Community alcohol detoxification – Local Public Health service

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<th>5</th>
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<td>Date issued:</td>
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Published Local Public Health service:

Community alcohol detoxification in primary care.

1. Purpose

The purpose of this primary care enhanced service is to improve the health and quality of life of people whose health may be compromised by their use of alcohol by providing patient-centred, systematic and on-going support.

The service directly contributes towards reducing the rate of alcohol-related hospital admissions, Vital Sign VSC26.

Community alcohol detoxification is delivered as a ‘shared care’ service, in partnership with the East Sussex Community Alcohol Team.

2. Period of Service

This service will run for a period of twelve months from 1st April 2014 – 31st March 2015, extended subject to satisfactory annual review.

3. Scope and Definition of Service

Community alcohol detoxification is the medically assisted withdrawal from alcohol using prescribed medication. Community detoxification can often be safely carried out in the home or other community settings, such as day centres.

Community alcohol detoxification is open to male and female adult patients aged 18 and over who are drinking to dependent levels.

The intervention is provided as part of a jointly planned care programme, and is NOT intended as a crisis or emergency service.

There may be other community prescribing interventions delivered either before, during or following the intervention:

- Medications to promote abstinence or prevent relapse, including sensitizing agents.
- high-dose parenteral thiamin for the treatment of Wernicke’s encephalopathy and its prevention.

Pharmacological therapies should be delivered in the context of structured care-planned treatment and are not a stand-alone treatment option.
4. Service Objectives and Intended Health Outcomes

The service is delivered as a ‘shared care’ service through joint work with the East Sussex Community Alcohol Team. Joint working between service providers is critical to achieving the following list of service objectives and intended health outcomes for the local population:

i. To improve the identification, assessment and intervention offered to people at greater risk of alcohol morbidity through the primary care setting, particularly those drinking to harmful and dependent levels.

ii. To provide quicker access to early assessment of potential alcohol related harm, early intervention and timely referral to specialist help for those who show signs of dependence on alcohol.

iii. To reduce consumption levels in people who are drinking at harmful or dependent levels.

iv. To improve the health outcomes of people who are drinking at harmful or dependent levels by improving the management of physical and mental well-being and clinical co-morbidities.

v. To provide further choice of interventions for people who are drinking at harmful or dependent levels closer to home and outside of a secondary care setting.

5. Service Outline

i. The practice will establish effective links with the Community Alcohol Team. The Community Alcohol Team will provide a named alcohol key worker, attached to the practice and working on-site at the practice wherever it is practical to do so.

ii. The Community Alcohol Team will provide operational guidelines for all practices providing the enhanced service. The alcohol key worker will be available to provide additional advice as appropriate.

iii. Referrals may come from the Community Alcohol Team, or from general practice.

iv. The practice will keep an accurate record of patients receiving interventions for alcohol misuse problems. Information should be recorded in the GP system using the Read codes provided which identifies patients as dependent drinkers. These patients will normally have a full AUDIT score of 20 or more.

v. There will be a comprehensive and holistic assessment of the patient’s needs. The medical assessment will include:

- general physical health
- heart rate
• blood pressure
• Liver function with gamma-glutamyl transferase (GGT or ‘gamma GT’)
• full blood count

Other tests may be appropriate, depending on the patient’s presentation. Results will be shared with the Community Alcohol Team alcohol key worker.

vi. The Community Alcohol Team alcohol key worker will produce a written and comprehensive care plan. Any care plan will be tailored to the patient’s needs and circumstances, following discussion with them, and will need to respond flexibly to patients’ problems.

vii. For community detoxification, the prescriber’s choice of dosing regime should follow according to a SADQ score (Severity of Alcohol Dependency Questionnaire).

viii. The practice will work with the Community Alcohol Team to establish and maintain referral and joint working arrangements with local pharmacies.

ix. The practice will work with the Community Alcohol Team to develop mechanisms for liaison with and referral to secondary care when management becomes problematic or more complex (e.g. co-morbid mental health, co-morbid drug dependency, delirium tremens, Wernicke-Korsakoff syndrome).

x. Practice staff involved in providing the service will be required to demonstrate appropriate training and continuing professional development in line with national guidance. Provision of a range of interventions to meet patient need is usually required, which broadens practitioner skill base. Evidence based interventions require a trained and competent workforce. The Department of Health publishes web-based training – see www.alcohollearningcentre.org.uk

6. Local pathway
i. Screening by all GPs.
ii. Referral of appropriate cases to East Sussex Community Alcohol Team.
iii. Comprehensive assessment led by East Sussex Community Alcohol Team.
iv. Care plan agreed.
v. Patients suitable for community alcohol detoxification provided through this enhanced service referred to a practice participating in this enhanced service based on availability of treatment places and patient choice.
vi. Joint work with East Sussex Community Alcohol Team to deliver care planned interventions.
vii. Patient’s care plan reviewed and planned care continued, or patient discharged from treatment as appropriate.
viii. A follow-up at three months following discharge to include repeat blood tests to check liver function.

7. Support for Self Care

Providers should be in a position to identify those individuals who would benefit from additional support for self care and enable these individuals to access the four main areas of self care.

- Skills and Education;
- Information;
- Tools and Devices;
- Self Care support networks.

All patients should be offered information about local self help groups (such as Alcoholics Anonymous or similar).

Additional detail around support for self care can be found on the Department of Health website at www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/DH_4128529

8. Location of Service

The service shall be provided from premises that are fit for purpose in a modern way and address issues of service user needs and uptake, particularly in communities with poor health outcomes.

9. Integrated Governance

i. Any commissioned service must meet all national standards of service quality and clinical governance including those set out in Standards for Better Health (updated April 2006). These core and developmental standards of provision are designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The seven domains are safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, the care environment and public health.

ii. Providers will be required to demonstrate that evidence based clinical guidelines are being used. All practitioners should prescribe within their own level of competence as defined by Roles and Responsibilities of Doctors in the provision of treatment for drug and alcohol misusers (RCGP & RCPsych 2005) and the Department of Health’s ‘Drug Misuse and Dependence – UK guidelines on clinical management ‘(2007).

iii. Providers are encouraged to complete the RCGP Certificate in the Management of Alcohol Problems in Primary Care 2010. Information about the course is published at the RCGP website (www.rcgp.org.uk).

iv. NICE is developing three pieces of guidance relating to alcohol use disorders for publication in 2010.

Part 1 - Public health guidance: Alcohol use disorders in
adults and young people: prevention and early identification (publication expected May 2010)

Part 2 - Clinical guideline: Alcohol use disorders in adults and young people: clinical management (publication expected May 2010)

Part 3 - Clinical guideline: Alcohol use disorders: management of alcohol dependency (publication expected December 2010)

v. Until NICE guidance is available for the commonly used specific treatments for alcohol dependency (such as disulfiram), other sources may be utilised (such as those provided by the Scottish Intercollegiate Guidelines Network) (SIGN 2003).

vi. The specialist Community Alcohol Team includes a GP with Special Interest (GPwSI). The GPwSI has completed additional specialist training with RCGP and has extensive specialist substance misuse experience. This doctor will provide a mentoring role for the service.

vii. The Department of Health publishes web-based training at the alcohol learning centre www.alcohollearningcentre.org.uk

viii. Patient, public and staff safety – Providers will be required to demonstrate that evidence based clinical guidelines are being used. Providers should have in place appropriate health and safety and risk management systems and that premises standards are met. They should also ensure that any risk assessments and significant events are both documented and audited regularly and outcomes of these implemented. Services should comply with national requirements for recording, reporting, investigation and implementation of learning from incidents. Further details can be found on the National Patient Safety Agency website www.npsa.nhs.uk

ix. The provider of this service is also required to have in place effective polices and procedures which promote the well being and safety of service users and staff. Providers should ensure safe staffing capacity at all times and staff should be able to demonstrate that they have participated in organisational mandatory and update training, for example infection control, manual handling, risk assessment as required.

x. Information management – Practices should each have local policies in place that describe access to medical records by local Community Alcohol Team employees.

xi. Furthermore, accurate clinical coding is vitally important to
capture enough information about a person who misuses alcohol to ensure better planning and monitoring of health inequalities.

xii. Clinical audit and review – Providers will be required to demonstrate their coordination of and involvement in regular inter-professional and inter-agency meetings and regular clinical audit of the service interventions and outcomes such as drug therapies or well-being and behaviour changes. This audit can be carried out by extracting data using the Read codes provided in the Suite of Supportive Resources. The results of any audits and learning will be fed back to the Drug and Alcohol Action Team via the Joint Commissioning Manager (substance misuse) for wider dissemination.

xiii. Patient and Public Involvement - Providers will be required to demonstrate active engagement with patients and local communities in commissioning and developing services, self care plans or in supporting patients to utilise self care opportunities. Providers should demonstrate how systematic patient feedback is being used to shape and improve services.

xiv. Involving family carers and supporters will help deliver the components within this service specification. Healthwatch, the voluntary sector and patient advocacy organisations are all further mechanisms to seek active involvement in service planning, delivery and monitoring.

xv. Equality and Human Rights - Delivering good quality care will require organisations to demonstrate competence in identifying and taking action on inequality and also needing to engage with communities that have not found accessing public services easy. Undertaking Equality Impact Assessments (EQIAs) is a specific legal obligation, and conducting EQIAs and using the evidence to create a meaningful dialogue with communities (especially seldom heard from groups) is central to effective commissioning and service provision. This will create an evidence-based approach. As a minimum, core standard C7e of Standards for Better Health stipulates “healthcare organisations should enable all members of the population to access services equally and offer choice in access to services and treatment equitably”. To assist this process, organisations may wish to refer to ‘Creating a Disability Equality Scheme: a Practical Guide for the NHS’ www.dh.gov.uk/en/Publicationsandstatistics/Publications/ PublicationsPolicyAndGuidance/DH_4139666.

xvi. Managing complaints – The existing practice complaints procedure will be used.
| **10. Medicines Management** | Prescribing audits: A prescribing audit will be required around the drugs linked to community based medical interventions:–
- Disulfiram
- Acamprosate
- Chlordiazepoxide
And any other drug included in the clinical guidelines

These should be linked to an appropriate diagnosis/treatment code such as those provided in the appendix to the enhanced service.

Patient medication reviews: These will be linked to the QoF clinical domain target Medicines Management 8 (medication review in notes with any repeat medication) as mandatory for all patients receiving medical interventions under the Local Public Health services. |
| **11. Information management** | The following data is required. Data collection should be undertaken at the patient contact point by using Read/SNOMED codes recorded in the GP system.

Providers should consider the following:

i. The number and percentage of patients drinking at hazardous and harmful levels in the practice population seen in last 15 months.

ii. The number of patients who have been screened using FAST or Audit-C in the last 15 months.

iii. The number of patients with a positive FAST or Audit-C score and full AUDIT assessment in last 15 months.

iv. The number of patients who have a full AUDIT score recorded in the appropriate AUDIT category.

v. The number of patients given brief advice intervention in the last 15 months.

vi. The number of patients with a full AUDIT score of 20 or more who have been referred to specialist alcohol misuse services.

vii. Regular monitoring of patient outcomes and service performance should also be undertaken by the provider.

viii. All of above specific patient details are collected for possible collaboration with partner organisations (in line with information governance principles) |
| **12. Service Monitoring and** | Service evaluation will consider the following areas:

Service Activity – Volume of work against any agreed activity |
Evaluation

levels and distance from profile, capacity, needs and demand analyses, workforce arrangements, real time referral data to other care pathways or appropriate agencies recorded in the GP system using the Read codes provided.

Clinical Outcomes – Regular analysis and interpretation of clinical outcomes data as well as regular analysis and interpretation of PPA data for prescribing.

Quality and Governance – Quality criteria will need to be established (in agreement with commissioners) and measured with standards needing to be met on a continual basis. Results of clinical audits will be used to inform service provision during the year.

Patient Experience – Patients’ views on their experiences and satisfaction levels will need to be measured through an on-going, systematic process to test whether the service is engaging with patients, family carers and supporters in a way that supports them.

The commissioner will arrange a joint meeting annually with the Community Alcohol Team to review the operation of the enhanced service.

13. Funding

In 20010/11 each practice contracted to provide these services will receive a £250 fee for each alcohol detoxification initiated per patient.

Practices will be able to claim for no more than three episodes of treatment per patient annually.

A maximum of 200 community alcohol detoxifications will be funded annually through the Local Public Health service agreement. Planned activity will be agreed in advance with any practice providing the service.
### Appendix One: Read Coding and e-templates for GP practices

Currently accepted Read Codes include:

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<th>Concept</th>
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<th>Read CTV3</th>
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<td>FAST alcohol screening test</td>
<td>388u</td>
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