NORTHUMBERLAND COUNTY COUNCIL

CARE AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

Notes of the Alcohol Consumption in Northumberland Task and Finish Group Meeting held in the Chairman's Dining Room, County Hall, Morpeth at 12:00 pm on Thursday 16 February 2017

PRESENT

Councillor A Wallace (In the Chair)

COUNCILLORS

Hunter, EI

OFFICERS

Allen, DP
Kelly, C
Robinson, L

ALSO PRESENT

Naylor, F
Sample, L

1 Apologies and Chairman's Remarks

Apologies for absence were received from Councillors PAM Dale and K Nisbet.

Councillor Wallace welcomed Dr Frances Naylor (GP/CCG) and Linda Sample (Alcohol Specialist Nurse, NHCT) to the Meeting.

2 Disclosure of Members' Interests

There were no declarations of interest.

3 Notes of Previous Meeting

The Notes of the Meeting held on 19 January 2017, having been circulated, were confirmed as a correct record.

4 Background Papers

It was AGREED that reference would be made to the background papers:

- PHE: Local Health and Care Planning - Menu of Preventative Interventions (Appendix 1)
- PHE link below (Appendix 2 - hard copies to circulate)

PHE Guidance: Health matters - harmful drinking and alcohol dependence

- Report to Health & Well-being Board 10 December 2015: The Impact of Alcohol Consumption in Northumberland (Appendix 3),

as appropriate during discussion.

5 NHCT Alcohol Care Team/Alcohol Development Group

5.1 Linda Sample gave a presentation on the work of Northumbria Healthcare's Alcohol Care Team, whose aim was to 'reduce alcohol related harm, injury and illness, halt the rise in hospital admissions for alcohol specific conditions and associated premature death' (copies of the slides were tabled).

During discussion with Frances Naylor and Linda Sample, the following points were noted:

(i) The Alcohol Specialist Nurse role at The Northumbria hospital, Cramlington, included:

- devising clinical pathway
- maintaining contact for continuity
- providing a single point of contact for patients and staff who required support around alcohol use
- consultation (family support)
- assessing and coordinating elective inpatient detoxification
- arrange safeguarding meetings for support of repeat clients
- ad hoc training.

(ii) Brief Intervention Workers undertook opportunistic screening 'front of house', using the AUDIT (Alcohol Users Disorders Identification Test - 10 questions developed by the World Health Organisation) screening tool. Linda

Sample tabled copies of the AUDIT questionnaire/score sheet (copies in file).

(iii) Family Members often requested that the client remain as inpatient for a cure, however the decision must be the client's, with the desire and determination to make a full recovery as the starting point. Recovery started in the community, not the hospital. The referral criteria for the Elective Inpatient Alcohol Detoxification Pathway were:

- high risk of withdrawal seizures
- history of delirium tremens
- vulnerable adult (frail, with cognitive impairment)
- multiple co-morbidities
- lack of social support
- learning disabilities.

This service was currently offered at North Tyneside General Hospital, but with limited resources. At Wansbeck General Hospital, alcohol treatment was available through the gastroenterology service, which offered specialist clinics for patients with alcohol related problems.

A complication in the provision of such services was that clients might not know when they were ready to follow a full recovery plan, requiring more than one attempt. Families could also be referred for interventions.

(iv) The Northumberland Recovery Partnership (NRP) provided a dedicated service for anyone over the age of 18 experiencing problems with drugs and alcohol.

(v) The National Institute for Health and Care Excellence (NICE) measured the cost-effectiveness of alcohol brief interventions. Brief interventions often revealed a number of related health issues, all of which then required action.

(vi) Additional support to boost resources for brief interventions would be considered by primary care providers through the Northumberland Local Medical Committee, however in this area as elsewhere, the shortage of financial resources was a problem.

(vii) The lack of consistent messages about alcohol was problematic and because of the requirement for self-referral, healthcare professionals did not receive feedback about which clients arrived for treatment. This tended to frustrate the efforts of the NRP.

(viii) The Alcohol Development Group, of which Dr Naylor and Linda Sample were members, acted as expert consultants/contacts for a range of services in

primary and secondary care, including the Drugs and Alcohol Steering Group (under the local authority), GPs (direct and through Northumberland Clinical Commissioning Group), AgeUK, the NRP etc., and Trust Management, clinical leads, A & E, Pharmacies, midwifery and the Mental Health Team.

(ix) Regarding public perception of alcohol risk, it was suggested that client guidelines could be better publicised. The public in general did not think of alcohol in terms of units and were therefore unaware when they were drinking above the lower risk guidelines, or did not regard lower risk guidelines as a problem. The association of alcohol dependence with a wide variety of other health conditions in addition to liver complaints was also generally unknown. An NHS form describing various alcoholic drinks measures graphically (from the alcohol AUDIT discussed earlier) was tabled as an example of material used to inform clients of alcohol risks.

(x) Members' considered the negative side of society's perceptions about alcohol dependence, leading to embarrassment and reluctance to seek help, particularly among older patients. It was noted that social media such as Facebook and Twitter, which provided communications at a remove from personal interactions, had been observed as a means of overcoming embarrassment when seeking information, particularly for younger people. It was also noted, however, that evidence consistently showed personalised counselling from trained staff to be considerably more effective than generic advice.

Outline figures presented to Members showed that in the period April 2016 to January 2017:

- a total of 5083 patients in NCHT had undergone opportunistic screening. These were single episodes (not repeats)
- 1790 cases had been undergone extended Brief Interventions (ie 35%)
- there had been 467 specialist referrals.

(xi) For families affected by alcohol related problems, a range of services, including Alcoholics Anonymous National Helpline, Women's Health Advice Centre, The Silver Line, SORTED, Macmillan Support Services, ESCAPE Family Support and NHS Talking Therapies, were available in addition to primary and secondary care.

(xii) Regarding Northumbria Healthcare's Alcohol Care Team itself, figures presented to illustrate cost benefits of the 7 day service were that:

- a 7-day service can save 2000 bed days, saving £536k through a cost

of £165k (that is, saving £3.85 from each £1 spent)

- an assertive outreach service reduced high impact users' average monthly admissions by 66 per cent, saving £556,500 through a cost of £300k (that is, saving £1.86 from each £1 spent).

5.2 Members had observed during discussions at the present and previous meetings that specialist services for adults misusing alcohol was different to support required for children and young people. It was agreed that, notwithstanding any suggested actions incidentally affecting children and young people arising from the current research, this project was concerned with the general population. Further work on the area of children and young people could be recommended to follow on as a separate project.

Further issues raised during discussion included:

- the impact of alcohol use on the workplace, where people used alcohol in an attempt to relieve the pressures and responsibilities of working life
- the need to recognise and communicate forcefully that alcohol was a toxin
- an individual becoming aware of drinking as a thing to hide from society could be regarded as an indicator of addiction, the problem having developed over an indeterminate period different for each individual, possibly traceable back to childhood and life experiences.
- seeking to introduce an element of compulsion as an impetus in the recovery process must be balanced against the illness itself (for example, possible toxic shock resulting from sudden withdrawal of alcohol) and recognition of the principle behind the therapy, that the route to recovery from addiction must be taken in small steps and be meaningful for the individual concerned.
- changing society's attitudes to drinking would be not be achieved in the short term, however attitudes to smoking had been influenced significantly by changes in the law.

5.3 In reaching agreement on recommendations arising from this project, Members noted a suggestion that part of the attitudinal shift away from alcohol as a cultural norm to more of a calculated risk would have to require the cooperation of the alcohol industry. Alcohol dependence needed to be recognised by everyone as a physical and mental illness, and higher taxes would not pay for care. The community at large needed to be better informed, with sufficient understanding of generally adopted terminology representing alcohol and its risks and effects to make informed decisions about responsible consumption. Creative use of the media would be an effective tool with which authorities could play their part in this process.

6 Recommendations

It was **AGREED** to recommend the following to the Care and Wellbeing Overview and Scrutiny Committee for onward referral as appropriate:

1 Provide leadership in the drive to encourage responsible drinking by deploying creative and multidisciplinary advertising techniques that enable the public to discern for themselves the truths about alcohol and to make informed decisions about its consumption

2 Embed routine and systematic alcohol screening and brief interventions across health and social care services and also recognise and explore the role that other services, eg criminal justice, can play in delivering alcohol screening and brief interventions

3 Note the conclusion of Public Health England that price controls such as a combination of sales tax and minimum unit pricing can be effective (following progress of the related draft Scottish legislation)

4 Recognise published support for pricing policies which address high strength, low cost alcohol, specifically white ciders that are more likely to be consumed by the vulnerable such as children and young people and dependent drinkers, for whom the local authority has a duty of care

5 Recognise the impact of the reduction in drink drive limits in Scotland, also that England has the second highest drink drive limit in Europe

6 Continue to invest in good quality community substance misuse services for those requiring specialist support

7 Call for a more robust system to regulate alcohol advertising to replace the alcohol industry self regulated scheme currently in place

8 Further work:

- issues concerning children and young people specifically

- consider using PHE Alcohol Learning Resources: CLeaR Self-Assessment Tool

https://www.alcohollearningcentre.org.uk/Topics/Browse/CLeaR/

to review leadership and governance and other issues related to Northumberland's strategic approach to alcohol harm reduction.

DPA/
2017-02-28