


Lancashire Transformation Fund Business Case	
Name of proposed project: Hospital Alcohol Liaison Services (HALS)	
Business Case developed by: Andrew Ascroft Public Health Associate Child Public Health & Risk Taking Behaviours Team, NHS Central Lancashire In consultation with local alcohol leads; Steve Owen – NHS East Lancashire Vicky Putt – NHS North Lancashire Helen Lowey – NHS Blackburn with Darwen Steve Morton – NHS Blackpool Stephen Boydell – Public Health Intelligence, NHS Central Lancashire	Date: 30 th 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) <ol style="list-style-type: none"> 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 liaison 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

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>

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. 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 multi-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)ⁱⁱ. 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)

Which element of QIPP does this scheme relate to?			✓			
Quality	✓	Productivity				
Innovation		Prevention	✓			
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 be 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
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.

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

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
- 7.

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

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:

<u>NAME</u>	<u>SIGNATURE</u>	<u>DATE</u>
Project Senior Lead:		
Project Manager:		
Project Clinical Lead:		
Project Lead Accountant:		

RESOURCES SUB-GROUP AGREEMENT TO PROCEED:

	<u>SIGNATURE</u>	<u>DATE</u>
Resources Sub-group Chair Agreement Received: YES/NO		

If no please state reason

**COMPLETED FORM TO BE RETURNED TO
ANDREA TRAFFORD, PROJECT OFFICE, JUBILEE HOUSE**

ⁱ Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care (2012): NHS Evidence

ⁱⁱ 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

Trust	Hospital(s)	Current arrangements for Hospital Alcohol Liaison
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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.

Lancashire-14 reduction in number of hospital admissions and subsequent cost saving estimate													
Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	46139	45277	862	£1,572,560	44846	1293	£2,358,840	44415	1724	£3,145,120	43984	2155	£3,931,400
2013/14	49171	46441	2730	£4,979,326	45102	4069	£7,421,812	43781	5391	£9,832,846	42476	6695	£12,212,430
2014/15	52203	46519	5685	£10,368,907	43824	8379	£15,283,451	41226	10977	£20,021,829	38724	13480	£24,586,873
2015/16	55235	45499	9736	£17,759,119	41111	14125	£25,763,347	37025	18211	£33,216,202	33228	22007	£40,141,251

Central Lancashire PCT reduction in number of hospital admissions and subsequent cost saving estimate													
Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	14560	14286	274	£499,252	14149	411	£748,878	14012	547	£998,504	13875	684	£1,248,129
2013/14	15434	14572	862	£1,571,528	14150	1284	£2,342,315	13732	1701	£3,103,116	13321	2113	£3,853,933
2014/15	16308	14523	1785	£3,255,307	13677	2630	£4,797,764	12862	3446	£6,284,621	12077	4231	£7,716,777
2015/16	17182	14140	3042	£5,548,995	12769	4413	£8,048,635	11494	5688	£10,375,194	10309	6873	£12,536,113

North Lancashire PCT reduction in number of hospital admissions and subsequent cost saving estimate													
Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	8919	8752	167	£304,703	8668	251	£457,055	8585	334	£609,406	8501	418	£761,758
2013/14	9485	8957	528	£962,567	8698	787	£1,434,709	8443	1042	£1,900,757	8191	1294	£2,360,712
2014/15	10051	8954	1097	£2,000,288	8435	1616	£2,948,253	7934	2117	£3,862,162	7451	2600	£4,742,565
2015/16	10617	8742	1875	£3,419,570	7898	2720	£4,960,481	7111	3506	£6,395,030	6380	4237	£7,727,774

East Lancashire PCT reduction in number of hospital admissions and subsequent cost saving estimate													
Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	12292	12062	230	£419,444	11947	345	£629,166	11832	460	£838,888	11717	575	£1,048,610
2013/14	13087	12359	727	£1,326,624	12003	1084	£1,977,353	11651	1436	£2,619,693	11303	1784	£3,253,645
2014/15	13881	12368	1513	£2,759,777	11651	2230	£4,067,753	10960	2921	£5,328,794	10294	3588	£6,543,655
2015/16	14676	12087	2589	£4,722,487	10920	3756	£6,850,745	9833	4842	£8,832,253	8824	5852	£10,673,290

Blackpool PCT reduction in number of hospital admissions and subsequent cost saving estimate													
Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	5281	5183	98	£178,688	5134	147	£268,032	5085	196	£357,376	5036	245	£446,720
2013/14	5663	5350	312	£569,746	5197	466	£849,258	5046	617	£1,125,196	4897	766	£1,397,561
2014/15	6045	5391	654	£1,193,766	5080	965	£1,759,771	4781	1264	£2,305,618	4493	1552	£2,831,630
2015/16	6427	5300	1127	£2,055,867	4792	1635	£2,983,048	4318	2109	£3,846,742	3878	2549	£4,649,646

Blackburn with Darwen PCT reduction in number of hospital admissions and subsequent cost saving estimate													
Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	5086	4992	93	£170,514	4945	140	£255,771	4899	187	£341,028	4852	234	£426,285
2013/14	5497	5196	301	£548,538	5049	448	£817,692	4903	594	£1,083,435	4759	738	£1,345,768
2014/15	5909	5274	635	£1,158,289	4972	936	£1,707,712	4682	1227	£2,237,728	4402	1507	£2,748,647
2015/16	6320	5219	1101	£2,008,469	4722	1598	£2,914,980	4259	2061	£3,759,886	3828	2492	£4,545,782

Based on average cost per alcohol related admission of (from business case):
£1,824

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

