community[8]. It was necessary to make targeted changes to primary health care provision and this was feasible through partnership between key organisations- NHS Glasgow and Clyde Addiction Services, Glasgow City Alcohol and Drug partnership and general practices in North West Glasgow.

The success of the pilot was measured against four outcomes:

1. Patient engagement in the pilot service
2. Patients into alcohol treatment and care
3. Accident and emergency hospital attendances
4. Unscheduled hospital admissions. [9]

DEEP END PILOT INTERVENTION

Two FTE Band 6 specialist addiction nurses were attached to Deep End practices working in partnership with the general practice team. They provided a flexible service of outreach in patients' homes or assessing patients in the GP surgery.

The nurses carried out physical health checks including routine bloods if required, Child Protection & Adult Support Protection risk assessments. On a few occasions mental health assessments were conducted when patients presented in crisis to their GP. Harm reduction, relapse prevention and dietary advice were given as part of a full psycho-social intervention program.

The nurses were also responsible for joint care planning and initiation of interventions for patients who have previous low engagement with alcohol and drug community services. This was conducted through a motivational approach for individuals with co-created recovery strategies.

Where appropriate the nurses supported patients through a home supported detoxification and administered intramuscular injections of Pabrinex (to reduce neurological consequences of alcohol dependency). This was followed up with the GP regarding commencing protective medications and seamless referral on to Glasgow alcohol and drug recovery services, formal purchased recovery services and recovery communities as appropriate.

The attached alcohol nurses accepted referrals from any GP working at a practice within the pilot area. There was a quarterly meeting with a designated lead GP from each practice to review day to day operational matters and the development of the pilot. The GPs and the wider primary care team worked directly with the attached alcohol nurses on complex cases as they arose. This was judged important so interventions could be tailored to address the individual needs of patients.

The participating GP practices provided a consultation room and working space for the attached alcohol nurses as required and all interventions and progress were recorded in patients' GP records.

PILOT ACTIVITY AND OUTCOMES

The following are data collated by the alcohol attached nurses (AAN) from the full 12 months of the pilot. A total of 132 unique patients were referred to the pilot with the pilot.

95 patients were seen by an AAN; 71% of the total patients referred.

86% (n=82) of patients seen by an AAN agreed to an assessment, although not directly linked to our pilot outcomes the assessment data provides some details about the patients seen (n=95) at the point of referral:

- The average amount of alcohol consumed was 125 units per week
- 58% patients were daily dependent drinkers
- 46% were drinking at hazardous levels
- 53% were prescribed antidepressants
- 59% were prescribed thiamine
- 42% patients reported living alone
- 21% were in employment
- At 6 months, 92% patients described their alcohol consumption as having a direct impact on their lives and affecting both their physical and mental health

At the 6 month point[1] of the pilot 40 (63%) patients were still engaged with services with the remaining 23 (36.5%) declining further care after completion of their planned intervention.

[1] Following the end of the pilot data was retrieved by the research assistant, retention in treatment data was not available. 6 months data was extracted by the nurses when still in post for the pilot.

Patient engagement in the pilot service

The nurses' patient engagement strategies were characterised in three ways-

1. ***responsiveness*, how quickly the nurses were able to make contact with patients after referral from the GP practice.**

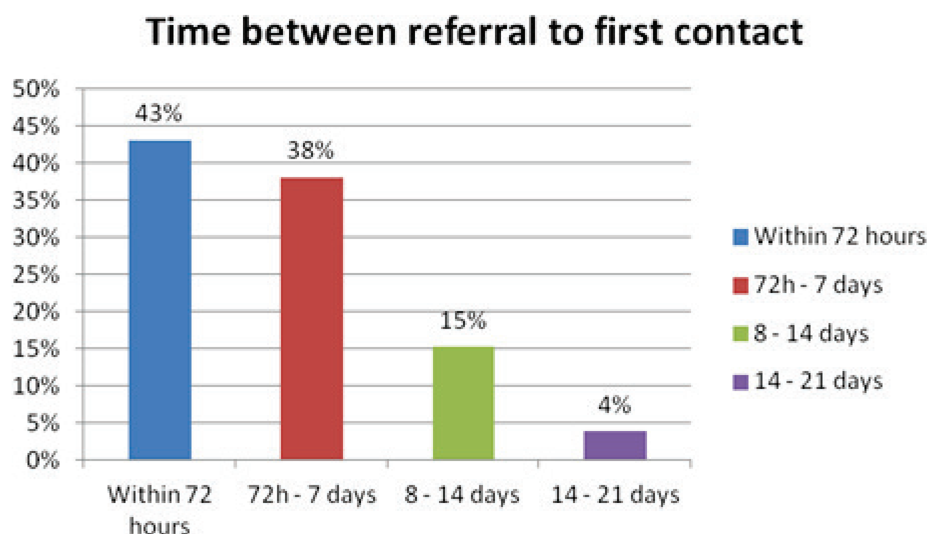

Figure 1 - Days between referral and First Seen by Deep End

Where referral information was available, 43% of those referred were seen within 72 hours of being referred. Overall 100% (n=79) of those referred were seen within the HEAT drug and alcohol treatment waiting time target of 3 weeks (21 days).

The cohort waited, on average 5 days before being seen by an AAN. Glasgow ADP overall achieves 97% achievement of the HEAT target on waiting times. This exceeded the HEAT target for access to alcohol treatment services[10]

Another important question was whether this pilot reached patients who struggle to engage with usual alcohol care in the community addiction teams.

Over the year of the cohort 72% (n=107) of those referred to the Deep End Project had had previous contact or a referral made to the Community Addiction Team.

2. ‘*stickability*’, how many repeated efforts the nurses made, to make contact with referred patients.

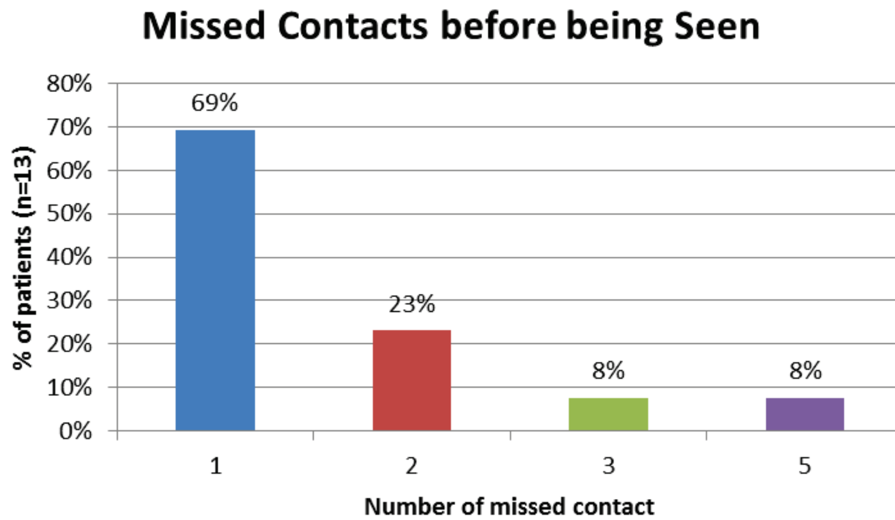

Figure 2 - Missed contacts before being seen

13 patients missed their first or subsequent appointments with the AAN after being referred, however 69% (n=9) were seen by an AAN on their second attempt after they had missed their first contact. 16 patients were referred by the GP more than once to the service within the 12 month period.

3. *flexibility* the location of the patient contacts for the AAN compared to CAT Nurses. Despite each practice providing clinical space for patient assessments the AAN’s carried out most of their patient contacts in the patients’ own homes which they reported was satisfactory for patients. 240 contacts with patients were recorded for the time period of the pilot[2].

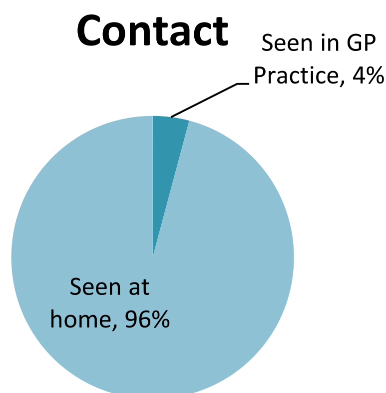

Figure 3 - Contacts

[2] Data missing for April 2016, not known why.

The majority of patient contacts with the service were at their home (96%, n=230).

An important aspect of the pilot was that the GPs reported feeling enabled to engage with the AANs, and that regular communication aided this. Communication included informally in the practice setting, and clinical information in the GP records which helped reduce clinical concerns about high risk patients and promoted joint working.

There was a sense of reduced stigma for patients in the pilot. The professionals involved reported that patients appreciated the contact being made through their GP practice rather than through the Community Addiction Team (CAT).

Patients into alcohol treatment and care

Comparison was made between the interventions carried out as part of the pilot and as usual care provided in the Community Addiction alcohol team.

Data is derived from an average that equates to 2 full time equivalent (FTE) 2 nurses in that team to enable comparisons with the 2 FTE Deep End Alcohol attached nurses (AANs). However this should be interpreted with caution as data from the CAT is reported for caseloads that are carried over a number of years in comparison to the short intervention timescale of this pilot.

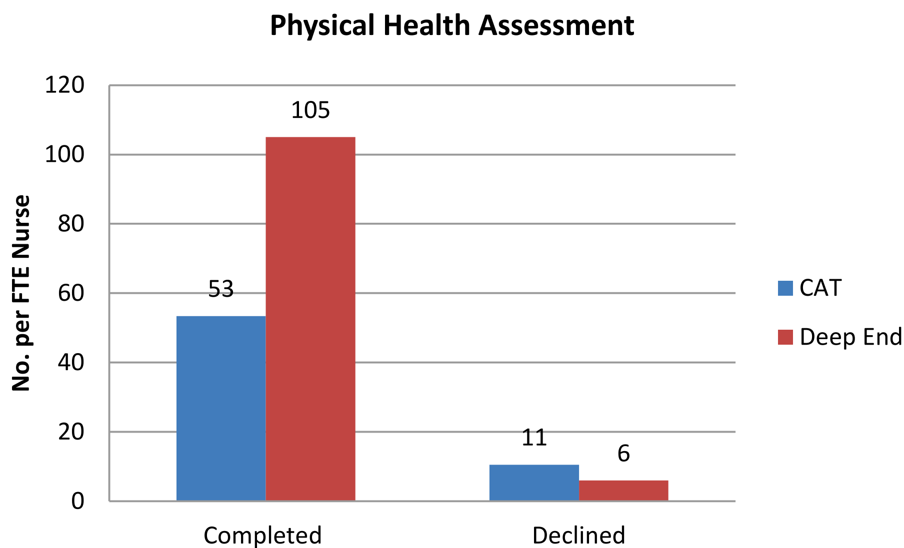

Figure 4 - Physical Health Assessments

The Deep End project provided 66% (n=52) more physical health assessments during the period of the project than the CAT team.

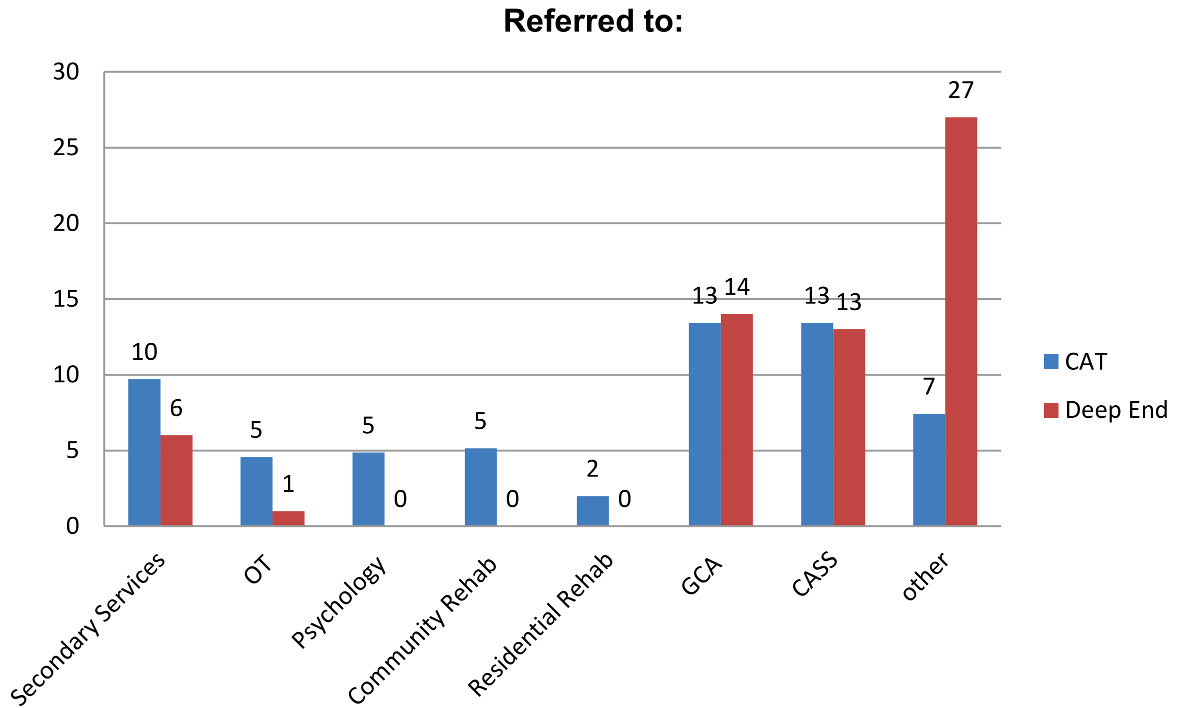

Figure 5 - Referrals made

Many of the 'other' referrals by the AAN's were to the CAT for ongoing support. Once linked in with the CAT patients would then obtain referrals onto psychology, community or residential rehabilitation via that route. Additional referrals would also be to Addaction, Drinkwise and Agewell. There were concerns from the pilot team that this requirement for onward referral would bring about disruptions to continuity of care that had been carefully built on.

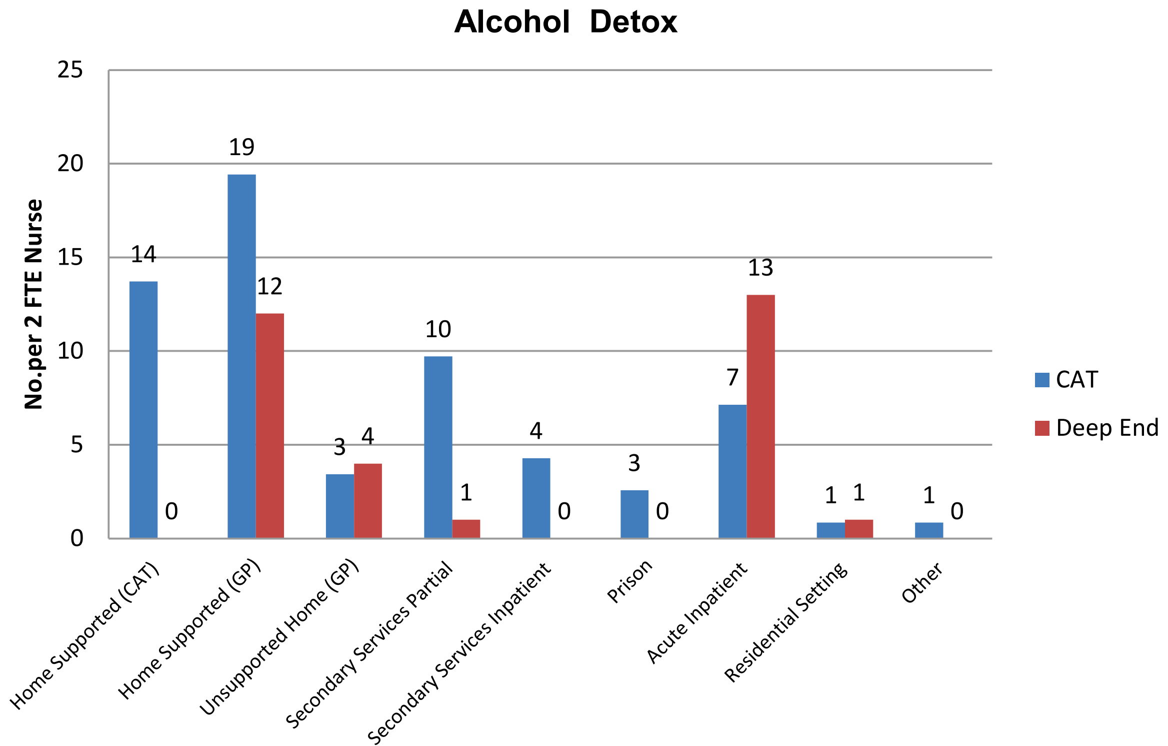

Figure 6 - Alcohol Detox

At the outset of the pilot, the AAN were not intending to carry out medication assisted detoxes, however as the pilot progressed, it was determined that providing this treatment within the Deep End setting was appropriate and indeed beneficial to patients. This enabled the AANs to respond appropriately to the needs of the patient group, along with linking patients in with the appropriate secondary service whilst providing appropriate pre and post detox support.

During the pilot period there was an 18.8 % (n=9) decrease in the number of patients prescribed chlordiazepoxide along with a 37.9% (n=60) decrease in the number of chlordiazepoxide prescriptions issued within the participating GP practices.

Appendix 1 includes additional measured AAN interventions compared to CAT care.

Accident and emergency hospital attendances

When considering possible impacts for patients an audit of A&E attendances and unscheduled hospital admissions was conducted for the 12 months before and after patients engaged with the Deep End pilot service.

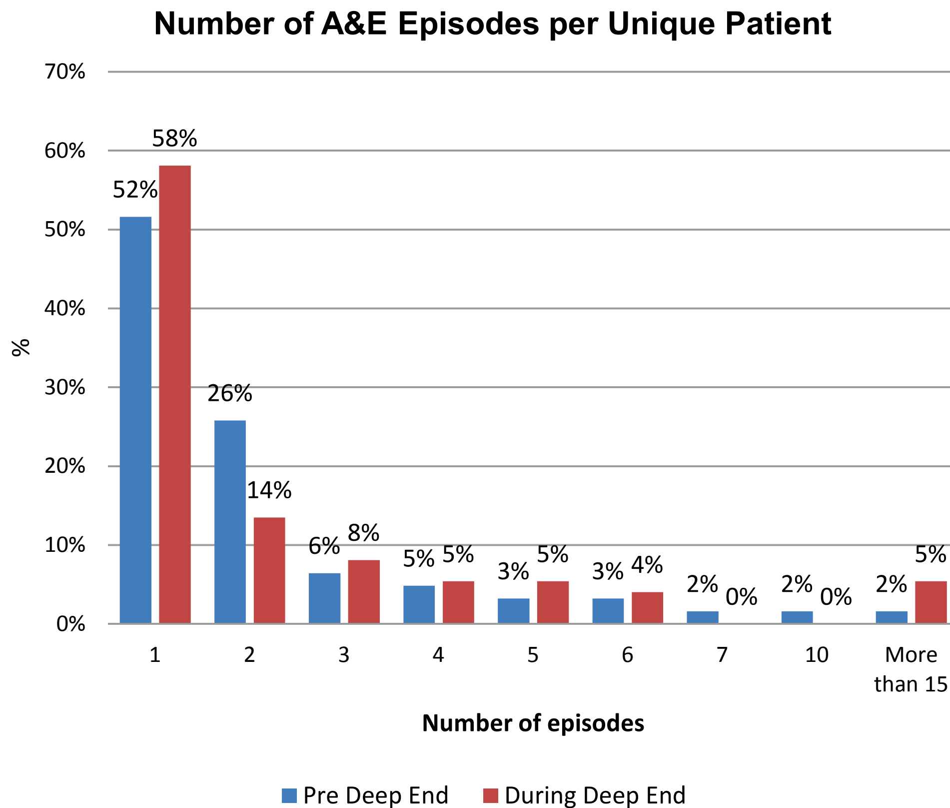

Figure 7 - Number of A&E Episodes per unique patient

62 patients had 165 A&E attendances (range 1-38, mean 3) in the year before the pilot, 62% of those were by patients self- referring with 32% being referred by a health professional or service.

During the pilot, 74 patients had 259 A&E attendances (range 1-45, mean 3.5) with 54% of patients' self- referring and 40% being referred by a health professional.

50 patients had no attendance at A&E in either time period and 42 patients had attended at A&E within both time periods.

The data is insufficient to infer statistical significance of change. It is possible that as patients engaged with care (via the pilot) they became more aware of health issues needing attention. It is also possible that patients in the pilot became more visible to health professionals and hence were more likely to be referred once they were involved in the pilot.

Unscheduled hospital admissions

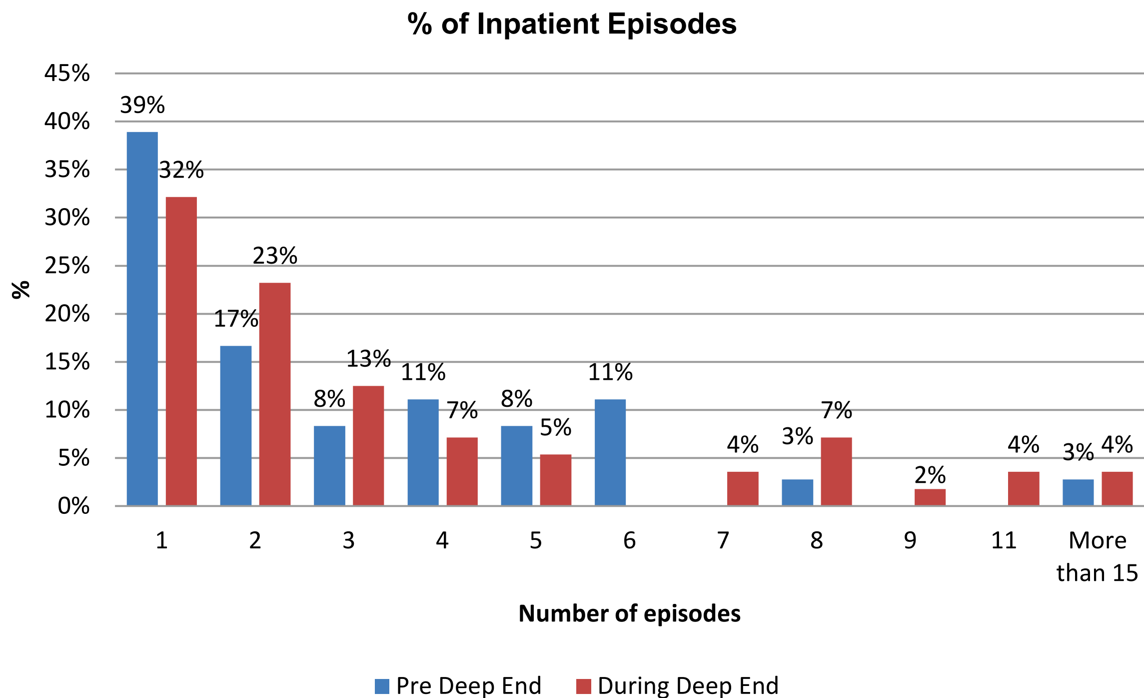

Figure 8 - % of Inpatient Episodes

36 patients had 130 inpatient episodes (range 1-31, mean 4) in the year before the pilot. Before the pilot 60% of hospital admissions were on an emergency basis. During the pilot this reduced to 56%. 73 patients had no in-patient attendances within the time period. 22 patients had episodes in both time periods.

Again because of the time interval and numbers of patients involved it is not reasonable to reach conclusions about this data.

DISCUSSION AND IMPLICATIONS

Importance of pilot target group

As this pilot intervention of attached alcohol nurses was finishing the clinicians involved were brought up short. This was by the conclusions of an in-depth study of alcohol related deaths in Glasgow which summarised the typical profile of a person likely to die an alcohol related death in Glasgow. "…*most likely be a white Scottish male between the ages of 45 – 54 years. He will be single or divorced and will live in his own home (council rented accommodation), alone, and will be located in the most deprived area of Glasgow.*
He will be unemployed at the time of death and in the years leading to it, he will have previously worked within a skilled industry and will have lost his post as a result of his alcohol use.

He will be a dependent drinker, drinking alcohol daily and will have experienced acute withdrawal symptoms and attended A&E services as a result. His GP will most likely be aware that he has had a long standing alcohol problem and he will carry the physical biomarkers of this, such as abnormal liver function tests, platelet levels and MCV levels. He will most likely have been prescribed Thiamine and Omeprazole by his GP" [11]. **Appendix 2** describes this profile in full.

This matches the profile of people who engaged with the Deep End pilot. 79% of those attending the pilot were male, with 94% of these classing themselves as white Scottish. The largest age cohort attending the service was between 45-54 years of age. The majority of those attending the service were unemployed (77%) and lived alone (48%). 65% of individuals attending the service were dependent drinkers. **Appendix 3** describes 2 anonymised case studies of patients who were cared for in the pilot.

Learning from the pilot

This was a one year test of a service delivery design without a formal evaluation embedded in it. The professionals involved in the pilot were unanimous in their view that this was an excellent pilot that had led to the outcomes they had hoped for in terms of patient and practice engagement in care (**Appendix 4** includes responses from participating GPs towards the end of the pilot).

Very quickly this pilot became an outreach project where the AANs visited patients at home. Vitally though, continuity of care between the AANs and the GP practice by having a team relationship, recording information in the GP notes and trust between professionals was a key ingredient in the high quality care being provided to patients.

Yet the group leading the pilot judged it important to explore what the routinely available data might tell us. We had the support of the attached alcohol nurses, GPs and a research assistant once the pilot was concluded to do this.

It is however difficult to draw firm conclusions from the data. This is partly because it seeks to quantify care rather than focussing on quality, but importantly also because it concerns a small number of patients over a short time period.

However as a group we did formulate a theory of change- what were the ingredients that led to the perceived success of the pilot?

A key one was the **team relationship and function that built up between the GP practices and attached alcohol nurses.** The other was the 3 **engagement strategies** the nurses used;-**responsiveness, 'stickability' and flexibility** in their engagement strategies with patients which contributed to a sense of reduced stigma. The data seems to back this up. However we cannot judge from this data whether the pilot had a positive impact on patient outcomes- even medium term ones like hospital admissions.

CONCLUSION

The Attached Alcohol Nurse Deep end pilot has successfully achieved a partnership between a specialist primary care service and general practice to seek to meet the needs of patients with problem alcohol use who previously struggled to engage in care. Using a proportionate universalism approach and by working in partnership with the

general practice team a flexible outreach approach was utilised to provide specialist alcohol treatment services for patients.

The reach of the service from the patients' general practice and into their homes has been critical in its engagement with the service participants. The number of individuals retained in service and the speed at which treatment was started demonstrates that the service was responding to both demand and the previous unmet needs of people with problem alcohol use. This pilot service provides a model of working that actively addresses the inverse care law so starkly illustrated by recent research about alcohol related deaths in Glasgow.

RECOMMENDATIONS FOR NEXT STEPS

The pilot should be repeated at scale in Deep End practices for a period of 3 years with a programme evaluation resourced and embedded in service delivery which will include feedback from patients.

This should be delivered by specialist senior alcohol nurses embedded in general practices providing the full range of alcohol treatment services using GP recording systems and with a team working approach.

Delivery of care should be characterised by these key ingredients for patient engagement-responsiveness, 'stickability' and flexibility.

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APPENDIX 1 Additional nursing caseload outcome comparison between Alcohol Attached Nurses and average 2 FTE nurses in the CAT

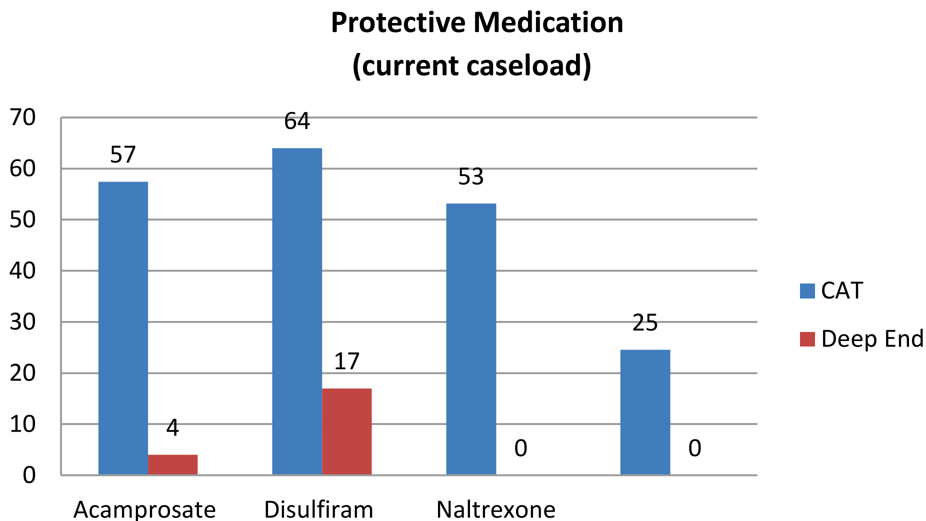

Figure 1 - Protective Medication

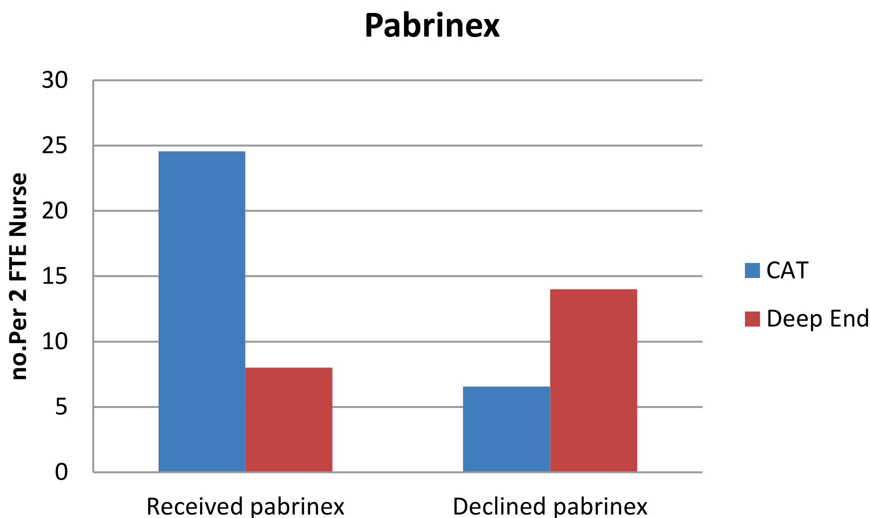

Figure 2 - Pabrinex

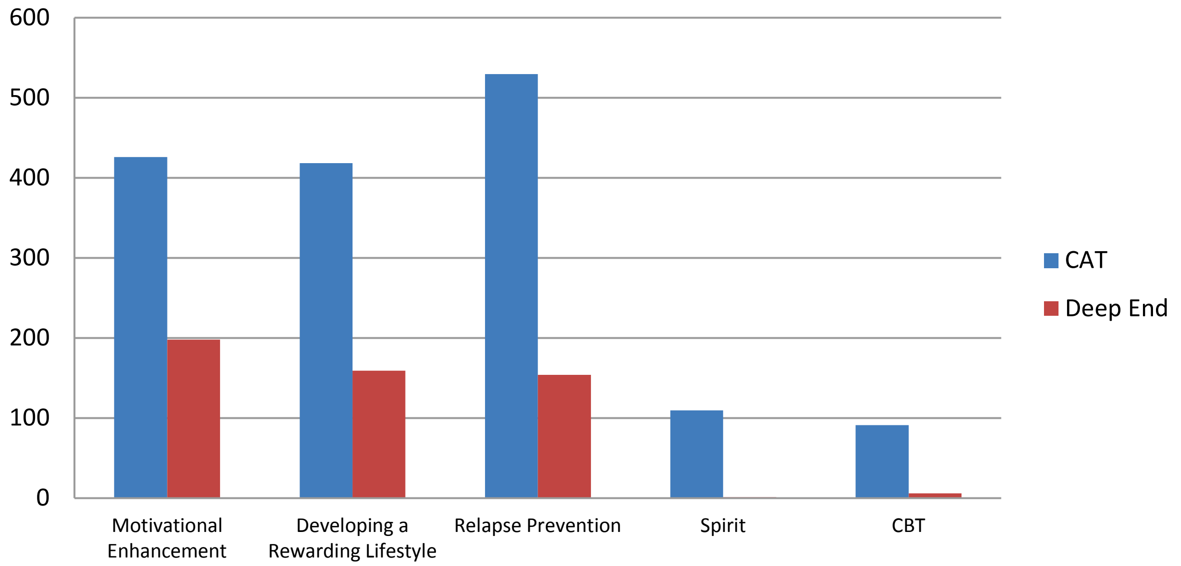

Figure 3 = Psychological Interventions

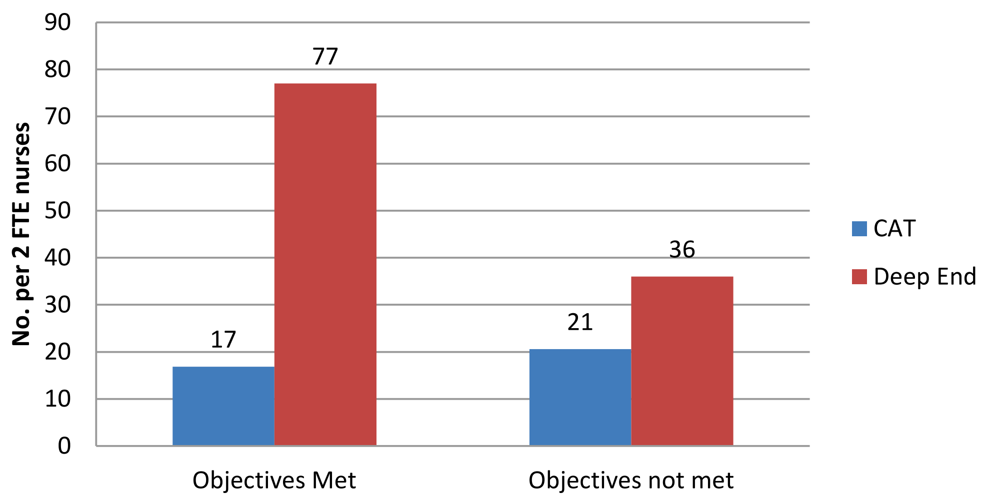

Figure 4 - Care / Recovery Plans

APPENDIX 2 Profile of an Alcohol Related Death (ARD)

"An individual who will die of an alcohol related death in Glasgow City will most likely be a white Scottish male between the ages of 45 – 54 years. He will be single or divorced and will live in his own home (council rented accommodation), alone, and will be located in the most deprived area of Glasgow.

He will be unemployed at the time of death and in the years leading to it, he will have previously worked within a skilled industry and will have lost his post as a result of his alcohol use.

He will be a dependent drinker, drinking alcohol daily and will have experienced acute withdrawal symptoms and attended A&E services as a result. His GP will most likely be aware that he has had a long standing alcohol problem and he will carry the physical biomarkers of this, such as abnormal liver function tests, platelet levels and MCV levels. He will most likely have been prescribed Thiamine and Omeprazole by his GP.

He will have Alcoholic Liver Disease and will have referred for acute outpatient appointments with Gastroenterology. He will have had on average 8 acute inpatient episodes, a result of emergency admissions, probably within a general medical ward. He will have received treatment for his alcoholic liver disease and acute withdrawal symptoms; he may have been in contact with the acute alcohol liaison service during one of these admissions.

He will have had contact, at some point in his drinking career, with an alcohol treatment services (including pre Community Addiction Team). He will have been in contact with a psychiatric service, most likely and Addiction specific psychiatric service and will have received a medically assisted detox in the form of a GP unsupported detox.

He may have attended a community addiction team and he will have also attended a community/voluntary alcohol service. It is more than likely that he will have defaulted from these services.

He would have been socially isolated with a lack of a social network and will most probably have a close relation with an alcohol problem. He will also have experienced some financial problems and housing issues as a result of his alcohol use and although likely to have been in contact with police, he is unlikely to have been charged or taken into custody.

He will have most likely have died in hospital of a condition related to the liver under the ICD 10 category of K70.

APPENDIX 3 Anonymised case studies of patients in the pilot

Case study 1

G is a man in his late forties who lives alone in a tenement flat. He has no children. He started drinking when he was 13 years old however alcohol did not start to become a problem until 2011 after his relationship with his partner broke down.

He describes himself as a binge drinker where he will binge for 3/4 days usually consuming around 160 units during each binge; he can remain abstinent for anything up to 5 weeks in between binges. He becomes physically unwell when he stops drinking, suffers from symptoms of gastritis and pancreatitis which then leads to him seeking medical support via acute hospital services:

2011	3 presentations &	3 admissions
2012	9 presentations &	9 admissions
2013	17 presentations &	16 admissions
2014	28 presentations &	28 admissions
2015	31 presentations &	28 admissions

By January 2016 – 4 presentations & 3 admissions.

Mr G has previously received support from a local community addiction team, attended outpatient tier 3 alcohol services, voluntary sector community services, AA, GCA and was opened to another community addiction team in 2014 after moving area.

His attendance and engagement with the above services has been poor & sporadic and despite having this support he continued to present at acute services. His relationship with the community addiction team had broken down and he refused to engage with their care. His GP referred him to the Deep End Pilot in January 2016 following a further hospital admission.

Initially 3 home visits were carried out and 2 letters sent before Mr G engaged with the Attached Alcohol nurse (AAN). He has been visited at home on a weekly basis where CBT self-help worksheets have been used in an attempt to support him in recognising and changing his behaviour.

There had been no hospital presentations or admissions during the first 3 weeks of engagement, however during a recent period of nurse annual leave Mr G presented & was admitted to GRI. The AAN visited Mr G at home on her return and discussed this and – support continued to be offered via weekly home visits for the duration of the pilot.

Case study 2

M a woman in here early 30's had recently been made homeless due to her increasing alcohol use over the past 3 months. Previously she lived with her mother who has multiple health issues and she was her main carer.

History

Previously M had lived with her partner but the relationship broke down. This had a major effect on her and she reported turning to alcohol and drugs to cope.

M had been drinking daily for the last three months and was alcohol dependent and underreporting her alcohol use.

Intervention

M was seen by the AAN in the GP surgery and following assessment sought to be alcohol free.

Due to her unstable accommodation issues a home detoxification was not suitable. More appropriate treatment options where discussed with her for example hospital or residential rehabilitation.

Following her initial appointment M was accompanied by the AAN to the casework team to be registered as homeless. Despite being offered emergency accommodation she elected to remain where she was and declined this offer. A further appointment was made with the casework team for the following week for a full assessment to be carried out.

The AAN arranged both with M and a residential rehab centre for an assessment to take place the next day. The following day M was accompanied by the AAN to the assessment which went well and she had to contact the project each day until a bed was available.

M was admitted to residential rehab the following weekend and under took a supervised alcohol detox. The AAN has arranged for her onward referral with both Glasgow Alcohol and Drug Recovery services (GADRs) and other appropriate services prior to her planned discharge from residential rehab.

APPENDIX 4 Statements from participating Deep End GPs

“We have found this a valuable resource. The statistics from referrals and, in particular, the engagement data shows benefit .However the statistics do not show the unrecorded and unmeasurable work that has been progressing since we have had the nurses attached to the practice.

The value of face to face informal discussions regarding patients – for referral or for feedback, has been huge. We have been able to easily identify, patients open to CAT services as well as those not open to CAT in the past with much more ease than previous .I feel that there are several patients who contact GP services less often, or we are able to direct to the attached nurses appropriately rather than use GP or hospital services.”

Dr Douglas Rigg (GP, Keppoch Medical Practice)

“This has been a fantastic project for our practice and our patients have found this very beneficial. Patients identified have all been seen very quickly and have usually been seen within a week of the referral going in and sometimes patients are seen within a couple of days. This has obviously been very beneficial and has helped numerous patients when they have needed support. We have had some great outcomes.

The support has been very focused and is very much been helpful to patients who have not engaged in the past and who have fallen away from the Community Addiction Team or other support. We have found at times there has been tremendous intervention which has been very helpful and supportive to our patients as well as for ourselves. We have had many patients during this project who have engaged in this alcohol service who in the past have not done so.”

Dr Linda Cherry (GP, Allander Surgery)

“Our experience of this project has been incredibly positive. Our patient's have been seen quickly, at a time they are ready for change, by someone we know and respect. Having you based within the practice has led to us referring patients that we would never have persuaded to go to CAT, especially those who are managing to maintain employment despite their alcohol problem. The feedback from our patients has been equally positive.”

Dr Alison Reid (GP, Balmore Road)