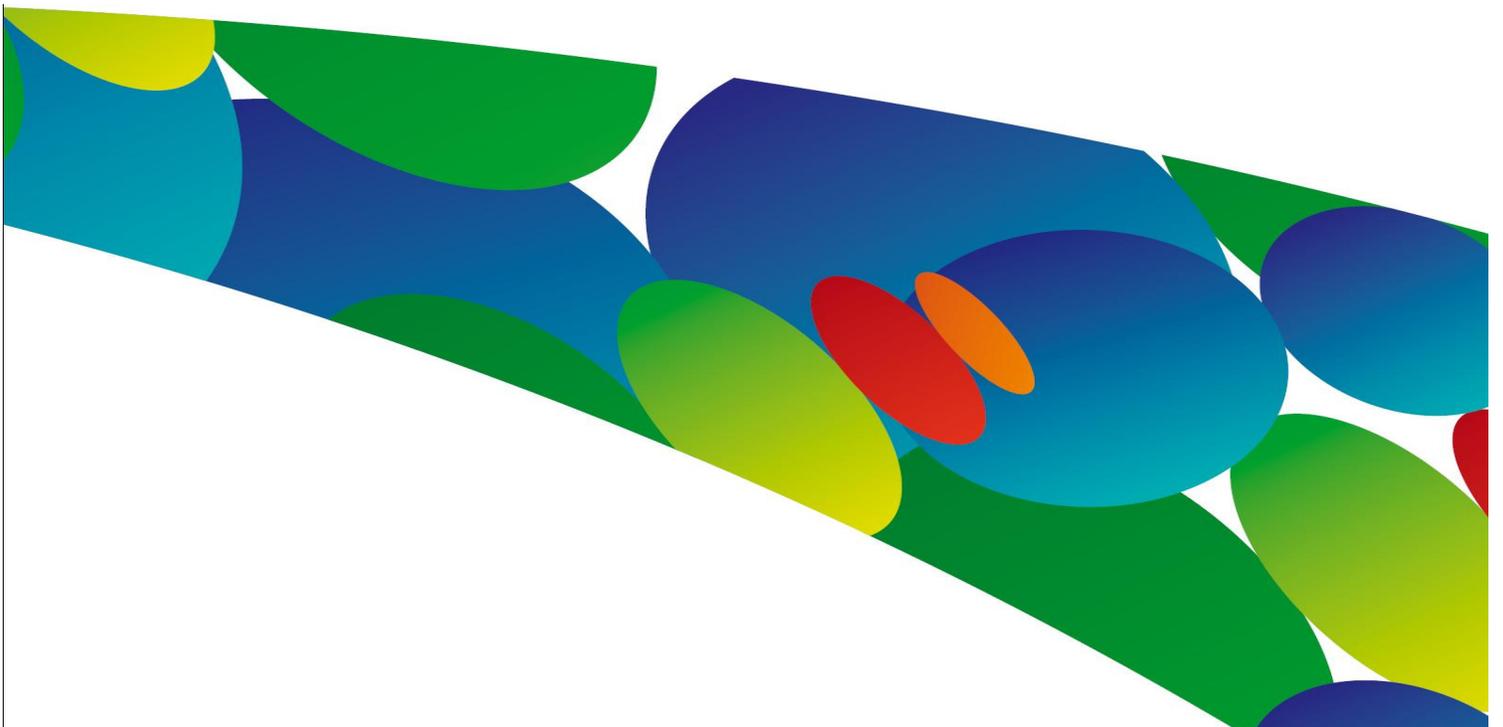


# Alcohol Harm Reduction National Support Team

**Engage • Recommend • Facilitate**

*Supporting Partnerships to Reduce Alcohol Harm:  
Key Findings, Recommendations and Case Studies  
from the Alcohol Harm Reduction National Support Team*



**DH INFORMATION READER BOX**

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## **EXECUTIVE SUMMARY**

### **Introduction to the Public Health National Support Teams**

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, ‘diagnostic’ visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Tobacco Control, Health Inequalities, Teenage Pregnancy, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People’s Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 480 visits to local partnerships during the course of the programme and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work. A further report that captures best practice identified by each team is planned to enable local areas to continue using the expertise and lessons learnt from the NST model.

The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity.

The Department is publishing a number of reports which distil the learning from the programme, and exemplify the methodology employed.

This document describes the work undertaken by the Alcohol Harm Reduction National Support Team since its formation September 2008. The Alcohol Harm Reduction National Support Team formed part of the Department of Health’s Alcohol Improvement Programme, and followed a similar methodology to the other Public Health National Support Teams.

Section one provides an overview of the methodology and the process followed by the team in providing support to Local Authorities, NHS organisations and local strategic partnerships in their efforts to reduce alcohol related harm. This section can be used to inform the development of further improvement support for areas that are looking to prioritise alcohol within the context of new Public Health environment

Section two provides an analysis of the findings of the team during these visits and outlines the common recommendations made to areas to accelerate their progress in

reducing alcohol related harm. This section has been developed to allow Local Authorities and their partners to understand fully the areas of particular challenge as they manage the transition, which will see alcohol embedded within their new Public Health responsibilities. This section also highlights some examples of good practice identified by the NST during the visits.

Section three uses case studies to illustrate the experience of areas visited by the NST. The case studies outline the key recommendations made by the NST, follow up support provided and describe the impact that this had in the area.

## **SECTION ONE: ALCOHOL IMPROVEMENT PROGRAMME**

The Alcohol Improvement Programme (AIP) was established in April 2008 by the Department of Health to help reduce alcohol-related harm. Alcohol-related Hospital Admissions across the NHS were used as a measure of this harm.

The objectives of the programme are to:

- Support capacity and capability building in local areas to ensure sustainable improvement in interventions to reduce alcohol-related harm.
- Collate and disseminate evidence, data, tools and guidance to support the NHS and local partners in delivering on the [Quality Innovation Productivity Prevention \(QIPP\)](#) agenda and making efficiency savings available from improved alcohol services.
- Produce guidance on the key enablers and activities for change
- Work with regions to ensure that local learning and innovation is shared nationally

In addition to the NST, the AIP have put in place a number of initiatives to support PCTs with taking action to reduce alcohol-related harm e.g. Regional Alcohol Managers and the Alcohol Learning Centre. Further information can be found in Appendix A starting on page 45.

### **The NST Process**

The AHR NST selects areas to visit in partnership with DH Alcohol Policy Team, Regional Public Health Leads and Regional Alcohol Managers, primarily focusing on areas with the highest rates of alcohol related hospital admissions.

The AHR NST usually operates by undertaking a four-day visit to a PCT area. During this time, the NST undertakes a number of discussions with individual stakeholders as well as contact with the local partnerships through two larger, multi-agency plenary sessions. The NST seeks to understand the local context and assess challenges to, and opportunities for, making progress. While a systematic process of enquiry is employed using a framework of key questions, these are designed to be free and frank discussions rather than formal interviews. All information given in these sessions is confidential.

The NST formulates and presents a report, based on the findings from the interviews and background documentation, on the final day of the visit. The report outlines the key strengths of the local partnerships, identifies barriers to delivery and provides recommendations to overcome these barriers and accelerate progress. The NST may also identify areas where further support can be provided. The NST returns soon after the visit to discuss the report with the relevant Chief Executive(s) and Director of Public Health to agree which offers of support they feel will assist them most in achieving their local targets.

### **Guiding Principles of the NST Approach**

An NST visit is **not** an audit, nor is it part of performance management. The NST approach involves using the knowledge and experience of experts in the public health and alcohol harm reduction field, through a diagnostic process to:

- Mirror back to the clients what they have said, with emphasis and understanding the technicalities of the delivery environment
- Offer solutions they can own
- Secure and utilise director-level buy-in
- Support leadership to deliver change
- Illustrate potential for scaling-up
- Provide a whole-system diagnosis

The NST methodology recognises that change must be owned and delivered by the local areas themselves and in this respect the NST acts only as an agent or catalyst for change. However, within this role, the NST can provide valuable support to help identify:

- Where to direct effort
- Where the driving forces are not sufficient to enable change
- Actions that will maximise the likelihood that change will have a sustainable impact on the area's identified outcomes

### **Diagnostic Process**

The NST is sponsored by the Department of Health and has a role in supporting efforts to reduce the impact of alcohol on health services, and in particular secondary care services. In developing the diagnostic process, however, it became clear that support would be inadequate if it was only targeted towards the NHS. In many areas, through local governance arrangements, it was other partners such as Local Authorities and Police who led funded or commissioned activities around alcohol. Therefore, the diagnostic process was developed so that recommendations could recognise the potential contribution of all these partners. As such, the recommendations and the visit report are primarily structured around the following themes and key lines of enquiry:

#### ***Vision, Strategy and Commissioning***

- Is there a clear and shared understanding about how alcohol fits into the area's vision for itself?
- Are the strategic outcomes, governance and delivery arrangements for alcohol related activity understood amongst partners?
- Where does commissioning to support delivery of the alcohol strategy take place; who leads this commissioning; what funding is available and is it proportionate to need?

### *Data*

- Is there a co-ordinated approach to data collation, analysis and dissemination?
- Is data appropriately used to inform commissioning, target service provision and validate impact?
- Is data, intelligence and information made available to maximise the contribution partners can make through their core business to the alcohol agenda?

### *Communication*

- How are elements of the strategic approach to alcohol communicated to partners?
- What use is made of social marketing techniques to raise awareness and change behaviour of the general population and targeted groups?

### *Treatment*

- Is there a comprehensive treatment system in place that is appropriately resourced to meet need?
- Are interventions and clinical treatment episodes appropriately delivered in respect of timeliness, quality, clinical governance, cost effectiveness and the evidence base?
- Is the system supported by appropriate pathways?
- Are mechanisms in place to capture the necessary data to inform quality service provision, competent case management and feed into the overall cycle of commissioning?

### *Targeted Interventions*

- Has the area identified groups or populations that require a targeted approach because they are either hard to reach or have multiple/complex needs that are impacting the ability to access or derive benefit from treatment or other interventions?
- Are interventions appropriate and proportionate to the targeted group and accurately capturing the cost benefits of the targeting approach?
- Does the area understand which groups or individuals they should target in order to have the greatest impact on reducing alcohol related hospital admissions?

### *Criminal Justice, Licensing and Availability*

- How is the supply of alcohol regulated locally?
- Is the local area proactively managing the availability and impact of alcohol through licensing and enforcement activities?

- Are the efforts to reduce alcohol related social harms and improve community safety actively aligned with those aimed at reducing alcohol related health harms?

#### *Workforce Training and Awareness*

- What are businesses and, in particular, local public sector employers doing to address the issues of alcohol harm within the workforce (e.g. workplace strategies/policies)?
- How are universal services supported to deliver Identification and Brief Advice (IBA)?

#### *Children, Young People and Families*

- Are the adult and young people treatment systems working to reduce the potential for individuals to drop out when they pass between the two?
- Are activities focussed on the welfare and safety of the child adequately recognising the influence and impact of parent/carer alcohol misuse?
- Are the most vulnerable young people being identified and receiving appropriate timely interventions to prevent / reduce alcohol misuse?

### **Stakeholder Interviews**

During a standard visit the Team interviews between 30 and 50 local stakeholders. These stakeholders represent a wide variety of local agencies and organisations. Stakeholders are also typically Chief Officers, Directors or senior managers. The NSTs accumulation of knowledge and expertise of local delivery and the opportunity to affect change is clearly demonstrated through the figures outlined below:

In 26 visits over 21 months, the Team interviewed over 1000 stakeholders and worked with 44 Chief Officers (PCT, Acute trust, Local Authority, Police and Third Sector). Approximately half of the interviewees were from the NHS community - predominantly the Primary Care (207), Acute and Mental Health (182) Trusts. Other interviewees include Local Authorities (364 - including 61 Elected County and District Members); Police and Fire Service (57); and Voluntary Sector (101).

### **Follow Up Support**

The availability of support following a diagnostic visit is just as important as the diagnostic phase of the process. Follow up support from the NST is available to all areas who have received a full diagnostic visit. The report presented at the closing plenary includes offers of support from both the NST and the Regional Alcohol Manager. The support is formally agreed with the area at a meeting soon after the visit involving senior key stakeholders and the local alcohol lead. An action plan is developed by the NST following the meeting to provide clarity about the support, who will deliver it and when. Typically, support from the NST can last for up to 12 months.

Follow up support provided by the NST may include:

- Facilitation of workshops and events on specific issues (e.g. visioning, action planning, integrated care pathways)
- Signposting to examples from other areas
- Acting as a 'sounding board' as the area makes progress against NST recommendations and in reducing alcohol-related harm
- Attendance at key meetings
- Signposting to Regional/National support

Examples of NST support delivered can be found in Appendix B starting on page 48.

## **SECTION TWO: KEY FINDINGS, RECOMMENDATIONS AND SUPPORT**

### **Analysis of Visit Reports 2009/10**

Since 2009, the NSTs have systematically assessed the types of recommendations made in order to identify common issues emerging around key public health topics. The methodology for this work can be found in Appendix C starting on page 51.

Systematic coding of the priority recommendations for each visit report Identified common themes. The most common themes to emerge were:

- Strategy and performance
- Alcohol services
- Organisational / Partnership arrangements
- Commissioning
- Vision
- Data
- Local Leadership

The following paragraphs explore the most common themes to emerge in more detail in order to describe:

- The main issues that the Team identified during visits
- Common recommendations made
- Support offered

### **Strategic Arrangements**

'Vision', 'Strategy and Performance', 'Local Leadership', and 'Organisational & Partnership Arrangements' are frequently occurring themes contained within NST reports. All but one of the reports analysed contained recommendations about Strategy and Performance. Recommendations about organisational and partnership arrangements were made in 80% of reports, recommendations about vision occurred in 70% of reports and recommendations about local leadership appeared in over half of reports during 2009/10.

### **Vision, Strategy & Performance**

The NST found that many areas did not have a clear shared vision for reducing alcohol related harm and that alcohol strategies were often out of date or in the process of being rewritten. Where areas did have a vision, or a strategy, this did not always reflect a partnership approach. The Team found that in several cases, one or two individuals developed the alcohol strategy in isolation and key partners were neither actively engaged in development nor the subsequent delivery of the strategy. Consequently, partners did not always fully understand either their contribution to meeting the desired outcomes of the strategy or recognise how their organisation

could contribute to reducing alcohol related harm. Many partners had not recognised the importance of embedding reducing alcohol related harm in their own strategic or operational plans.

The Team therefore recommended that areas agree a clear vision, aim and objectives for their strategy, so that all partners understood what they should be trying to achieve and were clear about the contribution that they could make to realising the vision.

#### **Tameside Alcohol Strategy 2010 -2013**

The Tameside Strategy was based on a needs assessment jointly commissioned by PCT and Community Safety, and produced by Public Health, following full consultation with stakeholders, including service users. The recommendations of the needs assessment were based on population need and the evidence of effective interventions.

The Strategy was produced with full partnership involvement and endorsed by Tameside Strategic Partnership. Commitment from the Local Authority Chief Executive ensured that reducing alcohol related harm became a Strategic Partnership priority.

An action plan was developed with the active involvement of each thematic partnership – each responding with the relevant actions to their partnership, addressing the findings of the needs assessment.

The Tameside Alcohol Strategy is available for download at:  
[www.tameside.gov.uk/alcohol.pdf](http://www.tameside.gov.uk/alcohol.pdf)

The NST frequently recommended that Alcohol strategies recognise a range of indicators, in addition to hospital admissions, to ensure that the focus is sufficiently broad and to foster the full engagement and commitment of all key partners.

Where delivery plans were in place, the absence of SMART objectives made it difficult for them to monitor whether their planned actions delivered the desired outcomes.

Several areas delivery plans did not: reflect local needs; include specific targets; or align the plan's outputs to the alcohol strategy objectives.

Consequently, the NST recommended that areas develop a clear delivery plan for their alcohol strategy. The Team suggested that delivery plans should include:

- A 3-year action plan with specific milestones
- Detailed SMART objectives

- Named designated operational leads responsible for delivery
- Sufficient resources to deliver the plan
- Performance indicators to monitor progress

#### **Darlington Alcohol Strategy 2008 -2011**

Darlington's Alcohol Strategy identifies 4 priority objectives for the Borough. For each of these objectives a series of key actions was identified, as well as a range of performance indicators, against which progress in achieving the objective would be monitored. Performance indicators used comprise both national indicators and locally devised measures:

##### **Reducing assault with injury crime rate (NI20)**

Reducing the percentage of people who perceive anti-social behaviour as a problem

Reducing the percentage of people who perceive drunk and rowdy behaviour as a problem

##### **Reducing substance misuse by young people**

Increasing the percentage of schools achieving National Health Schools status

Ensuring that Darlington's largest 10 employers have, and implement, Drug and Alcohol policies based on recognised good practice

Increasing the number of premises compliant with the Responsible Sales code

Increasing the number of premises compliant with the Responsible Drinking code

##### **Reducing alcohol-related hospital admissions**

Number of staff in generic/provider agencies trained in delivering alcohol Brief Intervention

Each of these indicators has a clearly defined baseline and target, and a timescale by which this is to be achieved.

These indicators have allowed the Darlington Partnership Board to monitor progress against the strategy. In late 2010, 7 out of 9 indicators are on, or ahead of, the agreed target.

#### **Support provided:**

Support provided by the NST has included facilitating visioning days and action-planning workshops (see Appendix A starting on page 45). The Team has also acted as a critical friend to support areas in developing or reviewing their strategies and action plans.

### **Organisational and Partnership Arrangements**

In several areas, the NST found a great deal of confusion regarding the governance and partnership arrangements for the alcohol agenda. It often noted insufficient processes to manage risk coordinate activity and actively monitor the implementation of alcohol strategies. Many alcohol strategy groups did not have mechanisms in place to enable them to escalate issues to their Local Strategic Partnership (LSP) board in order to improve their delivery. This was often due to a lack of clarity surrounding the links to LSP boards and the responsibility of their themed partnerships

In many areas, the NST identified the need for clarification of the purpose, membership and accountability of alcohol strategy groups, along with their position in the overall LSP structure. Representation across a broad range of partners was sometimes not evident. There were often significant gaps in attendance. Core members of these groups were not of an appropriate level of seniority to be able to instigate change. Confusion existed in some areas about roles and responsibilities, concerning which individual or organisation was the lead and who was the accountable representative from each partner organisation. In some cases, it seemed that individuals were attending partnership meetings but not then cascading information or stimulating action within their own organisation. Some partnerships lacked skills, capacity and resources to deliver the strategy.

In many cases, the NST recommended that areas review structures and governance arrangements to provide a clearer structure that held partners to account for joined up delivery of the alcohol strategy. Similarly, in many cases the NST recommended reviewing the 'Terms of Reference' and 'Membership' of alcohol strategy groups. Arrangements do not necessarily need to be based around an alcohol strategy group. Some areas had effective governance arrangements, which utilised other partnership groups and structures.

### Governance Arrangements for Stockton's Alcohol Strategy'

Stockton calls time on Alcohol Harm, the Alcohol Strategy for 2009 – 2012, has an accompanying action plan covering the themes of prevention, treatment and control for young people and adults. The Action Plan is monitored bi-monthly via a group consisting of members from young persons and adults commissioning, community safety and the police. Quarterly reporting on progress takes place at the Health & Well Being Partnership and the Safer Stockton Partnership. Progress reports on a six monthly basis are presented to the Local Strategic Partnership and Children's Trust Board.



In some areas, the NST recommended the identification of a dedicated officer with the capacity to perform a coordinating role, oversee action across the partnership and project manage the implementation of the strategy and commissioning. In addition, some areas needed to ensure that each partner organisation also identify a lead officer to coordinate and be held accountable for delivery of the Strategy action plans within their own organisation.

Support provided:

The NST has provided guidance to several areas to assist them in developing new organisational and partnership arrangements for their alcohol strategies.

### **Local Leadership**

Whilst there are clearly a number of committed individuals working to address the alcohol agenda at local level, the NST identified a lack of designated champions in key partner organisations.

Identifying champions to ‘influence change through advocacy’ and drive the agenda is a high impact change. The NST therefore recommended that areas identify designated champions, including clinical and elected member champions. The Team also suggested that the role of these champions should incorporate acting as an advocate, providing leadership within their organisation for actions to reduce alcohol related harm.

#### **North East Lincolnshire Alcohol & Violence Champion**

North East Lincolnshire established an Alcohol and Violence Champion role with the aim of reducing violent crime in the area by targeting the strong correlation with excessive alcohol consumption. The role was held by a Police Inspector who was responsible for coordinating all of the crime and disorder aspects of the Alcohol Harm Reduction Strategy and linking it to a Violence Reduction Strategy and Action Plan for North East Lincolnshire.

The Inspector was also responsible for drawing up and implementing initiatives to reduce violence and alcohol related crimes and establishing working partnerships with agencies such as trading standards, DAAT, PCT and local schools to work towards a partnership approach to reduce alcohol-related violence. A key success of the post has been to act as a single point of contact for all agencies seeking to link into police/criminal justice/licensing activity around alcohol

The post was funded for 3 years from various time limited funding pots but has now been ‘mainstreamed’. As well as the key coordination role, the post holder developed several new schemes and initiatives with various partners:

Initial action focussed upon the night time economy with impressive reduction in crime, violence and anti social behaviour

Development of an alcohol arrest referral and intervention scheme

Monitoring licensed premises to identify emerging problems and taking action – with a traffic light system, with ‘red’ saying ‘we’re watching you’. This involved multi-agency visits to licensed premises and licensing reviews

Daily monitoring of violent crime and incidents to identify hotspots and target enforcement action

Establishing a ‘Safe Haven’ and Street Angels scheme with local volunteers

## **Commissioning**

Recommendations about commissioning were included as priority actions in 70% of visit reports. Within this, three sub-themes figured prominently. These were:

- The need to improve commissioning structures and processes
- Ensuring that commissioned services are fully integrated
- The need to improve contract management and performance management of providers

### **Commissioning Structures and Processes**

The NST often recommended that areas review the commissioning arrangements for their alcohol strategy, with the aim of bringing together responsibility for commissioning across the strategy, rather than treatment and non-treatment commissioning taking place in silos. In several areas, the NST was able to link this to emerging arrangements in the locality for joint commissioning of health and social care services.

In some areas, the NST found that commissioning structures for alcohol were immature and local commissioning skills and expertise was not being deployed to support the alcohol agenda. Many of the problems that the NST identified in relation to alcohol commissioning related to areas not following the full commissioning cycle.

The NST therefore recommended that areas develop a more robust approach to alcohol commissioning in line with commissioning competencies including: establishing a clear commissioning cycle; ensuring that those responsible have the required commissioning competencies, or are supported to develop them, utilising commissioning expertise elsewhere in the partnership.

### Commissioning of Alcohol Treatment Services in Wigan

Wigan has a clear strategic planning and commissioning cycle in place for alcohol. In 2008 an in-depth alcohol needs assessment was undertaken. The findings of this needs assessment were then used to inform the development of a new alcohol strategy for the Borough and the commissioning of an integrated alcohol treatment system. An additional £650,000 was secured through the submission of a business case to Ashton Leigh and Wigan PCT to invest in alcohol services in the Borough from April 2008.

Commissioning intentions were outlined in the NHS Ashton, Leigh and Wigan commissioning prospectus in 2008/9, and alcohol services were put out to tender including:

- Identification and brief advice support team
- Extended brief interventions
- Single Point of Contact
- Assertive Outreach
- Community Alcohol Team (Tier 3)
- Hospital based alcohol service
- Employability and Employment Project

Wigan Drug and Alcohol Action Team (DAAT) work with service providers to review progress through quarterly contract monitoring meetings. Annual updates to alcohol elements of the Joint Strategic Needs Assessment are undertaken to review progress and patterns over time.

The NST found that commissioned services did not always reflect the needs of the population. In some areas, this was due to lack of resources, whereas in others this appeared to relate to a lack of understanding of available data.

In cases where commissioning did not appear to be needs led, the NST recommended that areas assess local service provision and capacity against local need and focus on populations that are likely to have the greatest impact on reducing hospital admissions.

The NST found that many areas lacked a full understanding about the range of funding streams that contribute to the Alcohol Harm Reduction agenda. Furthermore, the Team found evidence of confusion about where and who makes commissioning decisions. Whilst a few areas had robust arrangements in place for commissioning treatment services, the arrangements for commissioning to support other elements of the strategy were usually less clear.

The NST therefore recommended that areas map the level of investment across the alcohol agenda to identify both direct and indirect resource contributions. This could then form the basis of a 'Place-Based approach' to tackling alcohol harm.

### **Ensuring that Commissioned Services are Fully Integrated**

Whilst many areas had begun to invest in alcohol services, sometimes the commissioning of new interventions appeared to happen in silos, and lacked integration into the alcohol treatment system or the wider alcohol strategy. This appeared to be the result of commissioners only having access to short-term funding streams to commission for short-term isolated interventions and commissioners in different parts of the partnership working in isolation, rather than being able to collectively manage resources and look at commissioning across the system as a whole.

In visits undertaken by the NST during its first year of operation, the NST frequently highlighted the discrepancy in many areas between the lack of resources allocated to alcohol programmes and the priority afforded to alcohol in their Local Area Agreements and PCT Strategic Plans. More recently, as the financial position of many PCTs and Local Authorities began to change, the NST focused on recommending interventions that reduce the rate of hospital admissions and release cost savings elsewhere in the system. The NST highlighted the likely cost benefits of those interventions in its recommendations.

#### **Portsmouth Commissioning Plans**

NHS Portsmouth has a clear commissioning plan for alcohol, which sets out planned investment and activity to reduce alcohol-related hospital admissions. This plan was informed by the Portsmouth Alcohol Strategy 2009-13, which set the city's priorities. This was informed by a comprehensive alcohol needs assessment, undertaken by the University of Portsmouth.

The plan clearly sets out the anticipated impact on deflecting Emergency Department attendances and hospital admissions, in order to calculate the likely return on investment. For each area of investment, there is a separate activity plan, which gives more detail on the activity, milestones and outcomes of individual projects/activities.

### **Contract Monitoring and Performance Management of Providers**

The NST found that in some areas contracting of alcohol services was based on historic arrangements and sometimes part of large block contracts, which were difficult to disentangle. Service Level Agreements and regular monitoring arrangements were sometimes not in place. The NST recommended that Service Level Agreements should be in place for all commissioned services with regular monitoring arrangements, including outcome measures.

Support provided:

Support provided in relation to commissioning focused on signposting to promising practice in other areas. This included examples of clear commissioning cycles for alcohol, commissioning frameworks, Service Level Agreements and Total Place pilots.

The NST contributed to a range of tools developed by the DH Alcohol Policy Team. These tools were used to assist areas to understand the most effective interventions for reducing hospital admissions and the likely cost benefits of implementing these interventions at local level. Such tools and guidance included:

- Signs for Improvement
- Guidance on Commissioning Alcohol Interventions
- The 'Ready Reckoner'
- The Systems Dynamic Modelling Tool

The involvement of Regional Alcohol Managers in visits also provided areas with access to commissioning learning sets and mentoring from experienced alcohol commissioners.

### **Data**

Two-thirds of visit reports contained recommendations about data as priority actions. The need for local areas to undertake specific data analysis (particularly in alcohol needs assessment, analysis of hospital admissions for alcohol related harm data and identification of 'Patients repeatedly admitted to hospital for conditions related to alcohol') emerged as the most common sub-theme.

### **Needs assessment**

Many areas had not fully recognised the value of effective data presentation and the need to invest in making this a core part of the strategic approach to intelligence gathering and commissioning. The NST therefore recommended that data be presented in a way, which not only assists areas to understand the nature of the problem but also how individuals, and their organisations could contribute to the effort to manage such problems.

Many of the strategic data and information documents the Team saw did not enable partners to make decisions or inform commissioning. These included: Alcohol Needs Assessments, Joint Strategic Needs Assessments (JSNA) and Strategic Intelligence Assessments (SIA). The NST therefore recommended that when areas undertake such assessments they:

- Include a wide range of data sources from relevant partner organisations
- Use language that is widely understood amongst partners
- Spell out how an organisations core activity might have an impact on a particular phenomenon

- Provide advice about targeting for maximum gain
- Provide evidence based suggestions of input (or options appraisal).

An effective assessment will include sufficient information for the partners to be clear about the contribution that they can make and the types of activity that are likely to bring about an impact.

The diagnostic visits showed that partnerships would benefit from demanding more of their analytical functions. This was not about more analyses but about analyses that go beyond simply informing and describing. In order to do this, the partnerships need to ensure that they are asking the right questions of their analysts. In many areas, the NST became aware of analysts who reported that they were more than able to increase the efficacy of their products but were never requested to do so by the partnership.

The NST therefore recommended the designation of a central repository for alcohol related data or a joint intelligence function to minimise these problems and thereby enable a more effectual relationship to develop between the analytical, commissioning and strategic functions of the partnership.

### **Rate of Hospital admissions per 100,000 for alcohol related harm**

It is clear that the complexity of alcohol related hospital admissions, as a national indicator has been a recurrent issue for local areas. The information about hospital admissions is taken from Hospital Episode Statistics (HES). Many partners, even some of those accustomed to working with the NHS, are not readily familiar with HES data. The expertise around, and responsibility for, the alcohol agenda is commonly held in the public health domain whereas the HES data expertise is available in other parts of the PCT such as informatics. Being a relatively new measure, it was clear that in many areas, the two centres of expertise had not yet engaged with each other enough to develop a comprehensive understanding of the indicator.

The Team observed that the complexity of the indicator did present areas with an analytical challenge. However, they were not maximising the potential intelligence that further analysis provides. The NST therefore recommended that areas:

- Undertake a detailed analysis of their data
- Communicate their findings to ensure that all partners understand the target and the contribution that they can make to reducing alcohol-related admissions

Areas with large and diverse BME populations, rapidly growing or transient populations were keen to point out their deviation from the national norm and the implication that the rate of hospital admissions per 100,000 for alcohol related harm data was not representative or possibly relevant. Some areas also reported that they felt coding practices in their acute trust were affecting their rate of admissions. However, few areas were able to support their assertions with evidence.

Consequently, the Team made recommendations to encourage areas to investigate these claims further to support commissioning intentions.

### **Patients repeatedly admitted to hospital for conditions related to alcohol**

The NST challenged areas to make their analyses relevant so that they can be used to inform commissioning. In particular, using data to target those populations where an intervention will have the most impact. Often areas had only analysed depersonalised hospital data, therefore the NST recommended that areas look to other data sources to identify those individuals who are being repeatedly admitted for alcohol related conditions and target interventions accordingly

#### **Patients repeatedly admitted to hospital for conditions related to alcohol North of Tyne**

The work in NHS North of Tyne showed how an effective data analysis can be used to inform commissioning which has then delivered impressive results. NHS North of Tyne invested time to fully understand and identify their Top 60 repeat admissions to hospital and discovered that not only were some individuals being admitted many times per year but that they were also frequent users of other hospitals across the vicinity. The analysis of the types, location, times, conditions, bed days and cost for those frequently admitted, together with an assessment of their needs and what evidence suggests will work helped to create a case for commissioning a targeted response. A Community Team was commissioned to work exclusively with those who were most frequently readmitted and provide Secondary Prevention 'wraparound' services. The impact was that in just 4 months the number of alcohol specific admissions in the target group had halved with a projected cost saving of £540k per year. Whilst other comparable areas continue to see a rise in the rate of specific admissions of between 10 and 15%, Newcastle has seen a reduction of 5%

Support provided:

The NST support activities primarily involved signposting areas to examples of alcohol needs assessments and specific analysis of alcohol-related hospital admissions. The NST also supported the development of national support programmes, including a data workshop held in June 2009.

### **Alcohol Treatment Services**

The second most common theme to emerge from visits was alcohol interventions and treatment. Most areas accept that improving the effectiveness and capacity of specialist treatment is a High Impact Change and is a central component in reducing alcohol related hospital admissions.

In the first 6-9 months of visits, the Team found wide variations in specific alcohol treatment provision across tier 1-4, against a background of historical low-level provision. Whilst some areas had been successful in identifying resources for alcohol and were developing provision based on identified need, other areas were

facing challenges in identifying resources with no clear understanding of the needs of the population and the treatment provision required. Often, alcohol services were a bolt on to established drug services with little clarity on Service Level Agreements (SLAs), resources and capacity. Many areas were in the process of disentangling large block contracts with Mental Health Trusts. Early Implementer areas were mainly using the additional funding through the programme to improve treatment and were at various stages in this process.

After the initial 6-9 months of visits, the Team began to see more consistency in approach to alcohol treatment development with the re-design of alcohol treatment systems and tendering becoming more common.

Analysis of all the alcohol treatment and intervention recommendations from visits highlighted the three most common sub-themes as follows:

- Developing a fully integrated treatment system across tiers 1-4, including a clearly defined model and treatment pathways
- Developing primary care alcohol interventions, including the development of the Directed Enhanced Service (DES) or Local Enhanced Service (LES)
- Developing / reviewing alcohol interventions within the acute hospital

#### **Developing a Fully Integrated Treatment System Across Tiers 1–4, Including a Clearly Defined Model and Treatment Pathways**

The NST found in most areas there was a need to bring together service provision to form an integrated alcohol treatment system, as opposed to separate silos of provision with undeveloped connections between each component. In some areas, work had already started on this, but often the Team found confusion over the intended treatment system model and a lack of clear pathways. More often than not, there was confusion about access points and identification tools were being used inconsistently. In other areas, the Team found that whilst some tiers of provision were developed, other tiers, especially tier 1 and 2, were either absent or largely undeveloped. Additionally, areas frequently expressed their concerns over capacity in the current system to cope with the estimated drinking levels in the population.

Where the NST observed fully integrated treatment systems, this was usually where the whole treatment system had been redesigned and re-tendered to respond to local need and the national indicator for alcohol related hospital admissions.

Where the NST observed fragmented service provision, they recommended the need to connect these services into an integrated system of alcohol treatment, led by commissioners, through a programme re-design, based upon identified need. In making this recommendation, the Team also highlighted the steps and components to achieve this. For example:

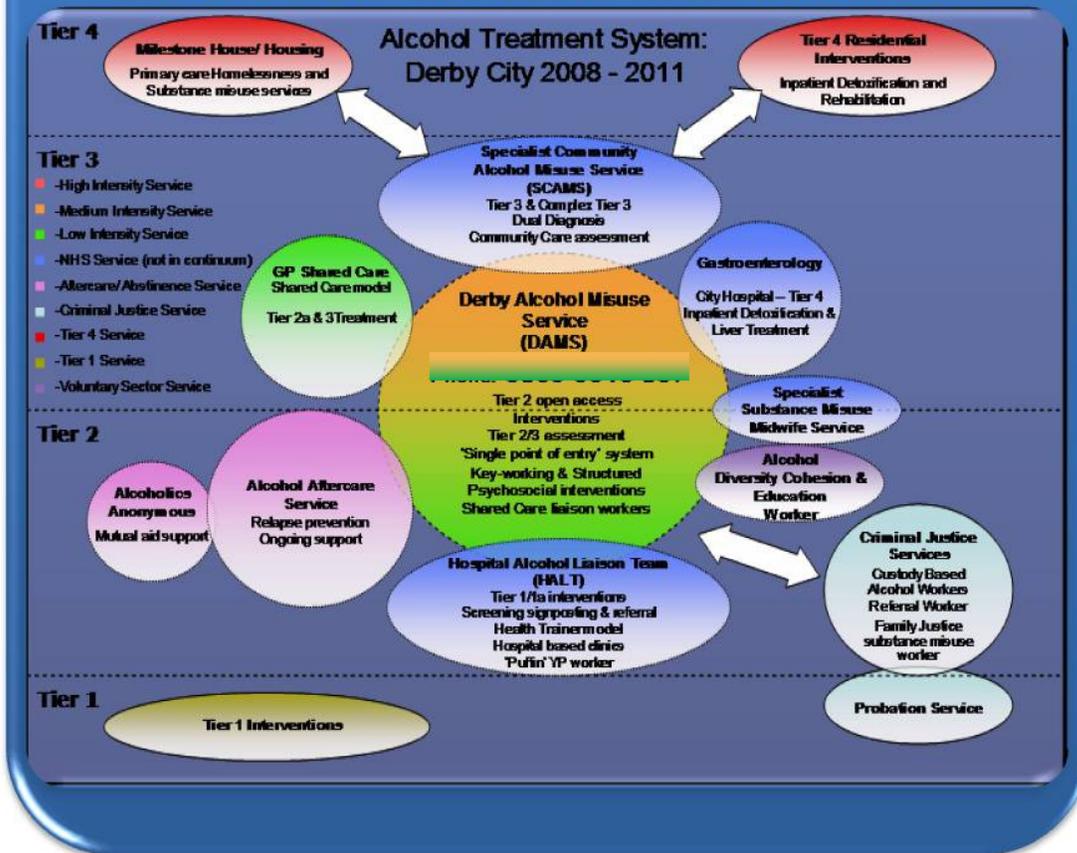
- Mapping the existing pathways to identify blocks to access, throughput and transitional fallouts

- Navigating the system through the medium of clearly identified and published pathways (for all treatment interventions and priority population groups)
- Describing entry points and the routes through, dependent on the needs of individuals

In conjunction with this, the Team also highlighted the need for a common assessment process and streamlining of referral routes to reduce the repetition of assessment and multiple referrals. To aid the understanding of the alcohol treatment system, the team commonly recommended the publication of the treatment model and pathways and/or a service directory.

### Derby Treatment Model

In 2009, Derby designed a new integrated model for alcohol treatment, informed by a local needs assessment. As part of the NHS Derby City Transforming Community Services Strategy, £2.1 million was identified for investment in alcohol services. A full open tender process was developed preceded by an extensive consultation and engagement exercise with key stakeholders - including service users, existing service providers and the public. Following the consultation, the model was further developed and put out to tender in early 2010. Services started delivering in June 2010



Support provided:

The NST supported areas by facilitating alcohol treatment workshops with the aim of agreeing the treatment model, mapping out and developing pathways.

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**Developing Primary Care Alcohol Interventions, including the Development of the DES or LES**

The NST found a wide variation in the provision of primary care alcohol interventions. Whilst most areas were implementing the DES, some areas had not developed a robust performance framework for the DES or had not developed further alcohol services in primary care beyond the DES. Some areas had developed a LES or were planning to do so. The delivery of Identification and Brief Advice (IBA) in primary care varied greatly from well-implemented and monitored systems to inconsistent ad hoc delivery. Some areas had invested in primary care support functions to assist in the development of interventions.

The Team often recommended that primary care need to deliver IBA on an industrial scale, as this is a High Impact Change. In establishing a model of delivery, the Team recommended areas consider the Primary Care Alcohol Pathway, other evidence based models and the national guidance on enhanced services in primary care. Alongside this, the NST recommended the use of identification tools, brief advice scripts, care pathways and Read codes.

Support provided:

The NST supported areas by signposting to delivery examples, encouraging the application of learning from other locally successful LES frameworks, signposting to GP champion role descriptions, and using nationally recognised GP champions in pathway workshops to engage GPs.

**Developing /Reviewing Alcohol Interventions within the Acute Hospital**

During visits, the Team found many areas had introduced an alcohol liaison post/s within the Emergency Department and acute hospital wards (High Impact Change), and other areas were planning this development. There were frequently issues with the coverage of the alcohol liaison service out of hours and covering leave, with usually only one or two post holders covering the service.

The Team also found wide variations in the core purpose and essential elements of the alcohol liaison role. Pathways to divert inappropriate hospital admissions were generally not well developed and there was often confusion over the evidence regarding the most effective model. We found some excellent systems in place for identifying and targeting repeat alcohol related attendees to the hospital, and other areas where repeated attendees had been identified but no system put in place to target and work in partnership with them.

We found blocks to progress centred on the lack of engagement from acute hospital trusts and lack of formal hospital champions. A few areas were using the contract with the acute hospital to embed IBA in the hospital through the use of Commissioning for [Quality & Innovation \(CQUIN\)](#) indicators and Health Gain Schedules, whereas other areas had not considered this.

### CQUIN – Nottingham City

Nottingham City Alcohol CQUIN provides an effective way to ensure alcohol IBA is targeted at people who walk in to the Emergency Department (ED) or who are admitted to an inpatient bed.

The CQUIN has four main parts including validated training in IBA for ED and ward staff. The identification of alcohol misuse uses a simple validated screening tool (AUDIT C), offering brief advice and an information leaflet where appropriate, onward referral to the hospital liaison team where indicated and a GP discharge letter for any intervention carried out.

The CQUIN provides an incentive for staff to carry out IBA whilst encouraging a better level of understanding and integration between ED/ admission ward staff and the hospital alcohol liaison team

In order to take hospital-based alcohol services forward, the NST usually made a series of recommendations, including:

- The introduction of a multi-agency steering group to oversee and coordinate developments
- Identifying senior clinical and operational champions within the hospital to assist in implementation
- The use of diversion schemes to reduce alcohol related ED attendances
- Establishing a system for identifying and targeting high impact users
- Developing pathways from hospital into specialist alcohol services
- The use of CQUIN and Health Gain Schedules in contracting

## SECTION THREE: CASE STUDIES

The following case studies illustrate the experience of areas visited by the NST. The case studies outline the key recommendations made by the NST, follow up support provided and describe the impact that this had in the area.

### PCT Area: Bolton

- Visit Date: 2<sup>nd</sup> March 2010

### Key Recommendations from NST

- Complete Alcohol needs assessment
- Ensure a strategic approach is the foundation on which the new alcohol strategy is built
- Develop primary care alcohol interventions and shared care
- Ensure designated clinical expertise is included in new Tier 4 panel arrangements
- Continue pathway development commenced as part of the treatment workshop

### Progress Recommendation

- Needs assessment completed
- Work on new alcohol strategy has commenced and will be completed to deadline for launch March 2011
- A tier 4 panel was superseded by closer partnership working between providers, PCT commissioners/finance and the Drug and Alcohol Strategic Commissioning Team (DASCT). Agreement has been reached, in principle, for the DASCT to establish a formal Section 75 agreement on behalf of the Local Authority and the PCT.
- Pathway development has moved on to link into liver disease care pathways and dual diagnosis pathways as part of further work on Alcohol Attributable Fractions (AAFs) and repeat A&E attendances.

## Follow-Up Support

- In developing a new Alcohol Strategy based on a series of broad strategic objectives, which are owned by all partners.
- In developing a 'Total Place' approach to alcohol to bring together both financial resources and personnel to ensure that they can be effectively and efficiently deployed to maximise impact on achieving the Alcohol Strategy objectives.
- In facilitating an awareness-raising event to clarify and communicate the shared vision in relation alcohol harm reduction, which informs Bolton's Alcohol Strategy.
- In developing an alcohol needs assessment, making full use of the regional insight work to inform the development and targeting of interventions.
- To Royal Bolton Hospital in identifying alcohol related repeat attendees to the hospital.
- In the development of a communication plan as part of the new Alcohol Strategy.
- In the development of alcohol interventions in primary care, with particular focus on the LES and a prescribing shared care system
- Support in pulling together the ongoing work on pathways, finalise the pathways and agree the overall alcohol treatment model.

## Detailed Case Study Narrative

- It is not possible to provide detailed case studies as the NST visit was undertaken relatively recently (March 2010).
- The most valuable part of the visit was the treatment workshop, which looked at pathway development and key issues for service providers. This has resulted in much better engagement with providers and improved willingness for providers and secondary care clinicians to engage with commissioners in relation to service re-design.
- The visit itself also influenced key clinicians and has had a positive impact on support from NHS Bolton colleagues in terms of encouraging primary care professionals to carry out IBA in GP practices.
- Other positive spin offs have been achieved in terms of raising the profile of alcohol across the Bolton Vision Partnership (LSP) and emphasising the importance of wider partnership working in relation to trading standards, licensing and the night time economy. These elements will be key features in the new Alcohol Strategy.

## Learning

- Progress has been hindered by competing priorities and commitments of Bolton based partner agencies and by the current economic climate. This could not have been anticipated or avoided.

## Any Other Comments

- A treatment pathway workshop attended by representatives from the full range of service providers in any locality is likely to be easy to replicate and deliver with positive outcomes.

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## PCT Area: Sandwell

- Visit Date: 7<sup>th</sup> October 2008

## Key Recommendations from NST

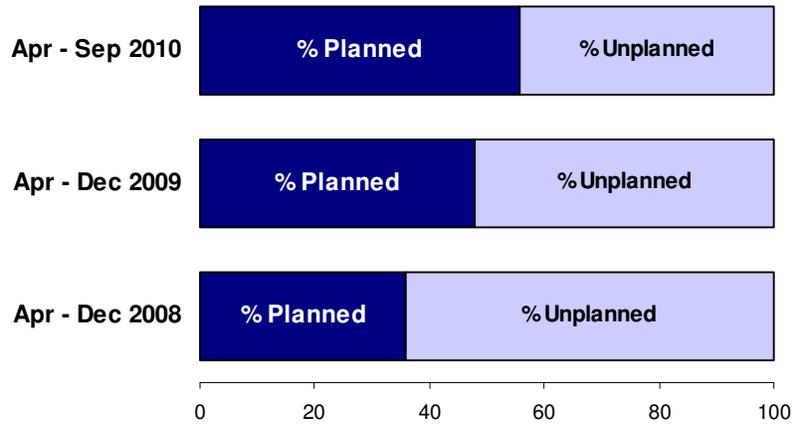
- Creation of vision (and Visioning Day)
- Alcohol Care Pathways
- IBA training and involvement of front line staff
- Review of tier 3 and case management
- Social marketing
- Data

## Progress Recommendation

- Alcohol commissioning and performance group
- Care pathways – especially informing future service provision and service reviews
- Integrating the alcohol agenda into the partnership

### MEASURABLE IMPACT: Outcomes from Treatment

The proportion of clients leaving structured treatment through a care-planned completion has shown a substantial increase since the NST visit.



**Chart 1 - Proportion Leaving Treatment through a Planned Completion, 2008-2010**

In April – December 2008 36% of those leaving treatment in Sandwell left in a planned way, in the same period in 2009 this increased to 60%; higher than the national average (51%). The most recent information available for April – September 2010 shows that the rate of planned completions in Sandwell remains high at 70% (compared to 56% nationally). [Chart 1]

Source: NATMS

## Follow-Up Support

- Support with Visioning Day
- Care pathway
- Health gain schedules
- Regular visits and telephone contact

## Detailed Case Study Narrative

- Raising the profile of the alcohol agenda and where it fits in Sandwell i.e. making it everyone's business – is a key part of promoting the importance of working together. We now have an alcohol commissioning group, chaired by a senior police officer and which has developed a partnership action plan. This group, and partnership work within it, has been crucial to the promotion of the alcohol agenda. This promotional work started with the Visioning Day held in October 2009.
- This group is a sub group of the Joint Commissioning Group and reports to the Safer Sandwell Partnership and the Health and Wellbeing Board. It is through this group we will be promoting a service review to look at other areas of NST comment. Also, the work we have undertaken in developing care pathways will inform service redesign work we hope to carry out, subject to partnership endorsement.
- Partnership working with providers and care pathway work allowed us to achieve a Local Area Agreement Target of doubling the number of people accessing alcohol support over 3 years (from 1,200 to 2,400).
- The work undertaken to achieve this target helped us to see barriers, especially around working practices and challenge them. This process will also inform service development and re-design: we are now at a stage of potentially re-commissioning large parts of the Sandwell alcohol services.

**MEASURABLE IMPACT: Numbers on the Structured Alcohol Treatment Caseload**

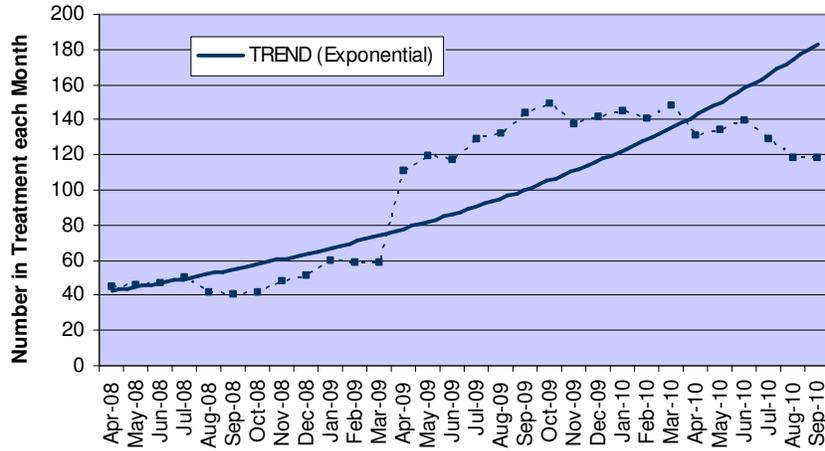


Chart 2 - Number Engaged in Structured Treatment each month, April 2008 – September 2010

Chart 2 shows the increase in the number on the structured treatment caseload since October 2008.

Source: NATMS

## Learning

- Setting up the alcohol commissioning group earlier: thus emphasising the alcohol agenda within the partnership and how partnership solutions are the most efficient way of tackling the problems.

## Any Other Comments

- Interested in sharing work/development experiences.

## Contact Details

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## PCT Area: Tower Hamlets

- Visit Date: 8<sup>th</sup> September 2009

## Key Recommendations from NST

- Multi-agency steering group to integrate Alcohol Nurse Specialist (ANS) hospital based work
- Multi-agency stakeholder event to drive development of strategy
- Development of communications strategy as integral part of alcohol harm reduction strategy
- Mapping treatment pathways
- Identification of dedicated alcohol champions/advocates

## Progress Recommendation

- Establishment of multi-agency steering group to drive ANS work
- Alcohol harm reduction strategy multi-agency stakeholder consultation event
- Development of communications and engagement strategy

## Follow-Up Support

- The NST supported the development and delivery of a visioning event designed to elicit feedback and insight from key stakeholders on the priorities to be contained within the 2011-2014 alcohol harm reduction strategy and to achieve consensus on partners roles/responsibilities in driving the strategy.
- The NST also provided a range of additional supporting information such as exemplars of alcohol strategies successful elsewhere and model job descriptions for the role of alcohol strategy coordinator.

## Detailed Case Study Narrative

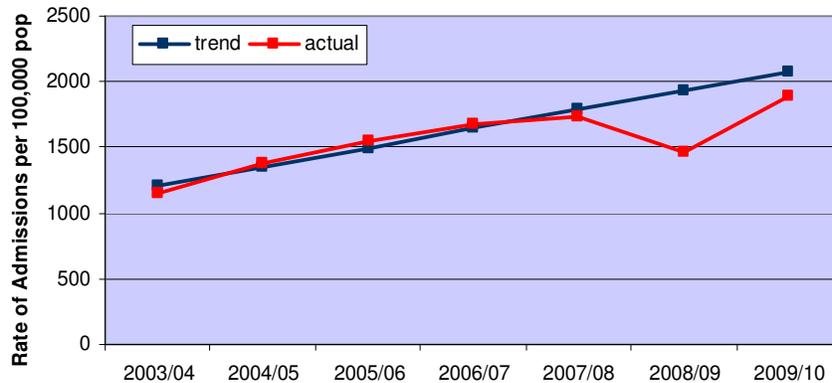
- A dedicated band 7 Alcohol Nurse Specialist (ANS) was commissioned and commenced work at the Royal London Hospital in April 2009 in response to concerns regarding the volume of alcohol related admissions, A&E alcohol related attendances and high rate of alcohol related ambulance call outs and in acknowledgement of the need for a dedicated role to galvanise renewed enthusiasm and vigour to address alcohol harm reduction in the acute Trust setting.
- The current local model was adopted in recognition of the demonstrable effect of such a resource (as evidenced elsewhere e.g. St Mary's Hospital Paddington) in reducing the impact of alcohol related harm on the hospital as a whole and in successfully reducing the number of admissions, repeat admissions (and length of admission/bed days) to hospital. The preparatory work in reviewing the evidence and best practice available, demonstrating the cost effectiveness in investment in an ANS, reviewing the various models of delivery and preparing the specification for ANS work was conducted by the DAAT and the Public Health department in partnership.
- The existing ANS has, in her 7 month tenure, successfully delivered brief interventions to patients attending A&E as well as to current inpatients, has trained clinical staff in the delivery of screening and brief interventions, reviewed clinical and prescribing protocols for safe and effective/sustainable detoxification, supported and advised clinical staff in the management of alcohol dependent patients and developed referral pathways to clinical (e.g. primary care, community alcohol team, detoxification or rehabilitation services) and other support services for patients (e.g. hostels, social services, outreach).
- The ANS also chairs a multidisciplinary strategic group consisting of representatives from within the hospital (e.g. A&E, ward staff, gastroenterology and hepatology, psychiatric liaison, outpatients etc) and external partners (e.g. commissioners, public health, hostels, community alcohol services, housing services, primary care) which is pivotal to the successful buy in of all partners to alcohol harm reduction and has ensured that all involved understand clearly their respective roles and responsibilities across the partnership in achieving a reduction in alcohol related admissions. Pivotal to this success has been the physical presence of the nurse on the wards and in departments to remind staff to make the links between an admission and possible excess alcohol consumption.
- In recognition of the need for both a strategic and an operational function, a second dedicated nurse (at band 6) has recently commenced work with a focus on delivery of brief interventions to patients initially concentrating on those originating from the A&E department. This additional capacity means that the senior nurse can focus efforts on sustaining buy-in and support from other departments, supporting inpatient wards in management of more complex patients, training staff and in the strategic oversight of the work.

**MEASURABLE IMPACT: Rate of Hospital Admissions per 100,000 for Alcohol Related Harm**

As the NST visit took place in September 2009 it is not possible to compare the period leading up to the NST visit with the same period in 2010 as the data is not yet available.

Taking into account the whole year period in which the visit took place (2008/09) the area saw an increase of 29% between 2008/09 and 2009/10 compared to an increase of 10% nationally.

Despite this, the area actually experienced a 9% decrease from the projected rate of admissions based on the rate of admissions from 2002 -2008 (Chart 3).



**Chart 3 - Rate of Hospital Admissions per 100,000 for alcohol related harm in Tower Hamlets: Actual Performance Compared to Linear Projection, April 02 - March 10. Source: LAPE**

## Learning

- The ANS has made considerably swift progress in a very challenging environment. Had we been able to recruit the band 6 nurse sooner, the service would probably have been even more effective as the senior nurse has been working autonomously to balance both a strategic and operational role.

## Any Other Comments

- This is a readily replicable model appropriate for dissemination beyond the local area. Principal to its success is due consideration of the governance and sustainability of such an initiative.

## Contact Details

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## PCT Area: County Durham & Darlington

### Key Recommendations from NST

- Review the alcohol strategy implementation plan to maximise the contribution that all partners can make through their mainstream activities and future plans
- Review and communicate the commissioning arrangements for alcohol
- Develop a clear commissioning cycle for alcohol, with service level agreements, performance targets, and contracts for integrated services rather than individual posts
- Commission specialist provision for alcohol inpatient detoxification to reduce admissions for primary inpatient detox to the Darlington Memorial Hospital and the impact on the rate of hospital admissions per 100,000 for alcohol related harm

### Progress Recommendation

- Established an alcohol commissioning group
- Finalising contracts with providers (Tier 3)
- Have a clear treatment pathway across 4 tiers
- Have specifications and pathways for the range of Tier 4 providers

### Follow-Up Support

- Provided examples of good practice elsewhere particularly around the LES
- Facilitated an Alcohol Pathway Workshop to establish an agreed pathway across County Durham and Darlington

## Detailed Case Study Narrative

- As above. Having an externally facilitated workshop helped to bring together all providers to understand each other's roles and work together on the pathway despite the commissioning/provider split and competition between providers.

## Any Other Comments

- Happy to share the pathway.

## Contact Details

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## PCT Area: Stoke-on-Trent

- Visit Date: 4<sup>th</sup> February 2009

## Key Recommendations from NST

- It would be beneficial to map the existing pathway to identify blocks to access, throughput and transitional fallouts – please see case study for more details
- In view of the current waiting times, there is a need to review the capacity at each Tier to ensure that the treatment system is capable of meeting needs, with treatment modality matched across the spectrum of drinking behaviour including drinking at increased risk (hazardous), higher risk (harmful) and dependence - Recommendation 2 helped to support Safer City Partnership's intention to expand services and rebalance treatment numbers available across all of the tiers. This recommendation will have strengthened the business case for the Primary Care Trust to commit to increased financial support for alcohol treatment.
- Through splitting recommendations across eight varied themes, it enhance political understanding of a need to further support a holistic approach to reducing alcohol related harm. Critical to successfully reducing alcohol-related hospital admissions is through a balance of short, medium and long term projects and working to achieve a culture change. This is not achievable without supporting expansions in the treatment system with a programme of prevention, early intervention, wrap-around support, crime and disorder initiatives, and clear and consistent communication strategy.
- Many of the outcomes of the National Support Team report were commending existing plans of the Safer City Partnership, including:
  - Intention to develop integrated pathways
  - The NST endorses your intention to develop an external and internal communication strategy aligned to the alcohol harm reduction strategy – this included some clear guidance around how to achieve this which have since been developed e.g. unit measures

# Progress Recommendation

- Expanded treatment services

### MEASURABLE IMPACT: Numbers in Structured Alcohol Treatment

The number of individuals engaged in structured treatment in Stoke-on-Trent has increased substantially since 2009. During April 2008– January 2009 750 clients in Stoke accessed treatment; this increased by 68% to 1,260 during the same period the following year. This compares to an increase of just 12% nationally.

The caseload expanded considerably during the year following the NST visit [Chart 4].

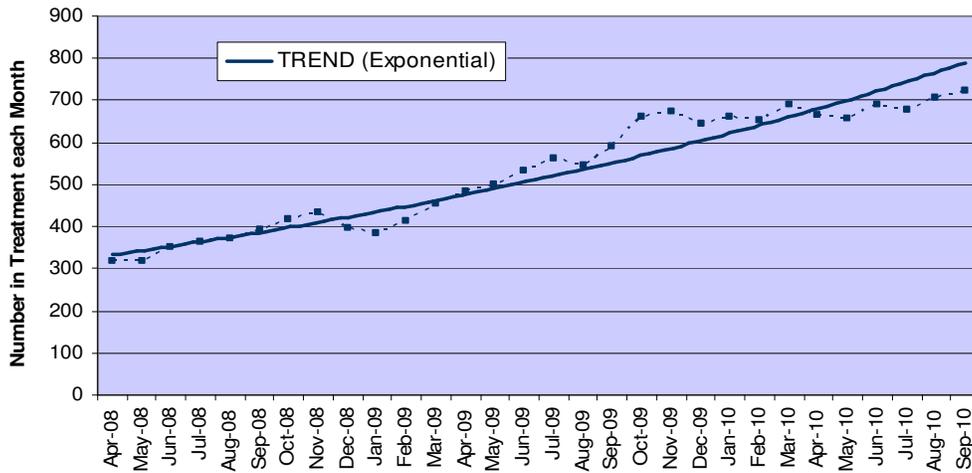


Chart 4 - Numbers in Treatment each Month: April 2008 - September 2010. Source NATMS

- Integrated alcohol treatment pathway

### MEASURABLE IMPACT: Waiting Times for Treatment

The proportion of clients waiting less than three weeks to access structured treatment has improved substantially since quarter 3 2008/09. In October – December 2008 just 55% of clients began treatment within three weeks of referral, this increased to 67% in the same quarter the following year (October – December 2009) and recent figures suggest that 79% of clients now begin treatment within three weeks

- Increased financial support from PCT and Area Based Grant to support a balanced alcohol delivery plan with five themes: Children, young people and families, early intervention, treatment, crime disorder and the alcohol industry and communication

### MEASURABLE IMPACT: Rate of Hospital Admissions per 100,000 for Alcohol Related Harm

Whilst Stoke saw a small (1%) increase in the rate of hospital admissions for alcohol related harm during 2009/10 (from 2008/09), the area actually experienced an 11% decrease from the projected trend (Chart 2).

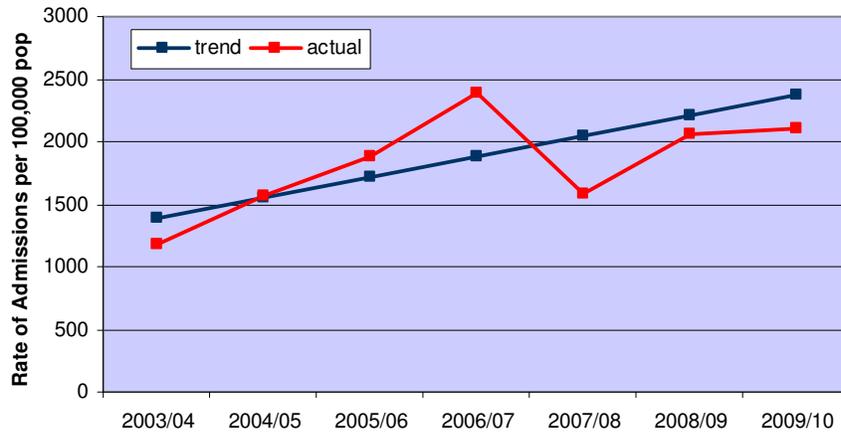


Chart 5 – Rate of Hospital Admissions per 100,000 for alcohol related harm in Stoke-on-Trent: Actual Performance Compared to Linear Projection, April 03 - March 10. Sources LAPE

## Detailed Case Study Narrative

and

## Follow-Up Support

- Following the National Support Team Visit, two members of the team offered to facilitate a workshop in the city. The Safer City Partnership wanted to enhance understanding locally of alcohol treatment pathways, specifically in the first instance amongst the service providers.
- The alcohol programme lead worked with the National Support Team to establish desired outcomes of the day and share current pathways and eligibility criteria. The National Support Team then developed an afternoon's workshop.
- The event was extremely well ran and proved very informative. It highlighted confusion amongst service providers and misunderstandings around referral pathways. The event helped to establish where the focus needed to be and this was around supporting a simple, integrated care treatment pathway supported by very practical guidance on roles and responsibilities.

## Learning

- I think that the support offered by the team could be enhanced through targeted follow-up with key partners. A lot of the work was facilitated through the alcohol lead whilst many actions are reliant upon partner's accountability and ownership. If a National Support Team were to make contact directly with key people, it may have improved ownership and timeliness against certain projects. For example, it has been very challenging establishing a liaison team within the hospital and some targeted support to help support ownership within the hospital from the Department of Health may have helped.

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## PCT Area: Tameside & Glossop

- **Visit Date: 1<sup>st</sup> July 2009**

## Key Recommendations from NST

- Accelerate alcohol strategy development with action plan, identify champions and advocates
- Design an integrated local alcohol treatment system based on outcome.
- IBA on an industrial scale
- Development alcohol/hypertension LES
- Integrate identification, advice, signposting and referral in A and E and hospital wards
- Maximise the opportunities offered through the Criminal Justice system and the use of ATRs.

## Progress Recommendation

- Development of Tameside alcohol strategy endorsed by Strategic Partnership – action plans for each thematic partnership.
- Redesign of treatment system in progress with new specs to be produced by March 11 – all stakeholders engaged in process.
- Training in IBA for front line staff across partnership commissioned from Alcohol Concern.
- 20 practices signed up to alcohol/hypertension LES
- A and E dept have developed alcohol action plan with involvement of senior managers and clinicians including training and IBA. Work in progress on “Patients repeatedly admitted to hospital for conditions related to alcohol”.

### MEASURABLE IMPACT: Hospital Admissions for Alcohol Related Harm



In the quarter before the NST visit (Jan – March 2009) there were 577 hospital admissions for alcohol related harm per 100,000 population. In the same period the following year (Jan – March 2010) the rate had increased by 2.2% to 590. This compares to an increase of 10% nationally and 11% regionally [Chart 6].

Chart 6: Percentage Change in the rate of Hospital Admissions for Alcohol Related Harm

Jan - Mar 2009 to Jan – Mar 2010

Source: Local Alcohol Profiles for England

## Follow-Up Support

- The NST provided support for treatment service redesign, facilitating 3 workshops on the system overall and dedicated workshops on the Criminal Justice system and on children and young people.

## Detailed Case Study Narrative

Alcohol strategy development:

- The NST recommended acceleration of the production of the alcohol strategy with a SMART action plan.
- The Tameside strategy was based on the needs assessment jointly commissioned

by PCT and Community Safety and produced by Public Health following full consultation with stakeholders including service users. The recommendations of the needs assessment were based in population need and the evidence of effective interventions.

- The strategy produced with full partnership involvement and endorsed by Tameside Strategic Partnership. The NST visit was key in assuring the support of TMBC chief executive whose commitment ensured that reducing alcohol related harm became a Strategic Partnership priority.
- The action plan was developed with the active involvement of each thematic partnership – each responding with the relevant actions to their partnership addressing the findings of the needs assessment.

The action plan addresses the wide-rooted determinants of alcohol related harm through the scope of each partnership – children and young people, health, crime and disorder reduction, housing, economic and learning and older people. It represents a need and evidence based strategy to reducing alcohol related harm and alcohol related hospital admissions

## Learning

Limited resource has slowed the implementation of the strategy but strong partnership commitment has meant that progress has been maintained.

## Any Other Comments

We are happy for the case study to be disseminated further.

## Contact Details

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## APPENDIX A

### Components of the alcohol improvement programme

**Regional Alcohol Managers (RAMs):** provide linkage between SHAs, GOs, RDPH & DH, assure local delivery & performance monitoring, and provide regional & local advocacy & championing. The RAM is invited to be part of the NST visit team for all visits undertaken in their region. The RAM and the NST work together to deliver support following visits.

**Improvement Support Team:** providing learning sets and healthcare collaboratives to facilitate active resolution and shared problem solving across PCTs. The NST has provided information to the Improvement Support Team on common themes emerging from visits in order to inform national support products.

**Alcohol Learning Centre:** disseminates local information and resources to support the PCTs and wider NHS in delivery.

**Hub of Commissioned Alcohol Projects and Policies (HubCAPP):** an online resource of local alcohol initiatives throughout England and Wales. The Hub has a particular focus on capturing the policies, decisions and strategic history that enabled projects to come into existence. Where the NST identifies potential good or innovative practice during visits, areas are encouraged to submit this information for inclusion on HubCAPP.

**Early Implementer sites:** 20 PCT areas were selected from those that face the highest challenge to "go further a little bit faster" in implementing improvements to reduce alcohol related admissions. All Early Implementer sites agreed to receive a visit from the NST as part of this programme. The Alcohol Improvement Programme has also developed a number of tools and guidance documents to assist PCTs and their partners, these include:

IBA tools and e-learning

### Guidance

**Local Routes: Guidance for developing Alcohol Treatment Pathways (DH, 2009):** provides good practice guidance on the development of integrated care pathways for people with alcohol problems – alcohol treatment pathways (ATPs). The NST has provided support to several areas in using this guidance to develop and map Alcohol Treatment Pathways.

**Signs for Improvement: Commissioning interventions to reduce alcohol related harm (DH, 2010).** This guidance is designed to direct commissioners in areas where tackling alcohol harm is an identified priority, to the resources and guidance, which will assist them in commissioning interventions to reduce alcohol-related harm in their local community.

In 'Signs for Improvement' the Department of Health identified a number of [High Impact Changes](#), which are calculated to be the most effective actions for those local areas that have prioritised the reduction in alcohol-related harm. High Impact Changes have been extensively used across the NHS and local government to highlight practical measures that can be implemented at local level:

1. [Work in partnership](#)
2. [Develop activities to control the impact of alcohol misuse in the community](#)
3. [Influence change through advocacy](#)
4. [Improve the effectiveness and capacity of specialist treatment](#)
5. [Appoint an Alcohol Health Worker](#)
6. [IBA - Provide more help to encourage people to drink less](#)
7. [Amplify national social marketing priorities](#)

The implementation of the High Impact Changes has had a strong focus in the reports that the NST has provided to areas visited, and in the follow up support delivered.

## Tools

**Ready Reckoner** aims to assist PCTs to select interventions to reduce alcohol related admissions in the short term, by calculating the likely cost benefit of Alcohol Health Workers, Delivery of IBA and increasing the proportion of dependent drinkers receiving treatment.

**System Dynamic Modelling Tool** can be used by PCTs, in conjunction with their Regional Alcohol Manager to help in planning local implementation strategies. The model tests the impact of introducing three of the established High Impact Changes in relation to Alcohol – IBA in Primary Care; Alcohol Health Workers; and Specialised Services.

**The Alcohol Harm Reduction Partnership Progress (AHRPP) Tool** is designed to be used by PCTs and their partners to help them assess progress across local partnerships in improving their ability to reduce incidence of harm related to alcohol misuse. The tool reflects many of the themes that would usually be covered during an NST visits and allows partnerships to identify strengths and areas for improvement.

## Data

**Alcohol Related Admission Trend Data** provides quarterly and annual admission trend data for every PCT against each of the conditions which are significantly (>20%) attributable to alcohol.

**The Local Alcohol Profiles for England (LAPE)** are available through the North West Public Health Observatory. The profiles contain 23 alcohol-related indicators for every local authority and 24 for every primary care trust in England. Key indicators in healthcare, criminal justice, benefits claimants, drinking patterns and life lost due to alcohol are used in combination to identify and map those areas experiencing different overall levels of alcohol-related harms.

**The National Alcohol Treatment Monitoring System (NATMS)** is a part of the National Drug Treatment Monitoring System (NDTMS). It provides reports and statistics regarding tier 3 and tier 4 treatment services for clients who are resident in England and whose primary problematic substance is alcohol. Monthly reports include a brief summary of statistical indicators nationally and for each SHA, PCT and service provider. More detailed quarterly "purple" reports include figures around waiting times, modalities of treatment and patterns of referral and discharge among various other indicators.

## APPENDIX B

### Visioning Event Example

**Aim:**

To agree the vision and priority actions for reducing alcohol-related harm

**Objectives:**

- raise the profile of the alcohol strategy amongst all stakeholders – including the public
- inform the refresh of the alcohol strategy
- create a vision of where xxx wants to be in relation to alcohol in 2020 that promotes the health, safety and wellbeing of communities across the county
- begin to identify the actions necessary to realise this vision in the medium and longer term
- identify how all partners can work together to realise the vision (build on/augment existing partnerships and strategic structures or create new ones)

#### Outline Agenda

- Registration and sign up to groups (15 mins)
- Presentation: Chairs introduction to the day (10 mins)
- Presentation: Overview of the prevalence of alcohol related harm, issues and strategic response (20 mins)
- Group work: Agreeing the vision for 2020 (45 mins)
- Group work: Working together to realise the vision (45 mins)
- Presentation: What works in reducing alcohol harm (20 mins)
- Whole group discussion: Consensus on the vision (20 mins)
- Group work: Winning hearts and minds – promoting ownership of the vision (20 mins)
- Group work: Making the vision happen (30 mins)
- Group work: Securing commitment from partners (30 mins)
- Round up and close (10 mins)

## Treatment Pathway Workshop Example

### **Aim:**

To develop a shared understanding of the commissioning plan for the alcohol treatment system in xxx, the proposed new alcohol treatment model and agree the pathways and flows required in the system

### **Objectives:**

Participants will:

- Understand the national alcohol treatment context and guidelines
- Understand the local alcohol commissioning plan and the key stages and milestones for implementation of the new alcohol treatment system
- Understand the planned alcohol treatment model for Tiers 1 to 4
- Agree how service users will ideally move and flow through the system
- Agree any potential blocks or gaps within the new system
- Agree the new integrated pathways that will need to be developed for the new system
- Agree the key actions required to take this work forward

### Outline Agenda

- Welcome, introductions, aim and objectives for the session (15 mins)
- Presentation: Setting the national context for alcohol treatment (15 mins)
- Presentation: Setting the local context, commissioning intentions and plan (20 mins)
- Presentation: The new alcohol treatment system for xxx explained (15 mins)
- Full group discussion: Questions/ comments on the new alcohol treatment system (25 mins)
- Group work: Mapping service users pathways through the system using case studies (90 mins)
- Full group discussion: Feedback on mapping exercise (60 mins)

## Developing Hospital-based Alcohol Interventions Workshop

### **Aim:**

To agree an appropriate model for the delivery of alcohol interventions in local hospitals

### **Objectives:**

Participants will:

- Understand national guidelines on the delivery of hospital alcohol services
- Explore best practice models for the delivery of alcohol interventions in hospital settings and the likely return on investment
- Understand how alcohol interventions are currently being delivered in local hospitals
- Agree actions to further develop provision of alcohol interventions in local hospitals

### Outline Agenda

- Welcome, introductions, aim and objectives for the session (15 mins)
- Presentation: National guidance and best practice models for hospital based alcohol services (30 mins)
- Presentation: Hospital alcohol services in the local area – Commissioner perspective (20 mins)
- Presentation: Hospital alcohol services in the local area – Provider/Hospital Trust perspective (20 mins)
- Group work: Developing the model for hospital alcohol services in Northamptonshire (90 mins), focusing on:
  - Group 1: Delivery of identification and brief advice, and education and support for other healthcare workers in hospital
  - Group 2: Medical management of patients
  - Group 3: Liaison with community services
  - Group 4: Organisational/Structural arrangements
- Full group discussion: Feedback on developing the model (60 mins)
- Group work: Identifying Quick Wins (20 mins)
- Full group discussion: Action Planning (30 mins)
- Presentation/Full group discussion: Commissioner summary of next steps (10 mins)
- Evaluation and close (5 mins)

## **APPENDIX C**

### **Methodology for coding of visit reports**

In order to understand the range of recommendations made by national support teams, and identify any common themes emerging, a project was undertaken to categorise the recommendations included by each National Support Team in their visit reports.

A series of themes and sub-themes were developed, to describe the wide range of recommendations that have been made to local areas by NSTs. This project involved members of each NST using a 'grounded theory' approach, whereby staff scrutinised recommendations from actual visit reports to create discrete sub themes. In addition, a smaller number of sub-themes specific to each NST topic area were created.

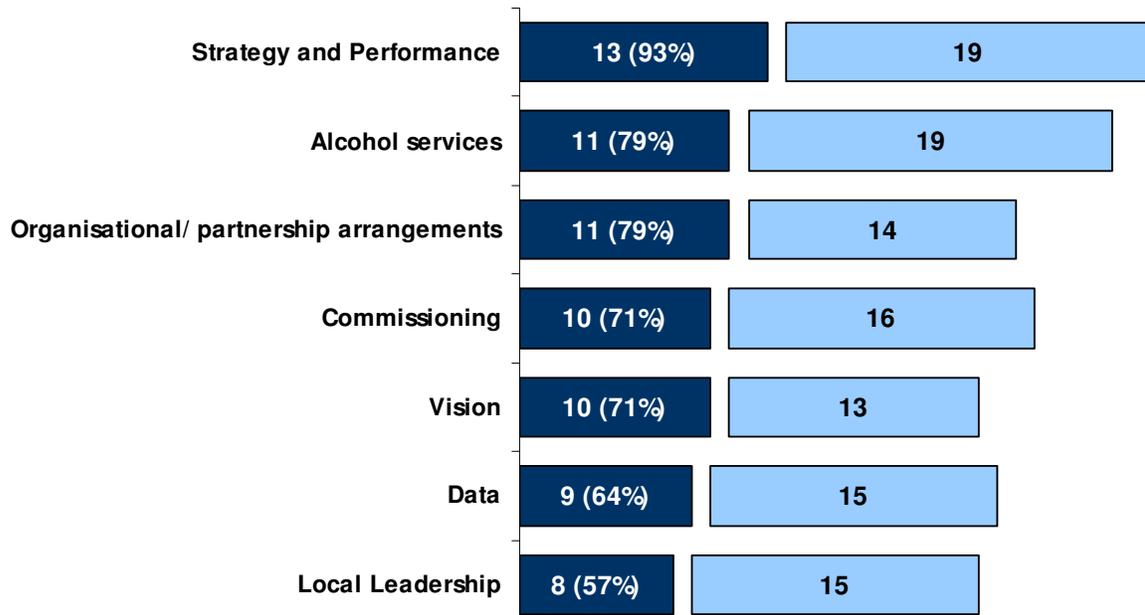
For alcohol harm reduction, 13 main themes were created, these included:

- Care pathways.
- Alcohol treatment in primary care.
- Alcohol treatment in hospital settings
- Alcohol treatment in criminal justice settings.
- Use of powers in the night time economy.
- Safeguarding children and families.

Following the creation of sub-themes, analysis was subsequently carried out using previous visit reports.

Scrutiny of 14 AHR visit reports, for visits conducted during the 2009/10 financial year, revealed 112 priority recommendations. The number of key recommendations ranged from five to 13 per visit, averaging 12 per visit report.

Systematic analysis of the 112 priority recommendations suggested that Strategy and Performance was a dominant theme. However, several common themes also emerged, as illustrated below:



■ Number of visit reports where the team recommended this theme as a 'priority action' (%)  
 □ Total number of sub-themes contained within the 'early priority' recommendations for each main theme

**Chart 6 - Summary of Key Themes Emerging from Analysis of Alcohol Harm Reduction NST Visit Reports**

The recommendations made under each of these themes have been explored in more detail in part 2 of this document.