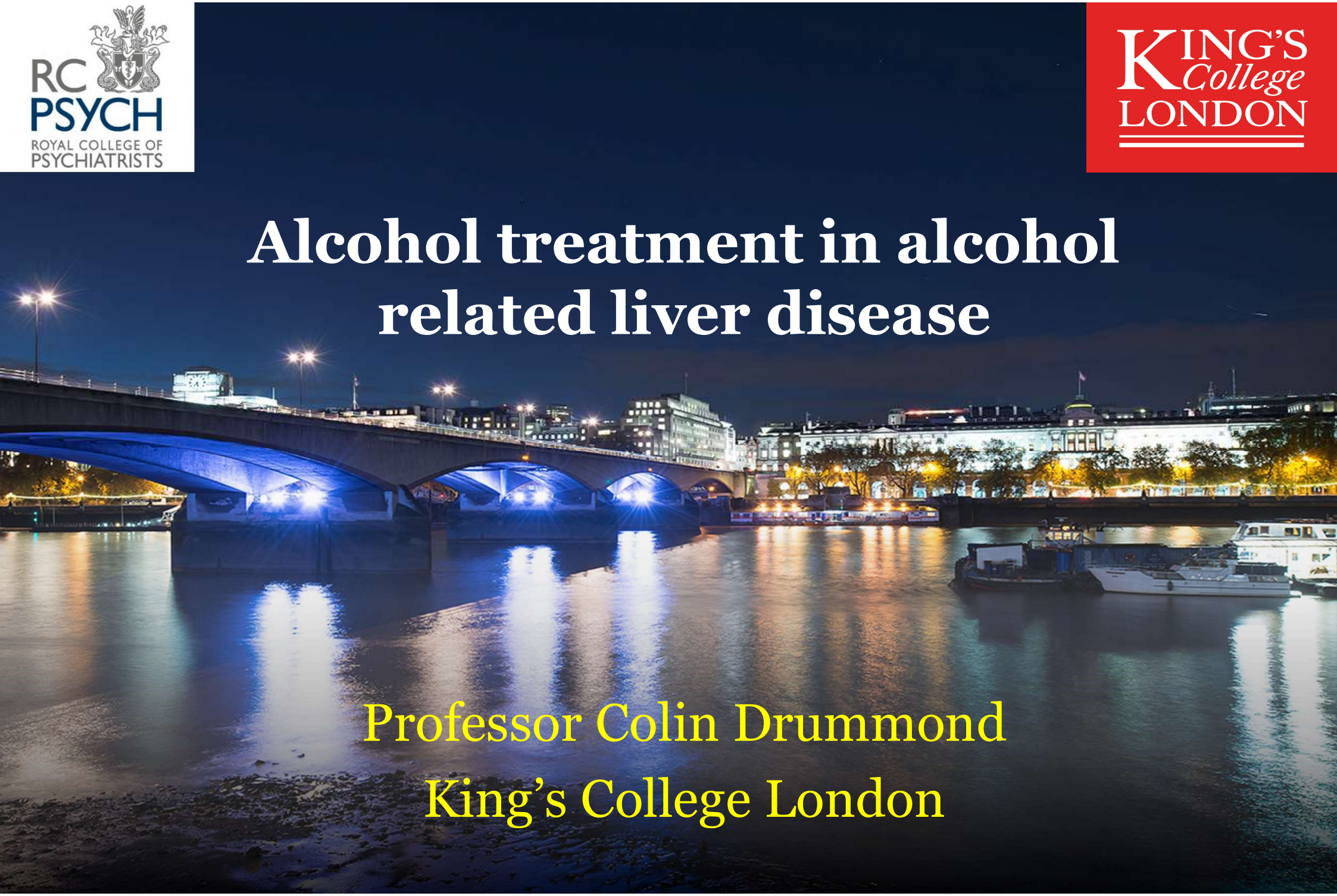
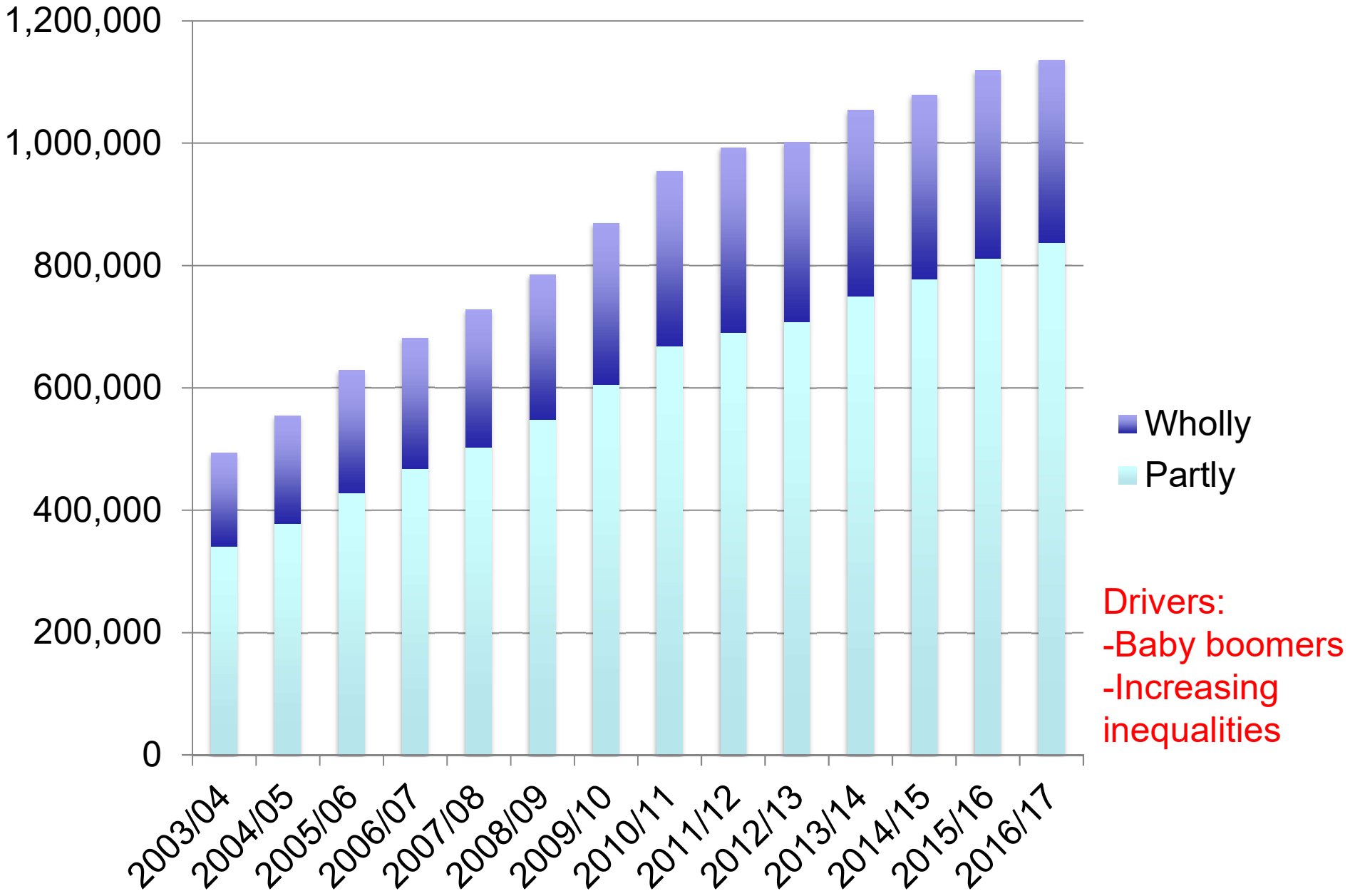
Alcohol treatment in alcohol related liver disease



Professor Colin Drummond
King's College London

Alcohol related hospital admissions England 2003-2017



Positive developments in ARLD

- Increase in number and scope of alcohol care teams in acute hospitals in England
- Will benefit ARLD patients as well as wider group of patients with alcohol related admissions
- National Alcohol CQUIN rolling out alcohol screening and brief intervention in all hospitals in England in 2018/19
- PHE ambition of 900,000 SBIs delivered per year and 60,000 alcohol dependence referrals to specialist treatment

But

- Cuts to public health budgets mean reduced access to community alcohol treatment
- How will 60,000 extra demand generated by CQUIN be met?
- Recently 19% fall in number with alcohol dependence accessing alcohol treatment
- England half the rate of alcohol treatment access compared to Scotland and Wales (Lancet Liver Commission, 2018)

Evidence base for alcohol treatment in ARLD

- Currently limited
- Systematic reviews by NICE CG115 and CG100 revealed very few studies specifically in ARLD populations
- Hence applicability of research in treatment seeking patients without ARLD unknown
- Most ARLD guidelines say “see relevant alcohol treatment guidelines”
- Could mean limited impact of alcohol care teams/interventions
- Could result in loss of interest/confidence in alcohol care for this patient group if impact is not evident following investment

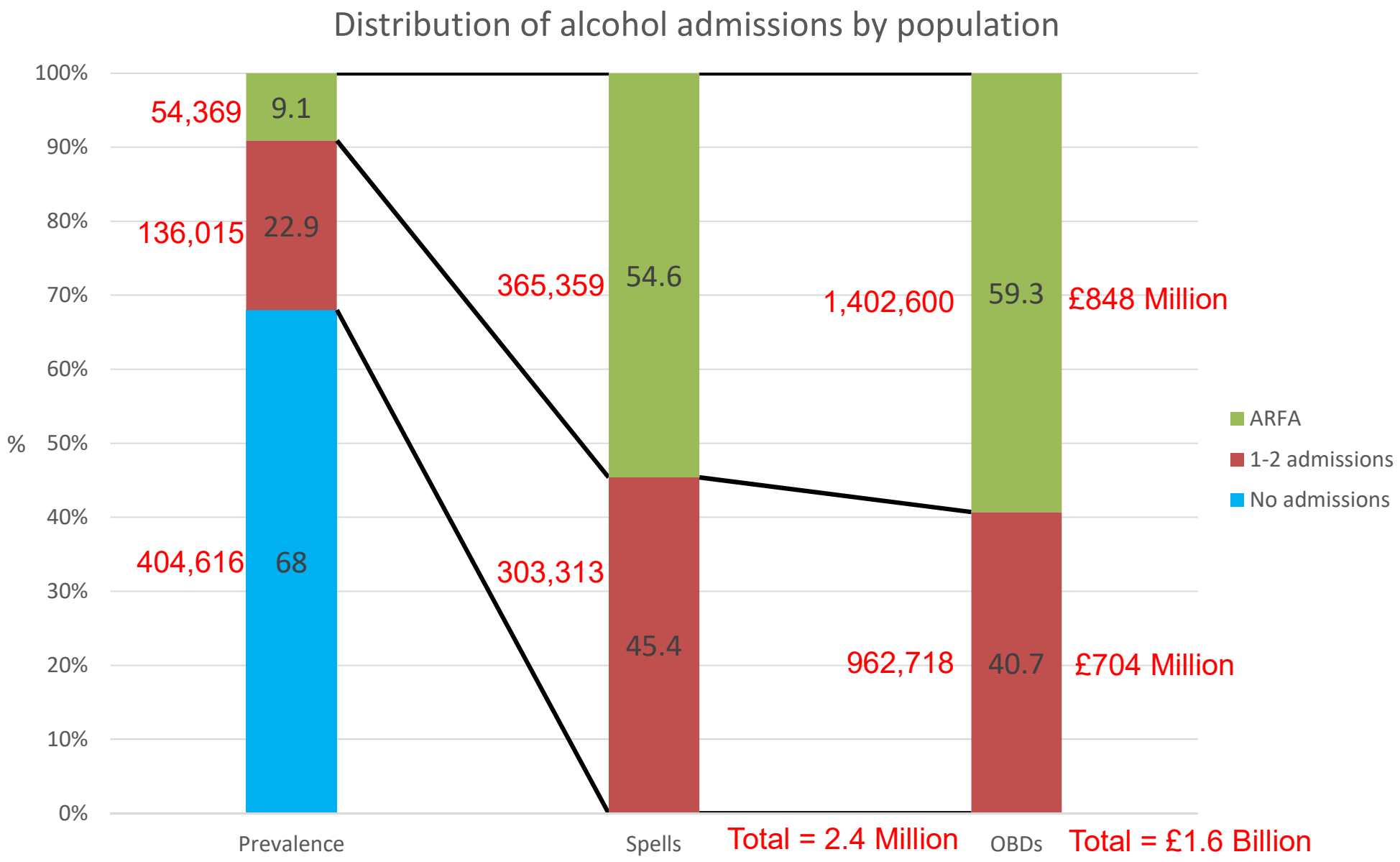
Opportunities

- James Lind alliance (funded by NIHR and BSG) prioritized alcohol treatment research in ARLD
- Current research collaborations and applications
  - Alcohol Assertive Outreach trial King's
  - HTA application for trial of psychosocial intervention in ARLD
  - Paul Richardson's meeting on pharma interventions for ARLD under BSG umbrella
  - Nick Sheron's POLEMMIC application

ALCOHOL RELATED FREQUENT ATTENDERS

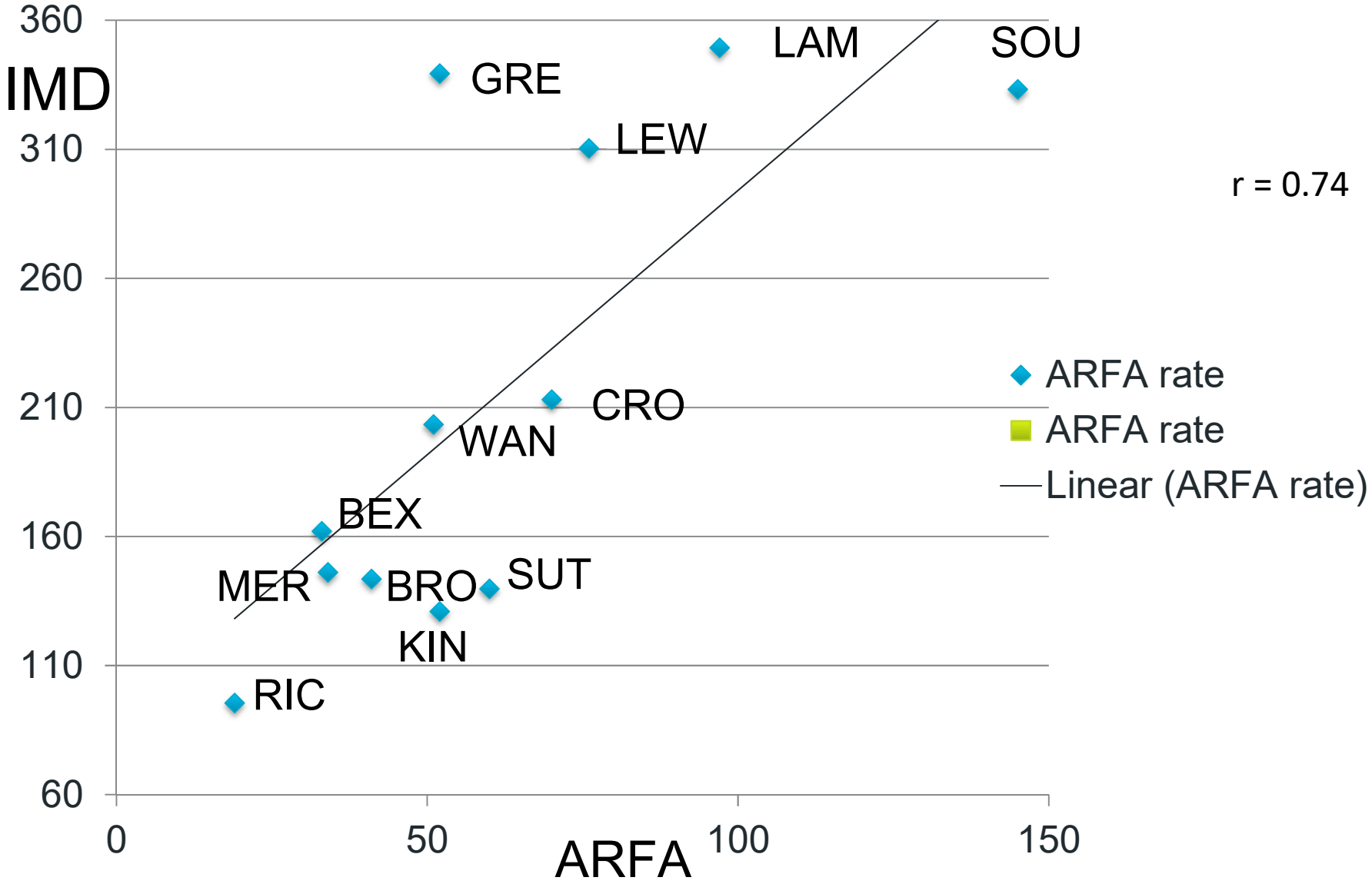
Alcohol Related Frequent Hospital Attenders

- Small number, high unplanned A&E attendances and admissions to acute and mental health care
- Priority to reduce readmissions – bulk of costs
- Many with severe alcohol dependence and complex mental/physical health and social care needs
- Difficult to engage with conventional addiction services
- Potential of assertive outreach (MRC ACTAD study)
- More costly intervention BUT potential cost impact


Distribution of alcohol admissions by population
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
%
54,369
9.1
136,015
22.9
404,616
68
365,359
54.6
303,313
45.4
1,402,600
59.3
£848 Million
962,718
40.7
£704 Million
ARFA
1-2 admissions
No admissions
Prevalence
Spells
OBDs
Total = 2.4 Million
Total = £1.6 Billion

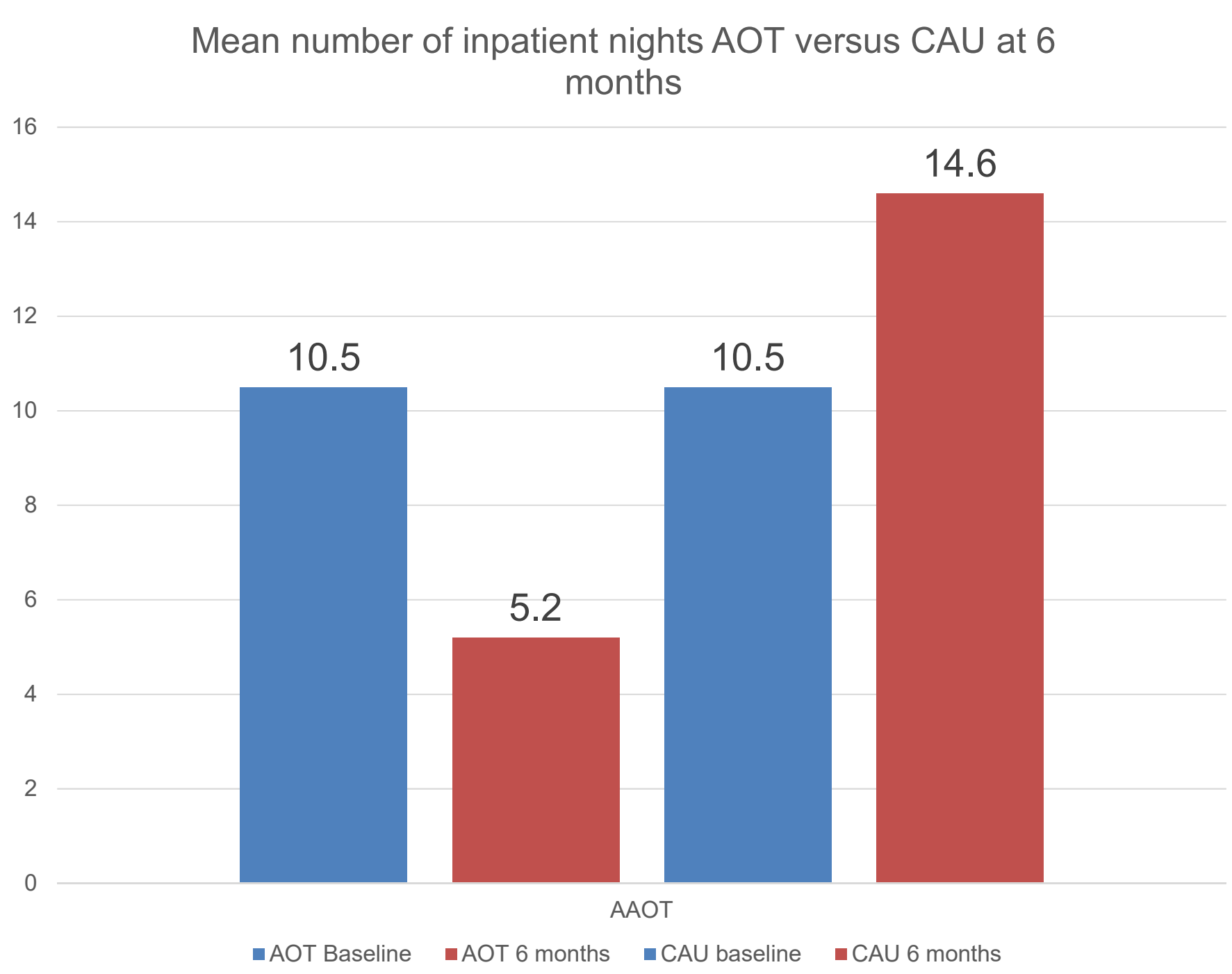
Alcohol Frequent attenders per 100,000 and Index of Multiple Deprivation x10 South London

Health inequalities and the alcohol harm paradox

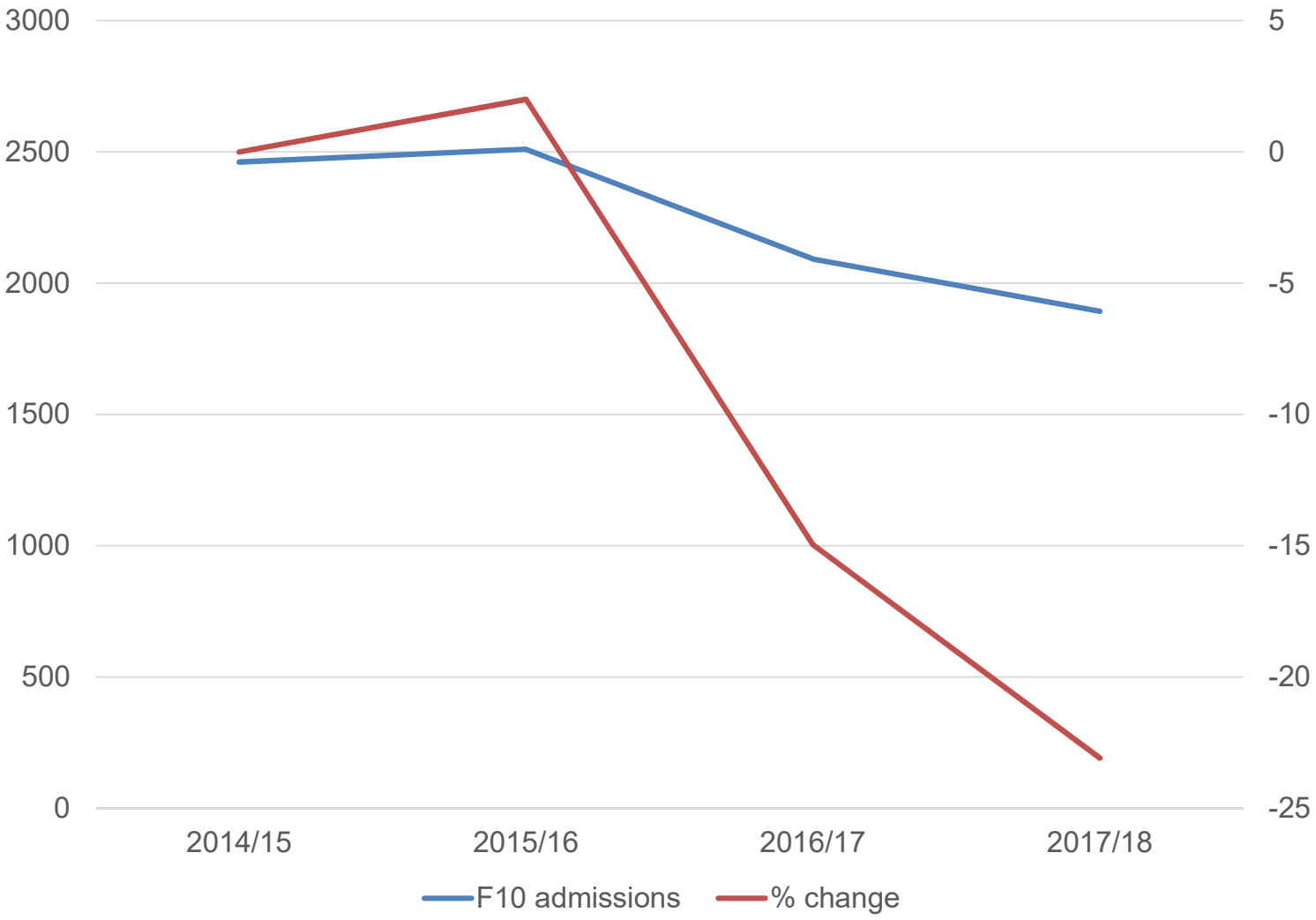


KHP Assertive Outreach Service

- Funded by Guy's and St Thomas' Charity
- Hosted by SLAM, serving three NHS trusts
- Targeting top 100 ARFA patients
- Multidisciplinary team (consultant psychiatrist, community nurses, therapists, support workers, support volunteers)
- Evaluation of effectiveness and cost effectiveness compared to care as usual
- Anticipated savings: £840K pa NHS, similar CJS
- Savings approximately 4 x cost of service


Mean number of inpatient nights AOT versus CAU at 6 months
16
14
12
10
8
6
4
2
0
10.5
5.2
10.5
14.6
AAOT
AOT Baseline
AOT 6 months
CAU baseline
CAU 6 months

Change in F10 alcohol admissions via ED in KCH



Extrapolation to national ARFA data

- England 54,369 ARFAs OBDs 1,402,600 Cost £848M
- Saving AOT compared to CAU = £13,819/case = £751M
- AOT treatment cost = £2,979/case = £161M
- Net saving = £10,840/case = £590M
- For every £1 spent, net cost saved = £3.66
- So potential cost saving overall = £590M in England

- Lambeth and Southwark
- ARFA n = 324
- Saving £3.4M
- Implementation £1M

Alcohol CQUIN – expected impact

Smoking

~1.6M smokers should receive very brief advice due to PIHCQUIN; of whom **~486K** can be expected to take up a referral; and we could expect **110K** may quit.

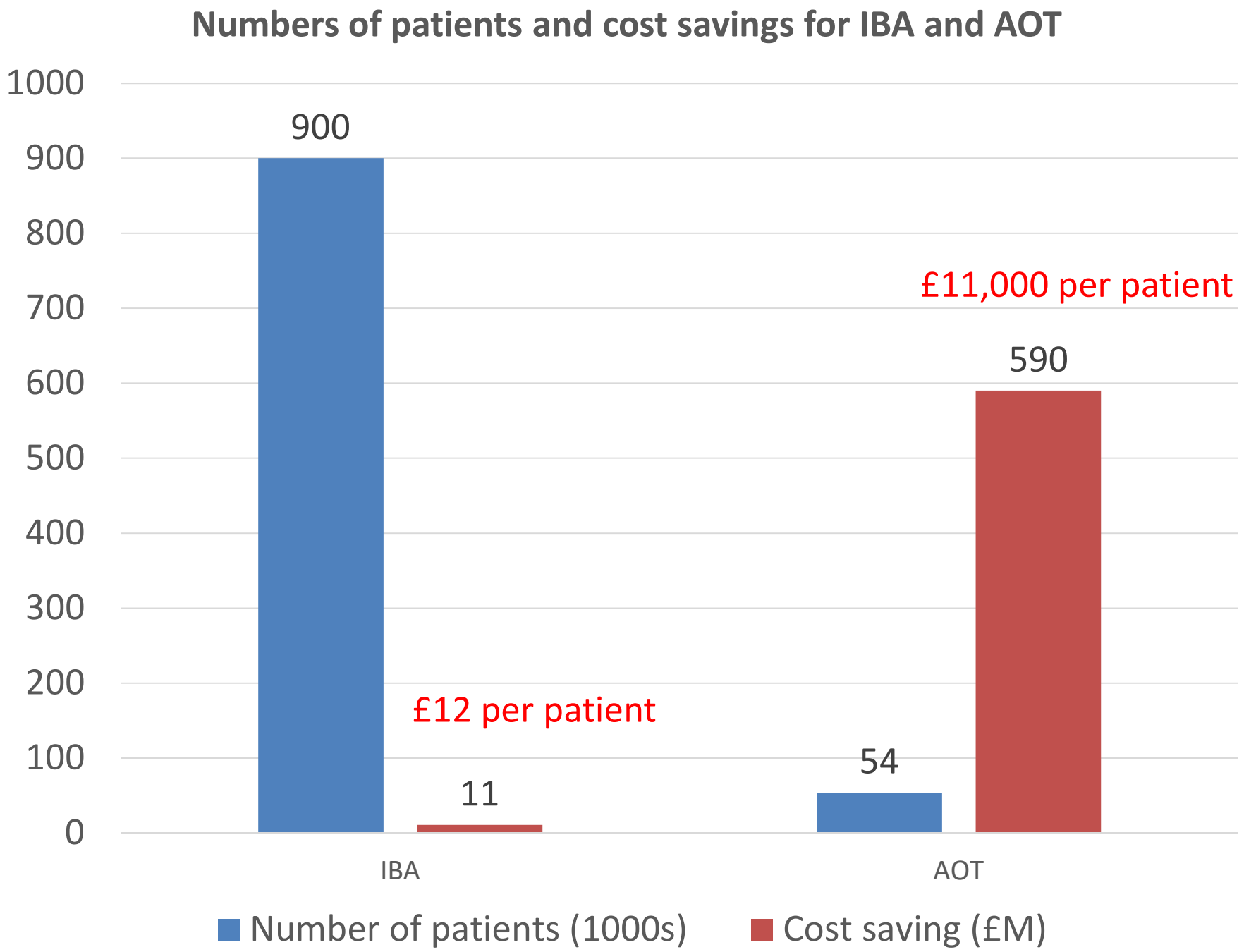
Alcohol

Even if only half of patients get screened.

~896K of patients drinking above the low-risk guidelines will get IBA & **~64K** will be referred to treatment in the community.

The NHS could save **>£20M** per year from reductions in ill-health caused by drinking.

Cost of implementation: BA £10 per case (SIPS ED) = £10 x 900,000 = **£9M**
Net saving = **£11M**


Numbers of patients and cost savings for IBA and AOT
1000
900
800
700
600
500
400
300
200
100
0
900
£12 per patient
11
£11,000 per patient
590
54
IBA
AOT
Number of patients (1000s)
Cost saving (£M)

What we could do

- Set out the current state of science on alcohol intervention in ARLD highlighting gaps in evidence
- Systematic reviews (either stand alone or as part of a programme grant)
- Engage with research funders to raise profile of ARLD alcohol intervention (NIHR already supported James Lind Alliance work)
- Vehicle for collaboration (between specialities and centres)
- Research grant applications – e.g. NIHR
- Clinical guidelines and clinical standards
- Clinical audit of current practice (e.g. based on RCPsych audit of detox)