A national study of acute care Alcohol Health Workers

Sarah Baker
Charlie Lloyd
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AUTHOR DETAILS

Sarah Baker
Department of Nutrition and Dietetics, Faculty of Health and Social Sciences, Leeds Metropolitan University, Leeds, LS1 3HE

Charlie Lloyd
Addictions Lead, Mental Health and Addictions Research Group, Department of Health Sciences, The University of York, Heslington, YO10 5DD

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Executive summary

Alcohol is an important factor contributing to nearly 50 medical conditions, including liver disease and cancer and is thereby associated with large numbers of hospital admissions. The annual cost of such alcohol-related harm to the English NHS has been estimated at £3.5 billion and reducing such admissions is a Government priority. One response to this problem is to employ Alcohol Health Workers (AHWs) in hospitals. AHWs can perform a number of roles, including screening patients for alcohol problems, conducting brief interventions, referring patients for more intensive treatment and detoxification. Despite their potential importance in helping patients who are drinking too much to reduce their drinking, we have a limited understanding about the work of AHWs nationally, other than that their numbers have rapidly increased.

The two-fold aim of this study was to provide a greater understanding of the extent, role and function of AHWs in order to feed into current and future policy in the field; and to provide a firm basis for future outcome evaluations. To meet this aim, a multi-methods design was adopted. A quantitative survey described the extent and diversity of AHW provision across England and qualitative interviews provided a more detailed understanding of commonly implemented, well-established, and unique approaches to AHW services.
1. Introduction

The annual cost to the National Health Service of alcohol-related hospital admissions in England in 2009/10 has been estimated at £3.5 billion (HSCIC, 2014) and is likely to have risen since. Much of this cost is made up of alcohol-related admissions to hospital and reducing such admissions has become a central focus of the Government’s policies on alcohol, reflected in the adoption of an alcohol-related hospital admissions indicator in the public health outcomes framework for England (DoH, 2013).

Alcohol Health Workers (AHWs) represent one means of targeting such alcohol-related admissions. AHWs are specialist staff – usually nurses (Alcohol Liaison Nurses) – who identify and work with patients drinking at levels that may impact or have already impacted their health. The first recommendation for the expansion of AHW provision came from the Royal College of Physicians in its influential report, Alcohol – can the NHS afford it? (Royal College of Physicians, 2001). This report proposed that each Acute Hospital Trust should have “one or more dedicated alcohol health workers employed by and answerable to the Acute Trust, their roles to include:

- Implementation of screening strategies
- Detoxification of dependent drinkers
- Brief interventions in hazardous drinkers
- Referral of patients for on-going support
- Provision of links with liaison/specialist alcohol psychiatry
- An educational resource and support focus for other health care workers in the Trust”.

1
Alcohol Health Workers were also one of the four approaches identified by the Department of Health in its commissioning guidance, *Signs for Improvement* (Department of Health, 2009) “that are calculated to impact most effectively on alcohol-related harm and reduce the rate of rise in alcohol-related admissions” (p.26). Likewise, the current Alcohol Strategy (HM Government, 2012, p.25) encourages all hospitals to employ Alcohol Liaison Nurses (nurse AHWs).

Despite their current popularity in recent strategic documents, there is a paucity of published research on the effectiveness of the AHW role (Ryder et al., 2010).

Research at St Mary’s Hospital Paddington has shown how brief intervention delivered by an AHW in an Accident and Emergency Department was associated with a significant and cost-effective impact on patients’ drinking levels and rates of re-admission (Barrett et al., 2006; Crawford et al., 2004; Touquet and Brown, 2006). At the other end of the scale, Ryder and colleagues (2010) evaluated a nurse liaison service aimed at patients with serious alcohol-related illnesses in hospitals in Nottingham. Evaluating the delivery of the service over a five year period, these authors concluded that the intervention had a substantial impact on alcohol intake and reduced hospital admissions and bed stays. Perhaps the clearest evidence of impact came from the service’s work on detoxification, whereby traditional in-patient detoxification had been partially replaced by supervised outpatient detoxification, freeing up hospital beds (but not reducing the number of admissions). Lastly, a prospective cohort study by Cobain and colleagues (2011) found that brief interventions given by AHWs to alcohol-dependent patients in one hospital lead to a decrease in alcohol consumption among these patients in comparison to a control group drawn from another hospital. However, although length of
hospital stay and attendance at A&E were also reduced, this did not differ significantly between the groups (Cobain et al., 2011).

Despite evidence pointing to the effectiveness of brief intervention when delivered by dedicated AHWs, one study found that only 31.5% of patients attending A&E who were offered an appointment with an AHW actually attended. Attendance was much more likely amongst older patients and those who believed their A&E admittance was related to their alcohol consumption (Patton et al., 2005). Evidence also suggests that the time between alcohol-related admission and follow-up is important in terms of attendance rates. Research conducted in the A&E department at St Mary’s Hospital London found that attendance rates were higher when patients were offered ‘same day’ or ‘next day’ appointments with an AHW, thus emphasising the need for a dedicated AHW in each Acute Trust to reach patients during this “teachable moment” (Williams et al., 2005).

A relatively recent study carried out in an acute hospital in Scotland sought to describe the alcohol liaison service and define both the referral criteria and the role of the ALN (alcohol liaison nurse). The authors concluded that ALNs should be considered expert sources of information for patients and accomplished at delivering brief intervention (Johnson, 2007). Other recent research conducted by Ward and Aulton (2010) has focussed on a purposive sample of eight services operating in different PCTs across England. Service specifications, structures and protocols, job descriptions, data collection and other information were outlined for each model. It was found that AHWs operate on a continuum, with activities such as Intervention and Brief Advice work at one end and medical interventions such as detoxification at the other (Ward and Aulton, 2010). This limited study raised a number of issues in addition to those
referred to above, including the division between in-hospital and outpatient work and a tendency for nurses to prioritise medical interventions rather than Intervention and Brief Advice (IBA). A systematic review of qualitative studies of screening and brief intervention studies in a range of settings included 22 UK studies and pointed to a lack of resources, lack of training, lack of time and lack of support from management as barriers to implementation (Johnson et al., 2011). Lastly, both Ward and Aulton (2010) and Ryder et al (2010) point to the lack of relationship between the level of need and the extent of AHW services. Ward and Aulton (2010) compared number of AHW staff with the population covered by the hospitals concerned and the standardised rate of alcohol-related admissions and found no relationship.

Most recently, an evaluation of the Alcohol Improvement Programme (AIP) conducted for the Department of Health has shown how the number of posts have grown, with considerable resources expended on developing AHW provision, a wide range of models of working, no common terminology and overlapping roles with other health issues such as drugs and mental health (Thom et al., 2013). Individual AHWs are employed by a range of voluntary and statutory sector organisations with concomitant differences in qualifications and roles.

Considering the evidence outlined above, employing AHWs might be best described as a ‘promising approach’. For such an important plank of government alcohol policy, the evidence base is surprisingly weak. There is little understanding either of the national coverage of this service overall, nor how these different AHW models might be distributed across the country. In particular, there remains very little qualitative research available with which to establish a more detailed understanding of the operationalisation of hospital-based AHW
services. This study aimed to fill these gaps by addressing the following aims and objectives:

1.1. Aims

- What is the extent and diversity of the provision of hospital-based AHWs in England?
- What are the main features of services?
- What are the similarities and differences between services?
- What are the positive and negative influences on services?

1.2. Objectives

- To conduct telephone/online interviews with a representative sample of AHWs who work in acute hospitals across England
- To define different ‘service types’ from the information gathered in the telephone questionnaires
- To identify a number of ‘case-study’ hospitals on the basis that they are: representative of the most commonly implemented models of working, examples of well-established services, or unique service examples
- To conduct semi-structured interviews with key NHS staff at the ‘case-study’ sites
2. Methods

This study used a pragmatic, multi-methods approach, employing those methods best-suited to addressing specific research questions. There were two distinct research questions:

1. What is the extent and diversity of the provision of hospital-based AHWs in England?
2. What are the main features of different ‘service types’ in acute hospitals in England, and how do different ‘service types’ compare?

Firstly, survey data were used to ‘set the scene’ in terms of the extent and diversity of the provision of AHWs in England and enabled us to develop a conceptual framework that grouped different ways of working into the following service types:

- The most commonly implemented models of working
- Well-established services
- Unique service examples

Secondly, qualitative interview data provided insight into the similarities and differences between ‘service types’ according to their operationalisation. A more detailed description of the quantitative and qualitative data collection follows.

2.1. Quantitative data collection

At the time of data collection, there were approximately 451 Acute NHS hospitals in England (NHS Choices, 2013). 59% of these hospitals (n
were excluded from our sample because they were either: too small (no A&E department), specialist hospitals, rehabilitation hospitals, maternity hospitals, children's hospitals, or dental hospitals. From the remaining hospitals (n = 187), 115 hospitals were randomly selected (Haahr, 1998), proportionately representative in terms of geographical location (NHS cluster n = 4).

Our approach was to make contact with key informants from each eligible hospital, initially through an AHW forum website and through direct contact with NHS hospital Trusts. Following this initial contact, potential participants were followed up via email with further information about the study (Error! Reference source not found.) and to arrange a time and date for the telephone interview to take place. Consent was obtained by way of replying to the email and agreeing to set a date to take part in the telephone questionnaire.

Quantitative data was successfully obtained from AHWs (n = 45) and managers (n = 3) (when there was no AHW provision) using a telephone/online questionnaire (Error! Reference source not found.). Secondary hospital-level data not readily available was obtained from the NWPHO (North West Public Health Observatory) on alcohol related admissions (the sum of hospital-related admissions solely as a result of alcohol and those partially attributed to alcohol).

Telephone and online surveys are a common means by which to gather data, with the distinct advantage of reducing the need to travel (Carr and Worth, 2001; Barriball et al., 1996). As such, telephone and online surveys provided a cost-effective and rapid method of data collection whilst retaining some flexibility, allowing the researchers to adapt and clarify participant responses as necessary (Carr and Worth, 2001; Barriball et al., 1996).
2.2. Qualitative data collection

In total, 4 hospitals were selected for the qualitative study based on the fact that they were identified during the preliminary quantitative exploration as either; representative of the most commonly implemented models of working (number 4 below), examples of well-established services (number 2), or unique service examples (numbers 1 and 3 below). See Table 1.

Table 1: Hospital ‘case-study’ sites.

<table>
<thead>
<tr>
<th>Alcohol related admissions</th>
<th>Qualifications</th>
<th>% Patients seen</th>
<th>Age groups</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 6218.24</td>
<td>Nurses 3 F.T.E</td>
<td>Dependant: 0*</td>
<td>Adults (18+)</td>
<td>Partnership: Third sector provider &amp; Acute Trust &amp; Mental Health Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher risk: 43*</td>
<td>Adolescent (10-19)**</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increasing risk: 57*</td>
<td>Paediatric (0-18)**</td>
<td></td>
</tr>
<tr>
<td>2 6135.01</td>
<td>Nurses and non-nurses 6 F.T.E</td>
<td>Dependant: 89</td>
<td>Adults (18+)</td>
<td>Partnership: Acute Trust &amp; Mental Health Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher risk: 8</td>
<td>Adolescent (10-19)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increasing risk: 3</td>
<td>Paediatric (0-18)</td>
<td></td>
</tr>
<tr>
<td>3 6705.50</td>
<td>Non-nurse 1 F.T.E</td>
<td>Dependant: 60</td>
<td>Adults (18+)</td>
<td>Partnership: Third sector provider &amp; Primary Care Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher risk: 40</td>
<td>Adolescent (10-19)†</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increasing risk: 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 8153.88</td>
<td>Nurse 1 F.T.E</td>
<td>Dependant: 90</td>
<td>Adults (18+)</td>
<td>Third sector provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Higher risk: 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increasing risk: 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Figures based on young people’s alcohol liaison services

** Dedicated young people’s alcohol liaison services

† 16 years+

Initial contact was made with participants whom had previously taken part in the quantitative telephone/online survey and who had given consent to be re-contacted along with information about the study (Error! Reference source not found.). Those who agreed to take part
were then invited to suggest additional participants (AHWs, psychiatric nurse, commissioners) for interview on the basis that they were significantly involved with the service provided by hospital-based AHWs. Following Research and Development approval and written consent from the participant (Error! Reference source not found.), a number of face-to-face interviews \( (n = 10) \) took place which were audio recorded and then transcribed verbatim. A pre-defined framework of the types of information sought helped guide the interview schedule (Error! Reference source not found.). All of the data was anonymised at transcription and was stored securely in a locked drawer at the University of York.

2.3. Ethical issues

This study was framed as an audit/service evaluation of the current provision of hospital-based AHWs and as such was not problematic in terms of ethics. However, ethical consideration was given in terms of the time demands on AHWs and other NHS staff who took part in the telephone/online questionnaire and face-to-face interviews. For example, the telephone/online questionnaire was short and structured and took approximately 20 minutes to complete. Similarly, the interview schedule was designed to capture as much relevant information whilst being sensitive to the time demands on staff and took approximately 30-60 minutes to complete. During the interviews, there were no instances of staff disclosing any aspects of the service that they deemed to be unsafe or that put themselves or patients at risk.

This study was approved by the University of York’s Department of Health Sciences Research Governance Committee, York, UK.
2.4. Data analysis

Using SPSS (version 20) (IBM Corp, 2011), basic descriptive statistics were carried out on the resulting telephone and online survey data that also include a small number of hospitals \((n = 3)\) that did not currently employ a dedicated alcohol worker. Means (standard deviations) and proportions were calculated for continuous and categorical data respectively and non-parametric tests were carried out to determine whether there was a significant correlation \((p < 0.05)\) between variables.

Qualitative data was analysed using NVivo 10, a qualitative data analysis package (NVivo qualitative data analysis software, 2010). Thematic analysis was used to identify and group the interview transcripts into themes according to their substantive content. This was a continuous process that began immediately after each interview was transcribed and one which continued to evolve until no ‘new’ themes emerged from the data. The resulting themes then went through a process of refinement resulting in several iterations of themes and sub-themes.
3. Results

3.1. Quantitative research findings

48 participants took part in the survey and our response rate (56%) was good in comparison to previous telephone (Dillman et al., 2009) and online (Cook et al., 2000) questionnaires, with average response rates of 44% and 39.6% respectively. Moreover, our sample was geographically representative (Cook et al., 2000) spanning each NHS cluster (NHS North n = 21, NHS Midlands n = 11, NHS London n = 9, and NHS South n = 7).

The quantitative survey data enabled us to quantify the extent and diversity of hospital-based AHW provision in England. Specifically, how many AHWs work in hospital, who they are, where they work, their roles, who they see, and who funds their work. The following results are organised according to the six aforementioned categories.

3.1.1. How many AHWs work in acute hospitals in England?

Of the 48 hospitals who took part in our questionnaire, the majority (n = 45, 94%) had at least one AHW and the number of alcohol-related admissions was significantly correlated with the total number of AHWs, r = .341, n = 45, p < .022 (Table 2).
Table 2: The number of alcohol-related admissions per year and the corresponding number of AHWs (n = 45)

<table>
<thead>
<tr>
<th>Number of AHWs</th>
<th>Admissions per year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;= 4550.94</td>
<td>4550.95 – 6454.49</td>
</tr>
<tr>
<td>&lt;= 1.0</td>
<td>8 (17.8%)</td>
<td>6 (13.3%)</td>
</tr>
<tr>
<td>1.1 – 2.0</td>
<td>3 (6.7%)</td>
<td>6 (13.3%)</td>
</tr>
<tr>
<td>2.1+</td>
<td>3 (6.7%)</td>
<td>4 (8.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>14 (31.1%)</td>
<td>16 (35.6%)</td>
</tr>
</tbody>
</table>

3.1.2. Who are AHWs?

In the majority of hospitals AHWs were qualified nurses (80%, n = 36), however, 20% (n = 9) also employed staff with alternative qualifications (NVQ in health and social care, counselling skills) or experience in substance misuse. The titles used within and between hospitals to describe staff whose role was predominantly dedicated to, or specialising in, alcohol use varied. Only 2% (n = 1) used the title AHW, and the majority (n = 21, 47%) used the term Alcohol Liaison Nurse. Other categories included: alcohol nurse (n = 13, 29%), substance misuse nurse (n = 4, 9%), and other (n = 19, 42%) (peer support worker, alcohol liaison worker, alcohol support worker).

3.1.3. Where do AHWs predominantly work?

AHWs reported working across the hospital with most services available between 9am and 5pm, fewer services included evenings (n = 17, 38%) and weekends (n = 19, 42%). AHWs predominantly worked in non-emergency admission units (n = 20, 45%) followed by A&E (n = 15, 33%), specialist gastroenterology/liver wards (n = 9, 20%), and general medical wards (n = 1, 2%) (Figure 1).
Analyses found no association between services who employed staff with and without nursing qualifications and their predominant place of work $\chi^2 (3, n = 45) = 1.0, p = .772, \text{ Cramer's } V = 0.15$ (Table 3).

**Table 3: AHWs predominant place of work and the corresponding qualifications of staff (n = 45)**

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>Predominant place of work</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A&amp;E</td>
<td>Gastro/Liver wards</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td>13 (28.9%)</td>
<td>7 (15.6%)</td>
</tr>
<tr>
<td><strong>Nursing and non-nursing</strong></td>
<td>2 (4.4%)</td>
<td>2 (4.4%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15 (33.3%)</td>
<td>9 (20.0%)</td>
</tr>
</tbody>
</table>
3.1.4. What do AHWs do?

There were a number of activities common to all AHWs including: assessment, identification and brief advice, and liaison with outside agencies. The vast majority were also involved in: detoxification support \((n = 41, 91\%)\), education, research and support \((n = 44, 98\%)\), development of protocols and care pathways \((n = 44, 98\%)\), follow-up and discharge planning \((n = 42, 93\%)\), and management of ‘frequent fliers’ (repeat hospital attendees) \((n = 40, 89\%)\). More than half were involved in: prescribing and medical management \((n = 31, 69\%)\) and outpatient clinics \((n = 27, 60\%)\) (Figure 2).

![Figure 2: Role of acute hospital-based AHWs \((n = 45)\)](image-url)
3.1.5. Who do AHWs see?

Of the acute hospitals included in this survey, all those with AHWs provided care to adults (aged 18+ years), less than one third ($n = 14, 31\%$) provided care for adolescents (10-19 years) and one fifth ($n = 9, 20\%$), provided care for paediatrics (0-18 years) (Figure 3). The majority worked on the proviso that they provided cover for all hospital patients regardless of age, only one service was specifically dedicated to younger age groups.

![Figure 3: Provision of acute hospital-based AHW services by patient age (n = 45)](image)

Patients admitted to hospital with alcohol-related problems can be categorised as: dependant drinkers, at high risk of alcohol-related harm (Men: $>8$ units/day, Women: $>6$ units/day regularly), and at increasing risk of alcohol-related harm (Men: $>3$-$4$ units/day, Women: $>2$-$3$ units/day regularly) (Anderson, 2008). The largest proportion of patients seen by AHWs in acute hospitals per year were dependent on alcohol (mean 70.9\%, S.D: 22.1), followed by patients at higher risk of alcohol related harm (mean 20.4\%, S.D: 13.7), and those at increasing risk of alcohol related harm (mean 9.8\%, S.D: 13.4).
3.1.6. Who funds the work of AHWs?

AHWs were most frequently funded by a partnership (n = 16, 36%) - most often the PCT and Acute Trust - followed by: the PCT alone (n = 15, 33%), Third Sector providers (n = 5, 11%), the Mental Health Trust (n = 4, 9%), the Acute Trust alone (n = 3, 7%), and the Drug and Alcohol Team (n = 2, 4%) (Figure 4).

![Image of a pie chart showing funding sources as percentages: 36% Partnership, 33% PCT, 11% Third Sector, 9% Mental Health Trust, 7% Acute Trust, 4% Drug and Alcohol Team.]

*Figure 4: Funding provision for acute hospital-based AHW services (n = 45)*

Analyses revealed no significant differences across the 7 different funding categories with regards to the proportion of patients seen who were dependent drinkers $\chi^2 (5, n = 36) = 2.37, p = .796$, high risk drinkers $\chi^2 (5, n = 37) = .845, p = .974$, and at increasing risk $\chi^2 (5, n = 37) = 3.41, p = .638$.

The quantitative findings provided an overview of the extent and diversity of hospital-based alcohol health worker provision across England. Building on these findings, a number of face-to-face interviews were carried out with AHWs and associated staff to make
better sense of the alcohol services they provided, to identify effective ways of working and to highlight potential areas for improvement.

3.2. Qualitative research findings

In total, 10 individuals gave their consent to take part and were successfully interviewed across 4 hospital sites between September and November 2013. Table 4 provides a summary of the characteristics of those participants who took part in the face-to-face interviews.

Table 4: Characteristics of interview participants

<table>
<thead>
<tr>
<th>Site</th>
<th>Participant ID</th>
<th>Gender</th>
<th>Role</th>
<th>Employer</th>
<th>Qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PJSZ</td>
<td>Male</td>
<td>AHW manager</td>
<td>Mental Health Trust</td>
<td>Nurse</td>
</tr>
<tr>
<td>1</td>
<td>NNE5</td>
<td>Female</td>
<td>AHW</td>
<td>NHS Hospital Trust</td>
<td>Nurse</td>
</tr>
<tr>
<td>1</td>
<td>9LBE</td>
<td>Female</td>
<td>AHW</td>
<td>NHS Hospital Trust</td>
<td>Nurse</td>
</tr>
<tr>
<td>2</td>
<td>DKG0</td>
<td>Female</td>
<td>AHW</td>
<td>Third sector provider</td>
<td>Non-nurse</td>
</tr>
<tr>
<td>2</td>
<td>BO2F</td>
<td>Male</td>
<td>Psychiatric nurse</td>
<td>Mental Health Trust</td>
<td>Nurse</td>
</tr>
<tr>
<td>2</td>
<td>84QW</td>
<td>Female</td>
<td>Commissioner</td>
<td>Local Authority</td>
<td>Non-nurse</td>
</tr>
<tr>
<td>2</td>
<td>XWZP</td>
<td>Female</td>
<td>Commissioner</td>
<td>Local Authority</td>
<td>Non-nurse</td>
</tr>
<tr>
<td>3</td>
<td>4RT7</td>
<td>Male</td>
<td>AHW</td>
<td>Third sector provider</td>
<td>Nurse</td>
</tr>
<tr>
<td>3</td>
<td>RU4B</td>
<td>Male</td>
<td>AHW manager</td>
<td>NHS Hospital Trust</td>
<td>Nurse</td>
</tr>
<tr>
<td>4</td>
<td>GA8G</td>
<td>Male</td>
<td>AHW manager</td>
<td>NHS Hospital Trust</td>
<td>Nurse</td>
</tr>
</tbody>
</table>

Following analysis of the qualitative data a number of themes emerged under the overarching theme ‘embeddedness’. These included: ‘ownership’, ‘sense of belonging’, ‘divided loyalties’, and ‘proving your worth’. Figure 5 provides an illustration of the final thematic schema.
Direct quotations obtained during the face-to-face interviews with participants are included to support theories relating to AHW services. Quotations were chosen on the basis that they were particularly illuminating in relation to the key themes.

### 3.2.1. Ownership

Several of the participant’s accounts revealed that the funding of AHW posts had resulted in significant variation in the delivery of such services. The extent to which agencies funding AHWs have ownership over the implementation of alcohol services within hospitals appears to be largely dependent on whether the funding body is integral to the Acute Trust in which it is delivered. For example, AHWs felt that a service funded by external agencies without local (acute hospital) ownership or accountability was often seen as low priority.

A: “Well, the reasons are alcohol is not deemed to be a priority again. There’s a disconnect between two different Trusts, and of course not just the two different Trusts, the DACT (Drug and Alcohol Commissioning Team) as well, DACT they commission the
service of course, but this hospital doesn’t understand that”.
(‘GA8G – site 4: Male nurse, AHW manager, employed by the Acute Trust’)

A: “The amount of meetings I’ve been at where…and sitting with gastro consultants, intensive care consultants, medical consultants and it’s been like well, this isn’t our problem. And I’m like no; it’s all of your problems. If you walk down any ward in the hospital there will be an alcohol related problem in any one of their wards, whether or not they’re still a drinker or they’ve had a fall. Any ward I would guarantee you that we would come across somebody”. (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

In this respect, one AHW described their struggle to integrate their alcohol service in secondary care.

A: “…..for two years I’ve had an alcohol leaflet that I’m still not, I’m still not allowed to print, because they’re still not happy with it, because you get more than three commissioners in a room and they argue”. (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’)

It is clear from the above quotation, that competing interests from too many agencies had a negative impact on the delivery of alcohol services within the hospital trust. Likewise, all of the participants who took part in the interviews stated that the short-term funding of alcohol services significantly impacted on the services they were able to deliver. They felt that too much time was spent deciding on who should fund alcohol services and too little time was spent deciding how best to deliver the service for the benefit of patients.

A: “…..funding should not be short-term, it’s the short-termism that we waste a lot of time and energy on. We’re, we’re constantly having to think about where we will be next year. So
we’re, we’re, we’re currently in the middle of a tender, OK, and you are spending, and, and that’s absolutely necessary, of course and, you know, there should be a tendering process, but the, the funding, we, we need to be spending less time working on where more funding comes from and more time doing the job, OK”. (‘PJSZ – site 1: Male nurse, AHW manager, employed by the Mental Health Trust’)

A: “this is everyone’s business in this county, you can’t escape doing brief interventions and offering very simple advice or giving people a leaflet, but that might be all you do”. Q: “So it’s getting staff to take ownership of that”. A: “Yeah, very much so, because we can’t have a million posts, we don’t have the money for that, so it is about if everybody does their little bit”. (‘B4QW – site 2: Female non-nurse, commissioner, employed by the Local Authority’)

Moreover, AHWs expressed their frustration that despite widespread acknowledgement (including that of commissioners) that alcohol services were necessary and important, and that not to commission services would be a “retrograde step”, funding for alcohol services did not reflect this.

A: “Yeah, I mean I think what would be staffing as well, make sure that we are well staffed, but it all comes down to funding again, make sure that there’s funding there, this is the third biggest killer in this country, we need to invest in it”. (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

A: The lack of provision from within this Trust, the Teaching Hospital Trust, to actually meet half way and provide at least one nurse within. You know, the model would be to have one nurse from the teaching hospitals and one nurse from the specialist alcohol services, that could be certainly a vast improvement and
improve quality and consistency. (‘GA8G – site 4: Male nurse, AHW manager, employed by the Acute Trust’)

Financial accountability was an area that was considered by some AHWs as important in terms of valuing and delivering alcohol services. In the main, AHWs felt that despite the good will of hospital staff, without “financial pressure” providing the impetus for hospital managers, areas other than alcohol were likely to be prioritised.

A: “I think the issue here is that actually it’s become a free service or it’s a free service for the hospital, they don’t...they have no financial input into the service, so therefore they have no, you know, they’re not interested in the achievements of the service, because it’s not necessarily...so although we can go to them and say, actually, we are making things better for you, you know, we are removing some of the finance issues for you by removing the repeat attenders, by having less bed days, you know, it’s a relatively small amount”.

Q: “Do you feel that if they were in some ways involved in the funding of services that would provide the impetus for them to be more interested in the services you provide?”

A: “Possibly, possibly”.

Q: “Do you feel they should be involved in funding the service”.

A: “If it would make a difference and actually have them own the service, because that has been the big thing for me, the fact that...lack of ownership”. (DKG0 – site 2: Female non-nurse, AHW, employed by a Third Sector Provider’)

One AHW manager reflected on a time-period during which alcohol targets had been linked to financial incentives and identified how this had effectively engaged hospital managers in the alcohol service.
A: “........a CQUIN target brings with it financial implications which brings with it incentivised managers, shall we say, and incentivised managers within hospitals make things happen”.

(PJSZ – site 1: Male nurse, AHW manager, employed by the Mental Health Trust)

Likewise, several of those interviewed described how the ways in which AHWs were managed influenced service provision and their ability to evolve over time.

Q: “Do you think that the [management] structure shapes the service in anyway or influences how you work?”

A: “Yes, very much so. Not necessarily in the most positive way, because the teaching hospitals don’t own me, and consequently there’s two strands to it, they don’t necessarily understand alcohol services from a mental health point of view, and when you…and the other side of it, the other strand of it is if you try and develop or commission further services, because they don’t own you, there tends to be, although there is goodwill and some good relationship building, they don’t really have control of the service, so attempting to expand, develop, is very difficult when you’ve got two separate organisations involved in what the post holder ultimately does. So, there’s a lack of understanding from both sides, I would imagine". (‘GA8G – site 4: Male nurse, AHW manager, employed by the Acute Trust’)

A: “.....having managerial support in A & E and in the community. That is a massive thing. And managers that are supportive and know that you know what you’re doing so they don’t, you know, so they give you that autonomy. It would be very difficult to do the job if you, if, if you, if you were very constricted on what you could do”. (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’)

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Several of the AHWs concluded that their hospital-based alcohol services, which were managed by a number of different organisations and whom often had conflicting priorities with regards to outcome measures and objectives, felt rather disjointed.

A: “I can only think that if different people are running one service, that doesn’t feel that cohesive, it kind of feels better to all be under one umbrella. Perhaps that’s looking at it too simplistically, I’m not an accountant”. (BO2F – site 2: Male nurse, Psychiatry, employed by the Mental Health Trust’)

A: “…all of the substance misuse services have been re-commissioned, so …my post is being transferred over to another agency and at the moment, I haven’t met them, I have no idea what their views of this service are and what the future is going to look like for it, I’m hoping that it will continue in a similar vein to what it has been”. (DKG0 – site 2: Female non-nurse, AHW, employed by a Third Sector Provider’)

In particular, some AHWs felt that because alcohol services were externally managed, the hospital themselves had no “internal impetus” to fully embrace screening and brief intervention with regards to alcohol and therefore did not encourage any programmes of education for staff. Likewise, the majority recalled having experienced little support from hospital management, one interviewee described how they found themselves having to make their own way. They felt that a lack of support and proven model of working was a hindrance to the implementation of alcohol services.

A: “I’ve literally been making it up as I go along like (laughs) you know, and pretty much kinda making it up and seeing what
works and improving things as I go along. So in terms of stuff that could be working better I've kind of got over the fact that there's no model to prove effectiveness, because I nearly had a breakdown trying to prove that I was cost effective”. (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’) 

Q: “What about senior management, so not the clinicians themselves, do you feel you get support from senior management?”

A: “No, they don’t know about me, they don’t know about me. I recently was in contact with a senior manager, who said, oh, I didn’t know you were in this Trust. I’ve been here for three years. I’m not in the Trust, but I’ve been working on the Trust, clinical shop floor, for three years”. (‘GA8G – site 4: Male nurse, AHW manager, employed by the Acute Trust’) 

The above quote illustrates how this particular AHW recollected still feeling like an outsider despite having worked in the hospital for a considerable length of time. Several other AHWs expressed similar concerns in relation to how they were managed and supported within the hospital.

A: “I didn’t have anybody to go to, except from an external commissioner. So if I’ve got an internal in-house problem there was nobody for me to go and chap on the door and go you need to help…” (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

A: “It’s quite difficult, last year, when we did the training, one of the nurses was acting up as matron and was actually quite shocked that I’d been here for so long and not any line management or at least any support from the hospital”. (DKG0 – site 4: Female non-nurse, AHW, employed by a Third Sector Provider’)

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Support from senior management was viewed by all of the interviewees as a necessary component in order to embed an alcohol service within secondary care. Nevertheless, there was the sense that AHWs were attempting to build services without this support and that they were battling against the hospital hierarchy.

A: “one of the issues that I’ve had is the lack of involvement by the management staff in the hospital, because, at times, it would be really useful for it to be led top down, rather than pushing from bottom up, you know”. (DKG0 – site 2: Female non-nurse, AHW, employed by a Third Sector Provider’)

A: “….there’s a lack of, if you like, what would I, how would I term it, there’s a lack of any champion, at any level, whether it’s medicine, whether it’s senior nursing or whether it’s clinical directorship or management board level for alcohol”. (‘GA8G – site 4: Male nurse, AHW manager, employed by the Acute Trust’)

A number of AHWs implied that having in-house (hospital) management support would most likely improve their overall effectiveness and benefit patients.

A: “….whilst I think the links with the community-based service have been really valuable, we may have been able to achieve more screening if there had been that line management responsibility, I guess. And we try to achieve that by getting the senior level support from the outset, we really think that having that senior-level champion is important.” (XWZP – site 2: Female non-nurse, Commissioner, employed by the Local Authority’)

A: “Yeah….well, I think it is about ownership, because if people truly embraced it, we wouldn’t be seeing 200 a month, we’d be
seeing 2000, you know”. (B4QW – site 2: Female non-nurse, Commissioner, employed by the Local Authority’)

On the contrary, a small minority of AHWs did describe what could be considered one of the difficulties associated with being managed within the Acute Trust. For example, some of the AHWs recalled a number of occasions when they had been drawn into the wider hospital needs during times of crisis.

A: “...there was one occasion a couple of years ago where, you know, it was winter, there was shortages of staff, there was one occasion where we were taken away from the team actually to work on the assessment unit for a couple of weeks”. (’9LBE – site 1: Female nurse, AHW manager, employed by Acute Trust’)

A: “If there’s people in where alcohol or drugs are involved I’ll go and speak to them, but if there’s not then I’m the extra pair of hands. So if the little old lady in cubicle five needs her IV antibiotics I’ll draw ‘em up and I’ll give ‘em. And that was seen as a fundamental way to embed me as being seen as part of the A & E team and not as separate”. (’4RT7- site 3: Male nurse, AHW, employed by a Third Sector Provider’)

However, the nurses were keen to point out that this was not something that they felt was inappropriate, in fact, it cemented their sense of belonging within the acute environment and the nursing profession evident in the following quote.

A: “I think if we get pulled into general nursing stuff it’s because it’s appropriate and we want to, it’s in the patient’s best interest, and I, and I think we all do that, once you’re a nurse you always are, aren’t you…” (’NNE5 – site 1: Female nurse, AHW, employed by the Acute Trust’)
One of the AHWs interviewed was a non-nurse employed by an external agency and felt that one of the benefits of this was that they were seen as a “separate entity within the hospital” and did not get drawn into clinical work outside their remit.

A: “I do believe that actually having an external worker, rather than a nurse works, because, you know, I don’t get caught up in the nursing stuff, I can stay very separate from that, you know, I’ve had a learning curve like that (raises hand above head) when it comes to actual medical terminology, but, you know, you put yourself out and it’s very quick to learn and not being afraid to actually…I never made any bones to anyone, when I’ve been called a nurse, I’ve always told them I’m not, you know…” (DKG0 – site 2: Female non-nurse, AHW, employed by a Third Sector Provider)

3.2.2. Sense of belonging

AHW services were predominantly reliant on a small number of staff, many of whom were lone workers. As a result, several of those who were interviewed spoke of feeling isolated within the hospital environment. This was reportedly exacerbated when managerial or peer support was absent.

A: “I feel a bit disjointed, a bit like not part of any team, I’m like me own team and it’s just me and, woo-woo, go me, you know. You know like cos we all need support from our colleagues and things at times…” (4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider)

A: “I think when I first came in, the idea was that I would be line managed by the senior nurse in A&E, but that very quickly became apparent that that wasn’t going to happen. So it was
quite a lonely time for a little while here”. (DKG0 – site 2: Female non-nurse, AHW, employed by a Third Sector Provider)

Furthermore, practicalities such as, lack of desk or office space was raised as an issue during the interview process. This led to one AHW in particular, feeling excluded and undervalued.

A: “what I don’t like is not having any sort of space on A & E. I, I tell a lie, I do have a locker to put me bag in. What else do I have? And I have a drawer, I have a drawer that me referrals go in, and, and leaflets and whatever. And that’s pretty much it. So it’s, it’s a lack of space, it’s, it’s, and that is something I really dislike because it’s almost as if you’re saying we don’t allow you, you enough, you know…” (’4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider)

Many of those interviewed suggested that this was as a result of the diverse nature of their role that led to them not having a sense of belonging either within the hospital environment or among peers whose work was often incomparable.

A: “….there’s no network, and it’d be very difficult to create a network because [this area] doesn’t do anything, you know, my area does, but then another area down the road don’t do anything, but, and then another area does but the criteria’s so different but it’s not comparable”. (’4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider)

A: “……a lot of our patients do flit between hospitals and they might get a different service at one hospital to us. So in an ideal world, it would be better if we were all working on the same
Similarly, a number of AHWs employed by external agencies described feeling like outsiders whose roles were not understood by hospital staff. In addition, the nature of the work served to further segregate AHWs.

A: “I feel like quite isolated. And it’s the same with community services, because they don’t completely understand everything that I do…” (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’)

A: “See, when you go out it can be banging your head against the wall sometimes, it’s so frustrating and there’s times that I do come home from work and think why do I do that? There’s no thanks in it, there’s very, very little reward. Staff don’t like you because you’re challenging them, patients don’t like you because you’re not telling them what they want to hear”. (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

In contrast, several AHWs felt that they had successfully managed to integrate a hospital alcohol service. Commonalities between services that had been successfully integrated included: hospital managerial support, demonstrable success, and the provision of services over a prolonged period of time. One AHW manager spoke of how they were now able to champion alcohol services at a much higher level which had resulted in greater acknowledgment of the services provided by AHWs within the hospital.

A: “Now, I’m having a bit more of a senior voice in the organisation, that I’m sitting at meetings and I’m able to champion the services and actually the benefits of that is already showing because we’re getting consultants coming to
ask us can we come and sit on this liver disease group? So we're being more noticed now which is great, which is what I wanted, and more recognised for the work that we're doing actually, because people are hearing it’s now. It's not stopping. I think before the only person I had to speak to was a band eight who wasn't interested in alcohol, that wasn't so... So it was stopping there. It wasn't going any higher. Whereas now I am that band eight and it's going higher because I'm shouting higher which is great.” (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

However, despite managerial support, AHWs acknowledged that for any service to be embedded within a hospital takes time.

A: “We're improving care, we're improving standards, service development, we're still in our infancy even though it’s been a few years, but for any NHS service to become...it can take a decade and I'm perfectly aware of that. So it's small steps but we are getting there and it is, and it's a worthwhile job and somebody’s got to do it because they're such a vulnerable group that they need somebody to champion for them”. (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

Several of those interviewed revealed how in an attempt to embed services they had utilised NICE recommendations to ensure that a component on alcohol was included in mandatory programmes for staff.

A: “NICE says that every adult being admitted to a hospital should be screened for alcohol misuse, and every health professional in a hospital that’s dealing with people who may be withdrawing from alcohol should be educated for this, this and this. So we can use that, and it is a continual dance and negotiation with the education providers of the hospital, the
people who do the mandatory update, because these are always pressured programmes, to say do we really need to have this there? Yes, we do, because the evidence says that you’ve got to and you would not be fulfilling NICE requirements unless you were, and so on and so on and so on”. (‘PJSZ – site 1: Male nurse, AHW manager, employed by the Mental Health Trust’)

Similarly, other tactics included the inclusion of alcohol screening within an already established document (e.g. admissions form), increasing the likelihood that it would be completed and encouraging staff, many of whom were described as reluctant, to broach the subject of alcohol consumption with patients. Furthermore, linking alcohol services with well-established services (safeguarding/ mental health) appeared to be an effective means with which to integrate alcohol services within the acute hospital.

A: “I was glad that it was actually coming under a bigger umbrella of something and wasn’t going to be sitting isolated”. (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

A: “…..for example with mental health, you know, you can do that joint assessment and link ‘em both in, rather than doing one assessment with them, one assessment with us and, so it’s, it’s really good in that respect I think”. (‘9LBE – site 1: Female nurse, AHW manager, employed by the Acute Trust’)

Another key factor described by AHWs as necessary for them to be integrated within the hospital was the ability to establish solid working relationships with staff. The majority of AHWs were qualified nurses and as such felt they had an affiliation with the nurses working on the wards as well as an understanding of the demands placed upon them.
A: “I think the credibility thing as well, because we’ve, we have been on that side, we understand how it is to work on the wards and, and the constraints and, and, you know, it’s very, it would be very easy to be sort of, you know, why haven’t you given this medication every fifteen minutes. I mean I had somebody in DTs the other week and, you know, they were giving the medication every fifteen minutes, and then the nurse got busy with a poorly patient, and I understand that fully and I’m not gonna be making her feel any worse, you know, cos I say “I know how hard it is, do you want me to, you know, take over while you go and do that?” And, cos you do understand, and I think that helps with your relationships cos they’re, they’re not like that, ‘who does she think she is?’ (Q laughs) you know, ‘a nine to five worker, she’s never been in clinic in her life’, cos they know that we have, and I think it obviously helps”. (‘NNE5 – site 1: Female nurse, AHW, employed by the Acute Trust’)

There was also a general consensus among AHWs that in order to become embedded within the hospital it was important that services were not “faceless”, they needed to be seen, to have a “presence” within the hospital. Several of those interviewed recalled making access into alcohol services as simple and flexible as possible to encourage staff to engage.

A: “….the staff around the hospital are more aware of us and feel that they can approach us, you know. I mean we say referrals are simple enough, just give us a call, you know, it doesn’t matter who you’ve got, you just, just give us a call, discuss ‘em with us and we’ll, we’ll help you out with that really. And even if they’re not, even if it’s not patient-related, they’re not sure about management issues and, and things like that, we, we can support them on that, and hopefully they see us as, as quite a supportive team and, and who are quite approachable
really”.' (‘9LBE – site 1: Female nurse, AHW manager, employed by the Acute Trust’)

Despite the AHWs attempts to fully integrate alcohol services within their hospitals, one universal area of concern voiced by the vast majority of those who were interviewed was the periodic uncertainty in relation to the commissioning of those services. One AHW reflected upon how this affected staff.

A: “I think other staff, not me but other staff, do put off doing things cos they don’t know if they’re gonna be here or not. I think it does give them kind of a sense of insecurity and almost, they’re, they’re, they’re less likely to be innovative. I, I think sometimes they’re probably, you know, more likely to be on NHS jobs than, than, you know, doing the job.................. All we do is other motivate other people, but how do you motivate, and is it for you when you don’t know if you’re gonna have a job in two months?” (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’)

AHWs expressed that the uncertainty arising from re-commissioning of alcohol services and their subsequent short-term contracts prohibited the embedment of services. Most AHWs found hospital staff reluctant to engage with alcohol services fully due to the near constant threat of the withdrawal of those services. In addition, several AHWs also believed this to be one of the reasons they had difficulty developing long-term plans and demonstrating their effectiveness over-time.

A: “….it’s a three year contract, which is a lot better than some of me colleagues, but it’s still not great, because if you’ve not got permanency, you know, I had a week off and staff thought I’d left, in A & E, you know. Yeah, granted that was in the beginning but they still keep thinking I’m just gonna go away in a few years cos me money’s gonna run out or whatever, and then
that doesn’t help cement, you know, you’re trying to embed new practice into staff’s practice, and that doesn’t help with it…” (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’)

3.2.3. Proving your worth

Due to the uncertainty surrounding the commissioning of alcohol services, the ability to demonstrate effectiveness was considered a priority by the majority of AHWs and organisations providing alcohol services within acute hospitals. Nevertheless, concerns were raised with regards to the ways in which effectiveness was measured. Several participants felt that their worth was not adequately captured using numbers alone. One AHW in particular felt strongly about the way in which their work was reduced to the number of intervention leaflets they handed out.

A: “It’s a tick box exercise some of the time and as much as we can do training with the clinicians and nurses we’re not... Yeah, when we’re there they will do it absolutely perfectly. But I know come two o’clock in the morning you’re not going to... People aren’t doing it right, it’s like giving them a booklet and that’s their intervention, which SIPS have said that that’s an intervention in itself. However, if that’s the case why do we not just give everybody a booklet, a little health promotion bag when they book into A&E with diet, smoking, alcohol, they can pick what they want out of it, we’ve gave everybody an intervention then if that’s the level that they’re happy with. And that’s how it’s measured”. (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

Some AHWs also expressed concern over the fact that those commissioning services often had very little understanding about the role of hospital-based AHWs.
A: “I would argue that my current commissioner doesn’t have any idea what I actually do, even though I send [them] nice big reports and stuff, I don’t think they really read them. They’re both, they’re bothered about that people having an intervention, what that intervention consists of, what I actually do, they don’t know”. (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’)

In an attempt to counteract this, a number of AHWs described having incorporated “qualitative case-studies” in their feedback reports as a means of presenting a more “holistic” picture of the work they undertook, as a method of engagement, and as a tool with which to increase the understanding of alcohol services.

A: “We try and do about four case studies a year, so it’s not a lot, it’s like one a quarter, and it just gives you a real true depth of understanding about, what are these [patients] we’re seeing are like, what are the issues they’re presenting with, and what am I doing about it?” (‘4RT7 - site 3: Male nurse, AHW, employed by a Third Sector Provider’)

A: “Mm, so you can measure impact from, from such process measures and about how many people do you see and how many referrals do you receive and how many people do you have referred to you that you don’t see, and so on and so on and so on. But the more qualitative stuff is, is perhaps the bit that keeps you doing the job……. For me, the most valuable feedback, the most valuable qualitative measure, is the feedback you get from the clients, the service users, they, the patients.” (‘PJSZ – site 1: Male nurse, AHW, employed by a Third Sector Provider’)

The majority of those interviews felt that the reason their work was not fully understood and was considered low priority was due to the fact
that AHWs were able to stem the flow of alcohol problems within the hospital. Several AHWs commented that the extent of alcohol-related problems presenting in hospital would be better realised if alcohol services did not exist. They felt that perhaps they were victims of their own success, effectively managing to keep problems at bay, yet without the resources to realise their full potential long term.

A: “I think what it boils down to is extremely busy people with targets in any number of areas of which alcohol is deemed to be low priority and non-problematic. Yes, and again, possibly a victim of my own success, because we tend to manage situations before they get out of hand and before anybody gets hurt, and before anybody gets into newspaper headlines, you know, random patient creating havoc in local shopping area, that sort of thing. So, possibly a victim of my own sort of success. You know, cynically, sometimes services are commissioned or money has become available on the back of certain tragedies in some cases or near misses or complaints”. (‘GA8G – site 4: Male nurse, AHW manager, employed by the Acute Trust’)

A: “……it’s impossible only to do what you’re commissioned to do. So we do the extra work above and beyond what we’re paid for and what our roles are paid for. But it’s because it’s necessary and it’s very, very hard to justify yourself when you’re trying to provide a service; yeah, I’ll provide it for you but I won’t provide it for actually probably the most vulnerable people that actually could really doing with that specialist input”. (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

As a result, outcome measures reported by AHWs and those involved in commissioning services tended to focus on numbers of patients screened and the total number of brief interventions carried out. The
reasons behind this tended to be as a result of research suggesting that such interventions were beneficial. However, most AHWs felt that the “nitty gritty” of their role was not something that commissioners were interested in.

A: “….currently the funders, they wanna know the numbers seen, whether they were male or female, what age and ethnicity they are. So all your kind of demographical data. They, they wanna know some, some very brief qualitative, what, what is the value of the work that you’ve done, but mainly it’s pretty much numbers. How many people have you seen? They don’t care about what you do with them, but how many people have you give like leaflets to, how many people have you done something with, I guess.” (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’)

A: “The people who fund us, like I said, they want us to focus on increasing in higher risk drinkers. Now, the way they measure whether or not we’re doing that is we tell them every month how many people over the age of 16 have attended the A&E department. We then tell them out of that eligible amount how many people have been screened using Audit C, and then we tell them how many people out of that lot scored more than five, scored positive, and that’s how it’s measured. Now, what we are noticing with that is screening somebody, the people could do… What counts in my head is the intervention. Screening somebody is pointless unless somebody is taking the time to do something with that answer”. (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

Widespread incongruence between the outcome measures specified by commissioners and the AHW role that has evolved over time was evident in participant accounts. Most hospital-based AHWs who were
interviewed tended to be less involved in screening and brief advice and were increasingly likely to be involved in liaison with outside agencies and the medical management of patients experiencing acute alcohol withdrawal. Consequently, several AHWs queried whether the data they were being asked to gather was meaningful and proposed that greater emphasis on the “feedback you get from the clients, the service users” and long-term outcomes (abstinence, re-admission rates, social re-engagement) was a better reflection of their achievements. However, many of the interviewees asserted how difficult it was to measure these aspects of their role.

A: “We can’t measure the liaison stuff, we’re not great at measuring that sort of stuff. We have a database we put it all on, and I think they are looking at it now cos they’re looking at, you have to put times in, how long you were on the phone for and stuff. But at the minute we don’t. But there’s, some of the conversations that we have with people aren’t measurable, because some of the conversations just aren’t about alcohol or drugs. It’s a holistic assessment, so it’s about their entire life, you know”. (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’)

A: “the stats don’t show it for what it really is, because when a person comes in they’re not always put down as intoxicated, and on computer systems, if you’ve not checked a box you can’t pull off the data correctly. So there’s a massive issue with recording data for people, cos if you look at people there’s probably, what, a hundred, if that, coming through our A & E. But I’m telling yah that when I did informal clinical audits, so I might have missed one or two, there were two hundred and fifty through, who came through last year, so it’s like double what the actual figure said”. (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’)

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In addition, a number of AHWs discussed the difficulties associated with having to engage staff when the benefits of intervention were unlikely to be realised immediately.

A: “The other thing is it’s [effect of IBA] very difficult to measure, it’s also very difficult to...when we’re trying to promote how beneficial IBA is to emergency care staff. Now, they save lives every single day, they like immediate effects. If they’ve got a cut they want to put a stitching in it, that’s it, dealt with. You’ve got a broken arm, put a plaster on it. With this it's like in ten years' time you’re going to see the benefit”. (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

The dictionary definition of a ‘Catch-22’ could be used to encapsulate the thoughts of many of the AHWs interviewed in relation to the provision of alcohol services based on the effectiveness of services:

Catch-22, noun.

A dilemma or difficult circumstance from which there is no escape because of mutually conflicting or dependent conditions. "A catch-22 situation".

AHWs felt that in order for services to prove their effectiveness there needed to be appropriate outcome measures and sufficient provision in place to be able to achieve their potential in the first instance.

A: “I personally feel about the value of that role in the hospital, in very crude terms, we’re not making such a significant dent in savings that we could say actually look how much of a positive impact this is having, you know, because the bottom line is about cash in an environment which is under a lot of pressure to save money and certainly in [this area], there is significant
pressures in the local authority, let alone within the NHS bits, CCG locally about savings and getting best for services, it wouldn’t be high on the list, if I’m completely honest, on numbers terms, so if you’ve got more of the hospital staff really embracing it, then actually you begin to see, we want that to go on and actually you’d be uncovering more people that could benefit from additional work, because that’s the bit about we don’t want to stop, we want the wider work force doing that, to grow doing that, but then it’s the capacity behind for community services or more specific specialist services in the hospital to pick that up, so if you’ve got more of the hospital screening, then you could say, actually, we probably need two posts, three posts and one of them could be a nurse and what value would that give?” (B4QW – site 2: Female non-nurse, Commissioner, employed by the Local Authority)

A: “There was just sufficient evidence to know what was necessary in a general hospital, and so by doing that the, the need increased, and that, that was a little bit around we know that more people get admitted to hospital than they used to, but it was also about we became, we, as in the host Trust, became better at identifying them, so better at screening and the brief advice, the identification brief advice element, and obviously identification and brief advice in isolation is unlikely to work because all that’s gonna do is identify the ones that need more than identification and brief advice. So as that happened they needed, at the same time, the service to refer to, so. And, and, and I think there’s a significant evidence base for this now that IBA by itself is insufficient, IBA needs to be grown at the same time as the support services to deal with the issues that you identify”. (PJSZ – site 1: Male nurse, AHW manager, employed by the Mental Health Trust)
3.2.4. Divided loyalties

The external funding and management structure of the majority of hospital-based alcohol services and AHW posts were described by AHWs as effectively creating a dichotomy between public health needs and the acute health care needs of the hospital population.

A: “The hospital doesn’t understand the...what is commissioned by the local CCGs and DACT, et cetera, they don’t understand the targets, for instance, triages, screenings and delivery of tier 3 interventions, et cetera, and why would they? There is a lack of understanding about what happens beyond the general hospital, i.e. what happens when somebody goes to a specialist alcohol facility? Primarily the general hospital, I think, is concerned with clearing beds early and save money that way, I would imagine”.

Q: “Yes, and do you find that that causes a problem, that kind of disconnect between the hospitals aims and objectives and perhaps the aims and objectives coming from the alcohol service, the in-reach service?”

A: “Yes, definitely”. (‘GA8G – site 4: Male nurse, AHW manager, employed by the Acute Trust’)

A: “I think in terms of funding it needs to be less patchy. We shouldn’t be reliant on charities to, to fund this sort of work, because what the charity ultimately wants to get out of it, and what we as a health NHS Trust want to get out of it, sometimes are conflicting and are different”. (‘4RT7 – site 3: Male nurse, AHW, employed by a Third Sector Provider’)


The perceived need for AHWs to focus their attention on dependent patients within the acute hospital was eloquently captured in a quote from one of the AHW managers interviewed.

A: “what we always do is we need to look at what the hospital needs, we’re working in a hospital, we need to see where the greatest need is. The greatest need when you talk to anybody is we’re not talking about the likes of myself that maybe have a couple of glasses of wine with a dinner of an evening. Yes, it’s too much and I would need brief advice, absolutely. But if I’m on a ward with a broken arm, I’m not causing problems. However, if I was alcohol dependent and I was on a ward with a broken arm, I would be causing lots of different problems because I would be withdrawing, I would need more medication, I would be anxious, I would need support. They’re the people that…and I’m using the word problem patients and I’m not talking about everybody’s personality, I’m talking about they demand more work, they need more work…” (‘RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust’)

However, one of the commissioners interviewed had a different opinion and felt that hospital-based AHWs should focus on identification and brief advice whilst encouraging ward staff to take ownership of this.

A: “It was always our intention that...as we know that brief interventions are effective and we know that there’s evidence that brief interventions work with increasing and higher risk drinkers, that was where the focus would be, because dependent drinkers need something different. And they would be more obvious to staff and... I guess that has been a, kind of, spin off that, at least staff who are seeing patients with a more obvious alcohol problem know that there is a community-based service to whom they can refer. But, we really wanted to target
the increasing and high risk drinkers who may not be so obvious and for whom that opportunistic intervention would make a real difference”. (XWZP – site 2: Female non-nurse, Commissioner, employed by the Local Authority)

Nevertheless, all of the hospital-based AHWs interviewed reported predominantly working with alcohol dependent patients as opposed to those at ‘increasing risk’ and ‘high risk’ of alcohol related harm.

A: “They [dependent patients] need a lot more input and that’s where I see the alcohol services in acute hospitals really focusing the majority of the work and I know my teams try and spend…we spend as much time as we can on IBA but actually where we’re spending the majority of our work is with dependent drinkers”.

(RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust)

A: “…the message we get across is that everybody who is alcohol dependent should definitely get referred to our team. They’re likely to need medications for withdrawal symptoms and, you know, we, we want to refer on even if they don’t consent, just so we can get involved with that medical management”.

(9LBE – site 1: Female nurse, AHW manager, employed by the Acute Trust)

The majority of AHWs described feeling “torn” between addressing the public health needs specified by the organisations funding their posts and the needs of the patients who presented in hospital.

A: “The alcohol service has changed over time because when we were first employed it was a public health approach, so it was very much health promotion, identification and brief advice of harmful and hazardous drinkers, and we were expecting frontline staff to do a lot of screening and give out booklets and
a lot of health promotion stuff. That's obviously got its place and that's got to be done, I understand that. However, you're torn from an alcohol service because that's what commissioners want to see. What the Acute Trust want to see is that chaotic patient that we spoke about, getting brought into meetings, being strategically managed, being case managed, care facilitated really and that's what the Acute Trust want us to see”. (RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust)

A: “I think my teams are going to have to be split up where we might have to have a case manager on the teams and somebody else that's just doing warding and IBA work”. (RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust)

In addition, a number of AHWs also spoke about external agencies with whom they liaised and described how they also felt a sense of loyalty towards them. As a result, AHWs often found themselves ‘piggy in the middle’ having to negotiate conflicting demands on their time and resources to ensure continuity of services. In this regard, one of AHWs expressed that they considered it inappropriate for charity organisations to fund NHS work in view of their different perspectives.

A: “...providing that conduit, so for community drug and alcohol services we represented the hospital, to the hospital we represented community alcohol and drugs services. So it was a two-way thing, a daily ongoing passing of information to improve patient care, seamless patient journeys and such things”. (PJSZ – site 1: Male nurse, AHW manager, employed by the Mental Health Trust)

A: “I think the Acute Trust need to take some responsibility for paying for it themselves, because at this moment in time they don't at all, and they're probably the ones that are getting the most benefit out of it. It should come from an Acute Trust but then we would only have to answer to an Acute Trust as well, so
we could do what the Acute Trust needs and what they want. So actually do we get better results because we could focus all our heart and energy into what is needed in that hospital instead of pacifying? Well, I pacify, for eight different organisations, four different commissioners in four different hospitals I'm trying to juggle with which is ridiculous. ......if it was just the trust that was saying this is the service that we provide, that's it, instead of commissioning, different individual commissioners having influences over what we need to provide in each area". ("RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust")

What became apparent was that despite AHWs’ propensity to work with dependent patients within the hospital setting, the resources available to them to facilitate their treatment and provide what they considered to be an adequate service were limited.

A: “.....if we’re all full-time, you know, we could do seven days a week, we could run our clinic, outpatient clinic, at the weekend, we could do our liver disease clinic more often. You know, we’re, we’re only doing that with one consultant at the minute, you know, there would be work maybe to do with other consultants, as well, with their patients, you know, and, and there’d be more scope to implement other services as well. We’d like to also do an alcohol, so for example, those patients who are discharged early without finishing our detox, we’d like to commence a clinic where that detox, detox could continue. But that would need more staff cos they would need to come in each day, etc.” ("9LBE – site 1: Female nurse, AHW manager, employed by the Acute Trust")

A: “Obviously if they’re known to alcohol services we’d liaise with them, community services, but I doubt that they would be able to go out every day. But we don’t have that facility that I’ve
heard some people do, where they go out to the house or whatever and give them the medication. I, I think we'd like, as a team, to be able to say come back to clinic and we'll give you your medication every day, and do it that way, but we're not in that place at the moment to do that”. (‘NNE5 – site 1: Female nurse, AHW, employed by the Acute Trust’)

Several AHWs spoke of the difficulties associated with detoxification of patients within the hospital. One of the main issues for the majority of AHWs was that patients could not be admitted for detoxification alone and had to present with another condition for which they were receiving treatment. This meant that patients were not detoxed on a specialist ward, had variable detox regimes, and were often discharged having only completed part of their detoxification. This resulted in several AHWs reportedly having told patients to recommence drinking in order to control their withdrawal symptoms.

A: “GPs might do a GP referral saying I’ve got somebody coming in, they want a detox, and you would find that the reason for admission is alcohol withdrawal, kinda thing. But then that’s unfortunate, in my opinion, because then that all depends on the consultant in charge of their care to keep ‘em in for the full detox, and if there’s no other medical reason they might decide on day two/three, oh let’s get, let’s get you home, and their detox isn’t complete. So they’ve started it, you know, and we don’t discharge with detox medications, and it’s, it’s a case of us saying to them, well you, you may have to drink to con, control your withdrawal symptoms, you know. It’s a bit unfortunate, you know, kinda thing”. (‘9LBE – site 1: Female nurse, AHW manager, employed by the Acute Trust’)

A: “We’ve got a ruling at the Acute Trust, unless you’re admitting for another medical reason you do not purely for an alcohol
detox and it makes sense. It breaks my heart sometimes but it makes sense because you get people turning up to A&E...and I'm going to say people, I mean plural, every single day coming in and requesting a detox from alcohol. And it's like oh, it's Tuesday, I feel like giving up drinking today. There's been no preparation, there's been no motivation beforehand, it's just now wife has said I'm kicking you out if you don't stop drinking. So they've came to A&E for that. You come to a hospital, you don't get a proper...yeah, you get a detox because you get the pharmacology, what you need to stop your withdrawals. But when it comes to the psychosocial the only thing you're going to get is maybe three quarters of an hour a day with an alcohol nurse. The rest of the time you've not got anybody coming round and talking to you, upping your motivation. So actually how successful hospital detoxes are I think are questionable as well.”

('RU4B – site 3: Male nurse, AHW manager, employed by the Acute Trust')

Furthermore, community detox services appeared to be few and far between as a result of inadequate funding and staffing. In some instances, patients were told to “complete their detox using alcohol” with telephone support from AHWs and outpatient clinic appointments. Where in-patient detoxification beds were available, this was described as advantageous and a dedicated facility was considered the “gold standard”. Similarly, links with community teams were considered key to the success of treatment.

A: “I've got very, very good relationships with the majority of the consultants and the doctors, especially in A&E and on the emergency admission ward and medical assessment unit, again, I think it helps me being external, because they know that actually we've had people come in that are unable to work at, you know, to know immediately whether there's a plan going on.
I work very closely with the doctors as to whether or not it’s relevant to keep people in for detox or whether I’m going to pick up and we’ll take them out...we’ll sort them out in the community, we have a real ongoing dialogue with regard to, you know, what’s a relevant path and having access to [an alcohol service] outside and [alcohol] key workers for anyone that’s here, then I know exactly what’s going on". (DKG0 – site 2: Female non-nurse, AHW, employed by a Third Sector Provider’)

3.3 Summary
Together the quantitative and qualitative findings provide us a unique portrayal of the role of hospital-based AHWs. Furthermore, they help to identify areas for improvement and provide information with which to develop a basic prototype for hospital-based AHWs. What follows is a discussion relating to four main components of hospital-based AHW services: service delivery, management structure, funding provision, and demonstrating effectiveness. Each will be discussed in turn to identify the extent and diversity of hospital-based AHW provision across England and to describe what have been found to be effective ways of working.
4. Discussion:

In discussing the implications of the findings, it should be borne in mind that our survey covered only 45 hospitals out of our random sample of 115 and we focused on four hospitals in the qualitative research. Nevertheless, we are confident that this study makes a useful contribution in a field that has been rather neglected in terms of research, despite the increasing saliency of AHWs as a policy issue.

4.1 Precarious services

The overriding impression from this study is that AHWs represent a somewhat variable and precarious service. Part of the apparent insecurity and uncertainty that pervades these services no doubt relates to their novelty: AHWs are a relatively new phenomenon and these services have expanded rapidly in recent years (Thom et al., 2013). Many of these services were therefore still ‘bedding in’, responding to initial problems and finding their place within the hospital. As one of the interviewees pointed out, ‘it can take a decade’ for a new service to really take root within the NHS.

However, there seemed to be other reasons for this precariousness. There was considerable variation in the funding arrangements, often with multiple funders. Only 7 per cent of AHW provision in the survey was funded solely by the Acute Trust. The largest category of funding arrangement was partnership funding majority of services (36%) – the majority of these partnerships between the PCT and the Acute Trust. The qualitative research suggested that these funding arrangements could be associated with a lack of ownership of the service – particularly where there was no funding from the Acute Trust. There was a strong sense that Acute Trusts needed to have a literal and figurative
investment in services if they were to be recognised and supported within the hospital environment: not least because they benefitted most from the work they undertook.

While concerns about short-term funding are becoming familiar in the addictions field, there seemed to be particularly insecure funding arrangements in place for AHWs. For some, this could affect motivation and use up valuable time in putting together bids and applications. Furthermore for qualified nurses, the precarious nature of these posts was starkly in contrast to other nurses working the same hospital [any evidence to support this?]. Complex funding arrangements and limited acute trust involvement often came with a perceived lack of support from management. Several interviewed AHWs expressed concern over the way in which they were managed and many stated that their management was inadequate in terms of the support they received within the acute hospital. In such a situation, it was easy for AHWs to feel invisible and isolated – particularly where they were not part of a larger team.

4.2 Variation and coverage

The survey found that 94% of responding hospitals had a dedicated AHW. This suggests that these posts have indeed spread like wildfire through acute care. However, there may be a bias here in that non-responding hospitals may have chosen not to respond because they had no-one to talk about AHWs because they had no provision. The number of AHWs employed by hospitals varied between 0.6 and 6 WTEs. This is represents a very substantial variance in provision. While we found that the level of need (alcohol-related admissions) was positively associated with acute hospital-based AHW provision, it certainly does not explain this level of variation. Nevertheless, our finding is in contrast
to previous research that showed no such relationship between need and provision (Ward and Aulton, 2010).

Our research found considerable variation in terms of the coverage of hospital-based AHW provision. The majority of services ran from 9am to 5pm on weekdays. However, 38% of services provided evening cover and 42% provided cover at weekends. Only a minority of services provided care for adolescent and paediatric patients.

The AHW role is clearly multifaceted: the large majority undertaking IBA, liaison with outside agencies, education, detoxification, protocol and care pathway development, follow-up and discharge planning and the management of ‘frequent fliers’. Over two-thirds were involved with prescribing and medical management and a similar proportion worked in outpatient clinics. However, there was clearly variation in how AHWs work was distributed across these tasks. Ultimately, given the number of alcohol-related admissions, most services had to prioritise. Interestingly, there was a tendency for AHWs to migrate up the alcohol problem ladder. While services tended to start with a strong focus on IBA, over time services increasingly worked with dependent drinkers. Of the patients seen by AHWs, dependant, high risk, and increasing risk drinkers accounted for 70.9%, 20.4%, and 9.8% respectively. This increasing focus on dependent drinkers is likely to reflect the pressing issues posed by detoxifying patients.

### 4.3 Detoxification

While not a particular focus of the study, problems with hospital detoxification arose as a significant issue in the qualitative study, with some detoxifying patients being advised to start drinking again on departure from hospital to avoid withdrawal symptoms. AHWs are ideally placed to facilitate a smooth transition from the acute setting.
into community services and clearly defined treatment pathways would go some way to ensuring consistency among alcohol dependent patients. It was clear from interviewees that liaison with external agencies involved in alcohol services was imperative.

4.4 Demonstrating effectiveness
Throughout the qualitative interviews, AHWs emphasised the importance of being able to prove their effectiveness and in doing so, secure the future of the alcohol services they provided within the hospital. Nevertheless, AHWs were frustrated by the lack of congruence between the work they did in the hospital and the outcome measures used to demonstrate their overall effectiveness. AHWs asserted how difficult it was to accurately measure their performance based on statistics relating to admissions, screening and brief intervention, since they were often reliant on other members of staff to deliver these. The qualitative data indicates that embedding alcohol screening tools within existing universal patient documentation may increase the likelihood of completion by ward staff. Similarly, NICE recommendations can be utilised to support the implementation of guidelines within the hospital and to encourage and motivate staff.

Qualitative case-studies, used by several of those interviewed, appeared to be a useful way of capturing the holistic work of AHWs within hospitals and may improve the understanding of those funding alcohol services. In addition, AHWs felt that greater emphasis should be placed on patient satisfaction and the trajectory of patients’ alcohol consumption following intervention, by establishing joint working with external agencies and community NHS services. Likewise, hospitals should contemplate developing a clear pathway for patients dependent on alcohol and a consistent approach to their treatment according to evidence based guidelines.
4.2 The Future

The precarious nature of AHW services raises questions about whether and how these services could be given a firmer footing. The Government simply ‘encourages’ all hospitals to employ Alcohol Liaison Nurses in the current alcohol strategy but this may not be encouragement enough if a minimum national service is to be developed. Given strong financial pressures and the immediacy of ill-health and disease, the more preventive role played by AHWs may require financial incentives from the centre.

The variability in provision raises questions about standardisation. Of course, local services need to reflect local needs. However, the considerable variation in AHW provision does not simply reflect local needs: it is likely to reflect the presence or absence of local champions and the degree to which alcohol is taken seriously by commissioners. There may be worth in drawing up minimum requirements for AHW teams – or alcohol teams – in hospitals.

An important issue here is the strength of the evidence base. If AHWs unarguably could be shown to decrease admissions and save money, the argument for a properly resourced service is greatly strengthened. While the multi-faceted nature of their role and the frequently delayed nature of their impact makes outcome evaluation challenging, nonetheless this should be a priority for future research.

More immediately, there seems to be a clear need for better management and peer support. There is a worrying tendency for AHWs to feel undervalued and isolated in their posts. It may be that this is partly a consequence of the cross-cutting nature of the role, which is largely peripatetic. However, proper ownership of AHW services by NHS hospital trusts, with attendant management would be likely to go some way towards improving this situation.
4.1. Limitations

The cross-sectional nature of this study design means that we were only able to capture the state of play at a national level at one ‘snap-shot’ in time. In addition, the generalizability of the results are limited to English NHS Hospitals, and may not be comparable with hospitals in other countries within the United Kingdom (Scotland, Wales and Northern Ireland) as a result of different policies and agendas that influence the services they provide. Nevertheless, the findings provide a point of comparison for future studies that aim to capture the changing landscape of AHW provision, something that has not been attempted since a 2003 survey, which identified only 21 specialist alcohol nurses at the time (Owens et al., 2005). A more recent survey focused only on Specialist Alcohol Nurses working in emergency departments (Patton et al., 2007). Similarly, the qualitative interviews only portray the perceptions of AHWs and associated staff at one moment in time. Moreover, although the case-study hospitals were chosen on the basis that they represented the spectrum of alcohol services across England, the diverse nature of such services increases the likelihood that there are alternative models of working. Therefore, the qualitative findings from our exploratory study provide insight into hospital-based AHW roles on which further research could be based.
5. Conclusion:
The extent and diversity of acute hospital-based AHW provision across England is variable with regards to: staffing, roles, operating hours, patient type, and funding. Nevertheless, we have shown that AHWs who work in acute hospitals are most often qualified nurses who predominantly work in the admissions unit and see a high proportion of adults who are alcohol dependant. Our qualitative data contributes a deeper understanding of the extent and diversity of AHW services currently in operation and enables us to draw conclusions about specific aspects that potentially facilitate or hinder services.

Our research suggests that hospital-based AHWs should have an in-house (hospital) point of contact. In addition, support from management within the acute hospital appears imperative for the successful integration of alcohol services. Linking alcohol services to other well-established specialities such as mental health or safeguarding may provide the opportunity for AHWs to increase the awareness of their work and take advantage of existing support mechanisms.

**Significance**

- Our research provides an up-to-date representative picture of the extent and diversity of AHW provision in England.
- Our research provides a point of comparison for future studies that aim to capture the changing landscape of AHW provision.
- Our research contributes a deeper understanding of the different AHW services currently in operation
- Our research has the potential to inform future policy and practice development in this area at central and local levels.
6.1. List of publications

• Baker, S. Lloyd, C. and Mdege, N. A National Study of Acute Hospital-based Alcohol Health Workers. British Journal of Nursing. (Submitted)

6.2. List of conferences

• SSA (Society for the Study of Addiction) conference (7th & 8th November 2013). Poster presentation: A national study of acute hospital-based Alcohol Health Workers (Error! Reference source not found.).

• Drawn on in a plenary presentation at the Royal College of Psychiatrists Joint Addictions & Liaison Psychiatry Conference, 5 June 2014.
7. References


Touquet R and Brown A. (2006) Alcohol misuse: Positive response. Alcohol Health Work for every acute hospital saves money and


Appendices

Appendix 1: Participant information sheet (telephone questionnaire)

We are inviting you to take part in a telephone survey that forms part of a national study of acute care Alcohol Health Workers. Your decision to take part is entirely voluntary. If you do not wish to take part, this will not affect you in any way. If you agree to take part you can withdraw from the study at any time and do not have to give a reason.

Why are you asking me to take part in this study?
At present, there is limited understanding of the national coverage of services provided by Alcohol Health Workers. Therefore, we are interested in quantifying the extent and diversity of the provision of hospital-based Alcohol Health Workers in England.

What will be involved if I agree to take part in the study?
If you agree to take part, a mutually agreed time and date will be arranged on which the telephone questionnaire will take place. During the questionnaire you will be asked to talk about key facts in relation to Alcohol Health Workers at your hospital. For example, information relating to the numbers of staff employed, their professional qualifications, their working hours, their role in the hospital, their areas of work, referral data (processes and sources), patient contact data (referrals, contacts, routine data collection) and information relating to the funding and ownership of the service Alcohol Health Workers provide. The discussion will not be tape recorded and the researcher conducting the telephone questionnaire will take notes. This should take approximately 20 minutes.

Who will have access to the information I provide?
Telephone conversations will be conducted in a separate room to maintain confidentiality and will not be recorded. Any transcribed material will be kept in a locked drawer at the University of York, accessible only to the research team. Data transferred for analysis purposes will be anonymised upon transfer and will be password protected. Any information you provide is confidential. Any quotations used in future publications will be anonymised so that you cannot be identified.

Where is the study taking place, and for how long?
The telephone questionnaire will take place at a pre-arranged time convenient to you. The time taken to complete the questionnaire will be approximately 20 minutes.
What will happen with the information you gather?
We aim to publish the study in journals and present our findings at conferences so that the results are disseminated to a wider audience, including health professionals. No names will be mentioned in any publications and care will be taken so that individuals cannot be identified in reports of the results of the study.

What are the benefits of taking part?
There may be no direct benefit to taking part. However, the information we obtain will improve our overall understanding of the extent and diversity of the provision of Alcohol Health Workers in acute hospitals in England and may contribute to policy and practice development in this area.

What happens next?
If you would like to discuss the study before deciding to take part, then please contact me or send an email (see below).

If you want to take part, please contact me via telephone or email to arrange a convenient time to conduct the telephone questionnaire. Please note that in doing so you are providing your consent to take part.

Thank you

Sarah Baker
Research Fellow
Room A/RC/206
Department of Health Sciences
The University of York
Alcuin C Block
Heslington
YO10 5DD
(01904) 321516
sarah.baker@york.ac.uk
Appendix 2: Telephone questionnaire/ prompt sheet

Telephone Questionnaire/ Prompt sheet

Name of Interviewee:...........................................................................................................
Position held by interviewee:..............................................................................................
Strategic Health Authority:.................................................................................................
Hospital Trust:......................................................................................................................
Hospital site:.........................................................................................................................
Total population covered:....................................................................................................
Alcohol related admissions 2011-2012:..............................................................................

1. Please could you give me a brief summary of the services your hospital provides in relation to alcohol

2. Does your hospital have one or more individuals whose work is predominantly dedicated to/specialising in alcohol? (please circle)
   Yes          No    (if no go to question 29)

3. How many FTE are there at your hospital whose work is predominantly dedicated to/ specialising in alcohol?

4. Which year was a dedicated/specialist alcohol worker first introduced in your hospital?
   Number of years established:
5. What are the role objectives of dedicated/specialist alcohol workers in your hospital? (please circle all that apply)

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<tr>
<th>Role Objective</th>
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<td>Assessment</td>
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<td>Intervention/ brief advice</td>
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<td>Prescribing/ medical management</td>
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<tr>
<td>Follow-up/ discharge planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>'Frequent fliers' project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provision of written information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. What titles are given to dedicated/specialist alcohol workers in your hospital?

<table>
<thead>
<tr>
<th>Title</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Health Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Liaison Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol (Specialist) Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol counsellor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Misuse (Specialist) Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. What qualifications are held by the dedicated/specialist alcohol workers in your hospital?

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Does the service provision provided by dedicated/specialist alcohol workers in your hospital include evenings? (please circle)

<table>
<thead>
<tr>
<th>Service Provision</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
9. Does the service provision provided by dedicated/specialist alcohol workers in your hospital include weekends? (please circle)
   Yes   No

10. Who funds the work of dedicated/specialist alcohol workers in the hospital?

<table>
<thead>
<tr>
<th>Fund Source</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Trust</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>PCT</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>DAT (Drug and Alcohol Team)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Third sector Provider (please specify who)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Partnership (please specify who)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other (please specify below)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

11. Who has overall responsibility for the service dedicated/specialist alcohol workers deliver in the hospital?

<table>
<thead>
<tr>
<th>Fund Source</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Trust</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>PCT</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>DAT (Drug and Alcohol Team)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Third sector Provider (please specify who)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Partnership (please specify who)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other (please specify below)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

12. Where do dedicated/specialist alcohol workers work in the hospital? (please circle all that apply)

<table>
<thead>
<tr>
<th>Location</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Intensive care</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Surgical ward</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Appendix 3: Participant information sheet (semi-structured interview)

We are inviting you to take part in a face-to-face interview that forms part of a national study of acute care Alcohol Health Workers. Your decision to take part is entirely voluntary. If you do not wish to take part, this will not affect you in any way. If you agree to take part you can withdraw from the study at any time and do not have to give a reason.

Why are you asking me to take part in this study?
At present, there is limited understanding of the national coverage of services provided by Alcohol Health Workers. Therefore, we are interested in quantifying the extent and diversity of the provision of hospital-based Alcohol Health Workers in England.

What will be involved if I agree to take part in the study?
If you agree to take part, a mutually agreed time and date will be arranged on which the interview will take place. The interview will take place at the hospital site at which you work. During the interview you will be asked to talk about key themes in relation to the services provided by Alcohol Health Workers at your hospital. For example, the history of the service, the aims of the service, the factors that influence services and how the service management shapes the work done by Alcohol Health Workers. The discussion will be tape recorded and the researcher conducting the interview will take notes. This should take approximately 30-60 minutes.

Who will have access to the information I provide?
Interviews will be conducted in a designated room to maintain confidentiality and will be audio recorded. Any transcribed material will be kept in a locked drawer or password protected file on a computer at the University of York, accessible only to the research team. Once the data has been retrieved from the recording devices the recordings will be erased. All data transferred for analysis purposes will be anonymised upon transfer. Any information you provide is confidential. Any quotations used in future publications will be anonymised so that you cannot be identified.

Where is the study taking place, and for how long?
The interview will take place at the hospital site at which you work at a pre-arranged time convenient to you. The time taken to complete the questionnaire will be approximately 30-60 minutes.

What will happen with the information you gather?
We aim to publish the study in journals and present our findings at conferences so that the results are
disseminated to a wider audience, including health professionals. No names will be mentioned in any publications and care will be taken so that individuals cannot be identified in reports of the results of the study.

What are the benefits of taking part?
There may be no direct benefit to taking part. However, the information we obtain will improve our overall understanding of the extent and diversity of the provision of Alcohol Health Workers in acute hospitals in England and may contribute to policy and practice development in this area.

What happens next?
If you would like to discuss the study before deciding to take part, then please contact me or send an email (see below).

If you want to take part, please contact me via telephone or email to arrange a convenient time to conduct the interview and return the signed consent form to the address below.

Thank you

Sarah Baker
Research Fellow
Room A/RC/206
Department of Health Sciences
The University of York
Alcuin C Block
Heslington
YO10 5DD
(01904) 321516
sarah.baker@york.ac.uk
Appendix 4: Participant consent form

CONSENT FORM FOR PARTICIPANTS

Title of Project: A national study of acute Alcohol Health Workers

Name of Researcher: Sarah Baker

1. I confirm that I have read and understood the information sheet dated October 2012 (Version: 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I understand that any information I provide, including personal details, will be confidential, stored securely and only accessed by those carrying out the study. The interview transcripts will be stored securely for approximately two years (the duration of the project).

4. I understand that any information I give may be included in published documents and every effort will be made to protect my identity, including the use of pseudonyms.

5. I agree to take part in the above study

6. I agree to you contacting me to confirm the venue/time/date of the interview by telephone or email

Preferred telephone/ email address………………………………………………

Name Date Signature

…………………………………………………………………………………………

Name of Person Date Signature

Taking consent

…………………………………………………………………………………………
Appendix 5: Interview topic guide

**Introductions** (2 minutes)

- Check consent/ understanding/ confirm timings (approx. 30-60 minutes)
- 

**Key topics:**

1. How would you describe the history of alcohol services in your hospital?
   a. Why was it needed?
   b. How has it changed over time? And why?

2. What are the key aims of the alcohol service in your hospital?

3. How would you describe the management structure of the alcohol services in your hospital?

4. How does the management structure influence the way medical staff work with AHWs?

5. How do AHWs fit into the alcohol services provided by medical staff?
   a. Relationships
   b. Identification/ screening of patients
   c. Notification of patients
   d. Treatment

6. What titles are used to describe AHWs in your hospital?
   a. What attracted you to the role?

7. What do you perceive to be the main roles of AHWs in your hospital?
   a. Are AHWs involved in detox?
      i. How does it work? (who, where, when)
      ii. What works well?
      iii. What doesn’t work well?
      iv. How could it be better?
   b. Do you consider yourself a specialist?
8. What are the key aims and objectives of the services provided by AHWs in your hospital?
   a. Are there specific targets/ measurable outcomes AHWs need to achieve?
   b. Who specifies these targets and why?

9. What types of impact do AHWs have in your hospital?
   a. How is this impact measured?

10. What factors influence the services AHWs provide?
   a. Factors that facilitate
      i. Relationships with staff
      ii. Support from senior management
      iii. Protected time dedicated to alcohol related work
      iv. Funding (time period of funding/ future of funding provision)
   b. Factors that hinder
      i. Relationships with staff
      ii. Support from senior management
      iii. Protected time dedicated to alcohol related work
      iv. Funding (time period of funding/ future of funding provision)
      v. What would help improve the work done by AHWs?

11. In your opinion, what would be an ideal AHW service?
   a. How would it work?
   b. How many staff would be required?
   c. What qualifications would the staff require?
   d. How would such a service be funded?
   e. How would the service fit with other hospital services?

**Conclusion/ debrief** (5 minutes)

- Ask interviewee if there is anything they would like to add.

Thank participant for taking part and ask if they have any further questions about the study.
A National Study of Acute Hospital-Based Alcohol Health Workers

Sarah Baker\(^1\) and Charlie Lloyd\(^2\)

Research Fellow\(^1\), Addictions Lead\(^2\), Mental Health and Addictions Research Group, Department of Health Sciences, The University of York, Heslington, YO10 5DD

Introduction

- AHWs (Alcohol Health Workers) have been identified as an effective means of tackling alcohol-related hospital admissions\(^3\).
- However, there is limited understanding of the national coverage and the extent and diversity of the service hospital-based AHWs provide.

Research objectives

- The aim of this survey was to establish the extent and diversity of AHW provision at a national level.
- Our broad definition of an AHW includes any number of staff whose role is predominantly dedicated to recognising and, in alcohol use.
- This is the first study to explore the current provision and extent of AHWs in acute hospitals across England.

Research methods

- A geographically representative sample of large acute NHS hospitals was chosen at random (n = 115).
- 44 hospitals took part (42%), of which 45 (94%) employed an AHW.
- Eligible AHWs participated in a telephone (n = 30) or online (n = 10) questionnaire between December 2012 and April 2013. The data was analysed using SPSS.

Results

- The majority of hospitals employed one AHW. Most services were available 9am to 5pm, fewer services included evenings (n = 17, 38%) and weekends (n = 19, 42%).

Who are AHWs?

- In the majority of hospitals AHWs were qualified nurses (80%, n = 36), 20% of hospitals (n = 9) also employed staff with alternative qualifications (NVQ in health and social care, counselling skills) or experience in substance misuse.

Who do they see?

- Proporion of patients seen by AHWs in each drinking category (n = 27):

  - Drinking category: Mean ± S.D.
  - Increased risk of alcohol related harms: 9.8% ± 13.4
  - Higher risk of alcohol related harms: 20.4% ± 13.7
  - Dependent: 70.9% ± 22.1

Discussion

- Hospitals might wish to consider employing staff whose role is to target non-dependent drinkers for brief intervention, a group of patients who appear to have been underserved yet may provide a unique opportunity to intervene prior to the onset of dependency.

Final thoughts

- Numbers of AHWs have increased significantly in recent years\(^7\). The overwhelming majority of AHWs are nurses.

Most patients seen by AHWs in acute NHS hospitals are dependent drinkers.

References/acknowledgements


\(^{4}\) This work was supported by the National Institute for Health Research, Collaborations for Leadership in Applied Health Research and Care, and Alcohol Research UK.