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Quality standards

Consultation summary report: alcohol-use disorders: diagnosis and management

Quality Standards Advisory Committee post-consultation meeting: 11 April 2023

1. Introduction

The draft quality standard for alcohol-use disorders: diagnosis and management was made available on the NICE website for a 4-week public consultation period between 31 January and 28 February 2023. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 17 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement-specific questions:

4. For draft quality statement 4: How does assessment and monitoring based on locally specified protocols work in current practice? What do these protocols generally include?

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* There was support for the quality standard in general and it being updated, including that it is clear, and achievable.
* Stakeholders felt that the draft quality standard does accurately reflect the key areas for quality improvement.
* It was noted that specific statements on assessment and interventions for children and young people, as well as a statement on treatment for Wernicke’s encephalopathy, are no longer included in the quality standard which makes it less comprehensive.
* It was noted that while there is no direct statement on support for families and carers, it is welcomed that they are referenced in supporting information in statements 3, 4 and 5.
* It was suggested that more emphasis could be put on staff training and awareness.
* It was suggested that reference to pastoral, spiritual and religious care could be referenced for statements 2 and 4, as well as social prescribing in statement 4.

### Consultation comments on equality and diversity considerations

* Stakeholders suggested that there should be a reference to establishing communication needs from the beginning of care, so that practitioners can adapt accordingly.
* It was suggested that the term ‘learning disability’ is used rather than ‘learning disabilities’ and the term 'advocate with appropriate training and skills’ is used rather than ‘advocate’.
* The importance of referencing PTSD throughout the quality standard was highlighted, specifically allowing for identification as part of validated alcohol questionnaires, when informing people of help that community support networks and self-help groups can offer in supporting it as a comorbid condition, and mention of eye movement desensitization and reprocessing as a psychological intervention in statement 5.
* The need to identify and treat older people in care homes with alcohol use disorders was highlighted, including for statement 5 where they may undergo unplanned and unsupported withdrawal.

### Consultation comments on data collection

* There was some concern that the majority of the statements are not measurable and need to be more clearly defined in order to be audited.
* One stakeholder fed back that service providers should be able to capture most of the data required, in particular for statements 1, 2, 3 and 5.
* It was noted that local systems and structures may not be in place to collect necessary data and are variable, including being dependent on the presence of specialist teams in the relevant setting. This includes measures for community support networks and self-help groups where delivery organisations are varied, however some estimated information on usage was provided by a provider stakeholder.
* It was suggested that measurement would rely on manual reviews of care records, or development of new data collection templates, both requiring additional resource.
* Stakeholders fed back that improvements are being made to shared access to data across the system and through partnership working in Integrated Care Partnerships. They also fed back that coding could be adjusted and more widely undertaken in primary care, and that some systems such as Electronic Patient Records could be used to gather data.

### Consultation comments on resource impact

* There was feedback from stakeholders on general staff shortages nationally that would limit the delivery of statements 1, 2 and 3.
* Stakeholders reported that staff training and awareness on alcohol and alcohol use disorders, expertise of staff completing assessments (specifically in co-morbidities) and education of staff on alcohol screening questionnaires and acute alcohol withdrawal protocols would have a resource impact.
* There was concern that due to pressure in the community services sector for alcohol problems service capacity may not match need from any increased identification and referral rates.
* One stakeholder highlighted that statements 1, 2 and 5 are already current practice in primary care to some degree, and that adjustments to templates and increased awareness of coding for measurement would not have significant resource impact. Another fed back that the statements would be particularly deliverable if there is close working between community, primary and secondary care.
* It was noted that funding and wider availability of Alcohol Care Teams would enable implementation of the quality standard, particularly statement 4.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

People who are being asked about their alcohol use have a validated alcohol questionnaire completed to identify any need for intervention. **[new 2023]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

* There was general support for the statement, with stakeholders noting that it is clear, measurable, and has potential to improve quality of care by addressing under use of validated tools in current practice and consistency of those that are used. They also felt that it could improve accuracy of assessment.
* It was suggested that brief intervention and referral to specialist alcohol services should both be available for those with high-risk drinking, and that current statement wording suggests it must be one or the other.
* One stakeholder queried if the statement should specify who should validate the recommended alcohol questionnaires.
* Addition of the [ASSIST-lite tool](https://www.gov.uk/government/publications/assist-lite-screening-tool-how-to-use/how-to-use-the-assist-lite-screening-tool-to-identify-alcohol-and-drug-use-and-tobacco-smoking), the [CAGE questionnaire](https://patient.info/doctor/CAGE-Questionnaire) and [SMAST-G](https://catch-on.org/wp-content/uploads/2016/12/SMAST-G-1.pdf) as examples of validated alcohol questionnaires was suggested. One stakeholder queried if brief triage assessments/questionnaires should be referenced.
* One stakeholder noted that staff completing the questionnaires would need to be appropriately educated in administrating and interpreting them.

Measures

* There was concern that the statement may be hard to measure without a national standard to monitor use of validated alcohol questionnaires, and that it would therefore be subject to local variability.
* It was highlighted that rates of brief intervention and rates of referral to specialist alcohol services may be gleaned from primary care data, but they are not currently well recorded. Additionally, there isn’t a combined field for all the screening tools when completing data entry.

Equality and diversity

* Feedback was given on wording of the equality and diversity considerations section, to specify availability in non-written-language, or in plain language.
* One stakeholder noted that for older people, the questionnaire is more effectively administered as part of a general discussion.

### Issues for consideration

#### For discussion:

* Can any examples of validated questionnaires be added that are supported by guidance?
* Is the statement measurable in practice?

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 2

People seeking help for an alcohol-use disorder are given information and support to access community support networks and self-help groups. **[new 2023]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

* There was support from stakeholders for the statement as an area for quality improvement.
* Stakeholders fed back that more detail was needed on how information would be provided and what support would be offered to facilitate access. Additionally, there were questions on how the information would be obtained by practitioners and what the content would be in the absence of national standardised materials.
* Stakeholders suggested that the statement should mention referral, as opposed to signposting.
* It was suggested that GPs are highlighted as a health and social care practitioner in the audience descriptor.
* It was suggested that the information should include a list of places that people can go to seek help with their alcohol use disorder, such as primary care, pharmacies and specialist providers.
* It was noted that for implementation of statement 2, resources would be needed to ensure that practitioners had details of available local support groups, particularly SMART recovery. Additionally, stakeholders commented that use of peer led recovery groups has a minimal resource impact on the health and social care system, and suggested that their use be widened, including in inpatient settings.

Measures

* It was highlighted that there are not currently systems in place to collect data for the outcome measures, and that current database systems focus on data from structured treatment.
* Stakeholders also fed back that due to anonymity of membership in many community support networks and self-help groups that do not report on membership to referral sources, data collection on uptake would not be possible.
* A stakeholder provided evidence on the outcomes of peer led recovery groups and professionally delivered 12 step interventions.

### Issues for consideration

#### For discussion:

* Can detail be added on provision of information, and the type of support offered?
* Is the statement measurable in practice?

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 3

Adults seen by specialist alcohol services have a brief triage assessment that includes comorbidities and associated risks. **[new 2023]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

* Stakeholders approved of brief triage assessments as a vital area for quality improvement and noted that it would be more holistic than initial assessments and enable recognition of physical health needs.
* It was confirmed that some stakeholders already do this as current practice, and that complex comorbidity is observed at point of hospital attendance.
* It was suggested that statement wording could be changed to describe the brief triage assessment as a brief holistic assessment of health, needs and risks.
* It was also suggested that the statement should not use the term ‘comorbidities’ and should instead list specific harmful effects of alcohol which would require further assessment.
* One stakeholder also suggested using ‘risks’ in place of ‘associated risks’ to account for the risk of abrupt withdrawal.
* A stakeholder felt that there could be more clarity on what is included in the assessment including any tests, and suggested that alcohol related brain disease and alcohol-related liver disease is particularly important to recognise.
* It was fed back that there may be additional staff or time requirements to complete a holistic triage assessment.

Measures

* It was noted that a standardised assessment template would make assessment of outcomes easier. One stakeholder gave an example of the triage questions that they use in practice.
* Stakeholders fed back that it was unlikely that systems and structures for data collection were currently in place, though there was feedback that where correct coding is used data collection is possible.

### Issues for consideration

#### For discussion:

* Should statement wording change regarding the brief triage assessment, comorbidities, or associated risks?
* Can any detail be added on what is included in the assessment?
* Is the statement measurable in practice?

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 4

People in acute alcohol withdrawal in hospital are assessed and monitored following locally specified protocols. **[new 2023]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

* Stakeholders commented that local protocols for management of acute alcohol withdrawal are important.
* Stakeholders fed back that the statement could be more prescriptive, and make clear reference to validated alcohol withdrawal scoring tools such as CIWA-Ar to avoid variable approaches based solely on clinical judgement.
* However, one stakeholder highlighted that the CIWA-Ar does not have established applicability in emergency and acute medical settings.
* It was suggested that the statement should include people in acute alcohol withdrawal in community settings, including care homes and home detoxifications.
* It was highlighted that the nature of locally specified protocols could lead to variability in care, and that it is important that these are based on evidence and best practice as well as national or international guidance, and that standardisation is aimed for.
* There was also feedback that the protocols should be guidelines that are easily available to staff and that are delivered as an education package. They should include the type of medical treatment used and any exceptional circumstances which might indicate an alternative pharmacological approach.

Resource impact and current practice

* It was noted that implementation of the quality statement may be challenging because this is a small population that are in services that are facing significant pressures.
* Stakeholders felt that Alcohol Care Teams would be key to successful implementation of the statement, ensuring that there would be staff with the appropriate expertise for assessment and medication, who would be able to ensure liaison and arrangements for monitoring.
* On current practice, it was noted that there is current variability on what people in acute withdrawal can access in terms of specialist support and that this depends on local commissioning.

Measures

* Stakeholders noted that it is possible to ensure that systems and structures are in place for data collection. However current data collection is not as formalised and integrated as it needs to be.
* It was also noted that the outcome measure on rates of successful withdrawal may not be meaningful without successful withdrawal being clearly defined, and that it should also reflect the proportion of unsuccessful withdrawals.

### Consultation question 4

Stakeholders made the following comments in relation to consultation question 4:

How does assessment and monitoring based on locally specified protocols work in current practice? What do these protocols generally include?

* Stakeholders fed back that assessment includes risk of uncontrolled alcohol withdrawal and its prevention, risk of Wernicke’s encephalopathy and its prevention, and risk of severe electrolyte disturbances and cardiac dysrhythmias that can develop in people with alcohol-use disorders.
* It was noted that protocols include prescribing guidelines.
* One stakeholder highlighted that CIWA-Ar is the most commonly used scoring tool for guiding treatment. Another commented that PHQ-9/ GAD 7 questionnaires can be used to assess mental health.
* It was commented that an acute withdrawal protocol should include guidance for non-specialist clinicians in assessing alcohol misuse/dependence, regimens for withdrawal, guidance for treatment and prevention of Wernicke’s encephalopathy and delirium tremens. It also has information on referral pathways to further support based on individual needs, including in the community setting.

### Issues for consideration

#### For discussion:

* Should the statement be changed to include specific non-hospital settings?
* Should Alcohol Care Teams be added to supporting information?
* Can local protocols be defined according to stakeholder feedback and based on NICE guideline recommendations?
* Can the statement be implemented in current practice?
* Is the statement measurable in practice?

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 5

People with moderate or severe alcohol dependence are offered psychological and, if appropriate, pharmacological interventions, to prevent relapse following a successful unplanned withdrawal. **[2011, updated 2023]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

* Stakeholders generally supported the statement as an area for quality improvement, noting that it was clear and will improve care and consistency of delivery. They noted that its delivery would help to treat underlying issues associated with alcohol misuse.
* Stakeholders suggested addition of a timeframe to the statement (potentially within 2 weeks of discharge) and noted that there may be difficulty in offering a 12-week psychological intervention immediately after successful unplanned withdrawal.
* Stakeholders noted that measurement may be difficult as care records may not always have the relevant data, including where therapy is offered but refused and records of relapse.
* There was a request for more clarity on who delivers the interventions.

Resource impact and current practice

* It was commented that access to services that offer pharmacological or psychological therapy is variable nationally, and that additional funding is needed in order to improve capacity, though group therapy may be more achievable.
* It was suggested that the statement could be strengthened by referencing staff awareness of the interventions and ensuring that they implement them, and that reference should be made to the liaison role of primary care in this process.
* It was noted that GPs may not be commissioned to prescribe the appropriate medications for this statement and therefore access to them is not guaranteed.
* It was highlighted that benzodiazepines, diazepam, and chlordiazepoxide are not mentioned in the definition of pharmacological interventions. Additionally, an example was given of adjunct therapies that may also be prescribed in practice.

### Issues for consideration

#### For discussion:

* Is there a source for a timescale that can be added to the statement?
* Are there more details on delivery of interventions that can be added to the statement such as staff awareness and the liaison role of primary care be mentioned?
* Are there additional medications that need to be in the definition and is there a guidance source available?
* Can the statement be implemented?
* Is the statement measurable?

#### For decision:

* Should this quality statement remain in the quality standard?

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* Opportunistic screening of alcohol use disorders, including screening of alcohol use disorders and brief interventions in care homes (discussed at prior committee meeting, not progressed).
* Referral to specialist alcohol services (discussed at prior committee meeting, not progressed).
* Assessment and treatment for older people with alcohol use disorders (NICE quality standards QS50, QS123, QS132 and QS137 cover various aspects of assessment and treatment for older people and their health and social care needs, including QS50 statement 6 on access to healthcare services. CG115 recommendations 1.2.1.5, 1.3.4.6, 1.3.5.9, and 1.3.8 are relevant to this suggestion).
* Comprehensive assessment by validated tools for children and young people (discussed at prior committee under comprehensive assessment, not progressed).
* Long term physical health needs (discussed at prior committee meeting under coordination of care, not progressed).

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
|  | Alcoholics Anonymous | General | 1. **Alcoholics Anonymous Preamble.** Alcoholics Anonymous is a fellowship of men and women who share their common experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership; we are self-supporting through our own contributions. AA is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.   © Copyright the AA Grapevine Inc. 1947   1. **Alcoholics Anonymous Structure and Membership.** AA Great Britain (AAGB) and the English-Speaking Continental European Region (CER), one of sixteen regions of the General Service Conference of Great Britain, are served by the General Service Office (GSO) and General Service Board (GSB), based in York, England. There are approximately 81,000 members in Great Britain and 8,000 in the CER and 4810 groups registered with the GSO. 2. **Evidence-base for Efficacy of peer-led Alcoholics Anonymous and Twelve-Step Facilitation Interventions.** The key evidence-base is the Cochrane Database of Systematic Reviews www.cochranelibrary.com   Kelly JF, Humphreys K, Ferri M.  Alcoholics Anonymous and other 12-step programs for alcohol use disorder.  Cochrane Database of Systematic Reviews 2020, Issue 3. Art. No.: CD012880.  DOI: 10.1002/14651858.CD012880.pub2.  **Objectives.** To evaluate whether peer-led Alcoholics Anonymous (AA) and professionally-delivered treatments that facilitate AA involvement (Twelve-Step Facilitation (TSF) interventions) achieve important outcomes, specifically: abstinence, reduced drinking intensity, reduced alcohol-related consequences, alcohol addiction severity, and healthcare costs.  **Methods.** Participants were non-coerced adults with Alcohol Use Disorder (AUD). We included randomized controlled trials (RCTs), quasi-RCTs and non-randomized studies that compared AA or TSF (AA/TSF) with other interventions, such as motivational enhancement therapy (MET) or cognitive behavioral therapy (CBT), TSF treatment variants, or no treatment. We also included healthcare cost studies.  **Results.** We included 27 studies containing 10,565 participants (21 RCTs/quasi-RCTs, 5 non-randomized, and 1 purely economic study). AA/TSF was compared with psychological clinical interventions, such as MET and CBT, and other 12-step program variants.  **Results and Conclusions.** There is high quality evidence that manualized AA/TSF interventions are more effective than other established treatments, such as CBT, for increasing abstinence. Non-manualized AA/TSF may perform as well as these other established treatments. AA/TSF interventions, both manualized and non-manualized, may be at least as effective as other treatments for other alcohol-related outcomes. AA/TSF probably produces substantial healthcare cost savings among people with alcohol use disorder.   1. **Evidence-base for Efficacy of peer-led Alcoholics Anonymous and Twelve-Step Facilitation Interventions.** The distilled summary version of the Cochrane review is this paper.   Kelly JF, Abry A, Ferri M, Humphreys K.  Alcoholics Anonymous and 12-Step Facilitation Treatments for Alcohol Use Disorder: A Distillation of a 2020 Cochrane Review for Clinicians and Policy Makers  Alcohol and Alcoholism, 2020, 55(6) 641–651 doi: 10.1093/alcalc/agaa050  Data bases up till August 2019 were searched for randomized controlled and other studies in participants with alcohol use disorders that compared the efficacy and costs of treatment that facilitated use of AA versus treatment using other methods such as cognitive behavior therapy and motivational enhancement therapy. The search revealed 27 studies pertaining to 10,565 persons. Meta-analyses showed that AA and facilitating use of AA (‘TSF’) produced similar benefits to other treatments on all drinking-related outcomes except for continuous abstinence and remission, where AA/TSF was superior. Studies analyzing costing found that use of AA/TSF also tended to reduce healthcare costs.  **5. Alcoholics Anonymous 2020 Membership Survey and “Spirituality”.**  There is a commonly held view that AA is a religious organisation and many health and social care practitioners, service providers, commissioners, people seeking help with an alcohol-use disorder and the lay public are put off by the use of the 'God' word in AA literature and discourse. This has led to a reticence to access AA services.  AA has members of all religions, cultures and none. The concept that AA is a religious organisation is belied by findings from the 2020 AA Great Britain (AAGB) and English-Speaking Continental European (CER) Membership Survey. Of 1694 respondents who were asked about the foundations of their views on spirituality and their notion of a higher power (or God), 65% reported that these were based on a secular foundation, compared with only 35% who reported that their views of the above had an overtly religious basis.  <https://www.alcoholics-anonymous.org.uk/Members/2020-Survey> |
|  | British Association for the Study of the Liver (BASL) | General | BASL supports this much needed update. We note that the scope of the quality standard has been significantly reduced and no longer covers Alcohol Use Disorder (AUD) assessment and interventions for children and young people or Wernicke’s encephalopathy. The new standards are therefore less comprehensive. |
|  | Buckinghamshire Council | General |  |
|  | Church of England Faith and Public Life Division | General |  |
|  | Greater Manchester Mental Health NHS Foundation Trust | General | To respond to the questions further down the document:-   1. Yes, but it depends a little on the setting. 2. A good addiction treatment provider should capture most of this data, particularly QS1, 2,3 and 5. Acute Trusts may not capture QS4. There may be less data on whether people actually take up the offered signposting. 3. Not in all cases. The QS5 re psychological interventions is difficult to deliver on current resources except in group, and mostly virtual sessions. Few services could offer structured individual face-to-face relapse-prevention work. 4. Generally this works well in terms of supportive medication for detox and parenteral vitamins. 5. I think the main challenge would be for acute hospitals to ensure robust pathways in place to offer relapse-prevention PSI. This could be improved by having staff from the local addiction service working within acute hospital alcohol care teams. Currently the provision is patchy. |
|  | Hackney Council | General |  |
|  | NHS England Primary Care | General | Overall, this quality statement is clear and achievable. The importance of attention to ongoing physical health and continuity of care could come through more obviously. |
|  | NHS England Primary Care | General | Whilst the following statement “*For people with additional needs related to a disability, impairment or sensory loss, communication should be conducted as set out in* [*NHS England's Accessible Information Standard*](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fourwork%2Faccessibleinfo%2F&data=05%7C01%7Ccaitlin.davies7%40nhs.net%7C608476ff0b974d2b90e608db14c3389d%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638126600909875841%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=i4KkX8u9OrWZnvzZa50l6ic7GAbf5CukpadTVAtXpvI%3D&reserved=0) *or the equivalent standards for the devolved nations*.” is helpful it assumes the clinician/practitioner has already identified likely communication or other needs. For example, in the case of an autistic person (possibly undiagnosed) has sound cognitive abilities and good language skills, it may not be obvious that they have social communication needs.  It is strongly suggested that there is a statement inserted throughout that cites the importance of establishing from the outset if there are communication or other needs, e.g., even completing a questionnaire might be challenging and responses may not be appropriate or a true reflection of experiences. |
|  | Royal College of Paediatrics and Child Health | General | This commenter is happy with the draft quality standard. |
|  | Royal College of Physicians and Surgeons of Glasgow | General | The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the UK. While NICE has a remit for England (where 50% of our UK membership is based), many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments.  The College welcomes this NICE quality standard on alcohol-use diagnosis and management. The quality statements are to be welcomed but perhaps lack detail to allow effective audit of quality improvement. |
|  | Royal Surrey NHS Foundation Trust | General | - |
|  | University College Hospital NHS Trust | General |  |
|  | University of Bedfordshire | General |  |
|  | Alcoholics Anonymous | Question 1 | Does draft quality standard 2 accurately reflect the key areas for quality improvement? Answer **YES.** |
|  | British Association for the Study of the Liver (BASL) | Question 1 | The key areas for quality improvement are identification of Alcohol Use Disorder (AUD) in both high risk populations and the general public, provision of support and treatment to people with AUD.  The only missing area is to provide a statement around who, in what situation and by whom should people be asked about their alcohol use. In people with AUD, every contact with health and social care professionals is an opportunity to identify and support them. This group often present to services late after complications of alcohol use have developed. This was previously covered in 2011 Quality Statement 2 describing the need for opportunistic screening by all healthcare professionals. |
|  | Buckinghamshire Council | Question 1 | We welcome the addition of the use of initial triage assessment. This will allow early identification of responses without having to complete a comprehensive assessment for example an individual need for thiamine prescription can be identified at the triage stage via the initial treatment thus improving specialist services response to identification of immediate risk/need.  However, we would have concerns about the loss of opportunistic screening and proactive referral. There is also a need for this quality standard to stress that frontline staff should be using it opportunistically (not just when someone presents raising their own concerns over alcohol consumption). This was previously included as statement 2.  Referral (not signposting) is also very important (as it may capitalise on a teachable moment, and this client group may be less well motivated to self-refer than other cohorts self-referring for physical health conditions). This was previously included as statement 3.  The draft quality standards do not put sufficient emphasis on staff training and awareness on alcohol. The danger of not mentioning ongoing training (at the very least) is the assumption training on alcohol awareness is already embedded and established practice which in many agencies it is still not routine. In Buckinghamshire, Alcohol Change UK deliver IBA training and use of audit tool for frontline workers. With pressures on budgets, training is often the area that is impacted by a reduction and or cut on budgets.  The new quality statement now makes it clear that agencies must use a validated tool, the fact that the standard has listed the different ones that can be used, this is excellent as it then ensures consistency among agencies with regard to the tools and also increases understanding on the various tools. It is important to make clear the most important component is that screening and brief advice of any form happens, ie MECC, and that this is not just the business of specialised services.  The new statement 1 measure is good, as it is about people who have had a validated tool completed, however the proportion of people who are screened, ie whole population as a denominator rather than those screened as denominator would be more helpful.  Whether agencies have the systems in place to monitor and or share client scores when referring is an issue. Too often agencies rely on the specialist alcohol service to conduct the audit, and in some cases the specialist service is not the appropriate agency for the client, this links back to pathways etc being part of work force development/training to prevent people bouncing from service to service.  We note overall the quality standard covers identifying and supporting adults and young people ……. As well as support for their families and carers, although there is no specific reference to families and carers directly in the proposed new quality standards we welcome the references in the supporting detailed information described for quality standards 3, 4 and 5. |
|  | Church of England Faith and Public Life Division | Question 1 | No. We would add to Statement 2 the following, “pastoral, spiritual and religious care” and we would add to Statement 4 the above and social prescribing. These refer to the quality standards on alcohol-use disorders. |
|  | Hackney Council | Question 1 | Yes |
|  | NHS England Primary Care | Question 1 | Yes. The only area not captured is long term physical health since this cohort is very high risk for a number of conditions either directly related to chronic high level alcohol ingestion or as comorbidity. |
|  | Royal College of Physicians and Surgeons of Glasgow | Question 1 | Overall, the College considers these standards are useful additions. A concern is that few of them are measurable and therefore it may be challenging to demonstrate any improvement or change in the quality of care provided. |
|  | Royal Surrey NHS Foundation Trust | Question 1 | Yes it does and includes current practice |
|  | University College Hospital NHS Trust | Question 1 | Yes broadly. |
|  | University of Bedfordshire | Question 1 | Given the emphasis in the EIA on older people, there should be more specific statements about assessment and treatment of people in this group. |
|  | Alcoholics Anonymous | Question 2 | Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  1. Service providers, health and social care practitioners and commissioners of alcohol services do not have local systems and structures in place to collect accurate data for the proposed quality measures. This is also true for the number of people seeking help for an alcohol-use disorder, who are given information on local community support networks and self-help groups, such as AA, the benefits of attending these and whether they can also get help to access AA groups if needed. This would be very challenging since the quality measures of process, numerator, denominator, outcome and data sources are unknown and it would be extremely difficult for these to be systematically applied in the various healthcare and community settings for the four different audiences mentioned in the quality statement.  2. Alcoholics Anonymous can provide some data for the proposed quality measures as the AA website continually monitors hits. On December 7 2022, BBC2 televised “I’m an Alcoholic: Inside Recovery”. It is the first in-depth look at the work of Alcoholics Anonymous. It used Deep Fake Technology to change people’s facial profile to maintain anonymity. It is available on BBC iPlayer for one year. It was widely praised and traffic to the Alcoholics Anonymous website subsequently increased by 53%.  **3. Alcoholics Anonymous 2020 Membership Survey.**  The 2020 membership survey of Great Britain and the English-Speaking Continental European Region (CER) was the first online survey and the findings were impacted by the Covid-19 pandemic. The response rate was 36%. The following data from respondents were recorded:   * Demographics of the membership (age, gender) - 33% were over 60 years old, 29% between 51-60, 24% between 41-50, 11% between 31-40 and 8% were under 30 years old. The age profile of respondents differed significantly from the UK profile, with a much higher proportion in the age ranges 51-60, but much lower than the UK profile in the 16-30 age range.   The gender split was around 47% female and 53% male (compared to 51.1% female and 48.9% male in the UK population). Around 0.4% of respondents reported non-binary or transgender gender orientations.   * Length of membership in AA - 55% of the GB respondents had been members of AA for more than 10 years, 31% between 2-10 years, 7% between 1-2 years and 8% had joined AA in the previous 12 months. * Length of sobriety - 44% of the GB respondents had been sober for more than 10 years, 31% for between 2-10 years, 9% for between 1-2 years and 16% for the previous 12 months. * Frequency of attending AA group meetings - 1% of the GB respondents attended AA meetings less frequently than once per week, 15% attended weekly, 25% attended twice per week, 39% attended 3-4 times per week, and 20% attended 5 or more meetings per week. The mean number of attendances was 3.4 ± 0.1 per week. * How members first heard about AA - 20% of the GB respondents had first heard about AA from an existing AA member, 17% had come via a treatment centre, 13% through a phone directory, 12% had found details about AA online, 11% via their GP or other health and social care practitioner, 3% knew of AA from previous membership or contact with AA, 2% had heard about AA from television, 2% had seen a newspaper article about AA, 2% from affiliation with another 12-Step programme such as Al-Anon, 1% via the probation, prison or criminal justice system, 1% through social media, 1% signposted from the church or other clergy (e.g. their Imam), 2% had seen a poster, leaflet or notice, and 16% reported other pathways to AA. * Aspects of recovery - Members were asked to report on the factors (they could list more than one option) that they felt had significantly contributed to their recovery: 96% cited regular group meeting attendance; 90% cited “working the 12 Steps”; 89% the concept of “Acceptance”; 85% cited having a sponsor and helping others; 83% felt that belonging a Home Group was key; 83% cited Service in AA; 82% cited a sense of belonging and not feeling alone; 80% cited finding a Higher Power; and 50% cited sponsoring others. * Views on Spirituality – See General Comments, Point 5. * Disabilities – See Comments in Pre-Consultation Stage, Section 2.1. Point 1, Accessible Information Standard. * Ethnicity - See Comments in Pre-Consultation Stage, Section 2.1. Point 2, Ethnicity.   Estimates were also made of attendance and membership, characteristics of the membership, mental health history and working status. |
|  | British Association for the Study of the Liver (BASL) | Question 2 | Local systems are variable and not in place to collect data for statements 2-5. It will rely on manual review of care records, which may not be fully documented. Templates or proformas could be developed to facilitate data collection but this would require additional time/staff resource at the point of care to complete. |
|  | Buckinghamshire Council | Question 2 | Not yet but this is work in progress, currently different organisations collect data via different systems, whilst improvements are being made to accessing and sharing of data this is still not fully embedded across the system. Locally we have strongly promoted the use of AUDIT C in line with the RCP guidance to Integrated Care Boards and Partnerships and our lead acute and community health provider. Information governance sharing protocols take time to establish due to governance processes. It is very ambitious to aim to collect data identified for most of the quality standards. However, there is potential with the combatting drug partnership and ICP arrangements to put the systems and structures in place, however this is ambitious and will take time. |
|  | Church of England Faith and Public Life Division | Question 2 | Yes |
|  | Hackney Council | Question 2 | A review of the data collection forms across primary, secondary and other services is needed to ensure that the right level of detail is collected. For example, service data could have a specific system such as Quit Manager for Stop Smoking Services to collect standard information. |
|  | NHS England Primary Care | Question 2 | Yes, as stated below, coding in primary care is not widely undertaken for all relevant parameters but this could be adjusted, as could templates to ensure all markers are considered. |
|  | Royal College of Physicians and Surgeons of Glasgow | Question 2 | While structures for audit will exist in most trusts and health boards, the standards need to be more clearly defined if they are to be audited. Data collection is always an issue in conducting this type of audit. |
|  | Royal Surrey NHS Foundation Trust | Question 2 | Yes although depends if a specialist team is in situ eg hospital |
|  | University College Hospital NHS Trust | Question 2 | Somewhat, trust has EPR that some data can be gleaned from. Still using PHE Hospital Alcohol Data Set but some gaps. Need a national data set again now PHE no longer in place and ideally for this to be set up so information can be extracted from EPR. |
|  | University of Bedfordshire | Question 2 | No systems are in place to monitor the quality of care for alcohol use disorders (AUD) for the over 420,000 older people in care homes. The quality statement should identify the need to establish AUD monitoring in the care home population. |
|  | Alcoholics Anonymous | Question 3 | Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.  1. Alcoholics Anonymous is self-supporting and all service and treatment is free, with no direct cost implications. The limitations to achieving the draft quality standard are those due to the very limited access for AA members, especially Health Liaison Officers, to hospitals and primary care during the Covid-19 pandemic. Whilst these restrictions are easing, the pressures in hospitals, especially in emergency departments and acute wards, are continuing to severely limit access.  2. Alcohol care teams in hospitals primarily provide specialist expertise and interventions for alcohol dependent patients and those presenting with acute intoxication or other alcohol-related complications, attending emergency departments or admitted as inpatients across most departments of the acute hospital. Public Health England calculated that implementation of an alcohol care team in an acute hospital, by reducing hospital admissions and readmissions and improving quality of care, would produce a net cost saving to the NHS of £2.85 for each £1 invested by year one of optimisation. An Alcohol Assertive Outreach Team for frequent attenders would produce an estimated return of investment of £3.42 for each £1 spent. This has led to the roll-out of alcohol care teams by NHS England and NHS trusts. Further implementation will enhance these benefits and facilitate cooperation, especially between alcohol specialist nurses, ward staff and AA members.  **The absolute priority should be to establish inpatient AA meetings so that people with alcohol-use disorders will engage in hospital and then attend AA meetings rapidly following discharge to reduce the risk of relapse.**  References  NHS England. Long Term Plan. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/11/ACT-what-are-we-proposing-and-why-011119.pdf  NHS England. Long Term Plan. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/11/ACT-core-service-descriptor-051119.pdf  Moriarty KJ. Alcohol care teams: where are we now? Frontline Gastroenterology  <http://fg.bmj.com/cgi/content/full/flgastro-2019-101241>  3. In primary care, AA can deliver healthcare benefits that are again entirely free. If general practitioners, nurses or practice managers could help to establish AA, it could reduce workload and enhance alcohol care. Resource implications for primary care should be minimal.  4. In several healthcare undergraduate and postgraduate courses, AA meetings, mainly online, have proved very popular. Students and doctors particularly value listening to AA members share their experience and Continuous Professional Development (CPD) accreditation has been awarded. Feedback from the hospitals and universities has been excellent. This should be cost-neutral and an optimal use of teaching resources.  5. Service providers, health and social care practitioners and commissioners of alcohol services can contact the Helpline and local AA Health Liaison Officer. |
|  | British Association for the Study of the Liver (BASL) | Question 3 | Statement 2: Practitioners may need to obtain lists of local support groups for alcohol.  Statement 3: Alcohol services may need additional time/staff to complete a holistic triage assessment.  Statement 5: Access to suitable services that offer pharmacological or psychological therapy is variable across the country. Such services need better funding to improve capacity especially in areas of high need. |
|  | Buckinghamshire Council | Question 3 | Without addressing the workforce shortage, it will be difficult to fully implement quality statements 1, 2 and 3. The forthcoming outcomes from the national stocktake of workforce led by HEE will be identifying key issues in relation to workforce with a national implementation strategy to address these. |
|  | Church of England Faith and Public Life Division | Question 3 | Yes |
|  | Hackney Council | Question 3 |  |
|  | NHS England Primary Care | Question 3 | Statements 1, 2, and 5 already happen in primary care to an extent. Adjustment of templates and increased awareness of the need to code would require little resource. If practice is incentivised a greater cost would be incurred. |
|  | Royal College of Nursing | Question 3 | More information on SMART recovery particularly as this is a key intervention across most drug and alcohol providers. |
|  | Royal College of Physicians and Surgeons of Glasgow | Question 3 | Our expert reviewer had concerns that these may prove difficult to implement largely on account of the education which will be required for the alcohol screening questionnaires and the alcohol withdrawal protocols. In addition, community services for alcohol problems are under pressure in many places at present and therefore earlier identification of alcohol use disorder or increased referrals after unplanned alcohol withdrawal may not be matched by appropriate support services. |
|  | Royal Surrey NHS Foundation Trust | Question 3 | Yes particularly if community/hospital/primary care work closer together |
|  | University College Hospital NHS Trust | Question 3 | Yes, but only with sufficient resources in place. “every patient on admission to be assessed by competent person” not achievable by one or two people working limited hours. Opportunities to intervene and lead by example are lost. Delayed intervention due to low staffing leads to poor patient experience and extended stays in hospital. Resources for statement four in particular would require funding of Alcohol Care Teams in Hospital settings beyond the trusts that have already been identified and funded. |
|  | University of Bedfordshire | Question 3 | These statements would not be achievable in relation to older people in care homes. There is no national initiative to improve training of the care home workforce in detecting and managing AUDs in people in care homes. |
|  | Alcoholics Anonymous | Question 4 | **Not applicable to Alcoholics Anonymous** |
|  | British Association for the Study of the Liver (BASL) | Question 4 | All protocols for management of alcohol withdrawal syndrome should include a scoring tool used to guide treatment. Most commonly, the validated CIWA-Ar tool is used. When a score is above a pre-determined threshold, treatment (usually benzodiazepines) is administered. |
|  | Buckinghamshire Council | Question 4 | Quality statement 4 is supported but there are challenges for implementation. People in alcohol withdrawal in acute settings may not be regarded as priority and the numbers small. Acute settings continue to face significant pressures and the statement does not provide any further assurance this will be area of priority. The quality statement would be strengthened if there was advice regarding alcohol liaison teams/provision within acute settings. This would ensure there is dedicated support to ensure timely and appropriate assessments were completed in hospital and the necessary arrangements and liaison put in place in the local system for monitoring. Despite the numbers in this cohort being small the quality statement needs strengthening to ensure its proactive enough to part of the solution to addressing the increase in drug related deaths which the most recent data is showing. It would not be appropriate to wait until the data gets worse to strengthen the requirement of this standard. |
|  | Church of England Faith and Public Life Division | Question 4 | N/A |
|  | Hackney Council | Question 4 |  |
|  | NHS England Primary Care | Question 4 | Not relevant to primary care. |
|  | Royal College of Nursing | Question 4 | Perhaps a suggestion to acknowledge PHQ-9/ GAD 7 questionnaires to assess mental health state when working with people with alcohol dependency. |
|  | Royal College of Physicians and Surgeons of Glasgow | Question 4 | Guidelines for alcohol withdrawal should be written down and readily accessible for those implementing them. They should include an assessment of alcohol use disorder and an evaluation of risk of developing alcohol withdrawal in those yet to manifest symptoms and signs of this. There should be clear guidance relating to the type of medical treatment used and any exceptional circumstances which might indicate an alternative pharmacological approach, such as advanced liver disease, elderly people, head injury and type 2 respiratory failure. If symptom trigger treatment is offered, this should be done with a recognised withdrawal scale, but not limited to the CIWA-Ar. All of this requires an effective and recurring educational programme. |
|  | Royal Surrey NHS Foundation Trust | Question 4 | Patients are identified with alcohol misuse based on medical history and current usage. Alcohol use may also be present on admission. Protocol in place to initiate CIWA-Ar and prescribing guidelines included. This is on top of the patient’s initial assessment by both the treating nurse and medical staff. This will include prescribing Chlordiazepoxide/benzodiazepine based medication and Pabrinex ( to protect against Wernicke’s Encephalopathy). Not all patient assessed in A&E will need medically assisted withdrawal treatment- brief/extended brief advice given by appropriately trained staff. This may include referral to specialist community services/clinics if the patient consents for follow up on discharge. If medically needing admission, then CIWA-Ar monitored for 24-48 hours depending on need. This will determine if a medically assisted withdrawal pharmacological intervention is required. This is managed with support from medical colleagues. In some trusts this is managed by a nurse prescriber |
|  | University College Hospital NHS Trust | Question 4 | Initial identification by all health care staff followed by input from Drug and Alcohol Liaison Team in the hospital setting. Protocols in place for treatment of acute alcohol withdrawal and drug withdrawal. The Acute withdrawal protocol includes guidance for non-specialist clinicians in assessing alcohol misuse/dependence, regimens for withdrawal, guidance for treatment of wernikes encephalopathy and delirium tremens. It also has information on referring to further support in house and in the community. |
|  | University of Bedfordshire | Question 4 | No comment. |
|  | Alcoholics Anonymous | Statement 1 | **Not applicable to Alcoholics Anonymous** |
|  | British Association for the Study of the Liver (BASL) | Statement 1 | People with high risk drinking measured by validated questionnaire may benefit from both brief intervention and referral to specialist alcohol services. The rationale suggests these are mutually exclusive.  This statement is clear, measurable and will improve quality of care (increased identification of people at risk and delivery of brief intervention/referral for support). |
|  | British Liver Trust | Statement 1 | agreed. No comments |
|  | Buckinghamshire Council | Statement 1 | We support the reference and focus in quality statement 1 about the use of a validated tool for an alcohol questionnaire. This has been problematic and addresses the issue of agencies and organisations not using validated tools. Whilst we recognise the importance and emphasis on the use of a validated tool we are concerned that removal of quality standards relating to training may be interpreted as no longer being needed. We also have concerns about the loss of opportunistic screening and proactive referral. There is also a need for this quality standard to stress that frontline staff should be using it opportunistically (not just when someone presents raising their own concerns over alcohol consumption). This was previously included as statement 2.  Training programmes on alcohol awareness have been extensive. Measures relating to these are not relevant or appropriate, we would recommend a continuing reference to alcohol awareness training measures relating to this are removed. If there is no reference to alcohol awareness training there is a risk these awareness training programmes will reduce or cease and training will be viewed as not being important any more. Reference to a questionnaire being completed ‘routinely’ would further strengthen this statement. |
|  | Change Grow Live | Statement 1 | Validated alcohol questionnaire: Our consultants have suggested considering the ASSIST-lite instrument (general use and mental versions are available, with useful links to interventions):-  [https://www.gov.uk/government/publications/assist-lite-screening-tool-how-to-use/how-to-use-the-assist-lite-screening-tool-to-identify-alcohol-and-drug-use-and-tobacco-smoking](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpublications%2Fassist-lite-screening-tool-how-to-use%2Fhow-to-use-the-assist-lite-screening-tool-to-identify-alcohol-and-drug-use-and-tobacco-smoking&data=05%7C01%7CSara.Khan2%40cgl.org.uk%7C7ab80d4098d5435c40a408db134ab90d%7C50afbcdc4916445abbc1504fd063b671%7C0%7C0%7C638124983867597631%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=ULxLHGlYnwjYQ7L6PmYReTmd3FpnMEpOofjeMzNczws%3D&reserved=0)   * ASSIST-lite (Alcohol, Smoking and Substance Involvement Screening Tool – Lite) is a short screening tool for use with adults (aged 18 or over) covering alcohol, tobacco, and cannabis.   All questionnaires will need to be counted as and when used. Like the Paddington Alcohol Test, the CAGE is also a well-known four-question screening tool that clinicians may use to help in the diagnosis of alcoholism.  CAGE (C – Cutting down, A – Annoyance by criticism, G – Guilty feeling, E – Eye-openers) Alcohol questionnaire:   * Have you felt the need to Cut down on your drinking? * Do you feel Annoyed by people complaining about your drinking? * Do you ever feel Guilty about your drinking? * Do you ever drink an Eye-opener in the morning to relive the shakes? |
|  | Church of England Faith and Public Life Division | Statement 1 |  |
|  | Hackney Council | Statement 1 | For the process measure, it would be useful to measure the use of a validated alcohol questionnaire, but the denominator should be the total of the population rather than the number of people who are asked about their alcohol use. The idea is to increase the amount of information that we have and not only the quality of the information that we have.  For the outcomes, patient data can be potentially found on GP data but there are several similar fields and it seems not be well recorded. Also, the several screening tools don’t have a combined field. |
|  | Inclusion | Statement 1 | From service audit and incident reviews, we have identified that this is an area that requires improvement and therefore welcome the statement. Clinical database systems should be able to collate this data quite easily and services should already have the resources to cope with delivering on this statement. We appreciate that for some audiences, basic screening may be as far as they go with this statement, however for specialist services, who would go on to screen levels of dependence, using SADQ as another tool example would be useful. |
|  | Greater Manchester Mental Health NHS Foundation Trust | Statement 1 | Agree. Standards would be raised if all treatment providers used the same validated alcohol questionnaire. |
|  | NHS England Primary Care | Statement 1 | Equality and diversity considerations, page 8: We strongly suggest the paragraph reads “The validated alcohol questionnaire should be accessible to people in a language and format that they are able to read, at a developmentally appropriate level. Consideration should be given to (not an exclusive list) those who have a learning disability, have reading difficulties, have sight impairment, and whose first language is not English."  At present, the paragraph appears to conflate the need for the screening questionnaire to be available in different languages, with the need to have the tool available in non-written-language, or in plain language. |
|  | NHS England Primary Care | Statement 1 | I wonder whether “validated” is too broad without saying validated by whom, possibly could refer to the validated questionnaires currently recommended by the Office for Health Improvement and Disparities? |
|  | PTSD UK | Statement 1 | ‘to identify any need for intervention’ – we haven’t seen this questionnaire, but would like to suggest that it includes some wider context questions, to allow any intervention needed for conditions such as PTSD to be recognised (such as ‘have you experienced trauma’) as if they PTSD is treated, then the alcohol misuse can be more easily treated too. |
|  | Royal College of Nursing | Statement 1 | Page 4-5= pointers on questionnaires, why not include triage questionnaires/ assessments clustered ie SADQ and CIWR assessments- more clarity required please. |
|  | Royal College of Nursing | Statement 1 | Page 5- quality statement 1 rationale unclear- grammatical error. Identify what? |
|  | Royal College of Physicians and Surgeons of Glasgow | Statement 1 | This is a useful statement. Use of formalised (albeit abbreviated) alcohol questionnaires will allow more accurate assessment of alcohol use disorder. However there has to be consideration of the method and process of interpretation of the results of any such questionnaire to ensure that there are suitable services to react to a positive test. Therefore, education is necessary for the alcohol questionnaires to be administered and interpreted correctly. In turn adequate service provision must be available to permit effective intervention. There is little point in identifying the problem if there is no treatment option. |
|  | Royal Surrey NHS Foundation Trust | Statement 1 | This statement may be hard to measure if there is no national standard to monitor use ie not all hospitals have an alcohol care team and services report to different commissioning bodies. This will make having an accurate figure of the different types of assessments used as there is not a central return like TOP |
|  | University College Hospital NHS Trust | Statement 1 | Yes, Audit C is used, and we are looking to build this into our EPR to meet requirements of NHS LTP and screening universally. |
|  | University of Bedfordshire | Statement 1 | Our support for Statement 1 is qualified in three ways:  1. In our experience with older people, the questionnaire needs to be skilfully embedded in general discussion, rather than ‘administered’ as a separate part of the assessment.  2. SMAST-G should be considered as a shorter screening option for older people.  3. There should be a requirement to undertake alcohol screening for the care home population (420,000), to undertake brief interventions where need is identified, and to keep records on AUDs and treatment. The reliance on OHID data is too limited: it concerns patients entering treatment and is inadequate to detect the prevalence, treatment pathways and outcomes for people with AUDs in the wider population. |
|  | Alcoholics Anonymous | Statement 2 | Equality impact assessment  Alcohol-use disorders: diagnosis and management (update)  The impact on equality has been assessed during quality standard development according to the principles of the NICE equality policy. 1. TOPIC ENGAGEMENT STAGE1.1. Have any potential equality issues been identified during this stage of the development process? **a). Stigma in healthcare settings towards people who misuse alcohol in general**  1. There is a stigma in healthcare settings and with lay people associated with people who misuse alcohol. Alcoholics Anonymous and members self-define as “alcoholic”, which is fundamental. The World Health Organisation also uses the term “alcoholic”. Many healthcare professionals prefer the less stigmatising “alcohol-related”, as in Alcohol-Related Liver Disease (ARLD). Other terms include alcohol-dependent or misuser, problem drinker or person with lived experience. However, alcohol-use disorders are still often perceived as a self-inflicted lifestyle choice rather than a disease.  2. In 2013, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report showed that in patients who were admitted and died with severe acute ARLD:   * Patients had often been to hospital prior to the admission when they died, but not enough had been done about their harmful drinking at that time. * There was a failure to screen adequately for harmful alcohol use and, even when identified, patients were not referred for support. * Opportunities to improve their care were often missed. * Specialist review was often delayed or did not happen. When organ failure occurred and escalation of treatment was indicated, again the additional treatment that was needed was often not given.   National Confidential Enquiry into Patient Outcome and Death. Measuring the units: a review of patients who died with alcohol-related liver disease. 2013. https://www.ncepod.org.uk/2013report1/downloads/ MeasuringTheUnits\_FullReport.pdf (accessed Feb 8, 2023).  *Remeasuring the Units*, a NCEPOD follow-up report, published on Dec 15, 2022, describes a 2021 survey of admissions in 2019 to NHS Trusts in England, Wales, and Northern Ireland and shows that, although there have been some improvements in the care of patients with ARLD, there is still widespread failure to implement the recommendations of 2013. These findings come in the context of worsening ARLD in the UK.  National Confidential Enquiry into Patient Outcome and Death. NCEPOD survey  report: remeasuring the units. Dec 15, 2022. https://www.ncepod.org.uk/pdf/current/Remeasuring%20the%20Units\_full%20report.pdf (accessed Feb 8, 2023).  **b). Inequality in referral, access to and experience of services based on gender, age and ethnicity**  1. Access to AA members, group and intergroup meetings is variable in different geographical areas. Meetings are held every day in Great Britain. These are listed in local AA directories in print and online.  2. AA support from members is free and AA accepts no funds from any outside sources. Each group is autonomous, self-supporting by members’ voluntary contributions. These are important considerations, especially when patients are discharged from hospital and given the difficulties and variation in accessing community alcohol services. Moreover, AA/TSF, potentially, is a lifelong commitment, rather than typically time-limited NHS treatment.  3. Attendance at AA face-to-face meetings, especially during the Covid-19 pandemic, is especially difficult for people who are housebound, have illness, disability including sight, hearing and mobility problems, vulnerable people, parents with children, older and younger people, have work commitments and geographical considerations that make access difficult. Every effort is made to ensure wheelchair access at meetings.  4. Access to meetings is variable in prisons, probation and criminal justice services and the armed forces.  **c). Discussions and screening needing to be sensitive to people's age, culture, and faith, and tailored to their needs**  1. Some AA meetings cater to specific demographics such as age, culture, faith, ethnicity, gender, sexual orientation and profession, although these do not exclude other alcoholics.  2. AA highlights that its primary purpose is to help others achieve sobriety and that it is neither sectarian, denominational, political nor controversial.  3. AA stresses that it is anonymous and confidential, a personal subjective experience shared with another, with an informal person-to-person approach and self-help by trying to help others. AA relies on experience-based Traditions, suggestion and example.  4. “Alcoholics Anonymous (‘The Big Book’)”, the AA Twelve Steps, Twelve Traditions and Twelve Concepts, Declaration of Unity, Serenity Prayer and sponsorship are universal in AA. This facilitates a degree of common experiences worldwide.  5. Al-Anon Family Groups are for the families and friends of alcoholics who share their experience, strength and hope in order to solve their common problems.  [Al-Anon UK | For families & friends of alcoholics https://al-anonuk.org.uk](\\\\nice.nhs.uk\\data\\H&SC\\QS\\Work programme\\1. QS in development\\Alcohol use disorders (update)\\6. Consultation\\Al-Anon UK | For families & friends of alcoholics https:\\al-anonuk.org.uk)  6. Alateen is for teenage relatives and friends of alcoholics. They meet to share their experiences of having, or having had, a problem drinker in their lives. They help and support each other. Alateen is part of Al-Anon. 1.2 Have any population groups, treatments or settings been excluded from coverage by the quality standard at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?NICE Statement. “Children aged under 10 years. The evidence sources also make this exclusion”. **AA Response.**  1. The GSB has recommended to the AA Fellowship that, within the AA structure, AA groups appoint Local AA Safeguarding Representatives who are able to provide a DBS certificate, and who can help signpost members to the appropriate agencies, should the need arise. The GSB also advises that a Local AA Safeguarding Representative, an AA member who holds a current DBS certificate or has appropriate Child Safety Training, be consulted when a minor attends an AA meeting unaccompanied by an adult. This is taken from the AAGB Safeguarding Policy, see <https://www.alcoholics-anonymous.org.uk/Safeguarding>  2. The AA Structure handbook for Great Britain, chapter 5 gives guidance on “Safeguarding and Personal Conduct” and chapter 6 guidance on “Addressing Safeguarding Issues”. Two sections in chapter 6 are particularly relevant:  **6.6. Safeguarding Children and Juveniles. “**There are times when children or juveniles will be in attendance at AA open meetings or AA conventions. It is the responsibility of the group members to agree safeguarding policy. Parental responsibility is essential. If there are safeguarding issues involving children, we suggest that a trusted servant act in accordance with the General Service Board’s current Safeguarding Policy Document and consider whether it is necessary to report their concerns to the appropriate outside agency”.  **6.7. Minors attending AA.** “Minors are defined as children and young people under the age of 18, although this legal definition may vary from country to country. If, however, the Fellowship uses it as a guideline, we can better ensure the safeguarding of these younger members. We want to help minors who believe they may have a drink problem, but we must respect the law. Consideration should be given to laws protecting minors where best practice is for written parental or guardian consent to be obtained. It should also be understood that minors do have the right to make their own informed decisions”. 2. PRE-CONSULTATION STAGE2.1 Have any potential equality issues been identified during the development of the quality standard (including those identified during the topic engagement process)? How have they been addressed? NICE has identified this issue in red.  Equality and diversity considerations have been identified and highlighted for draft statement 2 on community support networks and self-help groups. They are regarding providing information that people can easily read and understand, and access to interpreters or advocates where needed.  **AA Response.**  **1. Accessible Information Standard.**  This standard is relevant to organisations that provide NHS care or adult social care. Whilst AA is not such an organisation, AA is guided by this Standard. In the 2020 AA membership survey, 81% of the GB respondents reported having no disabilities. This tallies closely to the national profile (82% in the Family Resources Survey 2018-19).  The Standard says that patients (people in the case of AA), service users, carers and parents with a disability, impairment or sensory loss should:   * Be able to contact, and be contacted by, services in accessible ways, for example via email or text message. **AA members provide these ways.** * Receive information and correspondence in formats they can read and understand, for example in audio, braille, easy read or large print. **These are available from the AA General Service Office, the AA website, AA Service News, SHARE and Roundabout publications. The “Big Book” is available in a braille version.** * Be supported by a communication professional at appointments if this is needed to support conversation, for example a British Sign Language interpreter. **AA sponsors, advocates and members endeavour to provide interpreters. British Sign Language interpreters were present throughout the AA 75th Great Britain Anniversary Convention and are being introduced in the national conventions.** * Get support from health and care staff and organisations to communicate, for example to lip-read or use a hearing aid. **AA has a card circulated to all groups that reminds members of the need to speak up for the hard-of-hearing.** * **There is a Sign Language group in London and every effort is made to arrange a meeting if needed.**   2. **Ethnicity.**  1. In the 2020 AA membership survey (2020) around 97% of the GB respondents identified as White; 1% as Asian; less than 1% as Black; 1% as Mixed and less than 1% as Other. This differs significant from the UK Census 2011 figures (88.4% of White; 6.6% as Asian; 2.8% as Black; 1.4%. as Mixed and 0.9% as Other) in key indicators particularly with respect to the participation of individuals from the BAME communities.  2. The stigma of alcohol misuse in some ethnic communities is considerable, with people in denial and sometimes being excluded from places of worship.  3. “The Big Book” has been published in around 50 languages. “The Twelve Steps and Twelve Traditions” book is available from the AA GSO in various languages. There is a variety of literature, books, pamphlets and other media in various languages, including Polish and Welsh, and copies of literature in many languages can be ordered.  4. The National Helpline provides FREE 24-hour access on 0800 9177 650.  5. AA Email: [help@aamail.org](mailto:help@aamail.org)  6. AA Website  <https://www.alcoholics-anonymous.org.uk>  This has a Live Chat Box and gives details of the history of AA, meetings, local helpline numbers, the 12 Steps, 12 Traditions and 12 Concepts, a Young Person’s video, literature and articles from the AA Sub Committees, including the Health Sub Committee.  7. The AA Service Handbook for Great Britain provides guidance for how AA members can provide service and includes a section on AA and healthcare in the community.  8. The AA Structure Handbook for Great Britain describes Groups and Group meetings, Intergroups, Regions, the General Service Conference, General Service Board and General Service Office.  9. AAGB produced a highly-praised video for the 75th Convention, which featured alcoholics from a number of different cultures and walks of life. This is available on the media page of the main AA website.  10. AA organised a Race Convention to engage ethnic communities and to carry the AA message of sobriety across all sectors of society. 2.2 Have any changes to the scope of the quality standard been made as a result of topic engagement to highlight potential equality issues? 1. "Open" meetings welcome anyone and non-alcoholics can attend as observers. "Closed" meetings welcome those with a self-professed "desire to stop drinking". At speaker meetings, members come to tell their stories or "share". At Big Book meetings, attendees read from the AA Big Book and discuss it. There are also discussion meetings, with or without a topic.  2. Online meetings are digital meetings held on platforms such as Zoom. Offline meetings, also called "face to face," or "in-person" meetings, are held in a shared physical real-world location. Some meetings are hybrid.  3. AA members, sponsors and health liaison officers cooperate with community elders and link workers in our ethnic communities to address the alcohol stigma and enhance engagement with AA.  4. AA members liaise with prison governors and other personnel to facilitate AA meetings in prisons, probation and criminal justice services and the armed forces. 2.3 Do the draft quality statements make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group? 1. There are challenges for people who are housebound, have illness, disability including sight, hearing and mobility problems, vulnerable people, parents with children, older and younger people, work commitments and geographical considerations that make attendance at AA face-to-face meetings difficult. The rapid development and continuation of online platforms with the Covid-19 pandemic has facilitated access and preserved anonymity for these groups and other AA members.  2. Engagement with homeless people is especially difficult until satisfactory accommodation has been arranged. 2.4 Is there potential for the draft quality statements to have an adverse impact on people with disabilities because of something that is a consequence of the disability? No adverse impacts for people with disabilities have been identified at this stage. 2.5 Are there any recommendations or explanations that the committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 2.1, 2.2 or 2.3, or otherwise fulfil NICE’s obligation to advance equality? **1. Current NICE Guidance 1.3.1.7.**  **For all people seeking help for alcohol misuse:**  • give information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous or SMART Recovery) and  • help them to participate in community support networks and self-help groups by encouraging them to go to meetings and arranging support so that they can attend.  2. NICE could support and disseminate awareness of the evidence-base for the efficacy and reduced healthcare costs of peer-led Alcoholics Anonymous (AA) and professionally-delivered treatments that facilitate AA involvement (Twelve-Step Facilitation (TSF) interventions) in people with alcohol-use disorders. This should promote the engagement of the four key audiences for the quality statement and cooperation with AA.  3. NICE CG115 Evidence should continue to highlight that this guidance includes many trials involving AA, as well as patient testimonies, as to the support and efficacy of AA.  4. NICE could support NHS England in the roll-out of hospital alcohol care teams to facilitate AA, especially health liaison officers, cooperation links with emergency departments, hepatology and psychiatry consultants and alcohol specialist nurses in liver, psychiatry and general wards and alcohol assertive outreach teams.  5. NICE support will facilitate AA cooperation with primary care, healthcare undergraduate and postgraduate courses, the voluntary sector, charities and pharmacists.  6. NICE support for AA meetings in prisons, probation and criminal justice services will help people who misuse alcohol to achieve abstinence, turn their lives around, restore their self-respect and return them to society and their loved ones, who will all rejoice in their renewed purpose in life and happiness.  7. NICE support for AA, a free service, will aid both management and also prevention, especially secondary prevention, of alcohol-use disorders and their devastating sequelae. |
|  | British Association for the Study of the Liver (BASL) | Statement 2 | The statement is too vague to deliver improvements in care. How will information be provided? What support will be provided to help them access community support? How will service providers and care practitioners obtain information about what local community support is available and ensure it is standardised across all providers/practitioners? There is no standardised material to present to people seeking help for AUD about the benefits of support groups/self-help; such material would be useful to produce and standardise. |
|  | British Association for the Study of the Liver (BASL) | Statement 2 | There are no systems in place to measure the outcomes associated with statement 2. To evaluate the process, individual care records will need to be reviewed or a report form will need to be implemented. Information not be routinely recorded in care records. |
|  | British Liver Trust | Statement 2 | agreed. No comments |
|  | Buckinghamshire Council | Statement 2 | Quality statement 2 has a broader focus than the 2011 quality standards and recognises the importance of non judgemental conversations taking place and range of networks and groups being identified who can support. However, there is no explicit reference to referral in the quality standard or additional content details. Referral (not signposting) is also very important (as it may capitalise on a teachable moment, and this client group may be less well motivated to self-refer than other cohorts self-referring for physical health conditions). This was previously included as statement 3. |
|  | Change Grow Live | Statement 2 | Our clinicians have pointed out that most community support / self-help groups are “anonymous” (an attraction for attendees) and so engagement / outcome data will not be available. Almost all community support groups do not provide feedback to ‘referrers’ or commissioners. |
|  | Church of England Faith and Public Life Division | Statement 2 | We would add to Statement 2 the following, “pastoral, spiritual and religious care.” |
|  | Hackney Council | Statement 2 | Ideally, it would be good to include all sites that people could go to seeking help for alcohol-use disorder (pharmacies, GP, specialist provider…)  The information from the provider would have the caveat that it was completed about its own performance. |
|  | Inclusion | Statement 2 | Again we agree with this statement and don’t identify it as an area that’s lacking, however right now this isn’t something that is easy to monitor. Our clinical database system largely captures information for people in structured treatment and could exclude a large proportion of people who only access brief interventions. In order to capture this information in the future, we would require a change in processes and a specific tagged intervention to our clinical database system; however, this would reflect offer rather than offer and uptake. If people are directed to community support networks and self-help groups via our website, we have no way of knowing about this. |
|  | Greater Manchester Mental Health NHS Foundation Trust | Statement 2 | Agree. It will be hard to compare areas though as different localities have different third-sector services. |
|  | NHS England Primary Care | Statement 2 | This is clear, would need to be coded in primary care which is not widely done at present. |
|  | NHS England Primary Care | Statement 2 | Equality and diversity considerations, page 11: We strongly suggest the above is incorporated to ensure information is accessible to people with a learning disability and autistic people. We strongly suggest that consideration should be given to (not an exclusive list) those who have a learning disability, have reading difficulties, have sight impairment, and whose first language is not English. |
|  | PTSD UK | Statement 2 | ‘how they can help people with an alcohol-use disorder.’ – we’d suggest that this should include an element of ‘and it’s comorbid conditions’ so that any ‘root-causes’ of alcohol misuse such as PTSD can be supported too. |
|  | Royal College of Nursing | Statement 2 | Page 9- Psychological interventions to consider healthcare service talking therapies, group work- vital to ensure relapse prevention and alcohol detoxification this is too descriptive. Several key papers have identified PSI need for alcohol abstinence – i.e. I worked with Christos Kouimtsidis and he has published several works over the past decade on the importance of structured PSI treatment and psychological interventions. |
|  | Royal College of Physicians and Surgeons of Glasgow | Statement 2 | This is important but highly variable in localities. Community and Recovery groups are vital to help those with alcohol use disorder. However, such groups vary between different areas and groups can be established and then be dissolved quite quickly. Therefore, to be effective, up-to-date local databases of active groups will need to be maintained. This requires a responsible organisation to take on this role. Otherwise, there is a risk people seeking help will be advised to attend inappropriate or inactive groups: such a poor experience may inhibit future engagement. |
|  | Royal Surrey NHS Foundation Trust | Statement 2 | Think need to highlight GPs in the health and social care practitioners as they are a great resource for small groups for local populations eg female only Muslim AA meeting |
|  | University College Hospital NHS Trust | Statement 2 | Good to see this added we routinely provide information to patients and carers on agencies we refer to from the hospital setting. This includes fellowship organisations. We have a particularly good relationship with polish AA and link patients directly to them for support that begins in hospital. |
|  | University of Bedfordshire | Statement 2 | No comment. |
|  | Alcoholics Anonymous | Statement 3 | **Not applicable to Alcoholics Anonymous** |
|  | British Association for the Study of the Liver (BASL) | Statement 3 | While the intent of the statement is good, the wording could be improved. It would be more appropriate to describe the initial triage assessment as a brief holistic assessment of the person’s health, needs and risks. Provision of a template/proforma to complete this in a standardised manner would assist with ensuring it is done consistently and would make the assessment of outcomes easier. |
|  | British Liver Trust | Statement 3 | Q1: Does the draft quality standard accurately reflect areas for quality improvement?  Answer: No, the wording if the quality standard should not use the word ‘co-morbidity’, but specifically relate to the harmful effects of excess alcohol  (ie assessment of liver disease, brain injury etc), which should be undertaken or further assessment organised.  Q2: Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  Answer: Potentially not at present in some places, but if coded correctly, then yes. |
|  | Buckinghamshire Council | Statement 3 | Reference to brief triage in quality statement 3 recognises the importance of adults receiving something more holistic than an initial assessment. The importance of recognising an adults physical issues and needs as part of a brief triage is vital and often an initial assessment does not detail this. A brief triage assessment would also enable an opportunity for an adult to consent to access for GP records. Brief triage also enables other health and social care practioners to be involved.  Quality standard 3 refers to adults seen by specialist alcohol services. All other quality standards refer to people. Given this we would support a quality statement that explicit referenced children and young people accessing specialist services and them receiving a comprehensive assessment which includes the use of validated tools and measures. |
|  | Change Grow Live | Statement 3 | Change Grow Live uses 12 in-house questions at Triage (see below), to prioritise and signpost according to comorbid needs. These questions are a health screen to highlight any urgent concerns. This will have to be identifiable and counted.  **If 'yes' advise the person to seek medical attention from their GP or ring NHS 111**  1. Do you ever experience a painful feeling of heaviness or tightness, usually in the centre of your chest, which may spread to your arms, neck, jaw, back or stomach?  Have you coughed up blood or noticed blood in your vomit?  Have you ever noticed or has someone else commented that the whites of your eyes or your skin have turned yellow?  Have you passed any blood from your back passage?  **If 'yes' seek support from a CGL doctor or nurse, either directly or at your next Alcohol MDT**  Do you have a sensation of numbness or pins and needles in your feet or hands?  Have you ever experienced fits (seizures)? Have you a history of head injuries (including non-alcohol related and as a child)?  Have you lost or gained weight unexpectedly recently?  Have you noticed that you bruise more easily than normal?  Do you experience, or have you experienced a severe, dull pain around the top of your stomach that develops suddenly?  Have you or a relative/carer expressed concerns about your memory?  Are you pregnant or thinking about becoming pregnant?  Have you or anyone else had any concerns recently about your blood pressure or a blood test? When was the last time you had your BP checked or a blood test? |
|  | Church of England Faith and Public Life Division | Statement 3 |  |
|  | Hackney Council | Statement 3 | Same as statement 2. |
|  | Inclusion | Statement 3 | We agree with this statement and already have processes and pathways in place to ensure all people who access services for support have a brief triage, which includes the required information. |
|  | Greater Manchester Mental Health NHS Foundation Trust | Statement 3 | Agree. There should also be some quality standards pertaining to the qualification of the staff member doing these assessments as co-morbidities in alcohol dependence are usually physical and either life-threatening or life-limiting. |
|  | NHS England Primary Care | Statement 3 | Could it be “risks” rather than “associated risks”? One of the greatest risks is abrupt withdrawal which is an inherent rather than associated risk and should form part of the initial assessment. |
|  | NHS England Primary Care | Statement 3 | Equality and diversity considerations, page 15: Strongly suggest use of the term 'learning disability' not 'learning disabilities'. Strongly suggest that 'advocate with appropriate training and skills' is used rather than advocate. |
|  | Royal College of Physicians and Surgeons of Glasgow | Statement 3 | Individual assessment of risks and co-morbidities is vital in this context. Recognition of alcohol related brain disease and alcohol-related liver disease is particularly important. The statement and briefing paper are however somewhat vague as to what should be included in such an assessment or what specific tests be considered indicative of significant co-morbidity. |
|  | Royal Surrey NHS Foundation Trust | Statement 3 | - |
|  | University College Hospital NHS Trust | Statement 3 | Good to see more focus on comorbidity and risk for community services. We observe complex comorbidity at point of hospital attendance in the cohort of patients already engaged in community treatment services. With less NHS participation in these services there will likely be training needs to achieve this. |
|  | University of Bedfordshire | Statement 3 | No comment. |
|  | Alcoholics Anonymous | Statement 4 | **Not applicable to Alcoholics Anonymous** |
|  | British Association for the Study of the Liver (BASL) | Statement 4 | The statement is not prescriptive enough. The recommendation from NICE CG100 1.1.2.2 is to “consider using a tool (such as CIWA-Ar) as an adjunct to clinical judgement”. The suggestion that local protocols for alcohol withdrawal can be based solely on clinical judgement may lead to a highly variable approach. The statement should be rephrased to specify that a validated alcohol withdrawal scoring tool must be used. This is more likely to ensure improvement in patient care. |
|  | British Liver Trust | Statement 4 | Q1: Does the draft quality standard accurately reflect areas for quality improvement?  Answer: Yes, it is important that there are protocols in place for the management of acute alcohol withdrawal. The incorporation of the work ‘local’ in the quality standard introduces the potential for a wide variation in the protocols between institutions or locations. The protocols used needs to be based on best practice and align with best evidence and national or international guidelines.  Q2: Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  Answer: Yes, simple to ensure that all sites have appropriate protocols/guidelines in place.  It is important to highlight that the stated outcome measure for this statement – ‘Rates of successful withdrawal from alcohol” is not meaningful. What constitutes a successful withdrawal from alcohol. Outcome should also reflect proportion of complication/unsuccessful withdrawals eg – number of patients over-sedated, number of patients sedated and ventilated to control withdrawal (ie representing uncontrolled withdrawal), number of patients with complications of withdrawal – cardiac arrest/death.  Q3: Resource requirements?  Answer: The existence of functional Alcohol Care Teams is of enormous benefit here. Assessment and monitoring of acute alcohol withdrawal requires different resources according to whether symptom-triggered or fixed-dose alcohol withdrawal regimes are used. The former needs nursing staff on wards to be specifically trained in the assessment of patients and therefore dosing of medication to control withdrawal. The advantage of applying symptom-triggered regime is that some patients’ are better managed with this and can be safely discharged from hospital earlier. Part of an appropriate protocol includes prevention of long-term irreversible brain damage through intervention with high-dose intravenous Vitamins, as well as monitoring and treatment of electrolyte disturbances and prevention of cardiac arrythmias. Hence the capacity of a complete protocol has the potential to reduce morbidity and mortality in patients admitted with, or developing, acute alcohol withdrawal.  Q4 How does assessment and monitoring based on locally specified protocols work in current practice? What do these protocols generally include?  Answer: As per response to Q3, assessment includes risk of uncontrolled alcohol withdrawal and its prevention, risk of Wernicke’s encephalopathy and its prevention, and risk of severe electrolyte disturbances and cardiac dysrhythmias that can develop in people with alcohol-use disorders. |
|  | Buckinghamshire Council | Statement 4 | Quality statement 4 is supported but there are challenges for implementation. People in alcohol withdrawal in acute settings may not be regarded as priority and the numbers small. Acute settings continue to face significant pressures and the statement does not provide any further assurance this will be area of priority. The quality statement would be strengthened if there was advice regarding alcohol liaison teams/provision within acute settings. This would ensure there is dedicated support to ensure timely and appropriate assessments were completed in hospital and the necessary arrangements and liaison put in place in the local system for monitoring. Despite the numbers in this cohort being small the quality statement needs strengthening to ensure its proactive enough to part of the solution to addressing the increase in drug related deaths which the most recent data is showing. It would not be appropriate to wait until the data gets worse to strengthen the requirement of this standard. |
|  | Change Grow Live | Statement 4 | One of our lead clinicians has highlighted that one of the areas of improvement that they think needs the most consideration in the guidelines is the area of acute withdrawal in a hospital setting and transitional support to specialist areas. It is perceived that there is considerable variance between areas and hence a need to provide a minimum commissioned standard of staffing and resources to carry this intervention out. There would be value in more robust and uniform monitoring standards. It appears that as local protocols are being employed, the monitoring of success of interventions seems limited. Standardisation would be beneficial to all stakeholders, and any variation should only be for practical reasons due to local settings. |
|  | Change Grow Live | Statement 4 | Our consultants have indicated that identification and counting of people with acute alcohol withdrawal is more reliable in acute hospitals as opposed to mental health units. Pathways need to be co-produced with relevant stakeholders, including acute and mental health units, primary care, and specialist substance misuse services. Patients should also be screened for alcohol related brain injuries using tools such as 6-CIT (Six-item Cognitive Impairment Test), MMSE (Mini Mental State Examination), MoCA (Montreal Cognitive Assessment (MoCA) Test for Dementia) and ACE-III (Addenbrooke's Cognitive Examination-III), as this may be an opportunity to refer for memory / dementia assessment without the confounders of alcohol intoxication and severe withdrawal (other confounders will be present – medication prescribed, comorbid medical and psychiatric conditions). This is a baseline and can be repeated post discharge if the person does not continue to misuse alcohol.  These can be recorded and counted. Alcohol Liaison Practitioners and Alcohol Care Teams, if present, will improve awareness amongst hospital staff. |
|  | Church of England Faith and Public Life Division | Statement 4 | We would add to Statement 4 the following, “pastoral, spiritual and religious care” and social prescribing. |
|  | Hackney Council | Statement 4 | It would be good to have a set period for the assessment. |
|  | Inclusion | Statement 4 | We agree with this statement but believe in order for this to be delivered as standard practice across all acute settings, much work is still required. There is a significant variation in how people who are in acute withdrawal are able to access and are provided with the support of specialist drug and alcohol staff and services. From a specialist service perspective, we are only able to offer alcohol liaison support in hospitals where our services are commissioned to do so by. In these cases, we have an identified alcohol liaison post. In other areas, we rely on the liaison services within the acute hospitals to link in with us in the community. We are aware that not everyone in acute alcohol withdrawal is referred to liaison workers and for those who do, locally agreed protocols can be somewhat uncertain, especially when it comes to roles and responsibilities and recording of information on different clinical database systems. Data collection is rudimentary and can do with being more formalised and integrated between acute and community specialist services. Where we have done this successfully, there have been additional resources in the form of funding for specific roles, which we suggest, are needed. Informal agreements seem to exist rather than formal protocols. Specialist service liaison staff have no control of admissions or discharge which can cause difficulties with continuity of care into the community and subsequent patient safety. |
|  | Greater Manchester Mental Health NHS Foundation Trust | Statement 4 | Agree. This applies to acute Trusts. We do have input to acute alcohol care teams, however, and encourage this and contribute to their protocols, if requested. |
|  | NHS England Primary Care | Statement 4 | N/A to primary care. |
|  | Royal College of Nursing | Statement 4 | Statement 4 page 3- consider alcohol dependency in the community, ambulatory and home detoxifications not only hospital. |
|  | Royal College of Physicians and Surgeons of Glasgow | Statement 4 | Clear protocols for the management of acute alcohol withdrawal are necessary. This should take the form of readily available written guidelines. However, for any guideline to be effective it requires an education package for those implementing it in practice. The statement specifically highlights the CIWA-Ar scale. Whilst this has been well studied in specialist addiction settings, its applicability in emergency and acute medical settings (where unplanned acute alcohol withdrawal will occur) is less established. The emphasis on the CIWA-Ar may lead to its application in clinically sub-optimal situations and alternative symptom-triggered scales should be acknowledged. |
|  | Royal Surrey NHS Foundation Trust | Statement 4 | - |
|  | University College Hospital NHS Trust | Statement 4 | Patients undergoing alcohol detoxification are monitored by the Alcohol Liaison team (2 Nurses Monday -Friday 8-6). The liaison team supports non-specialist staff caring for the patients to maintain this monitoring and support out of hours. Training is provided to staff across the trust to imbed this. |
|  | University of Bedfordshire | Statement 4 | The statement about acute alcohol withdrawal should not be limited to those in hospital: it should additionally apply to people in acute alcohol withdrawal in the community, including those in care homes. |
|  | Alcoholics Anonymous | Statement 5 | **Not applicable to Alcoholics Anonymous** |
|  | British Association for the Study of the Liver (BASL) | Statement 5 | The statement is clear and will improve care by increasing therapy to support abstinence. However, the provision of services across the country that can support this is insufficient. An additional challenge will be to measure the process. This may not be well-recorded in care records. People may be offered therapy but refuse to accept it – how will this information be captured? Relapse to alcohol is not usually recorded in the care record unless the person has another interaction with a healthcare practitioner. |
|  | Buckinghamshire Council | Statement 5 | We support quality statement 5 as we do not see this happening in any consistent way. Whilst the presenting issue is addressed the underlying moderate or severe alcohol dependence is not addressed and therefore associated interventions are not offered. This quality standard supports are local ambition to receiving referrals earlier. The quality standard could be strengthened if reference was made to ensuring the offer of appropriate interventions following a successful unplanned withdrawal was understood and implemented by staff across all departments in an acute setting. The quality standard could also be strengthened if specific reference was made to the liaison role played by Primary Care. |
|  | Change Grow Live | Statement 5 | According to our consultants, the patients with moderate or severe alcohol dependence generally do not respond to brief intervention. There is scope to count people engaging in specialist alcohol treatment providing a formal referral is made. Simply signposting should be discouraged, as no feedback can be given if no referrer is identifiable.  Note that pharmacological relapse prevention medication (primarily acamprosate and naltrexone) is not effective unless linked to regular psychological / social intervention (including self-help and mental health counselling – i.e. not just within substance misuse services). However, GPs are usually not commissioned to provide this medication (e.g. for people attending regular psychological / social intervention outside substance misuse services). This will need to be rectified to ensure that access to these medications is improved. Disulfiram, historically, does not require regular psychological / social interventions, but works better when these are in place. These medications have varying safety profiles and are generally offered for medium term use while people develop psychological and social relapse prevention strategies.  These can be recorded and counted. Alcohol Liaison Practitioners and Alcohol Care Teams, if present, will improve awareness amongst staff. |
|  | Church of England Faith and Public Life Division | Statement 5 |  |
|  | Hackney Council | Statement 5 | Again it would be important to include a timeframe. |
|  | Inclusion | Statement 5 | We agree with this statement but some of the difficulties expressed in our statement 4 response will feature here also. Who would be responsible for delivering the intervention in this statement? Is the expectation for GPs or specialist services to pick up relapse prevention medication prescribing? These medications remain on primary care amber/red lists meaning that GPs refuse to prescribe resulting in specialist community services prescribing for periods of time, sometimes longer than psychological interventions which run alongside. This results in service users having to remain in specialist services, despite them wanting and deserving independence from services as part of their ongoing recovery. In order for this to work more effectively, we believe a commissioning response is required. In order to comply with the definition of psychological interventions provided in this statement, additional resourcing would also required. |
|  | Greater Manchester Mental Health NHS Foundation Trust | Statement 5 | Agree in principle, but since some ‘unplanned withdrawals’ take place in acute settings, again, we cannot comment. It is a bit of a vague standard as it does not define ‘psychological interventions’. (Certainly if any unplanned cessation of alcohol happens in the community, patients would be offered relapse-prevention PSI) |
|  | NHS England Primary Care | Statement 5 | Nil to add. |
|  | PTSD UK | Statement 5 | Research shows that people with PTSD are around four times more likely to be affected by alcohol dependence than the general population – and so would be keen to see EMDR as a psychological intervention mentioned here |
|  | Royal College of Nursing | Statement 5 |  |
|  | Royal College of Nursing | Statement 5 | Page 23- pharmacological interventions= no discussion nor mention of Benzodiazepines either diazepam nor chlordiazepoxide. These medications are key to assist with alcohol withdrawal. |
|  | Royal College of Nursing | Statement 3 | Page 23- member feedback: ‘as a NMP I have prescribed adjunct therapies i.e. anti-emetics, anti-diarrhoea and non-BZD to aid sleep following alcohol withdrawal inpatient and in the community’. |
|  | Royal College of Physicians and Surgeons of Glasgow | Statement 5 | This is a welcome statement in the context of unplanned alcohol withdrawal. However our reviewer has concerns as to its applicability and anticipates difficulty in offering a 12 week psychological intervention in the immediate aftermath of unplanned withdrawal. Perhaps there should be some suggestion as to the timing of such treatment: a standard to be achieved would be the offer to start such treatment either prior to discharge from alcohol withdrawal or within a specific timeframe after discharge (such as two weeks?). After an unplanned alcohol withdrawal, there is probably a narrow window of opportunity for intervention with the best chance of behavioural modification. |
|  | Royal Surrey NHS Foundation Trust | Statement 5 | This needs to help support changes in the BNF as currently only specialist substance misuse teams can prescribe pharmacological interventions and would need this to expand to hospital services to then be supported by GPs if unplanned withdrawal is treated in hospital as not all who are discharged want/are willing to engage with community substance misuse teams |
|  | University College Hospital NHS Trust | Statement 5 | Should be offered currently not on hospital formulary. Again this could be a national requirement. Drugs non-formulary in hospital(s) mandating in guidance would support getting these drugs available for patients. Currently we share bloods etc to enable community prescribing on discharge. |
|  | University of Bedfordshire | Statement 5 | Our experience is that older people with alcohol dependence are sometimes admitted to care homes without alcohol screening, and undergo unplanned, enforced withdrawal without support. Therefore this statement should explicitly include people in care homes with moderate or severe alcohol dependence. |
|  | NHS England Primary Care | Equality Impact Assessment | Section 2.1: It is strongly suggested this is expanded to include people with communication difficulties. This would then include autism and other communication difficulties owing to hearing impairment etc. This is to align with references throughout the draft quality standard to people with a disability, impairment or sensory loss, for example. |

Note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

## Registered stakeholders who submitted comments at consultation

* Alcoholics Anonymous
* British Association for the Study of the Liver (BASL)
* British Liver Trust
* Buckinghamshire Council
* Change Grow Live
* Church of England Faith and Public Life Division
* Greater Manchester Mental Health NHS Foundation Trust
* Hackney Council
* Inclusion
* NHS England Primary Care
* PTSD UK
* Royal College of Nursing
* Royal College of Paediatrics and Child Health
* Royal College of Physicians and Surgeons of Glasgow
* Royal Surrey NHS Foundation Trust
* University College Hospital NHS Trust
* University of Bedfordshire