HOW DO NHS GENERAL HOSPITALS IN ENGLAND DEAL WITH PATIENTS WITH ALCOHOL-RELATED PROBLEMS? A QUESTIONNAIRE SURVEY

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Abstract — Aims: Alcohol-related disease represents a major burden on hospitals. However, it is unclear whether hospitals have developed the necessary expertise and guidelines to deal with this burden. The aim of this survey was to determine what measures general hospital NHS Trusts in England had in place to deal with alcohol-related problems, including the employment of dedicated alcohol specialist nurses. Methods: Two postal surveys of all NHS general hospital Trusts in England, the first in 2000 (n = 138; 54% response rate) and the second in 2003 after the publication of the Royal College of Physicians (RCP) report on alcohol in secondary care (n = 164; 75% response rate). Results: Between the two surveys, there was a significant increase (P = 0.005) in the number of dedicated alcohol nurses employed by general hospital trusts; however, the numbers remain low (n = 21). Additionally, the availability of prescribing guidelines for the management of alcohol withdrawal increased significantly (P = 0.0001). Conclusions: The survey indicates that most general hospitals do not have appropriate services in place to deal with such patients. Although there is a need and willingness to develop alcohol services in general hospitals, which is one of the key recommendations of the RCP report, the lack of funding is going to act as a major barrier.

INTRODUCTION

Alcohol misuse is common in the UK; the consequences represent an enormous drain on the economy (Strategy Unit, 2003), and are an ever-increasing burden on general hospitals (Pirmohamed et al., 2000). It is estimated that alcohol costs the NHS £1.6 billion per year, 32% of which is incurred in Accident and Emergency Departments, and a further 32% is incurred on hospital in-patient episodes (Strategy Unit, 2003). However, there is minimal investment in preventative approaches, particularly within general hospital settings. In recognition of this, a recent report from the Royal College of Physicians put forward a number of recommendations in order to address these problems (Royal College of Physicians, 2001). Prominent amongst these recommendations was the employment of a specialist alcohol worker within a general hospital setting. The concept of such a role for specialist nurses in secondary care is supported by the Medical Committee of Alcohol Concern, The Faculty of Accident and Emergency Medicine, and the Medical Council on Alcohol (Alcohol Concern, 1999).

Patients attending hospital with alcohol-related problems fall into two broad categories: (i) those with less severe drinking problems who may be amenable to brief interventions (Heather, 1996, 2002); and (ii) patients with features of alcohol dependence, requiring detoxification and ongoing treatment. Appropriate management of both types of patients in secondary care is important. For instance, screening for alcohol-related problems has been shown to be effective in identifying opportunities for alcohol-specific interventions (Wright et al., 1998; Hadida et al., 2001; Heather, 2002), including those administered by alcohol specialist nurses (Leslie and Learmonth, 1994; McManus et al., 2003). In alcohol-dependent patients, early detection improves patient outcomes (Saizt et al., 1994; Foy et al., 1997), and alcohol specialist nurses are well placed to provide advice on detoxification, and to optimize medical management through providing ongoing support, and information for referral for specialist alcohol treatment (Sander, 1997; Hillman et al., 2001).

In order to determine whether NHS hospitals are equipped to deal with patients with alcohol-related problems, we have undertaken two surveys: the first was in 2000, while the second was in 2003 after the publication of the Royal College of Physicians report (Royal College of Physicians, 2001). The aims of the survey were to determine the number of general hospitals that employed a dedicated alcohol worker, and what policies they had in place for the treatment and referral of patients with alcohol-related problems.

METHODS

Survey design

The survey was conducted in two phases, the first in 2000 (termed phase 1), and the second in 2003 (phase 2). On both occasions, the questionnaire was sent to the Chief Executive in each NHS hospital trust in England. In 2000, a list of 256 general hospital trusts was obtained from the Department of Health in London, whereas in 2003, the list comprised 209 general hospital trusts. The lower number of hospital trusts in 2003 when compared with 2000 reflects some hospital closures and mergers over the 3-year period.

Procedure

The phase 1 questionnaire focussed on the availability of specialist nurse support, the use of voluntary agencies, and the availability of guidelines for medical management of patients admitted with alcohol withdrawal (Fig. 1). In phase 2, the questionnaire was amended to determine whether the NHS Trusts were aware of the Royal College of Physicians report on alcohol (Royal College of Physicians, 2001).
Data analysis

Data for each survey are presented descriptively. However, the differences between the two surveys have been analysed by the Z-test with 95% CI calculated for the differences between the means. A $P \leq 0.05$ was considered to be statistically significant. All statistical analyses were performed using StatsDirect statistical software package (Sale, Cheshire, UK).

RESULTS

The overall response rate in phase 1 was 54% ($n = 138$ NHS Trusts) and 78% ($n = 164$) in phase 2. Of the 164 responses in phase 2, 110 (67%) stated that they were aware of the report from the Royal College of Physicians (2001).

The results of the two phases are summarized in Table 1. Only six hospitals employed alcohol specialist nurses in
Table 1. Responses from the surveys in 2000 (phase 1) and 2003 (phase 2)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Phase 1 responses</th>
<th>Phase 2 responses</th>
<th>Z-test (P value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of alcohol nurses employed</td>
<td>6 (4.3%)</td>
<td>21 (12.8%)</td>
<td>−2.6 (0.009)</td>
</tr>
<tr>
<td>Nurses employed by psychiatry</td>
<td>3 (2.1%)</td>
<td>8 (4.8%)</td>
<td>−1.2 (NS)</td>
</tr>
<tr>
<td>Nurses employed by medical/A&amp;E directorate</td>
<td>3 (2.1%)</td>
<td>13 (7.9%)</td>
<td>−2.2 (0.02)</td>
</tr>
<tr>
<td>Hospitals indicating they would benefit from a dedicated alcohol worker</td>
<td>70 (50.7%)</td>
<td>91 (55.4%)</td>
<td>−0.8 (NS)</td>
</tr>
<tr>
<td>Hospitals intending to employ a dedicated alcohol worker</td>
<td>4 (2.8%)</td>
<td>30 (18.2%)</td>
<td>−4.2 (0.0001)</td>
</tr>
<tr>
<td>Voluntary agencies visit the hospital</td>
<td>56 (40.5%)</td>
<td>53 (32.3%)</td>
<td>1.5 (NS)</td>
</tr>
<tr>
<td>Hospital has access to home detoxification</td>
<td>54 (39.1%)</td>
<td>50 (30.4%)</td>
<td>1.6 (0.1)</td>
</tr>
<tr>
<td>Hospital has prescribing guidelines for detoxification</td>
<td>42 (30.4%)</td>
<td>98 (59.7%)</td>
<td>−5.1 (0.0001)</td>
</tr>
<tr>
<td>Hospital has a care pathway for detoxification</td>
<td>19 (13.7%)</td>
<td>29 (17.6%)</td>
<td>−0.9 (NS)</td>
</tr>
<tr>
<td>Hospital has guidelines for screening and detection of alcohol-related problems</td>
<td>23 (16.6%)</td>
<td>32 (19.5%)</td>
<td>−0.6 (NS)</td>
</tr>
<tr>
<td>Hospital has a nurse training programme for care and management of alcohol-related problems</td>
<td>14 (10.1%)</td>
<td>22 (13.4%)</td>
<td>−0.9 (NS)</td>
</tr>
</tbody>
</table>

The response rate in phase 1 was 53.9% (n = 138) and 78.4% (n = 164) in phase 2. NS, not significant.

2000: four (3%) were full-time, and two (1.4%) were part-time (2 and 24 h per week). Qualifications held by the nurses varied: three were registered mental nurses (RMN), one was a general nurse, whereas two had dual qualifications. In 2003, the number of hospitals employing a dedicated alcohol specialist nurse had increased significantly ($P = 0.005$; 95% CI for the difference −0.1 to 0) to 21 (12.8%). Of these, 4 (19%) were part-time, working 8, 12, 18 and 23 h per week. Seventeen posts were full-time; however, five had other roles and responsibilities, four having responsibility for illicit drugs and one working with liver patients. The percentage of workers employed by Accident and Emergency Departments compared with Psychiatry was significantly greater in the 2003 survey ($P = 0.01$; 95% CI for the difference −0.1 to 0). The majority of hospitals in both phase 1 (90%) and phase 2 (87%) had no training program for nurses.

The percentage of hospitals that indicated that they would benefit from a dedicated alcohol worker did not change between phases 1 and 2 (51 vs 55%). Interestingly, however, there was a significant ($P = 0.001$; 95% CI for the difference −0.2 to 0) increase in the number of hospitals that were intending to employ a dedicated alcohol worker between 2000 and 2003. There was also a significant ($P = 0.005$; 95% CI for the difference −0.3 to −0.1) increase in the number of hospitals that had developed prescribing guidelines for detoxification. Conversely, the percentage of hospitals that had access to home detoxification was greater in 2000 than in 2003, although this failed to achieve significance.

The other aspects of management of patients with alcohol-related problems, such as availability of care pathways, guidelines for screening for alcohol-related problems, and multidisciplinary working with voluntary agencies did not change between 2000 and 2003 and was disappointingly low.

**DISCUSSION**

The Royal College of Physicians recommended employment of a dedicated alcohol specialist worker within each NHS Trust to optimize the management of patients presenting to hospitals with alcohol-related problems (Royal College of Physicians, 2001). Our surveys in 2000 and 2003 show that most general hospitals do not have such services in place. This is especially worrying given that the overall impact of alcohol on health and social disorder is enormous, and the burden of alcohol on the NHS is increasing year on year (Strategy Unit, 2003).

There does seem to be a general increase in awareness of alcohol-related issues in the general hospital setting; 67% of hospital Trusts indicated that they were aware of the Royal College of Physicians report. Encouragingly, the number of hospitals intending to employ a dedicated alcohol worker had risen significantly in the 3 years between the two surveys. Whether this is the result of the Royal College of Physicians report is difficult to say, but importantly, can be taken to indicate that beliefs and attitudes regarding the value of interventions for alcohol-related problems in acute care may be changing. However, there is a long way to go. Although there had been a significant increase in the number of dedicated alcohol nurse specialists in the hospitals surveyed between 2000 and 2003, only 12.8% of hospitals are currently employing such an individual. Such workers are highly effective in different health care settings (Ockene et al., 1999).

These nurses can adopt a multidimensional role ranging from optimization of medical management, screening for alcohol-related problems, and training other health-care staff, who generally lack confidence in dealing with these patients (Brown et al., 1995). However, a minority of the hospitals had nurse training programmes, which is also a crucial element in improving the response of all healthcare professionals to alcohol abusing patients (Gerace et al., 1995). Alcohol specialist nurses may represent a highly cost-effective mechanism for achieving the targets set out in the ‘Choosing Health White Paper’ from the Department of Health (2004).

Only a minority of the hospitals had guidelines for the screening and detection of alcohol-related problems. This is unfortunate as screening is the key to identifying the patients most in need of interventions, and ensuring that interventions are the most appropriate to the patients needs...
(Conigrave et al., 1991; Holder et al., 2000; Hillman et al., 2001). Of concern in both surveys was the reported lack of care pathways for the pharmacological and non-pharmacological management of patients with alcohol withdrawal (13.7 and 17.6%, respectively). Such care pathways would be ideal, but in the absence of such guidelines, it would be important to have clear prescribing advice in the hospital formulary on the pharmacological management of alcohol withdrawal. However, this was also lacking, but encouragingly, there was a significant increase between the two surveys in the availability of such advice. We did not inspect the quality of the advice and cannot therefore comment on its appropriateness. Nevertheless, clear guidelines regarding management of these patients are important and may reduce avoidable complications. They may also have added benefits in decreasing other complications and the length of stay in hospital (Foy et al., 1988; Wartenberg et al., 1990).

In summary, this survey has shown that there has been an increase in the number of alcohol specialist nurses in general hospitals, and that hospitals are positive about employing such individuals. Clearly, the ability to fulfill this will depend on the availability of resources. To this end, significant investment is required, which unfortunately has not followed on from the recent publication of the Alcohol Harm Reduction Strategy for England (Department of Health, 2004).

Acknowledgement — We thank all the NHS Hospitals Trusts in the UK that responded to these surveys.

REFERENCES


