**Appendix 'A'**

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| **Lancashire Transformation Fund Business Case** |  |
| **Name of proposed project:** Hospital Alcohol Liaison Services (HALS) |  |
| **Business Case developed by:** Andrew Ascroft Public Health AssociateChild Public Health & Risk Taking Behaviours Team, NHS Central LancashireIn consultation with local alcohol leads;Steve Owen – NHS East LancashireVicky Putt – NHS North LancashireHelen Lowey – NHS Blackburn with DarwenSteve Morton – NHS BlackpoolStephen Boydell – Public Health Intelligence, NHS Central Lancashire | **Date: 30th July 2012** |
| **CCG:** |
|  |
| **PROJECT LEADERSHIP:** |
| **Lancashire Improving Outcomes Programme Lead:**Dr. Sakthi Karunanithi | **Project Manager(s):**Alcohol leads in PCTs |
| **Project Clinical Lead:**(Ensure clinical focus throughout) | **Project Lead Accountant:**Chris Ridehalgh |
| **OUTLINE PROPOSAL:**  |
| **Background to the proposal:** (Include the business need, why it is needed now, and existing arrangements – such as current service delivery, technical standards)1. Alcohol misuse has a huge impact on the health of the population in Lancashire adversely affecting disadvantaged communities leading to loss of life as well as increasing costs to the NHS. In 2011/12, it is estimated that PCTs in Lancashire spent £71.9 million on PbR tariff alone treating alcohol related conditions, with £15 million in treating conditions wholly attributable to alcohol.
2. The increasing costs of alcohol related admissions are not sustainable and the hospital liason services to care for people with alcohol misuse needs to be transformed.
3. Addressing alcohol misuse is a priority for many CCGs. It has also been identified as a priority intervention within the draft health and well being strategy for Lancashire.
4. The Lancashire improving outcomes board has also identified addressing alcohol related admissions as a service transformation area.
5. There is inequity and variation in the hospital alcohol liaison service and targeted identification and brief advice - two of the seven high impact changes identified by the Department of Health’s Alcohol Learning Centre.
6. There is an opportunity to halt the rising trend of alcohol related admissions by utilising some of the non recurrent resources to pump prime the transformation of the alcohol services available in the hospitals as well as in primary care with a plan to sustain.

**Existing Arrangements:** Blackpool has got a Hospital Alcohol Liaison Service (HALS) and Identification and Brief Advice in the community. HALS does not exist in North Lancashire but a recurrent funding source has been identified for HALS and a community in-reach exists. East Lancashire has got a HALS but is not adequate to cover the whole population. Central Lancashire has an in reach model for hospital alcohol liaison as part of the community services. Further details of existing arrangements can be found in annex 1.This business case specifically focuses on expanding the capacity of HALS in East Lancashire and proposes setting up a HALS in Central Lancashire that incorporates assertive outreach alcohol service to integrate with the community based in-reach services. It also requests resources for training health professionals on identification and brief advice (IBA) in Central, East, BwD and North Lancashire.The investment proposals should be seen in the context of improving the returns on existing spend on alcohol related admissions, which is approximately £71.9 million per year in Lancashire of which £12m are for conditions wholly attributable to alcohol. |
| **Project Aim(s):**The project **aim** is reduce alcohol related admissions by ensuring an equitable level of service is in place across Lancashire.**Project deliverables:**1. To develop a hospital alcohol liaison service in Lancashire Teaching Hospital and Southport and Ormskirk Hospitals that is sustainable and incorporates assertive outreach and integration with community in reach services.
2. To expand capacity of alcohol liaison nursing in East Lancashire Hospitals Trusts and in urgent care settings that is sustainable and incorporates assertive outreach and integration with community in reach services.
3. To develop skills within primary and secondary care workforce through training in Identification and brief advice
4. To support peer to peer learning between organisations
5. To evaluate the impact of the changes on alcohol related admissions
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| **Clinical evidence base and technical standards:****There is numerous evidence to support the interventions proposed in this project. Some of the key ones are given below**NHS Evidence (2011): *Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care**NICE (2010):*  *Alcohol-use disorders: preventing the development of hazardous and harmful drinking**NICE (2010):*  *Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications**NICE (2012): Alcohol Pathways*  [*http://pathways.nice.org.uk/pathways/alcohol-use-disorders*](http://pathways.nice.org.uk/pathways/alcohol-use-disorders)Robin Touquet and colleagues in the Emergency department at St Mary's Hospital, London have designed the 1-minute Paddington Alcohol Test to identify patients with an alcohol-related problem. This resulted in a 10-fold increase in referrals to an Alcohol Health Worker (AHW). The AHW gave brief intervention and education, which resulted in a reduction of 43% in alcohol consumption. Every two referrals to the AHW resulted in one fewer reattendance during the following year. If patients are offered an appointment with the AHW on the same day, almost two-thirds attend. If the appointment is delayed for longer than 48 hours, only 28% attend. Hence, the intervention needs to be immediate (R Touquet et al, 2009)[[1]](#endnote-1). This also emphasises the need for the Hospital Alcohol Liaison service to be delivered 7 days a week**Evidence from transferrable case studies** The evidence from modelling using SRFT and WWHT suggests that a combination of alcohol liaison nurse, Identification and Brief Advice, and extended brief intervention could provide a decrease of 7.6% from the increase trajectory, with recognition that at least a one to two year period is required to achieve the activity benefits and a potential reduction of between 4 and 7 beds. The implementation of assertive outreach service will reduce admissions with AAF=1 by 10% in year 1, 20% in second year and 25% in the third. To be effective evidence from case studies suggest that the HALS needs to an embedded component of the hospital mutli-agency team. The Royal Bolton Hospital NHS Foundation Trust has an alcohol team, which systematically uses Brief Interventions and has strong links to community teams. The Royal Bolton Hospital collaborative care for alcohol- related liver disease and harm is a multidisciplinary team that consists of a Consultant Gastroenterologist, Liaison Psychiatrist, Psychiatric Alcohol Liaison Nurse, Liver Nurse Practitioner and all relevant health care professionals, including the dedicated social worker (K. J. Moriarty, 2010)[[2]](#endnote-2). This is outlined in the ‘interdependencies’ section of the report. The Royal Bolton Hospital NHS Foundation Trust for example has reduced inpatient detoxifications, saving the Trust more than 1,000 bed days annually, equating to £250,000 in reduced admissions. Also, in the 6 month pilot, this innovation has facilitated 541 discharges from the gastroenterology ward, compared to 355 in the comparable period last year, a 52% increase.Note on case studies: Lancashire model is underpinned by Salford Royal and Royal Bolton as most robust evidence from that reviewed to date. Liverpool outcomes not transferrable to Lancashire as the model focusses on detox – have assumed context of limited community alcohol services which is not the case in Lancashire. |
| **Deliverable Benefits/Impact:** (quantify the measurable benefits using SMART methodology including benefits to patients)**It is recommended that further calculation of benefits is done using the actual activity levels in hospitals due to alcohol related admissions. The details provided below are conservative estimates from NI39 admission figures only. In reality, the actual activity is estimated to be three times the number of NI39 admissions.** Benefits from the cost reduction would be realised by the PCTs through admission avoidance and could lead to bed based reductions for two categories of patients:1. Those with conditions partially attributable to alcohol, with a 0-1 LOS
2. Those with conditions wholly attributable to alcohol with a LOS typically >10.

The benefits have been quantified using the national planning tool to reduce alcohol related admissions based on the assumption that the interventions proposed in this business case would reduce the alcohol related admissions by at least 2%. A sensitivity analysis of the impact of this project ranging from 2% to 5% reduction in alcohol related admissions and the associated cost savings are provided in appendix 2.The case is predicated on national indicators and length of stay costs that assumes on average an alcohol related admission costs a PCT £1,824 per admission.Detailed graphs illustrating the projected trend and the impact of reducing the admissions by 2% to 5% and the associated cost savings can be found in the financial appraisal section and in appendix 3.A risk benefit sharing structure would be required to ensure stabilisation within the health economy during the reduction of admissions and the associated bed reduction.**Please see the attached spreadsheet for details of costs involved and the associated savings.**  |
| **Key Partners:** (which partners are essential for delivery/sustainability of project activities/achievements)Engagement and participation of the following partners will be essential for effective implementation of this project. All stakeholders will need to reflect arrangements pan-Lancashire;* Clinical Commissioning Groups (as future lead commissioners for acute services & for clinical input)
* Community Alcohol Service Providers (ensuring developments are embedded within/aligned to care pathways)
* Drug and Alcohol Action Teams (as current lead commissioners for community alcohol services)
* Finance leads (for modelling financial impact of project delivery)
* Primary care (as the setting for IBA intervention)
* Hospital Trusts (as the setting for HALS intervention)
* Lancashire County Council Adult Social Care (for reducing admissions by frequent attendees and for length of stay for general alcohol related admissions)
* Local alcohol leads (as project managers at local level – often also fulfilling the public health role)
* Patient involvement (appropriate to needs and circumstances of the diverse range of service users)
* Public Health (for evidence base including critical appraisal of scientific evidence and health needs)
* Upper tier and unitary authorities (as future commissioners of drug and alcohol services)
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| **Which element of QIPP does this scheme relate to?** |  |
| **Q**uality |  | **P**roductivity |  |
| **I**nnovation |  | **P**revention |  |
| **Which Lancashire cross-cutting theme does this scheme relate to?** |  |
| Prevention |  |
| Long-term conditions |  |
| Demand Management |  |
| End of Life Care |  |
| Safer Care |  |
| **TIMESCALES- KEY DATES:** |  |
| **Project Start Date: Implementation from Q4 onwards** | **Project End Date:** |
| **Review Date 1:**  | **Review Date 2:** |
| **Review Date 3:** | **Review Date 4:** |
| **Key Milestone Date including any additional reviews:** (This forms the basis for the plan so use a timescale and record the major milestones. **NB. In non-recurrent funding request please state the date by which non-recurrent funds will be used.)****Detailed milestones etc will be developed once the allocation is confirmed. It is expected that some of the funding will used in the next financial year.** |
| **FINANCIAL APPRAISAL: Please see Excel Spread Sheet for financials** |
| **Funding from Transformation Fund** | **Gross (total) cost to deliver the scheme** | **Recurrent****savings** **(Based on reduction in admission)** | **Net savings** (Total cost less total savings) | **Is there a need for non-recurrent set up costs? If so, how much?** | **Will savings be recurrent or non-recurrent?** | **Target year to realise savings** |
| £512k Includes non recurrent set up costs of £95k |  | Assuming 2%redn£1089k | £577k yr 1 but£672k recurrently | £95k  | recurrent | 2013/14 |
| £512k Includes non recurrent set up costs of £95k |  | Assuming 5%redn£2,723k | £2,222k yr 1 but£2,317 recurrently | £95k  | recurrent | 2013/14 |
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|  |  |  |  |  |  |  |
| **Activity Implications** **(-/+)** | **Provider** | **Year of implication** | **Impact** |
| -597 (Assuming 2% reduction) | Pan Lancashire | 2013/14 |  |
| -1493 (Assuming 5% reduction) | Pan Lancashire | 2013/14 |  |
|  |  |  |  |
| **Alternative options:** (Have any alternatives been considered? Can this be done another way?)Alternative options considered are as follows;1. Do nothing
2. Alcohol liaison service including with IBA in secondary care with training health professionals on IBA (cost and benefits above)
3. Alcohol liaison service with IBA in secondary care plus IBA in primary care for 50% of patients in most deprived practices in Central, East, BwD, North and Blackpool (Add extra costs £1,785,000)
4. Alcohol Liaison service including IBA in primary care for 25% of patients in most deprived practices in Central, East, BwD, North and Blackpool (Add extra cost of £882,000)

It is assumed that the non recurrent funding will be available for at least 12 months from the onset of this project. |
| **IMPLICATIONS and CONSTRAINTS:**  |
| **Interfaces:** (Which other services does this relate to: internal and/or external? What impact will this have on them?)The key interfaces for this project are as follows; **Internal Interfaces*** Implementation of this service will need local clinical leadership.
* It will lead to increased identification of alcohol misuse in patients attending the hospitals

 **External Interfaces*** Existing alcohol service providers including community services to take account of the place of HALS within comprehensive alcohol care pathways.
* Training conducted will also help deliver better quality alcohol misuse identification and brief advice that will be done as part of NHS Health Checks in subsequent months.
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| **Interdependencies:** (Identify where project progress or successful delivery is dependent on other factors external to the project, or vice-versa)The key interdependencies that are identified as affecting progress of implementing the project, successful delivery of the project or external factors required for successful delivery are as follows; **Factors affecting implementation progress*** Inability to recruit due to lack of appropriately skilled workforce (for HALS).

 **Factors impeding successful delivery*** Agreeing a consistent dataset by which to monitor the impact of the intervention so we know the numbers of admissions avoided and length of stays reduced so this can be equated to financial savings.
* Inflexibility of acute contracts so that any financial savings achieved cannot be released.
* Capacity within the emerging local public health services to sustain the input required to develop and deliver against the project.
* 3 month delivery period too short to effectively set up service, embed and deliver reductions in hospital admissions for HALS and demonstrate impact for IBA
* Lack of sustainable funding

 **External factors required for successful delivery** * Alcohol service provider engagement and buy-in to consider this non recurrent funding in the context of the comprehensive alcohol care pathway (for both IBA and HALS).
* Capacity in community alcohol service providers to effectively manage patients diverted from hospital admission or whose length of stay is appropriately reduced (for HALS).
* Embed HALS as part of multi-agency hospital team with strong links to social work and community substance misuse services
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| **Assumptions: (**State any assumptions made in making the Business Case, even if they seem obvious)**It is recommended that a detailed hospital level alcohol related activity is analysed to understand the impact of reducing NI39 admissions and validate the modelling done with SRFT and WWHT data.**The following assumptions have been made in developing the business case;1. Salford Royal NHS Foundation Trust and Royal Bolton Hospital NHS Foundation Trust outcome data has been used to underpin assumptions for modelling impact for the HALS element of the business case
2. There is an assumption that the average cost of an alcohol related admission is the same in Lancashire as documented nationally
3. There is an assumption that hospital coding practices will remain consistent
4. There is a presumption that the definition of alcohol related hospital admissions will remain consistent
5. Financial modelling relating to use of figures drawn from NHS Evidence apply
6. There is an assumption that secondary care contracting is able to utilise savings associated with this scheme to sustain the model
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| **Risks:** (Outline significant risks identified – stating if they relate to proceeding or not proceeding)* The business case does not take account of local service models and provision and as such does not achieve maximum impact from use of the potential resource.
* This risk would inform the detail of how the business case could best proceed.
* It is not possible to replicate a single model seen elsewhere to Lancashire that would deliver an agreed percentage reduction in the rate of alcohol related hospital admissions. There is therefore no guarantee that a 1% reduction will be achieved
* Local changes in recording can have significant impacts on the rate of alcohol related hospital admissions documented. This could affect performance monitoring of HALS
* Failure to sustain this approach beyond the 12 months identified will result in failure to deliver the identified % reductions in alcohol related hospital admissions
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| **ADDITIONAL CONSIDERATIONS:** |
| **Workforce:** (To include consideration of required capability (knowledge, skills & experience) as well as capacity – also training/development needs etc, for delivery of change as well as ongoing post-change implications)Providers Trusts need to identify the workforce to be trained and delivering the alcohol liaison service. |
| **Estates/Infrastructure:** (Consider buildings/transport , IT etc) |
| **Quality:** (Including legal implications such as NICE guidelines, specifications, standards, indicators/targets, QIPP/CQUIN links etc) |
| **PROJECT BUSINESS CASE SUMMARY:** |
| **Points in favour of this project proceeding:** | **Arguments against this project:** |
| **AGREEMENT TO SUBMIT TO RESOURCES SUB-GROUP FOR APPROVAL:** |
| *NAME* | *SIGNATURE* | *DATE* |
| **Project Senior Lead:** |  |  |
| **Project Manager:** |  |  |
| **Project Clinical Lead:** |  |  |
| **Project Lead Accountant:** |  |  |
| RESOURCES SUB-GROUP AGREEMENT TO PROCEED: |
| **Resources Sub-group Chair Agreement Received:** **YES/NO** | *SIGNATURE* | *DATE* |
| **If no please state reason** |

**COMPLETED FORM TO BE RETURNED TO**

**ANDREA TRAFFORD, PROJECT OFFICE, JUBILEE HOUSE**

1. Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care (2012): NHS Evidence [↑](#endnote-ref-1)
2. Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care (2012): NHS Evidence

**Annex 1: Existing Hospital Alcohol Liaison Services in Lancashire**

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| **Trust** | **Hospital(s)** | **Current arrangements for Hospital Alcohol Liaison**  |
| Blackpool Teaching Hospitals NHS Foundation Trust | Blackpool Victoria Hospital  | Hospital Alcohol Liaison Service in place, 4 hospital nurses based in BVH Gastro working across hospital. 1.6 in reach workers from Horizon linking patients to community services. Volunteer Health Mentors working across hospitals providing signposting and basic information. IBA staff training available regularly and built into some JDs. Anticipate need for 1 or 2 additional nurses but would envisage this to be via N Lancs funding. |
| East Lancashire Hospitals NHS Trust | Royal Blackburn Hospital  | HALS in place. Need to extend the hours and presence in urgent care centre |
| Burnley General Hospital | No alcohol liaison service |
| Lancashire Teaching Hospitals NHS Foundation Trust | Royal Preston Hospital  | No hospital based alcohol liaison service in place. Community substance misuse service ‘Discover’ commissioned to deliver an in reach model. IBA being delivered by hospital staff to adult admissions as per quality component of contract |
| Chorley and South Ribble Hospital  | As above |
| Southport and Ormskirk Hospital NHS Trust | Southport and Formby District General Hospital | Business case being developed with NHS Sefton and Southport and Ormskirk Hospital NHS Trust to develop Hospital Alcohol Liaison Service although no funding source identified for central Lancashire component of business case. Community substance misuse service ‘Discover’ commissioned to deliver an in reach model for central Lancashire patients only.  |
| Ormskirk and District General Hospital | As above |
| University Hospitals Of Morecambe Bay NHS Foundation Trust | Royal Lancaster Infirmary | Business case and service specification has been agreed by Lancaster, Wyre and Garstang CCG (as was) and the Urgent Care Network. Some recurrent funding has been identified internally but model is dependant on engagement from UHMBT to support a service redesign approach and resource shift in order to complement the recurrent PCT investment. Ongoing discussions with UHMBT regarding this approach have not yet realised an implementation plan. The non-recurrent funding can be utilised to support the proposed model by providing resource to train potential ALN staff and UHMBT medics. |
| Furness General Hospital | N/A |

**Appendix 2: Projected reduction in admissions and savings. This is for illustration purposes only.**

**Appendix 3 – Projected trend and impact of reducing alcohol related admissions from 2 – 5%**

 [↑](#endnote-ref-2)