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East London NHS Foundation Trust and Bedford Hospital Joint Liver and Alcohol Clinic

Best Practice Case Study

Transforming Engagement, Stigma, and Access to Hepatology Care

This best-practice case study documents the conception, implementation, development, and impact of a joint Liver and Alcohol Clinic delivered through collaboration between Path to Recovery (P2R, East London NHS Foundation Trust (ELFT)) and Bedford Hospital hepatology services. The initiative was designed to address persistently high non-attendance rates for alcohol-related liver disease referrals by relocating assessment, diagnostics, and engagement into a setting trusted by people accessing the service. Through in-service FibroScan delivery, monthly joint clinics, and deeply integrated multi-disciplinary working, the service has significantly improved attendance, identified previously undiagnosed cirrhosis and liver cancer, supported complex transplant pathways, and reduced stigma for people with alcohol-related liver disease (ARLD).

Identifying the Problem:

Before the development of the joint clinic, people within the community drug and alcohol treatment service (P2R) who were identified as being at risk of liver disease were referred into standard hospital hepatology pathways for investigation and follow-up. In practice, this approach was ineffective, and DNA (Did Not Attend) rates for alcohol-related liver disease referrals were reported to be approximately 90%, resulting in missed diagnoses, undelivered care, and wasted hospital capacity.

People frequently did not attend hospital appointments for scans or clinic reviews, meaning they often had no clarity about whether they had cirrhosis or progressive liver disease. From the hospital perspective, clinic slots were booked but unused, clinicians had little opportunity to intervene, and opportunities for early diagnosis were repeatedly missed.

“When we referred them to the hospital, they just didn’t turn up. So, they never knew whether they did have cirrhosis or not.”

Anna Lipinska

The Catalyst for Change:

Anna Lipinska began working within P2R in 2021. At that time, blood-borne virus (BBV) testing and basic health checks were undertaken in-service, with onward referral to hospital for any liver investigation. Following a subsequent six-month role as a liver specialist nurse outside of P2R, Anna gained training and experience in FibroScan delivery and interpretation, as well as enhanced knowledge of hepatology pathways and transplant processes.

Anna returned to P2R in April 2023 as the Physical Health and Hospital Liaison Lead, bringing with her both clinical skills and a strong understanding of the structural barriers that people who use substances face when accessing hospital-based care. This dual perspective proved critical in redesigning the assessment and management of liver disease in this population.

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Establishing In-Service FibroScan Delivery:

On returning to P2R, Anna explored whether FibroScans could be delivered directly within the community drug and alcohol treatment service. Her discussions with Bedford Hospital identified that the FibroScan machine was not routinely used on Mondays. With agreement from hepatology colleagues, Anna was granted access to the scanner on those days, enabling a pilot of in-service FibroScan provision.

Bringing FibroScan into P2R marked a fundamental shift. People were assessed in a familiar, trusted environment by a clinician they already knew. Blood tests, scans, interpretation, and immediate discussion of results could all take place in a single setting rather than across multiple appointments at different locations.

"Never had an appointment where I could talk so openly about my life and not feel judged. This was very unique!"

"I get very nervous having my blood tests done, but in this clinic Dr Patel orders them and then Anna sees me at P2R to do them. This small thing makes a huge difference as I trust Anna."

From Diagnostics to Joint Clinical Management:

While in-service FibroScan addressed diagnostic access, a further challenge quickly became apparent: what to do with people identified as having advanced liver disease, particularly cirrhosis. Referring these individuals straight back to standard hospital clinics risked losing them to non-attendance once again.

Anna therefore contacted Jay Patel, Consultant Hepatologist at Bedford Hospital, to explore whether joint working was possible. The approach was proactive and exploratory rather than formal, based on shared concern about extremely high DNA rates for alcohol-related referrals.

"I reached out to Jay on the off chance he might be interested – and he jumped on board straight away."

Anna Lipinska

FibroScan Machine

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Setting Up the Joint Liver and Alcohol Clinic:

A monthly joint liver and alcohol clinic was established for people who had undergone a FibroScan within P2R and demonstrated findings suggestive of cirrhosis. Clinics were held at the hospital, but people attended with familiarity and reassurance given that Anna Lipinska would be present throughout.

At inception, the clinic was developed largely through professional goodwill. Organisational support from the hospital was limited, with the consultant effectively fitting the clinic into existing commitments. Despite this, the model was prioritised due to its potential to reverse non-attendance and improve outcomes.

Impact on Attendance and Engagement:

The impact on attendance was immediate and striking. Whereas alcohol-related referrals historically showed DNA rates of around 90%, early joint clinics achieved attendance rates of approximately 92%. This represented a complete reversal of engagement patterns.

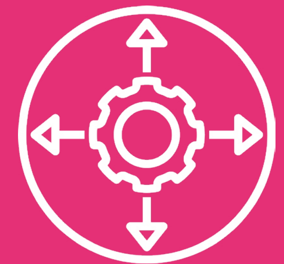
Several factors contributed to this change, including continuity of care with the clinician, multiple reminders via calls and texts, involvement of key workers from P2R, and reduced stigma due to the joint-clinic framing. People knew who they would see, what to expect, and that they would not be judged.

"It is great attending a new clinic where I already knew someone in the room. It made me less anxious. Plus Anna reminds me a lot about the appointments so I don't forget."

"I had previously been to P2R but then I stopped. Coming to this clinic and listening to Jay and Anna work together to help me made me give recovery another try!"

Progressive Expansion of Clinic Scope:

Over time, the clinic expanded beyond its original remit. People already under hepatology care who had alcohol dependency were referred to the joint clinic for additional support. Ward discharges with newly identified alcohol-related liver disease were also brought into the clinic for follow-up, allowing immediate linkage with specialist substance use treatment and support. Plans were subsequently developed to route GP referrals for alcohol-related liver disease directly into the joint clinic rather than standard hepatology pathways, further embedding addiction-informed care.



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Barriers to Engagement and the Role of Stigma:

Stigma repeatedly emerged as the most significant barrier to engagement. Many individuals described fear of being judged, blamed, or dismissed when attending hospital appointments. Previous experiences reinforced beliefs that they would simply be told to stop drinking without the appropriate support to do so.

"They don't want to go and be told they've done this to themselves."

Anna Lipinska

The joint clinic model directly addressed this by embedding drug and alcohol expertise within hepatology appointments. Over time, hepatology consultations themselves became more holistic, routinely exploring housing, employment, benefits, mental wellbeing, and recovery support.

"It has been fantastic working with Anna and the P2R service. Anna has shown dedication and commitment and has supported Hepatology tremendously. We are lucky to have a team that works very hard to provide support for our vulnerable adult population with alcohol addiction concerns. We do our ultimate best to provide a patient centred approach to helping support addiction, but the potential for real success is heightened working alongside P2R. Long may the relationship continue."

Jay Patel, Hepatology Consultant, Bedford Hospital

Holistic and Compassionate Care in Practice:

A further supportive measure put in place was that people who missed appointments were not automatically discharged back to their GP. Instead, follow-up phone calls were made and further attempts at engagement were prioritised.

Waiting times reduced from around nine months to approximately one to two months, ensuring people were seen while motivation and engagement were still present.

"They're much more holistic appointments now – not just blood tests and see you in six months."

Anna Lipinska

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Impact of FibroScan on Motivation and Behaviour Change:

Based on clinical experience rather than formal evaluation, Anna Lipinska estimated that around two-thirds of people made positive changes following having a FibroScan, even if initially small. Seeing tangible evidence of liver damage – or its absence – often prompted reflection and action.

Anna Lipinska reported that a small number of people seen in the clinic initially believed the damage was already done, or conversely felt falsely reassured by normal results. These people were offered ongoing monitoring, repeat scans, blood tests, and motivational support through key workers at P2R.

Outcomes and Indicative Data:

The clinic operates with approximately eight appointment slots per month and has reportedly seen around 150 patients overall, with approximately 12 DNAs recorded across its lifespan. At least one case of liver cancer was detected through the clinic in a patient who otherwise minimally engaged with services.

Impact at a glance - August 2023 to April 2026:

- **Number of Joint Clinics Held - 26**
- **Number of People Seen in the Clinic - 176**
- **Number of DNAs - 14**
- **Number of People Newly Identified with Cirrhosis - 37**
- **Number of People Supported Through Liver Transplant Pathway - 1**
- **Number of People Identified with Liver Cancer**
- **Discussion and Onward Support for Accommodation Reviews - 32**
- **Discussion and Onward Support for Review of Disability Allowances - 39**
- **Considered for Acamprosate - 30**
- **Increased Uptake of Preventative Interventions, Including Variceal Banding**
- **Reduced Hospital Admissions and Length of Stay Through Proactive Management (e.g. paracentesis pathways)**
- **Earlier Diagnosis and Improved Disease Monitoring**

Although some people sadly died due to advanced cirrhosis, staff reflected that many would not have engaged at all without the joint clinic.

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Case Example, Alcohol-Related Liver Transplant Pathway:

One particularly complex and illustrative case involved a Polish man in his late thirties who had been drinking heavily for many years. At the time of diagnosis he was housed and did not perceive his drinking as problematic.

After rapid decompensation and hospital admission, he lost his housing and was found to have minimal social support. Through joint working, housing services were engaged, Personal Independence Payment (PIP) applications completed, and specialist alcohol treatment initiated. Despite being approved for fast-tracked rehabilitation, he chose to pursue abstinence from alcohol within the community.

“He just needed somewhere that could help with all of it – and we could.”

Anna Lipinska

Six months of abstinence were achieved, his transplant assessment was completed, and a successful liver transplant ultimately undertaken. Intensive relapse prevention support continued both pre- and post-transplant, addressing high-risk periods such as transplant call-ins that did not proceed.

In 2025 the joint work between P2R (ELFT) and Bedford Hospital received deserving recognition when they won the British Association for the Study of the Liver (BASL) Quality and Service Improvement Award: dr-falk-basl-awards-2025-jay-patel.pdf

Feedback from People Accessing the Joint Clinic:

People accessing the joint clinic reported improved trust, reduced stigma, and feeling supported in navigating healthcare. One patient with advanced liver disease successfully underwent liver transplantation following sustained engagement, highlighting the impact of coordinated, person-centred care.

Key Learning and Advice for Replication:

The most significant learning was that relatively small, relationship-driven changes could generate proportionately larger benefits for both people in need of the service and services. Proactive outreach to consultants was essential, even when initial responses varied.

“Until you actually reach out, you don’t know how supportive someone might be.”

Anna Lipinska

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What's the financial cost and impact of the joint clinic?

The joint clinic was set up using existing staffing, equipment (FibroScan already purchased) and structures, meaning that this project was low cost but ultimately high impact.

The project was further supported through external recognition, with the team being awarded £1,000 from the FALK Service Improvement Award. This funding will be used to directly support engagement and access, including:

- Patient transport costs to attend clinic appointments
- Supermarket vouchers for individuals experiencing financial hardship

These targeted interventions aim to reduce practical barriers to attendance and improve ongoing engagement with care.

Financial impact:

- Reduced missed appointment costs (~£150 per DNA)
- Estimated savings of >£1500 per patient through reduced inpatient stays
- Avoidance of emergency admissions (e.g. variceal bleeding)

Future Vision and Development:

Future aspirations for Anna Lipinska and the P2R service include expanding the joint clinic model to other specialties such as respiratory medicine for Chronic Obstructive Pulmonary Disease (COPD) and urology for ketamine-related bladder disease. Anna recognises that increased investment into nursing capacity to deliver more diagnostics in-service will ultimately address the health inequality gap faced by people who use drugs and alcohol.

"This initiative is incredibly important for early identification of liver disease and delivering a multi-disciplinary service in a single setting. This has resulted in patients being offered longer and more flexible consultations alongside holistic support including mental health input, social care signposting, and advocacy. This is a great example of joint working between the community drug and alcohol treatment service and hepatology."

Charlotte Ball, Drug and Alcohol Public Health Principal

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Joint Liver and Alcohol Clinic, Replication at a Glance:

This guide summarises the key practical considerations for community drug and alcohol treatment services wishing to replicate the ELFT and Bedford Hospital Joint Liver and Alcohol Clinic model. It is intended as a quick reference for clinical leads, service managers, and commissioners.

1. The Core Problem to Address

The primary issue this model responds to is non-engagement, not lack of referral. Services should confirm whether people with alcohol-related liver disease are failing to attend hospital appointments, leading to undiagnosed cirrhosis and missed intervention opportunities.

2. Essential Ingredients (Minimum Requirements)

- A community-based clinician with liver competence (or a clear training pathway)
- Access to FibroScan (owned, shared, or borrowed)
- Strong engagement capability (reminders, key workers, persistence)
- At least one hepatology consultant willing to pilot joint working
- Protected capacity to coordinate and follow up people referred to the clinic

3. FibroScan in Community Settings

Delivering FibroScan within community drug and alcohol treatment services removes a major access barrier. This does not require owning a FibroScan; shared-use arrangements with hospitals are often feasible. Results should be explained immediately, focusing on motivation and next steps rather than fear.

4. Designing the Joint Clinic

- Start small (e.g. monthly clinics, limited slots)
- Allow longer appointment times than standard hepatology
- Ensure the community clinician is present throughout for continuity
- Clearly explain to people accessing the clinic who will attend and why
- Respond flexibly to missed appointments rather than defaulting to discharge

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Joint Liver and Alcohol Clinic, Replication at a Glance:

5. Engagement and Stigma Reduction

Anticipated stigma is a significant barrier. Community services should lead on engagement, reassurance, and follow-up. Joint clinics should explicitly signal that they are supportive and non-judgemental spaces.

6. Governance and Consent

- Obtain explicit patient consent for joint working
- Use transparent clinic letters and referral processes (reviewing letters to ensure information is clear and accessible)
- Non-NHS services should consider information-sharing agreements early

7. Managing Clinical and Social Complexity

People with advanced liver disease can present with housing instability, safeguarding concerns, relapse risk, and deteriorating health. Services should plan for multi-agency coordination and be prepared to advocate for extended support, particularly for transplant pathways.

8. Demonstrating Impact

In addition to clinical outcomes, capture engagement measures (attendance, reconnection to care) and qualitative feedback. These outcomes are critical for demonstrating value to partners and commissioners, as well as responding proactively to feedback for continuous improvement.

Key Message for Replication

This model is defined less by equipment or structures and more by relationships, persistence, and clinical credibility. Replication should focus on adapting these principles to local context rather than copying the model exactly.

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