Introduction

Deaths from liver disease (LD) have increased steadily over recent years and 70–85% of these are alcohol-related. Alcohol-related harm is putting a huge burden on NHS services and increasing focus on early identification and prevention is likely to provide benefits for both health outcomes and economically. To support the development of pathways for Alcohol Related Liver Disease (ARLD) it is essential to understand the pattern of hospital activity locally.

Methods

The study used a retrospective cohort design of secondary data from hospital episode statistics from nine Trusts in Wessex as part of the Wessex AHSN Reducing Harms from alcohol programme. The dataset comprised all admissions for LD January 2011 - December 2015. Admissions for ARLD were compared with non-ARLD for patient demographics, length of stay, mortality, and diagnoses.

Aims

To use local Trust data to map ARLD hospital activity in Wessex with the aim of providing evidence for decision making around service development to reduce service use and improve outcomes for patients.

Results

Between 2011 and 2015 across all Trusts:
• There were a total of 26,945 LD admissions, and a total of 9,957 of these were ARLD admissions
• On average there were ~865 new diagnoses of ARLD per year
• 85% of LD admissions were emergency
• The number of LD admissions has been increasing year on year (Fig 1), mainly due to an increase in the number of NAFLD/NASH admissions which are likely to be due to increases in obesity.
• Although the number of admissions for ARLD has remained relatively stable, it is likely to be underestimated due to a lack of screening for alcohol, or recording of this.

Characteristics of a cohort of patients with first admission in 2012:
• ARLD patients tended to be younger, more likely to be male, had more admissions and poorer outcomes (Tab 1)

Patterns of coding across Trusts:
• 32% of final LD diagnoses for an admission were given an ‘unspecified’ code (Fig 2). The high proportion of unspecified diagnostic codes may be due to lack of clarity in notes, including around alcohol use. This varied from 23% at Portsmouth Trust, to 39% at IOW Trust.

Conclusions

➢ ARLD constitutes a significant proportion of LD admissions and hospital activity, especially emergency admissions which will be putting strain on resources and reducing capacity for elective work
➢ Early Identification and treatment via standardised screening and pathways into alcohol services is key in managing these patients
➢ There are likely to be potential cost saving associated with early identification of harmful alcohol use, from reduction of service use and CQUIN
➢ Coding for liver disease could be improved and this should include better screening and recording of alcohol use
➢ Liver disease as just one example of the harmful impacts of alcohol on patient health and service use, other important conditions include heart disease and cancer

References:
2. Wessex Academic Health Science Network. Available at: http://wessexahsn.org.uk/projects/55/alcohol-related-liver-disease