MEETING: Haringey Clinical Commissioning Group Governing Body Meeting

DATE: Thursday, 25 July 2013

TITLE: Annual Public Health Report - Alcohol-related harm in Haringey

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SUMMARY:
The purpose of this report is to:

- Update the Governing Body on key issues emerging in the 2013 Annual Public Health Report on alcohol-related harm;
- Provide an overview of some of the key findings from a recent analysis of alcohol-related hospital admissions in the borough.

SUPPORTING PAPERS:
Copies of the APHR and Haringey profile of alcohol-related hospital admissions can be accessed at www.haringey.gov.uk or www.haringeyccg.nhs.uk

RECOMMENDED ACTION:
The Governing Body is asked to ENDORSE the recommendations listed in section 8.

Objective(s) / Plans supported by this paper: Reducing alcohol-related harm and in particular alcohol-related hospital admissions is a priority under outcome 2 (reducing the life expectancy gap) in the Health and Wellbeing strategy and has been chosen as a target by the CGG.

Audit Trail: Data in this report has been provided by Public Health in Haringey and Islington’s’ Public Health intelligence team and the North West Public Health Observatory.

Patient & Public Involvement (PPI): None.

Equality Analysis: Harms caused by alcohol and alcohol-related hospital admissions are more prevalent in men and people living in more deprived parts of the borough.
**Risks:** The CCG may not meet its target of 2,523 alcohol-related hospital admissions.

**Resource Implications:** Services to reduce alcohol-related harm are commissioned from the public health grant. Rising rates of alcohol-related admissions impact on the CCG budget.
Alcohol-related harm in Haringey

1. **Introduction**

Alcohol misuse imposes a major preventable burden to health. Its costly economic and social effects are felt across all of Haringey’s public services and the community. Recent analysis has estimated that in Haringey the cost of hospital admissions where alcohol was an attributable factor was £7.5 million or £39.40 per resident during the financial year 2008/09\(^1\).

This report provides an overview of the Annual Public Health Report (APHR) ‘Is Haringey over the limit?’ and summarises some of the key trends in alcohol-related hospital admissions taken from a larger public health intelligence report on alcohol-related hospital admissions in Haringey. Full copies of both reports can be found at: [www.haringey.gov.uk](http://www.haringey.gov.uk) or [www.haringeyccg.nhs.uk](http://www.haringeyccg.nhs.uk).

The borough faces significant challenges in addressing the upward trend in alcohol-related hospital admissions and the wider health and social consequences of alcohol-related harm. This summary provides findings and recommendations that are relevant to primary care practitioners.

2. **Key issues**

- Men in Haringey have the highest death rate specifically due to alcohol in London
- Haringey’s directly standardised rates of alcohol-related admissions per 100,000 population are higher than England and London rates
- The male mortality rates for alcohol-related and alcohol-specific causes is higher than the London rate (19.2 and 10.7) and (49.5 and 34.2) respectively
- Men, older people and people living in more deprived parts of Haringey have higher standardised rates of alcohol-related hospital admissions
- Around 6% of all hospital admissions in the borough are alcohol-related which is the 6\(^{th}\) highest in London.

3. **The rise in alcohol-related hospital admissions**

Alcohol-related hospital admission rates are increasing nationally and in London. However, while rates in England have almost doubled since 2002/3, rates in Haringey almost tripled between 2002/3 and 2011/12 to a rate of 2,472 per 100,000 population. Haringey’s rate is now above the regional and England average.

The majority of these admissions are due to hypertensive disease (39%), mental behavioural disorders (20%) and cardiac arrhythmias (13%). However, 13% of the

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alcohol-specific admissions are due to alcoholic liver disease. Men and women have similar causes of alcohol-related admissions.

Clearly this places a significant burden on health services in Haringey and it is clear that if consumption of alcohol could be reduced then so would the associated harm.

4. Demographic analysis of alcohol-related admissions

Compared to the Haringey average, men and people living in the more deprived parts of the borough are more likely to be admitted to hospital with alcohol-related conditions.

Alcohol-related admissions are highest in people aged 55 and over (60%); this is likely in part to be due to the higher prevalence of long term conditions in older people and more generally the higher burden of disease in this group.

Alcohol-specific admissions are most prevalent in people aged 40-49.

Alcohol-related admissions are higher than expected (indirectly standardised ratio of observed to expected) in Black Caribbean, Black African, Black Other and ‘Other’ (a category that is likely to include Eastern European) ethnic categories. This may in part be explained by the higher prevalence of cardiovascular disease in African Caribbean populations.

Alcohol-specific admissions are higher than expected in White Irish, White British and ‘Other’ ethnic categories.

The numbers of admissions per GP Practice range from 5 to nearly 300. A third of people were readmitted to hospital two or more times, 80 people (1%) were admitted more than 11 times. 39% of alcohol-related admissions were at the North Middlesex Hospital and 25% were at the Whittington Hospital. A full breakdown of admissions by practice can be seen at Appendix 1.

5. What are public health doing to reduce alcohol-related harm

Tackling alcohol-related harm is a complex issue and requires a partnership approach across health, the local authority, the police, probation and voluntary sector. Public Health commissions a range of prevention and treatment interventions to tackle health and social harms arising from alcohol. Specifically in the health arena the following are commissioned:

- Identification and Brief Advice (IBA) (screening and brief intervention) in A&E and across the community

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2 Alcohol-related includes conditions that are wholly caused by alcohol such as alcohol poisoning and partially caused by alcohol such as cardiovascular disease.

3 Alcohol-specific admissions are conditions that are caused solely by alcohol e.g. alcohol liver disease

4 Note that this is a composite measure which does not denote numbers of people being admitted. One admission may consist of several partially related admissions by more than one individual. One individual may have more than one admission a year. More information about the methodology can be found in the Haringey alcohol related hospital admissions report 2011/12.
Online IBA via www.dontbottleitup.org.uk;

- Alcohol primary care “hubs” or satellites operating from local GP surgeries via which individuals can access Extended Brief Interventions (EBI)

- A Community Alcohol Nursing Team offering comprehensive assessment, pre and post detoxification 1:1 and groupwork, and community and in-patient detoxification

- An Alcohol Liaison Service, incorporating an Alcohol Liaison Nurse and a Hospital Link Worker post, who targets a specific cohort of alcohol-specific repeat attendees to bring admissions, attendances and ambulance call-outs down in this high activity group

- Residential rehabilitation

- Group work programmes (abstinence and non-abstinence based)

- Counselling services

- COSMIC, service for children and families affected by parent/carer substance misuse.

Apart from these targeted services public health are working with licensing to explore how we can better regulate the environment in which alcohol is sold through, for example, a ‘responsible retailer scheme for alcohol sales’. A new Environmental Health Officer post has been commissioned from the public health grant to work with licensing more broadly on alcohol, food and tobacco control.

6. How can GPs help reduce alcohol-related admissions?

The key to reducing admissions is reducing consumption before dependency and / or more harmful levels of drinking are established. One of the best evidence-based approaches for people who are drinking above the recommended levels but who are not dependent is Identification and Brief Advice (IBA). IBA involves screening using an evidence-based tool, such as the Alcohol Use Disorders Identification Test (AUDIT) and, where patients are drinking at risky levels, offering five minutes of short, structured advice.

There is a particularly strong evidence base for screening and brief interventions in primary care with over 56 randomised controlled trials demonstrating effectiveness. One in eight patients who are screened and receive brief advice will reduce their consumption to within recommended government drinking levels.

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Primary care presents many opportunities to identify alcohol problems and use AUDIT: patients should routinely be asked about their alcohol consumption during new registrations, health checks and specific disease clinics (e.g. hypertension, diabetes).

Brief intervention can be delivered in the standard consultation time slot of 5-10 minutes, and if appropriate referral can be made to one of our four alcohol primary care hub clinics and/or GPs can simply give out ‘Haringey Brief Advice leaflet’. Just asking the question can often be enough for a patient to change their drinking behaviour and ultimately GPs will save time and money.

‘DrinkCoach’ is another option for GPs to consider promoting to patients who are drinking at increasing or higher risk, but who are ambivalent about changing drinking patterns.

Since April alcohol ‘hubs’ have been commissioned (primary care strategy funding) across four GP surgeries where Extended Brief Interventions sessions can be accessed by patients scoring 16 or more on AUDIT. The host surgeries are Dukes, Tynemouth, Queenwood and Lawrence House. Details at Appendix 2.

7. Conclusion

While alcohol-related harm can affect all population groups, those in the most deprived parts of the borough experience the most impact, driving health inequalities.

GPs come into contact with many of these patients every day and can have ‘the conversation’ that may lead to reduced consumption and save money in the long run.

8. Next step and Recommendations

Public health will be attending each collaborative meeting over the next month to present some of these findings and explore how we can better respond to these issues. In addition a lunchtime event is being planned where practice public health profiles will be presented and there will be an opportunity to explore how we can better implement brief interventions within primary care.

The CCG Governing Body is asked to consider how we can engage more GPs in the delivery of IBA in primary care and specifically to encourage the following:

- The completion of alcohol screening using ‘AUDIT’ for new patient registrations as part of the alcohol DES and NHS Health Checks.

- Self help of patients by signposting patients to the online screening tool where patients can screen themselves, receive brief advice and access a range of follow-up options for alcohol misuse [www.dontbottleitup.org.uk](http://www.dontbottleitup.org.uk)

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7 For iOS Smartphone or tablet owners only
• The screening of existing patients that GP’s may have concerns about, using AUDIT

• If patient is identified as Increasing “hazardous” (AUDIT score 8-15), GP’s should offer brief advice and/or give a brief advice leaflet which can be accessed at www.haga.co.uk/tools/htm

• If patient is identified as Higher Risk “harmful” (AUDIT score 16-19), GP’s should offer brief advice and refer to one of the alcohol hubs (full details in appendix 3)

• If score 20+ (High Risk/possibly dependent,) GP’s should refer patient to HAGA using the referral form available at www.haga.co.uk/tools/htm, or advise the patient to attend Monday to Thursday between 10am and 1pm. **Note that training on Identification and Brief Advice can be arranged by contacting HAGA on 07917 423 664 or laura@haga.co.uk.**
Appendix 1

Alcohol related and alcohol-specific hospital admissions by GP practice

Numbers of alcohol-related admissions, Haringey’s registered population, 2011/12

The total number of alcohol-related and alcohol-specific admissions varies by GP practice (ranging from 5 to 228)

Note: this analysis relates to the number alcohol-related/specific admissions. Some people will have more than one admission within the year. Six practices were excluded due to disclosive numbers.

Source: SUS 2012
Appendix 2  Alcohol primary care hubs

Alcohol hub appointments are open to any location resident i.e. not just patients registered at the host surgery.

Any patient scoring 16 or more on AUDIT can be referred to the hubs.

Fax referral for directly to the surgery itself, call the surgery to book the patient and appointment, and let the patient know their appointment time.

The hubs are in the following locations:

1. **Duke’s Avenue Practice**, 1 Dukes Avenue, Muswell Hill, N10 2PS
   
   Tel: 020 8365 5866  Fax: 020 8883 0194
   
   Time slots: Every **Monday** at 5pm, 6pm, and 7pm

2. **Tynemouth Medical Practice**, Tynemouth Road, Tottenham, N15 4RH

   Tel: 020 8808 4904  Fax: 0844 773 746

   Time slots: Every **Tuesday** at 3:30pm, 4:30pm, 5:30pm, and 6:30pm

3. **Queenswood Medical Centre**, 151 Park Road, London, N8 8JD

   Tel: 020 3074 2402  Fax: 020 3074 2403/4

   Time slots: Every **Wednesday** at 5pm, 6pm, and 7pm

4. **Lawrence House Surgery**, 107 Philip Lane, Tottenham, N15 4JR

   Tel: 020 8801 6640  Fax: 020 8493 0954

   Time slots: Every **Thursday** at 4pm, 5pm, and 6pm