Department of Health

Health Inequalities National Support Team

A Diagnostic Framework for Addressing Inequalities in Outcome at Population Level from Evidence-based Alcohol Harm Reduction Interventions

Identifying strengths and effective practice and making tailored recommendations on how to address gaps in service delivery

DH INFORMATION READER BOX

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Contents

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Foreword

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 450 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.

These workbooks are a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learning from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory.

Executive Summary

This workbook is one of a series developed by the Health Inequalities National Support Team (HINST), in its work with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. These workbooks are a summary of local views on good practice. The suggested approaches are not mandatory, and

reflect learnings from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory.

The topic of this workbook – **A Diagnostic Framework for Addressing Inequalities in Outcome at Population Level from Evidence-based Alcohol Harm Reduction Interventions** was selected for its potential impact on health and wellbeing, and on mortality and life expectancy in the short, medium and long-term.

This workbook seeks to examine what can be done to address the impact of harmful and hazardous alcohol use on recognised inequalities in health, cancer, stroke and coronary heart disease. As 23% of 16-64 year olds are drinking to harmful or hazardous levels it is crucial for health economies to address the issue in order to address the health inequalities gap. The average number of months of life lost attributable to alcohol increased by 25% among both males and females between 1995 and 2004[1].

Alcohol misuse, binge and chronic drinking are associated with a wide range of problems including personal impairment of physical and mental health and problems at a community level consequential of anti-social behaviours. The Department of Health's Models of Care for Alcohol Misusers (MoCAM) recognises four main categories of alcohol misuse:[2]

- Increasing risk drinkers
- Higher risk drinkers
- Moderately dependent drinkers
- Severely dependent drinkers

The diagnostic model described on page 10 can be applied to identify gaps in provision for alcohol harm reduction (AHR), allowing a better understanding of the local infrastructure and challenges faced, as well as supporting a comprehensive approach.

Central to AHR is the principle of multi-agency partnership working, effective planning and commissioning for AHR across the partnership (based on needs assessment and identification of those populations and areas bearing the greatest burden from alcohol) and a need for understanding of AHR at a high level to support appropriate resource allocation. Interventions needed for effective AHR fall mainly into the following categories:

- **Enforcement**
- **Working with the industry**
- **Treatment**
- **Young people**
- **Making it easier to stop alcohol misuse (including IBA)**
- **Communication including social marketing approaches**

To support the *QIPP (Quality, Innovation, Productivity and Prevention)* challenge it will be important to consider the costs and benefits of addressing prevention through AHR at a local level.

For the purpose of this workbook, interventions are defined in tiers, consistent with MoCAM:

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1 North West Public Health Observatory. *Local Alcohol Profiles for England*.
http://www.nwph.net/alcohol/lape/

2 Department of Health(2006) *Models of Care for Alcohol Misusers (MoCAM)* 2006
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136806

- **Tier 1:** alcohol related information and advice; screening; simple brief interventions and referral [3]
- **Tier 2:** open access - outreach, non-care planned, alcohol specific interventions included alcohol specific information, advanced brief intervention and alcohol-specific assessment
- **Tier 3:** community based, structured care planned approach
- **Tier 4:** specialist inpatient treatment and residential rehabilitation

Tiers are not discrete stages but may be cumulative, so one service user may undergo more than one tier of treatment at any one period. The tiers reflect the specialism required to deliver the intervention. The competences required for each tier of intervention are explained in the Drug and Alcohol National Occupational Standards (DANOS).[4]

This workbook – which is recommended for use either to carry out a stock-take or to run a facilitated workshop – provides advice on achieving best outcomes at **population level**, and for identifying and recommending changes that could be introduced locally. Recommended workshop invitees are provided.

Central to the HINST approach is a diagnostic framework – *Commissioning for Best Population Level Outcomes* (see p10), which focuses on evidence-based interventions that produce the best possible outcomes at population level. Part of the framework addresses delivery of **service** outcomes in the most effective and cost effective manner. This is balanced by considerations of how the population uses services, and is supported to do so, to aim for **optimal population level** outcomes that are fairly distributed.

The framework points to the following areas of consideration:

A CHALLENGE TO PROVIDERS

1. Known intervention efficacy
2. Local service effectiveness
3. Cost effectiveness
4. Accessibility
5. Engaging the public

B POPULATION FOCUS

6. Known population needs
7. Expressed demand
8. Equitable resourcing
9. Responsive services
10. Supported self management

11. Adequate service volumes
12. Balanced service portfolio
13. Networks, leadership and coordination

The workbook is made up of sets of detailed questions in the above categories. They provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done in relation to reducing the gaps in premature mortality and healthy life expectancy for people with alcohol problems** to further improve population health and wellbeing, capitalising on evidence-based interventions. How these improvements will best be achieved in a given locality will be for local participants to decide. The workbook signposts good practice and guidance where this may be helpful. Appendix 1 outlines high impact changes for successful interventions this area.

[3] *Screening and brief interventions: cost effectiveness review* can be found at; http://www.sheffield.ac.uk/scharr/sections/ph/series.html

[4] http://www.skillsforhealth.org.uk/site-search.html?q=danos&option=com_artofgm&filter=0&x=4&y=1

Introduction

This is one of a series of diagnostic workbooks developed by the Health Inequalities National Support Team (HINST), while working with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. The programme finished work in March 2011, but the Department of Health is publishing its key outputs for local commissioners and providers to use if they so wish. Each workbook topic was selected for the importance of its potential impact on health and wellbeing, and also on mortality and life expectancy in the short, medium or long term.

At the core of each workbook is a diagnostic framework – 'Commissioning for Best Population Level Outcomes' (see p10). The diagnostic focuses on factors that contribute to a process in which a group of evidence-based interventions produce the best possible outcomes at population level. Part of the structure addresses delivery of **service** outcomes in the most effective and cost effective manner. However this is balanced by considerations of how the population uses services, and is supported to do so, towards **optimal population level** outcomes that are fairly distributed.

The framework is made up of a set of detailed, topic-based questions. These provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done** to further improve population health and wellbeing, capitalising on evidence-based interventions. **How** these improvements will best be achieved in a given locality will be for local participants to decide. The workbooks signpost good practice and guidance where this may be helpful.

The resource represented by this workbook can make a significant contribution during a period of transition for the NHS, as responsibility for commissioning of health and health related services transfers to the NHS Commissioning Board, GP Commissioning Consortia and supporting Health and Wellbeing Boards in their contribution to reducing health inequalities locally. Changes are also in progress within local government, social care and the voluntary sector. Current policy in relation to public services highlights the centrality of engaging people – as individual service uses and patients, and as whole communities, in their own health and wellbeing and that of the wider community.[5] The workbook will support the newly emerging organisations and networks as an aid to understanding commissioning processes towards achieving population level outcomes. Key processes that should significantly influence local commissioning priorities such as the development of Joint Strategic Needs Assessment and Health and Wellbeing Strategies, will be highlighted through the use of the workbooks. The skills and knowledge embedded within the realigned local Public Health teams will be critical in development and coordination of these key processes with reference to Public Health England.

The workbook is designed and tested to help areas identify which factors are important in the systematic and equitable delivery of health improvement. They should, therefore, provide a good framework for early identification of local solutions driven by the new perspectives being brought to bear.

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[5] See for example NHS Constitution:
http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx and
Localism Bill: http://services.parliament.uk/bills/2010-11/localism.html
And NHS and Social Care Bill: http://services.parliament.uk/bills/2010-11/healthandsocialcare.html

The NHS also faces a challenging financial environment during the transition. Through the Spending Review, the government protected the NHS, with cash funding growth of £10.6bn (over 10%) by 2014/15. Nevertheless, by historical standards this remains extremely challenging and the NHS has been developing proposals to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge of efficiency savings of up to £20bn by 2014/15 for re-investment. This means that considerations of the affordability, and evidence on the cost-effectiveness and cost-benefit of the interventions presented should be of central consideration. Where possible priority should be given to interventions which are likely to lead to cash-releasing savings that can be re-invested in other services, based on a sound evidence base. Some of the relevant evidence has been referenced through the workbook.

Those involved locally in delivering the alcohol agenda will be aware of changes that may be outside the scope of this workbook and of any detail in the workbook that may have been superseded. These should be taken into account. To facilitate this, a generic workbook - *A Generic Diagnostic Framework for Addressing Inequalities in Outcome from Evidence-based Interventions* - has been produced that could be used to guide the diagnostic questions and discussion during the workshop, with this detailed workbook being used alongside the generic one for reference.

How to Use this Workbook – a guide

This workbook provides a diagnostic, which can be used in three ways:

1. For taking stock of the set of alcohol interventions to check their potential for delivering optimal population level outcomes that are fairly distributed and will have an impact on inequalities in mortality
2. With a group of commissioners and providers to develop a systematic approach to commissioning and delivering the set of evidence based alcohol interventions using this stock take approach.
3. In a workshop setting as described below

If used in a workshop setting, the objective of this workbook is to gain a picture of the local strengths and gaps in services in relation to the objective of achieving best outcomes at **population level**, and to identify and recommend changes that could be introduced. It is recognised that the alcohol agenda is multi-faceted and involves delivery across a range of providers. It will therefore be necessary, if the workbook is used in a workshop setting, to determine the focus of the workshop and concentrate on those questions which address that focus.

- The workbook is best used in a **facilitated** workshop setting for a **minimum of 8 and a maximum of 25 participants Allow 4 hours for the workshop.** The participants in the workshop should include key individuals who are involved in planning, commissioning and delivering services and interventions in relation to the workbook topic through a partnership approach. The make-up of the group will vary according to local situations but the suggested minimal attendee list for this workbook is set out below:

• Commissioner for Alcohol Treatment Service • Programme lead • Public Health Alcohol coordinator • Chair of the Alcohol Group • Clinical lead on Alcohol Group • Trading Standards Representative • Licensing Representative • Partnership Communications Leads • Acute sector alcohol strategic lead • Acute sector alcohol liaison worker(s) • Acute sector, young people's service lead	• Provider service representatives (from tiers 2, 3 and 4) • Drug and Alcohol Team (DA(A)T) coordinator • Crime Disorder Reduction Partnership Representative • Police representative with special interest • GP with Special Interest • Voluntary Organisations • Probation Service Lead • Domestic Violence /abuse service lead

Where there is more than one organisation (for example, hospital trust) providing local services, it is advisable to invite senior representatives from each.

Provide a copy of this workbook to each participant at the workshop. It is suggested that the participants do not see the workbook in advance, but are informed that the workshop will be an opportunity to explore their knowledge of approaches to the issue with others who will bring differing perspectives. This will mitigate against any participants over-preparing, becoming defensive or being resistant to discussing – and finding solutions for – local issues.

The facilitator should be familiar with the workbook questions and the model described below, for which a population level perspective is taken. It is suggested that facilitators introduce the participants to this model and approach. Following the introduction, it is useful to look at section 13 first as this gives an overview of the situation in the area for this topic and enables all participants to have an opportunity to contribute at the beginning. Finish by working through each of sections 1-12 of the model.

Group discussions about all of the questions in each section allow strengths, best practice and gaps to be identified, and the group to begin to think about where improvements could be made. A separate publication contains a facilitator's recording book, which can be used during the workshop to record this discussion. This need not be copied for workshop participants.

Key actions and lead stakeholders to take these actions forward can be identified during the workshop. The greatest impact is likely to result if summaries of these key actions and of the recognised strengths and recommendations from the workshop are produced and circulated to attendees and key accountable stakeholders within the partnership, following the workshop.

Throughout the workbook, some questions have been ***highlighted in bold italics*****.** These are questions that investigate areas of work that are likely to have the biggest effect on reducing health inequalities in the short term. They will help to inform the systematic delivery of services, reducing variability and resulting in population level change. It is sensible to place emphasis on these questions during the workshop.

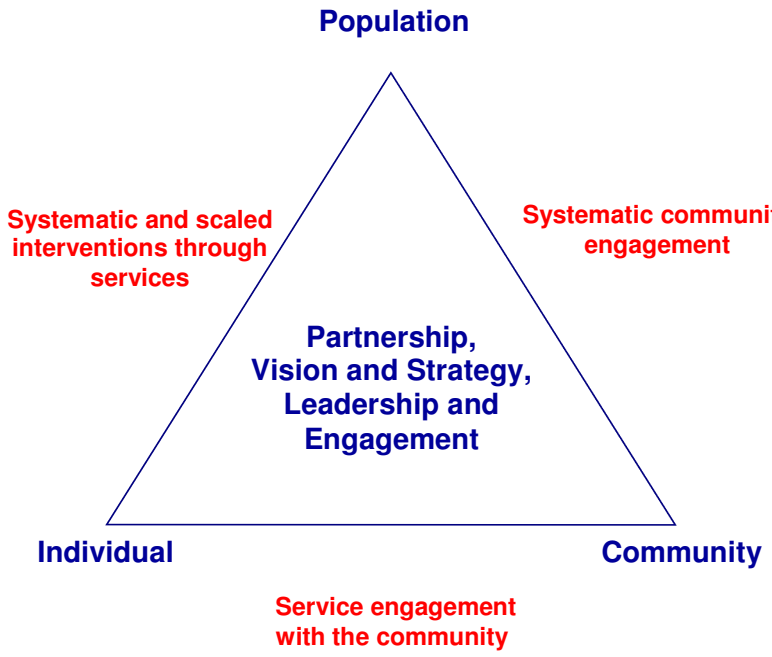
Background to Population Level Interventions

Challenging public health outcomes, such as achieving significant percentage change within a given population by a given date, will require systematic programmes of action to implement interventions that are known to be effective, and reaching as many people as possible who could benefit.

Programme characteristics will include being:

- **Evidence based –** concentrating on interventions where research findings and professional consensus are strongest
- **Outcomes orientated –** with measurements locally relevant and locally owned
- **Systematically applied –** not depending on exceptional circumstances and exceptional champions
- **Scaled up appropriately –** 'industrial scale' processes require different thinking to small scale projects or pilots ('bench experiments')
- **Appropriately resourced –** refocusing on core budgets and services rather than short bursts of project funding
- **Persistent –** continuing for the long haul, capitalising on, but not dependant on fads, fashion and changing policy priorities

Interventions can be delivered through three different approaches to drive change at population level, illustrated by the following diagram:



Producing Percentage Change at Population evel

C. Bentley 2007

Population Approaches
Direct population level interventions will include developing healthy public policy, legislation, regulation, taxation and public funding strategies. These elements should support making 'healthy choices easy choices' for individuals and communities.

The impacts of such population level interventions, however, will not automatically 'trickle down' to all, often in particular missing those who are socially excluded for various reasons. Strategies for targeted communication and education, service support and even enforcement will be required to achieve full impact.

Individual Approaches through Services
Some interventions taken up at individual level, such as support for environment and behaviour change, therapies, treatments and rehabilitation, can change individual risk significantly, in some cases by 30-40%. The challenge is to achieve so many of those individual successes that it adds up to percentage change at population level. This will be achieved only if services take into account issues of system and scale to enable this to happen, and work to address population level outcomes as well as those for individual service users.

Improvements in health and wellbeing will require some reorientation of health and other services to take a more holistic view of individual circumstances, with regard to any personal characteristics/sub-population group status or socio-economic status and to focus on development of personal skills of staff and service users, so promoting healthy choices and actions.

Community Approaches
Individuals will only choose to use and benefit from certain behaviours and actions if those behaviours fit with the cultural and belief system of their own community. Communities can be based on place (neighbourhood, school, workplace), culture (ethnicity, faith) and others (disability, sexual orientation). Community development is one way of facilitating communities' awareness of the factors and forces that affect their wellbeing, health and quality of life.

Community engagement is often patchy, favouring those communities that already have leadership, organisation and some resources. Instead, it needs to be systematic in bringing top-down and bottom-up priorities together into plans. This will strengthen community action to create more supportive environments and develop knowledge and skills of community members.

Service links into communities can be superficial, of poor quality, unsystematic, and based on low levels of understanding. Connectivity between services can be disorganised and confusing. Use of the voluntary, community and faith sector as a bridge between services and community based structures needs to be more systematic and based on need rather than supply. Commissioning is key to this.

Commissioning for Population Level Outcomes

Substantial progress can be achieved in making an impact in the short, medium and long term in relation to inequalities in mortality and life expectancy through a focus on existing services. Because of this, extra attention is given here to extracting maximum benefit from delivery of interventions for which there is strong evidence of effectiveness. In addition there is a deliberate emphasis wherever possible, on improving access to services of a scale that will impact on bringing about a population level improvement in mortality and life expectancy within a two to three year period.

The detail is illustrated in the attached diagram on page 10 with the title 'Commissioning for Best Population Level Outcomes', otherwise known as the 'Christmas Tree' diagnostic, with an accompanying description of its component principles. The framework balances two sets of factors that determine whether optimal outcome can be achieved at population level from a given set of personal health interventions.

The right hand side of the diagram (1 to 5) - a challenge to providers: links the factors that will influence health *service* outcomes, that is, how can we construct the most effective service.

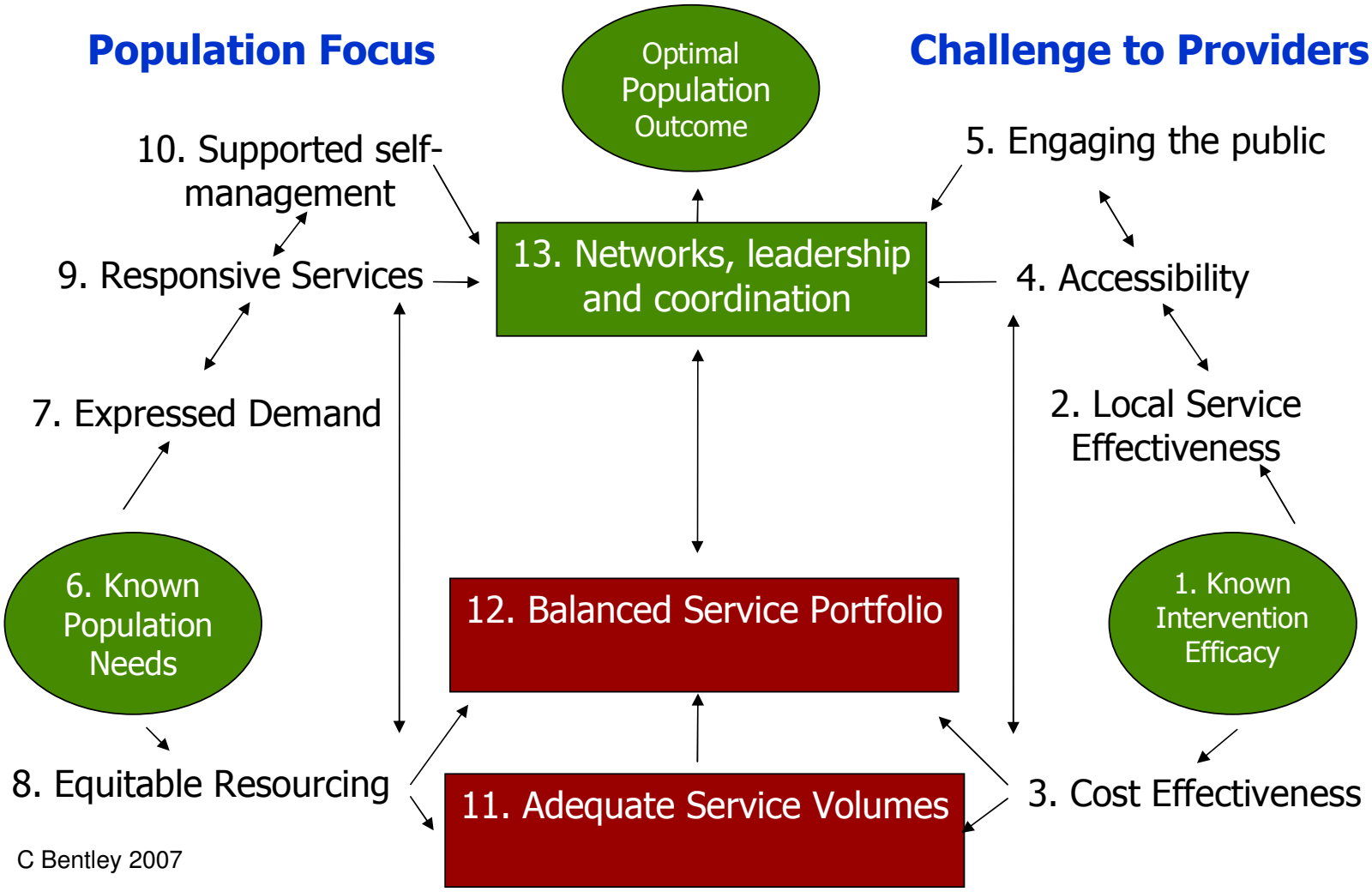
However, optimal outcomes *at population level* will not be obtained without the following:

The left hand side of the diagram (6 to 10) - a population focus: identifies those factors that determine whether a community makes best use of the service provided – for example, whether the benefits of personalised improvements to services are having a systematic impact on reducing health inequalities at the population level.

The balance between the two sides of the diagram - the commissioning challenge: Focusing on equality of outcome, not just equality of access to service provision and support, is a significant and crucial challenge for commissioners. The 'Christmas Tree' diagnostic, is a tool to help achieve this. The right side of the diagram enables commissioners to identify the best services available for their population. The left side allows commissioners to consider what is commissioned and delivered best meets the needs of all people in the local population. Attention to both sides of the diagram will help consideration that that all services are effective **and** engaged with and used by all of the diverse communities in the area they serve.

The central elements of the diagram consider how services/interventions are most effective when they are fully acceptable, accessible and effective in terms of take-up and compliance, there is adequate capacity to meet the need. Effective leadership and networks will enable all these elements to be kept under review to support continuous improvement and equality of morbidity and mortality outcomes.

Commissioning for Best Population Level Outcomes



C Bentley 2007

Commissioning for Best Population Level Outcomes

A CHALLENGE TO PROVIDERS

1. **Known Intervention Efficacy:** Looks for life saving interventions, for which there is strong evidence, to be implemented equitably and made available to as many people who could benefit as possible.

2. **Local Service Effectiveness:** Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit

3. **Cost Effectiveness:** Aim for programme elements that are as affordable as possible at population level

4. **Accessibility:** Aim for services that are designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.

5. **Engaging the Public:** Working with service users and communities to aim for needs and requirements being placed at the centre of service provision and for quality assurance systems in place that makes the services acceptable to service users

B POPULATION FOCUS

6. **Known Population Needs:** Aim for a realistic assessment of the size of the problem locally, and its distribution geographically and demographically and the level and type of service being based upon this assessment.

7. **Expressed Demand:** Aim for as many people as possible suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.

8. **Equitable Resourcing:** Aim for the distribution of finance and other resources to support equitable outcomes according to need.

9. **Responsive Services:** When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.

10. **Supported Self Management:** Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

11. **Adequate Service Volumes:** Commissioning adequate service volumes to aim for acceptable access times.
12. **Balanced Service Portfolio:** Aim for balance of services within pathways to avoid bottlenecks and delays.
13. **Networks, Leadership and Co-ordination:** Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

Whilst the service design elements are an immediate concern to providers, all sections of the 'Christmas Tree' diagnostic are of direct relevance to commissioners

Equality

Equalities perspectives need to be built into all whole population approaches. The Equality Act 2010 set out the public sector equality duty:

> *(1) A public authority must, in the exercise of its functions, have due regard to the need to:*
>
> > *(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*
> >
> > *(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
> >
> > *(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

The Act identifies a number of "protected" population groups/characteristics where specific elements of the legislation apply. These groups/characteristics are:

- *age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.*

Although socioeconomic inequalities are not specifically included in the Equality Act, there are a range of duties in relation to tackling inequalities included at different levels in new health and social care legislation, and for all key structures and partners involved in the commissioning and delivery of this legislation.
The Health and Social Care Bill 2010 proposes new legal duties on health inequalities for the Secretary of State and the NHS. Subject to Parliamentary approval:

- The Secretary of State for Health must have regard to the need to reduce health inequalities relating to the NHS and the Public Health
- The NHS Commissioning Board and GP consortia must have regard to reducing inequalities in access to, and outcomes of, healthcare.

In order to carry out these duties effectively an emphasis on socioeconomic disadvantage will be essential as it is recognised as a major driver in relation to inequalities of access to, and outcomes of, health and wellbeing services.[6]

Useful Materials[7]

[6] The Marmot Review (2010) *Fair Society, Healthy Lives - Strategic Review of Health Inequalities in England post 2010* http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

[7] Department of Health. *Making the difference – The Pacesetters beginner's guide to service improvement for equality and diversity in the NHS.* 2008. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086039

Why this topic has been chosen

This workbook allows exploration of what can be done at a local level to address the impact of harmful and hazardous alcohol use on recognised inequalities in health, cancer, stroke and coronary heart disease. As 23% of 16-64 year olds are drinking to harmful or hazardous levels it is crucial for health economies to address the issue in order to reduce the health inequalities gap. The average number of months of life lost attributable to alcohol increased by 25% among both males and females between 1995 and 2004[8]

There is evidence that alcohol can have detrimental effects on diseases of the circulatory system. Alcohol consumption increases the risk of cardiac arrhythmias and essential hypertension, with significant effects observed at levels corresponding to daily consumption of 25 g/day. There is consistent evidence of an increased risk of haemorrhagic stroke associated with alcohol consumption and consistent and significant effects of alcohol consumption on cancers of the oral cavity and pharynx, oesophagus, larynx, colon, liver and breast.[8]

Men appear to be more at risk of harm from their alcohol consumption than women. 4.4% of male deaths were alcohol attributable compared to 2.0% of female deaths. Alcohol attributable deaths also vary by age, and although the highest number of deaths were seen in older age groups, young people are disproportionably affected by their alcohol use, for example, among 16-24 year old males, 26.6% of all deaths were estimated to be attributable to alcohol consumption compared to 1.4% among those aged 75 and over. In those aged less than 35 years, deaths were most likely to occur from the acute consequences of alcohol consumption, in particular, intentional self-harm and road traffic accidents. Beyond the age of 35, liver cirrhosis, malignant neoplasm of the oesophagus and breast, and hypertensive diseases were the most common causes of death attributable to alcohol.[9]

Mortality caused by alcohol consumption can be reduced by implementing a strategic and comprehensive targeted approach to local alcohol treatment systems and working with a multi-agency partner approach.

The diagnostic model described above can be applied to identify gaps in provision of 'alcohol harm reduction' (AHR), allowing those with responsibility for this issue to have a better understanding of the infrastructure in their locality and the challenges they face. It will also provide the opportunity to explore the fundamental principles of AHR through the introduction of a comprehensive approach to this subject.

Alcohol misuse, binge and chronic drinking are associated with a wide range of problems including personal impairment of physical and mental health, and problems at a community level resulting from anti-social behaviours. The Department of Health's Models of Care for Alcohol Misusers (MoCAM) recognises four main categories of alcohol misuse:[10]

1. **Increasing risk drinkers:** drinking above recognised sensible drinking levels but not as yet experiencing harm

[8] North West Public Health Observatory. *Local Alcohol Profiles for England*.
http://www.nwph.net/alcohol/lape/
[9] Jones et al (2010*) Alcohol- Attributable fractions for England*
http://www.cph.org.uk/showPublication.aspx?pubid=403
[10]Department of Health (2006) *Models of Care for Alcohol Misusers (MoCAM)*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136806

2. **Higher risk drinkers:** drinking above sensible levels and experiencing harm
3. **Moderately dependent drinkers:** drinking is recognised as a problem, but has not entered into relief drinking, but have impaired control over drinking
4. **Severely dependent drinkers:** serious longstanding drinking problem**,** will have experienced withdrawal fits or delirium tremors[11]

While it should be recognised that drinkers move across categories, these definitions can be useful for commissioners to direct service provision.

Central to AHR is the principle of multi-agency partnership working. It is vital to have strategic partnerships and functional alliances at a local level to deliver evidence based interventions. These interventions need to be closely linked to regional and national action on alcohol.

Closely aligned to this is the need for effective planning and commissioning for AHR across the partnership. Planning and commissioning should be based on needs assessment and identification of those populations and areas bearing the greatest burden from alcohol. There is a clear need for understanding of AHR at a high level to inform appropriate resource allocation. Services and inputs must be based on the strategic approach adopted by local partnerships. Of course, any interventions need to be monitored and reviewed where necessary.

To support the *QIPP (Quality, Innovation, Productivity and Prevention)* challenge it will be important to consider the costs and benefits of addressing prevention through AHR at a local level. A resource pack to support local analysis of cost effectiveness of interventions for lifestyle issues is described below[12]

Interventions needed for effective AHR fall mainly into the following categories:

- **Tackling illegal/underage supply** focuses on issues such as targeted enforcement of age of sale legislation and interventions delivered to children and young people to address early or family alcohol use.

[11] NOTE: The Department of Health has adopted 'risk-based' language to describe these categories of drinkers. The public and generic health care professionals better understood the concept of 'risk'. Safe or Sensible drinkers are now referred to as "Lower-risk", Hazardous drinkers as "Increasing-risk" and Harmful drinkers as "Higher-risk". The terms for dependent drinkers remain the same.

[12] Yorkshire and Humber Public Health Observatory have in partnership developed the NHS Yorkshire and the Humber QIPP resource pack: May 2010 (STAYING HEALTHY) http://www.yhpho.org.uk/resource/item.aspx?RID=79123). The pack presents step-by-step analysis of lifestyle behaviours, cost implications and potential cost savings following intervention. The resource pack considers prevalence of lifestyle behaviours, cost to the NHS, attributable admissions, attributable deaths and evidence and cost of interventions.

Further modelling work has been conducted and trailed in a number of localities. The model was developed by Professor Malcolm Whitfield. Director of the Centre for Health and Social Care Research at Sheffield Hallam University and addresses on a locality basis the key questions:

- How much would we have to change the risk factors to reduce the burden of disease?
- What order of savings could we achieve on healthcare costs in the first five years?
- How much could we realistically invest in getting lifestyle change?

The decipher tool is available on the following website: http://www.sportseng.org/sheftool/

- **Making it easier to stop alcohol misuse** looks to the promotion of evidence based ways to help reduce alcohol misuse. This includes screening for alcohol use and delivery of simple and advanced brief interventions. Referral pathways and strategic framework for care pathways to alcohol treatment programmes are also considered.[3, 13]
- **Communication** with the public and between AHR advocates at a local level to enable priorities to be actioned, or, on a wider level, between localities and regional and national bodies to support concerted and consistent action on key issues.

- **Social marketing approaches** are also thought to be important to enable target audiences to be at the heart of messages and services

The overriding priority is to consider both sides of the 'Christmas tree' model towards a population focus to facilitate communities' optimal use of the services as well as providing the most effective evidence based interventions.

For the purpose of this workbook interventions will be defined in tiers, consistent with the Models of Care for the treatment of Alcohol Misuse (MoCAM).

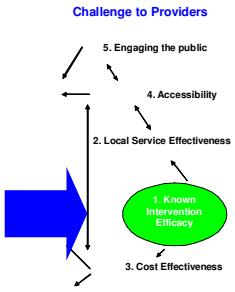
- **Tier 1:** alcohol related information and advice; screening; simple brief interventions and referral
- **Tier 2:** open access - outreach, non-care planned, alcohol specific interventions included alcohol specific information, advanced brief intervention and alcohol-specific assessment
- **Tier 3:** community based, structured care planned approach
- **Tier 4:** specialist inpatient treatment and residential rehabilitation

It is worth noting that tiers are not discrete stages but may be cumulative, therefore one service user may undergo more than one tier of treatment at any one period. The tiers reflect the specialism required to deliver the intervention. The competences required for each tier of intervention are explained in the Drug and Alcohol National Occupational Standards (DANOS).

[13] Macro-level interventions for alcohol use disorders: cost effectiveness review can be found at http://www.sheffield.ac.uk/scharr/sections/ph/series.html

The Workbook

Addressing Inequalities in Outcome at Population Level from Evidence-based Alcohol Harm Reduction Interventions



1. Known intervention efficacy

Looks for life saving interventions, for which there is strong evidence, to be implemented equitably and made available to as many people who could benefit as possible.

Interventions[14]

1. Identification and brief advice - delivered across:

- primary care, including GP Practices, community pharmacy, health visitors and targeting those at risk, which groups have been targeted
- secondary care, including ED, fracture clinics, maxofacial clinics, maternity
- criminal justice, including victims and perpetrators of domestic violence
- other frontline services, including teachers

2. Psychosocial and medical interventions[15]

- cognitive-behavioural therapy
- motivational enhancement therapy
- 12 step therapy
- coping and social skills training/social networking therapy
- community reinforcement approach
- cognitive-behavioural marital therapy
- medications for treating withdrawal symptoms, promote abstinence and nutritional supplements
- community, inpatient or residential detoxification
- residential rehabilitation
- relapse prevention, prolonged care and multiple treatment occasions as integral to the care packages and supported by mutual support groups

3. **Treatment plans**[16] **-** that address

- physical health needs
- psychological adjustment
- vocational adjustment

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[14] National Treatment Agency for Substance Misuse (2006) *Review of the effectiveness of treatment for alcohol problems*.
http://www.alcohollearningcentre.org.uk/Topics/Browse/Policy/?parent=4441&child=4654

[15] NICE.(2010) *Alcohol-Use Disorders Clinical Management Physical Conditions*.
http://guidance.nice.org.uk/CG100

[16] NICE. *Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence* (unpublished draft guidance) http://guidance.nice.org.uk/CG/Wave17/1

- social adjustment to include the family unit
- alcohol hospital liaison function – available across acute trust sites
- implementation of Alcohol Treatment Requirements (ATRs)
- alcohol arrest referral scheme/fixed penalty notices for low level alcohol disordered behaviour

4. Other
- workplace policies relating to alcohol in partnership organisations

Families and young people

5. Support for parents and/or children of those with identified alcohol misuse

6. Young people's education programmes to include:
- increase knowledge of potential damage of alcohol, incorporated into healthy lifestyle education
- provide the opportunity to explore issues relating to alcohol and educate on the influence of media on alcohol use
- provide the potential for the building of psychological and behavioural development skills with opportunities to enhance self-esteem and develop verbal and non-verbal skills to cope and assert decision-making.
- provide a holistic approach to development of policies including parents/carers, teachers and pupils

Licensing, availability and enforcement:[17]

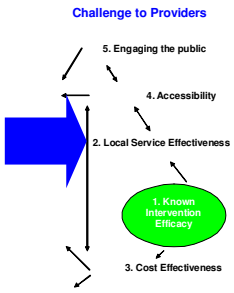
7. Measures to reduce underage and inappropriate sales
- Industry led Proof of Age Standards Accreditation Schemes (PASS) accreditation
- Challenge 21[18] or 25 schemes
- 'Top Ten Premises Enforcement Schemes'
- Pubwatch)
- Enforcement for off licences
- Tackling irresponsible alcohol promotions

8. Interventions to manage the night time economy:
- Staggered closing times
- Security Industry Authority licensed door supervisors (supported by police enforcement and included in licensing review)
- Taxi marshals and late night buses including queue control
- Operation/routine Breath Tests/Sobriety checkpoints

9. **Licensed outlet density** - considered in regeneration plans and licensing of premises

[17] NICE (2010) *Alcohol-use disorders: preventing the development of hazardous and harmful drinking*. http://www.nice.org.uk/guidance/PH24

[18] http://www.challenge21.co.uk/



2. Local service effectiveness

Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit

1. Systematic training

- Are there protocols in place so that staff are appropriately trained for each element of the AHR treatment? Are these protocols embedded in contracts?

- Are provider agency staff trained in screening and core assessments for a wide range of alcohol problems? Does this include instruments for mental health assessment and referral?

- ***What arrangements are in place for identification and brief advice (IBA) training? Do these include:***[3]
  - ***consideration of nationally available standard training materials and guidance***
  - ***an integrated framework for delivery across: secondary care, criminal justice, primary care, mental health, frontline services, housing and employment***
  - ***monitored and centrally recorded referring to AHR treatment***
  - ***systematic training for generic staff***
  - a comprehensive training programme that considers the link between alcohol abuse and domestic violence
  - routine training update sessions
  - feedback on referrals for staff
  - monitoring and systematic action taken to fill gaps in activity?

2. Local and Directed Enhanced Services for IBA[19]

- ***Have GPs and/or community pharmacists been supported to take up an Enhanced Service for IBA?*** Has this included
  - clear contracts, including specification for targeting people identified as at risk
  - brief advice scripts
  - care pathways
  - assistance with utilising practice capacity

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[19] Kaner E, Beyer F, Dickinson H, Pienaar E, Campbell F, Schlesinger C, Heather N, Saunders J, Bernand B. (2007) *Brief interventions for excessive drinkers in primary health care settings*. Cochrane Database of Systematic Reviews 2007, Issue 2. Art No.:CD004148 DOI: 10.1002/14651858.CD004148.pub3
Further references may be found at http://www.alcohollearningcentre.org.uk/Topics/Browse/HIC/IBA/

- systematic data collection system within primary care to capture alcohol interventions
- ***targeting those on chronic disease registers***
- ***including IBA in the disease management review?***

3. Auditing and Reporting

- What systems are in place to enable commissioners to support providers offering Tier 2, 3 and 4 services, to submit monthly Quality Performance Reports? Do these include, for example:
  - DNAs (do no attend)
  - number of admissions into services
  - numbers completing treatment and leaving in a planned way
  - re-admittance after 6 months
  - aftercare and follow-up activity post treatment?

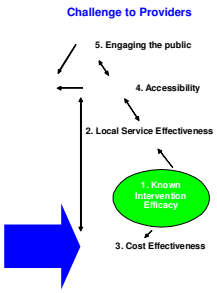
- Do Tier 3 and 4 submit data to the National Alcohol Treatment Monitoring System?

- Are pathways audited to help drive improvements in efficiency and effectiveness? Is there separate consideration of ATRs?

4. Monitoring

- What systems are in place to monitor adherence to licensing and trading standards for alcohol? Does this include:
  - 'test purchasing'
  - response to 'Top Ten Premises Enforcement Schemes' (e.g. Pubwatch)
  - training for traders
  - process for prosecution

- Is the effectiveness of social marketing campaigns and programmes monitored? Does this include key performance indicators set to review measurable behaviour change as a result of activity?



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3. Cost effectiveness[12]

Aim for programme elements that are as affordable as possible at population level

1. Cost effectiveness analysis and modelling[20]

- Has the cost effectiveness of the services been analysed, taking into account differing requirements of different population groups (see section 6 on Needs Assessment for more detail)?

- Are resources then prioritised and allocated according to need, towards equitable outcomes for all groups? Analysis should allow for the disproportionate cost of work with seldom seen groups.

- Has the impact of AHR services on costs and outcomes of other services been modelled and used to inform commissioning?

- Has there been any modelling to assess the impact or potential gains following investment in alcohol services in relation to health inequalities?

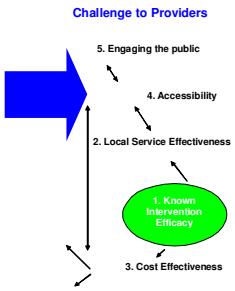
2. Analysis of systems for admission and/or chronic disease

- ***What analysis of systems has been carried out to assess or refer people with alcohol problems on admission and/or with chronic disease has been carried out in secondary and/or primary care? How has this informed strategy?***

3. QIPP

- ***How have considerations of quality, innovation and productivity been taken into account in designing the programme to maximise cost effectiveness?***

[20] NICE (2010) *Alcohol Use Disorders. Preventing Harmful Drinking. Costing Report.* Implementing NICE guidance
http://www.nice.org.uk/nicemedia/live/13001/49071/49071.pdf



4. Accessibility

Aim for services that are designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of that service.

1. Accessible treatment

- Does the treatment system consider:
  - clear accessible avenues for drinkers to refer themselves for screening and alcohol treatment services
  - marketed provision of service in user-friendly formats to target those of greatest need
  - treatment centres and drop-in clinics distributed to support equitable outcomes
  - location of clinics in areas of greatest prevalence
  - timings of clinics to suit users
  - acceptability to users
  - individual preference of alcohol treatment
  - geographical location of clinics and transport networks?

2. Patient pathway

- How are the different population characteristics considered through the patient pathway?
  - age
  - disability
  - gender reassignment
  - marriage and civil partnership
  - pregnancy and maternity
  - race
  - religion or belief
  - sex
  - sexual orientation.

3. Range of settings

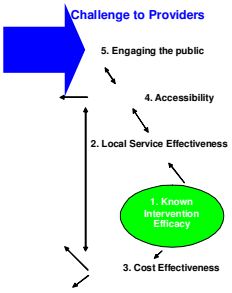
- Are Tier 2 and 3 advisors available to offer interventions in a range of settings including the home?

4. Pregnant women

- Is there a specialist service for work with pregnant women to address alcohol misuse? Is this delivered by a midwife? Is this available pre and post pregnancy? Does this include health visitors?

5. Housing and homelessness

- Are there clear pathways for access to alcohol services via housing and homelessness services? Is this supported by outreach work? Are there clear links to floating support?



5. Engaging the public

Working with service users and communities to aim for needs and requirements being placed at the centre of service provision and for quality assurance systems in place that makes the services acceptable to service users

1. Involvement of service users and the public in service development

- Are service users involved in the Alcohol Strategy Group to inform decision making?
- Is there a service user/carer group(s) which can advise the developments of the Strategy Group?
- Are patient forums/carers/service user groups/the public engaged in the commissioning cycle to identify the barriers to accessing the AHR interventions and resulting changes in provision?
- Are there measures in place to support inclusion of 'seldom seen' and targeted groups?
- ***Are user satisfaction evaluations carried out across all AHR service users and are outcomes acted upon to improve the service?***
    - ***Does this include DNAs?***
    - ***Is this information used to inform the pathway development at each entry point?***
    - ***Is this a requirement in service provider contracts and SLAs?***

2. Voluntary sector involvement

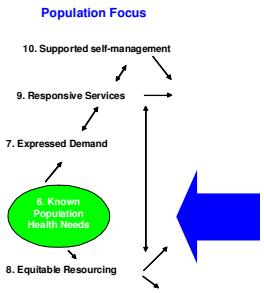
- Are there local Voluntary and Community Sector (VCS) networks in existence locally to coordinate and/or advocate for all the major communities of interest (e.g. a multi-faith forum, a disability forum etc)?

3. Families and young people

- Are parents/carers, teachers and young people/pupils engaged in the development of holistic policies/approaches for
    - alcohol harm reduction in schools
    - parenting/family programmes?

4. Licensing, availability and enforcement

- What is in place to encourage public complaints about on and off licence outlets? How has this been promoted? What has been the response?
- How has public opinion been sought to explore suitability and uptake of measures such as night time transport provision, environment health, town centre management, enforcement operations, etc?



6. Known population needs

Aim for a realistic assessment of the size of the problem locally, and its distribution geographically and demographically and the level and type of service being based upon this assessment.

1. Needs Assessment

- What information has been used to develop needs based services for the alcohol harm reduction agenda?
- How does alcohol feature in the Joint Strategic Needs Assessment (JSNA)?
- Does the JSNA include:
  - prevalence data
  - treatment provision (Tier 1-4)
- Is Crime Disorder Reduction Partnership needs assessment data used to inform the JSNA to inform full understanding and overlaps in alcohol related harms across the population?

2. Use of tools

- Are the following tools used to inform needs based services:
  - North West Public Health Observatory (NWPHO) Local Alcohol Profiles for England[21] (LAPE)
  - National Alcohol Treatment Monitoring System (NATMS) to estimate demand for alcohol services in the area? [22]
  - The Rush Model[23]?

- ***Has any segmentation of the population been carried out to target higher-risk drinkers? Has this included development of profiles for:***
  - ***communications purposes (with the use of, for example, the CACI ACORN segmentation tool or Experion's MOSAIC segmentation tools)***
  - ***targeting of activities (with the use of, for example, NWPHO Segmentation Tool)***

3. Use of GP data

- ***What are the plans to use GP data of alcohol status and alcohol related and specific hospital admissions for adults?***
- ***How will this link to chronic disease management?***
- ***Will this be used for targeting services?***

[21] http://www.nwph.net/alcohol/lape/
[22] https://www.ndtms.net/default.aspx
[23] Rush Model Spreadsheet available at:
http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/Datatools/?parent=5113&child=5134

- ***How will secondary care alcohol related/specific disease intelligence be used to inform primary care?***

4. Health Equality Impact Assessments

- Have Health Equity Audits (HEAs) been carried out to support equality of access to the Alcohol services across different population groups? For all categories of drinker?
  - age
  - gender
  - sexuality
  - race
  - religion or belief
  - patients in residential and nursing homes and housebound
  - neighbourhood
  - deprivation quintile
  - by practice
  - segmentation group
  - people with physical or learning difficulties or mental health problems
  - other relevant vulnerable groups e.g. prisons, Gypsies and Travellers
- As a result has there been any prioritisation or stratification of the extent of need? Have particular outcome 'black-spots' been identified?

5. Modelling

- Has the impact of alcohol on the mortality/life expectancy gap been modelled?
- Has this modelling formed part of local health inequalities action plans?

6. Pregnancy audit

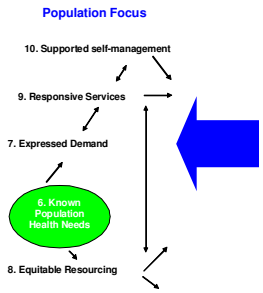
- Is accurate pregnancy and alcohol misuse data collected from the acute trust and has a similar audit been carried out for the pregnancy service? What is this data and how is it communicated?

7. Alcohol related admissions

- ***Has any analysis been conducted exploring alcohol related visits to ED in addition to alcohol related hospital admissions?*** Has this been explored considering:
  - numbers of visits by time of day
  - condition
  - severity
  - proportion admitted to hospital
  - antecedent behaviour/location
  - frequent attendees?

8. Sharing intelligence

- ***Do the police, ED and trading standards/licensing/probation/domestic abuse/ safeguarding children's boards and youth services routinely share intelligence to target interventions? Are hotspots defined by multi-factorial analysis?***
- ***Has the information been collated, analysed and interpreted for a range of audiences? Which ones?***
- How has the intelligence been disseminated/communicated, and to whom?
- Has it been received by all relevant parties who might use it to support decision-making and action?



7. Expressed demand

Aim for as many people as possible suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.

1. Need based strategy

- Is there a strategy/action plan to relate service provision to need, not just demand? Has market analysis been used to inform:
  - campaigns
  - training of frontline staff
  - community outreach workers
  - commissioning and decommissioning of tier and content of treatment service?

- Has there been a process which maps who is drinking at risk (including increasing-risk) and seeking to address any gaps in provision?

2. Targeting advice

- ***What is available to target alcohol advice to those suffering with identified illness such as depression, hypertension, cardiovascular disease, diabetes, specific liver disease? Are systems in place in:***
  - ***primary care***
  - ***secondary care***
  - ***mental health***
  - ***community care i.e. (falls prevention, elderly care)?***

3. Supporting all who will benefit to enter the appropriate service

- Are women who are pregnant or wishing to become pregnant identified for screening and brief advice? What systems are in place to offer information to pregnant women and those with infants, on the risks of drinking?

- Are perpetrators and those affected by domestic violence screened for alcohol use and referred to services to address alcohol misuse?

- What is available in mental health services for intervention to those in transition from inpatient to community follow-up care and those who have a history of self-harm and are not subject to enhanced care?

- Is there screening and triage function in custody suites? Are there clear referral mechanisms to support this?

4. Raising awareness of services

- Are community advisors/domestic violence workers/health trainers engaged in work with seldom seen, seldom heard groups raising awareness and accessibility to services?

5. Screening tools

- Is there a system used to screen ED attendees (using, for example, Paddington Alcohol Test) presenting with any of the 'Top Ten' reasons for alcohol admission, such as falls, violent injury?

- What systems are in place to enable screening for patients who are unconscious or unwell on attendance?

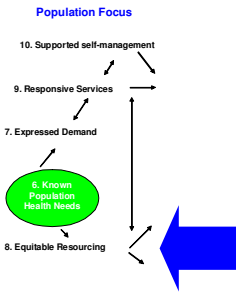
6. Multiple service users

- Are there any established mechanisms (e.g. Multi-Agency Risk Assessment Conference - MARAC) that review those at high risk who are or should be accessing services?

- What systems are in place to deliver brief advice and where appropriate refer to alcohol treatment services to provide a holistic approach to multiple needs?

- Are there any other case management systems to manage the care of other multiple service users?

- Are there formalised links to wraparound support agencies for Housing and Employment? Are these embedded throughout the patient pathway i.e.
  - homelessness, Supporting People, floating support (to sustain tenancies), involving independent housing organisation in particular registered social landlords?
  - Job Centre+, Connextions and other local initiatives?



8. Equitable resourcing

Aim for the distribution of finance and other resources to support equitable outcomes according to need.

1. Services specifications

- ***Are there Local Enhanced Services or service level agreements (SLA) in place to address alcohol harm reduction?***

- ***What proportion of GPs:***
  - ***are delivering IBA***
  - ***have designated Tier 2 advisors***

- ***If so, are they providing systematic coverage according to need rather than willingness of the practice?***

- Do the specifications consider Tiers 1, 2 and 3 interventions separately?

- Are Tier 3 community alcohol treatment resources targeted according to need rather than service 'interest'?

- Does the Tier 3 and 4 provision currently meet the expressed demand? Do you have the capacity to deliver service to 15% of the dependent population?

- How are 'General Practitioners with Special Interest' (GPwSI) used?

2. Capacity distribution to meet need

- Do services (GP practices, pharmacies, ED departments, general wards, maternity services, health visitors and facial surgery units) have sufficient trained (Tier 1 & 2) alcohol harm reduction support staff in place, or are bank staff distributed, to meet need presented by those drinking at increasing or higher-risk and moderately dependent drinking prevalence estimates?

- Is there sufficient capacity to fully implement Alcohol Treatment Requirements? Is this mapped levels of need for, uptake and use of services?

- Is resource allocation for the costs of service provision decided on an agency-by-agency basis, or is it coordinated across the partnership?

3. Funding for AHR treatment services

- Is there adequate, permanent funding for AHR Treatment Services and Coordination?

- How is the partnership planning to mainstream/ support sustainability of alcohol interventions?

4. Acute hospitals

- Do the acute hospital sites have alcohol health workers (AHW)? Do these AHWs include designated leads for:
  - ED and acute ward service for non-dependant drinkers and dependant drinkers
  - case workers for dependant drinkers?

- How are costs of alcohol treatment support covered in, or alongside, tariff costs for secondary care?

5. Commissioning

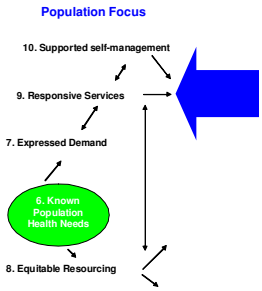
- Where AHR interventions have been/are jointly commissioned with drug treatments, what consideration has been given to the differences in profiles between alcohol and drug service users?

- Are AHR treatment services commissioned with a stepped care approach for:
  - provision of brief intervention not requiring further treatment
  - provision of treatment services for individuals with moderate or severe dependence related problems?

- Do commissioning plans consider the length of time treatment is required for drinkers with chronic problems rather than intensity of treatment?

6. Pregnancy

- Is there an efficient Tier 2 and 3 pregnancy service in place with referral links from midwifery services and ongoing support in both pregnancy and postnatal?



9. Responsive services

When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.

1. Seamless care pathways for all who could benefit

- Is there a clear protocol for seamless continuation of appropriate treatment following hospital discharge?

- Do existing treatment pathways consider the care needs for:
  - Clients with mental health needs? Does this include clear inclusion criteria for acceptance of patients by both mental health treatment and alcohol treatment providers? How does this consider primary and secondary care?
  - poly-substance use?
  - groups requiring special consideration (i.e. homelessness, domestic violence)?

- Where boundaries for commissioning are not coterminous, are there clear pathway agreements which allow referral across boundaries, to support geographically appropriate treatment and minimal fallouts?

- Does the treatment pathway enable equitable access to appropriate treatments where the client:
  - Is not registered with a GP? Is information on how clients can register with a GP with 'open lists' available as part of the referral pathway?
  - Presents to primary care experiencing withdrawal? What is available during anti-social hours?
  - Presents to secondary care experiencing withdrawal? What is available during anti-social hours?

- Are clear integrated care pathways (ICPs) outlining the anticipated course of treatment agreed across partners?
  - Are these plans written into SLAs?
  - Does this consider the distinction of alcohol reduction for harmful/hazardous and abstinence for dependent drinkers?
  - Are pathways supported by clear standardised criteria across all agencies including core assessment packages with well established psychometric properties and include:
    i. coordination of care
    ii. departure planning
    iii. onward referral pathways
    iv. agreed treatment goals?

- Have patient pathways been mapped enabling all patients wishing to enter alcohol treatment fast and efficient access to support? In particular, are all sources of brief intervention linked to direct booking for support?

2. Maximising service uptake and minimising service drop out

- ***Is active 'self matching' to treatment options available in:***
  - ***inpatient vs outpatient treatment***
  - ***one to one vs group setting?***

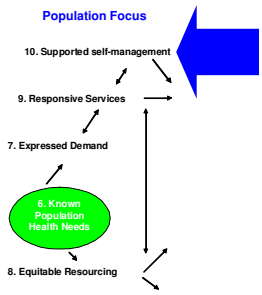
- ***Is there a directory of local services for alcohol misusers available to all frontline staff? Is this routinely disseminated and updated for all appropriate partners?***

- ***What outreach provision is there to minimise barriers to treatment and maintain engagement? Is this available following discharge from secondary care?***

- ***Are drop in centres available for those who have received intervention and may require further support?***

3. Young people

- What systems are in place to support appropriate referral to young people's treatment services? Does this include access points for those not attending school? Does this include:
  - identification of children and young people who display one or more risk factors (e.g. poor school attendance, inconsistent parenting) for alcohol use
  - response to ED attendance
  - is this supported by appropriate transition planning into adult treatment services?



10. Supported self management

Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

1. Prevention and support materials

- Are materials available for the population to understand alcohol misuse?
    - Do these materials define alcohol use in terms of risk rather than harm to enhance understanding (i.e. Lower Risk, Increasing Risk, Higher Risk)?
    - Do these consider matched communication methods to population need (e.g. audio, internet, leaflets)?

- Do materials offer a 'self-help pathway' that allows self identification of drinking risk levels and signposting to further support?

- Are these self-help materials targeted to different audiences
  e.g. 'Drinkcheck' [web-based], 'Your Drinking and You' [booklet], 'Drinkline')?

- Are there support materials available for people with:
    - poor literacy
    - low IQ
    - low vision
    - for young people and older groups?

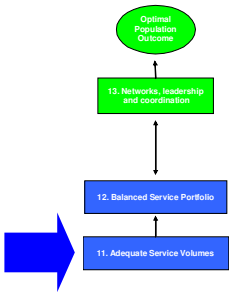
2. Licensing, availability and enforcement[24]

- Have any steps been taken towards designating public places as alcohol-free zones? Has the allocation of the places been established with particular focus on where public drinking and anti-social behaviour is the greatest problem?

- Do licensing agreements encourage social responsibility of drinking? Are licensed premises committed to providing water and reasonably priced soft drinks?

- Are trading standards monitoring and enforcing action on irresponsible promotions and unsustainable low priced drinks and work with licensees to encourage initiatives such as use of polycarbonate and refusal to sell beer in bottles in pubs and clubs? Is this part of a bigger scheme (e.g. NightSafe)?

[24] Evidence to support the use of Interventions on control of alcohol price, promotion and availability for prevention of alcohol use disorders in adults and young people, may be found at: http://www.sheffield.ac.uk/scharr/sections/ph/series.html



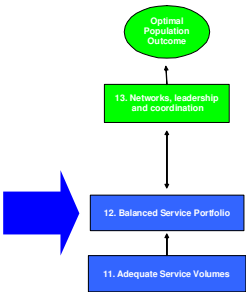
11. Adequate service volumes

Commissioning adequate service volumes to aim for acceptable access times.

1. Planning for changes in service volumes

- Are adequate AHR service volumes commissioned to meet demand and keep waiting times for access down to an acceptable maximum?
  - What is the current wait for Community and Residential Detoxification? Is this the same across all referral routes?
  - Are there any significant delays to screening and referral to treatment programmes?

- Are pathways flexible enough to allow for surges in demand?



12. Balanced service portfolio

Aim for balance of services within pathways to avoid bottlenecks and delays.

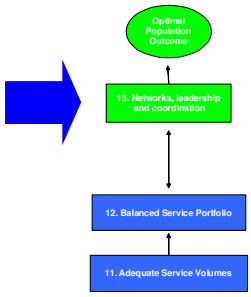
1. Preventing Bottlenecks and Delays

- Are there clear protocols to enable shared care in partnership between staff across tiers (and often across sectors) with clear pathways of care supporting seamless delivery of care to the service user with no bottlenecks?

- Are these protocols explicit regarding communication, sharing of information (with protocols) and consent?

- Are responsibilities for delivery of outputs and outcomes clear?
  - Do these responsibilities extend across whole pathways?

- Does this consider transition planning for young people?



13. Networks, leadership and coordination

Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

1. Networks/Leadership

- Is there a multi-agency alcohol harm reduction alliance/steering group in the area? What are the sub-groups? Who chairs this group?
- How does this alliance/group link with the Health and Wellbeing Partnership, Crime Disorder Reduction Partnership (CDRP) and Children and Young People's Strategic Partnership?
- How does this alliance/group link with the other thematic partners (i.e. economic and regeneration)? What measures are in place to enable this crosscutting theme to be considered across all strategic partnership agendas?
- Where there are separate operational groups are roles clearly defined?
- Does the group consider children and young people? Are maternity leads able to contribute to this group?
- Is there consistent high level chairing of this group?
- Are senior ED physicians supported to attend the CDRP or appropriate group?
- Do stakeholders represent the full breadth of public and voluntary sector?
- Does the alliance/group contain committed alcohol harm reduction advocates and/or named 'champions'? Do these provide sufficient clinical coverage across all hospitals, primary care, anti-social behaviour (including domestic violence), mainstream mental health providers and young people?
- Is there a distinct coordinator/project manager to support delivery of these actions?
- Is there director level ownership for AHR and is there a lead person on the SMT and regular reporting of progress to board?

- Is there a Joint Agency Licensing Committee in place to conduct multi agency visits and address outlets in breach of licensing agreements?

2. AHR Strategy

- Does the alliance/group work to an Alcohol Harm Reduction Strategy? Is this strategy
  - evidence based
  - supported by an action plan
  - supported by timelines and milestones
  - supported by action plan divided into clearly identified roles with names leads?

- To where is performance on the strategy reported?

- What are the key aims of the AHR strategy? To what extent are you on track to achieve them?

- Does the strategy link into and is it informed by regional expertise?

- How does the strategy on Alcohol Harm Reduction feature in other strategies and plans across the partnership (e.g. Supporting People, domestic violence, health inequalities, the Children and Young People's Plan)? What systems are in place to support alignment of these?

3. Commissioning of AHR Services

- Is the AHR Programme jointly commissioned? If not which elements are commissioned by which organisations?
  - Are there pooled budgets for AHR?
  - Is there ring-fenced money for AHR?

- Are all treatments led by one provider? If not how is work coordinated? What protocols are in place for this?

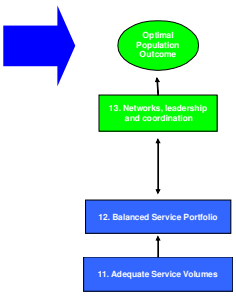
- Where there are cross boundaries what mechanisms are in place for collaborative working with:
  - acute trusts
  - local authorities
  - general practices outside locality footprint?

- How is commissioning of alcohol harm reduction addressed by GP Consortia commissioning?

4. Communication and coordination

- Does the local Alcohol Harm Reduction Alliance have a strong communications network or good links to an active generic one?
  - Does this communications function provide an internal and external communications function for and to all partners?
  - Do external communications link in with national campaigns?
  - Do social marketing programmes draw on regional and local stakeholders to aid implementation?

- Are social marketing campaigns/projects centrally coordinated?



Optimal Population Outcome

Are services being commissioned with the aim of reducing population level mortality from alcohol harm?

1. Are commissioning outcomes measurable by:
   - reduction in alcohol consumption
   - reduction in alcohol dependence
   - reduction in alcohol related health problems
   - reduction in alcohol related social problems
   - general improvement of health and social functioning[25]?

[25] Core strategies and guidance, which support AHR are available at the following website: http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/index.htm

Appendix 1 – Potential key actions to reduce alcohol-related harm

The high impact changes listed here are drawn directly from the guidance produced by the Department of Health in 2010[26]. The work of HINST in running workshops in local areas, using this workbook, has identified a similar list, although, additional areas of change which are investigated through the questioning in the workbook could also be identified as priority actions to reduce alcohol related inequalities in mortality, particularly in the short term. These have been highlighted in sections 1 – 13 of the workbook in ***bold italic*** to help emphasise the need to pay these questions particular attention during the running of the workshop.

Appendix 4 of the Department of Health guidance 'provides a 'how to' manual, designed to assist, guide and ultimately lead to reduced alcohol-related hospital admission and alcohol harm, strengthening the ability and capacity of local alcohol systems to make change happen' (Department of Health 2010)[26]

Deleted:[29]

Each of the High Impact changes, listed below includes a description of what the change means, a summary of the evidence which shows it is worth doing and a number of case studies showing how it has been successfully implemented.

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

[26] Department of Health(2010), *Signs for Improvement: Commissioning interventions to reduce alcohol-related harm*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_102813

Appendix 2: Acronyms and Abbreviations

AA	Alcoholics Anonymous
AHR	Alcohol harm reduction
AHW	Alcohol health workers
ATR	Alcohol Treatment Requirement
CDRP	Crime Disorder Reduction Partnership
DAAT	Drug and Alcohol Action Team
DES	Directed Enhanced Service
DNA	Did Not Attend
ED	Emergency Department
GPwSI	General Practitioners with Special Interest
IBA	Identification and Brief Advice
ICPs	Integrated Care Pathways
JSNA	Joint Strategic Needs Assessment
LA	Local authority
LAPE	Local Alcohol Profiles for England
LES	Local Enhanced Service
LSP	Local strategic partnership
MARAC	Multi-Agency Risk Assessment Conference
NATMS	National Alcohol Treatment Monitoring System
NI	National Indicator
NWPHO	North West Public Health Observatory
PASS	Proof of Age Standards Accreditation Schemes
PPI	Patient and public involvement
QIPP	Quality, Innovation, Productivity and Prevention
SMT	Senior management team
VS	Vital Signs