

Signs for improvement – commissioning interventions to reduce alcohol-related harm



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Executive summary

1 About this guidance

This guidance is designed to direct commissioners in areas where tackling alcohol harm is an identified priority, to the resources and good practice guidance, which will assist them in commissioning interventions to reduce the harm caused by alcohol in their local community. It offers ways to improve commissioning, looking at each World Class Commissioning competency and all stages in the commissioning cycle.

2 Background

*Safe. Sensible. Social. The next steps in the National Alcohol Strategy*¹, published in June 2007, sets out the Government's agenda on alcohol misuse. Several local areas have conveyed the need for guidance around commissioning services to meet local alcohol-related need and this document is intended to assist PCTs to commission interventions to reduce the harm caused by alcohol misuse and, in doing so, to reduce alcohol-related hospital admissions.

3 Why a focus on alcohol-related harm

Excessive drinking is a major cause of disease and injury, accounting worldwide for 9.2% of disability-adjusted life years with only tobacco smoking and high blood pressure as higher risk factors. For the NHS alone, the estimated financial burden of alcohol misuse is around £2.7 billion² in hospital admissions, attendance at A&E, primary care, etc. Health inequalities are clearly evident as a result of alcohol-related harm where Department of Health analysis of ONS data indicates that alcohol-related death rates are about 45% higher in areas of high deprivation³.

1 *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*, Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport, 2007 Gateway 8079.

2 *The cost of alcohol-related harm to the NHS in England*, Department of Health. 2008.

3 *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*, Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport, 2007 Gateway 8079.

4 Commissioning to improve the outcome for people at risk of alcohol-related harm

This section explores the important partnerships and commissioning actions to reduce alcohol-related harm. It proposes the outcomes to be achieved and specific approaches in commissioning, such as the Joint Strategic Needs Assessment (JSNA), which have been identified as offering opportunity for targeting local action and commissioning priorities based on evidence of effectiveness.

4.1 Commissioning for outcomes

Partnerships will need to commission outcomes. MoCAM⁴ describes the overall outcomes sought (to the individual, to others directly affected by their behaviour and to the wider community) and an improvement in the health and social functioning of the alcohol misuser. However, these goals are usually measured through progress towards measurable outcomes in the following domains:

- **reduction of alcohol consumption** – this may be an abstinence goal or a moderation goal
- **reduction in alcohol dependence**
- **amelioration of alcohol-related health problems** – such as liver disease, malnutrition or psychological problems
- **amelioration of alcohol-related social problems** – such as family and interpersonal relationships, ability to perform effectively at work, avoidance of criminal activity
- **general improvement in health and social functioning.**

4.2 Delivery through Partnerships:

The partnership forums to reduce alcohol-related harm are described and associated key deliverables outlined as below.

JSNA element specific to alcohol-related harm:

Through collaboration between the relevant partners, develop the JSNA to specifically understand the needs of alcohol-related harm. Clarify the impact arising across agencies from alcohol-related harm and the known expenditure through prevention and treatment.

4 *Models of care for alcohol misusers (MoCAM), Best Practice Guidance, National Treatment Agency for substance misuse Department of Health, Gateway 5899*

Set strategic priorities as appropriate:

Agree the appropriate partnership response to the needs and determine any strategic priorities for alcohol-related harm.

Commission across the spectrum:

PCTs will want to determine how they will undertake a joined up commissioning approach, which is resourced to a level that ensures needs assessment, strategic planning and implementation in contracting and performance review. The approach and governance will need to interface with other PCT commissioning functions and attain optimum collaboration with other local strategic partnerships such as the Crime and Disorder Reduction Partnership (CDRP). It is important to ensure the commissioning teams have the scope and skill to commission processes that support and identify people at risk from harm as well as those who are already experiencing harm and may require specialist services.

Develop the necessary information sharing protocols and agreed data sources:

Commissioners will benefit from building into contracts/SLAs specifications on data collection and sharing. This will ensure that relevant data are available for performance management and JSNA. Consideration should be given to data which will benefit other partners in their planning to reduce alcohol-related harm e.g. data from A&E concerning violent crime hotspots and monitor progress of initiatives.

4.3 High Impact Changes

The Department of Health has identified a number of High Impact Changes which are detailed in Appendix 4. This section identifies those which have the greatest impact on health commissioned outcomes and suggests some recommended actions for areas where tackling alcohol-related harm has been identified as a priority. These are laid out below.

- **Improve the effectiveness and capacity of specialist treatment:** Ensure the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in the PCT area.
- **Appoint an Alcohol Health Worker(s):** Commission an adequate number of Alcohol Health Workers or Alcohol Liaison Nurses to work across the acute hospitals.

- **Identification and Brief Advice (IBA) – Provide more help to encourage people to drink less:**

In primary Care:

- **New registrants;** Commission identification and brief advice as per the Directed Enhanced Service (DES) for all newly registered patients.
- **At risk groups;** Consider extending coverage through a Local Enhanced Service (LES) in primary care to additional at risk groups such as all men aged 35-54 or those patients on existing QOF registers.

In hospital settings:

- **IBA in A&E and specialist units (e.g. fracture clinics):** Commission a specialist alcohol nurse linked to every accident and emergency unit where there is apparent local need.
- **Amplify national social marketing priorities:** Commission local social marketing activity which builds on the evidence, strategy and tools provided by the national social marketing programme. Ensure this promotes the local available service response.

5 World Class Commissioning Competencies and the Commissioning cycle

The commissioning cycle is utilised in this section of the document, to identify appropriate actions to secure good health outcomes for interventions to reduce alcohol harm. This section draws upon those areas of effective action for alcohol-related-harm outlined in section 4 and shows how these can be delivered in the commissioning cycle. There are three phases to the commissioning cycle covering:

5.1 Phase 1: Strategic planning

In order to assess local needs in relation to alcohol-related harm, PCTs and their partners will need to build a picture of local alcohol harm and its particular impact on the community. The tools available to PCTs to support this process are described. The priorities for commissioning interventions to reduce alcohol-related harm determined in the process outlined will flow into the overall PCT strategic plans, LSP and where relevant the LAA .

5.2 Phase 2: Specifying service outcomes and procuring services

This stage will set out a clear, compelling vision of what the PCT wants alcohol services to look like in the future. The service model will be based on the achievement of outcomes known from best practice resources which are

referenced. A full understanding of the market, agreement on procurement routes to address gaps and the selection of providers supported by contracts and grants concludes this phase. The measurement of progress will feature in contracted service specifications and grant allocations. Potential output measures are suggested alongside outcomes.

5.3 Phase 3: Managing demand and performance

This phase involves equipping clinicians for decision making, regular monitoring of performance and intervening early when performance suggests that outcomes may suffer. This requires measuring delivery against particular standards and outcomes, reviewing agreed use of resources and whether service responses are targeted as effectively as possible against priorities. The document proposes the components of a comprehensive performance approach.

6. Conclusion

This document explores the commissioning cycle and the key actions in commissioning that will make a difference in preventing alcohol-related harm. The stages in moving to World Class Commissioning have been illustrated describing the key outputs from each phase of the commissioning cycle where best practice is being exhibited.

Best practice alcohol-related harm specific outputs

1. Strategic planning: Understanding the need and service responses.
 - Joint Strategic Needs Assessment
 - Analysis of service provision and related expenditure
 - Set of jointly agreed priorities for action
 - Programme plan to deliver
2. Specifying outcomes and procuring services: Creating the service model.
 - Service Vision
 - Care pathways
 - Market analysis including understanding of any gaps or areas for decommissioning
 - Agreed approach to addressing any gaps/decommissions
 - Contracts and grant agreements for all Providers with clear financial agreement, specifications, incentives and are measurable

3. Managing demand and performance: Holding the service providers to account.

- Clinician training and support materials
- Provider Performance management framework including escalation policy
- Routine process for performance management reports
- User feedback and other qualitative information to inform throughout the year and also future years JSNA, commissioning and contracting round
- Minimum standards in contracts shown as delivered and progress demonstrable in Aspirational standards
- Evidence that the PCT is moving towards improved outcomes

To support PCTs and their partners in commissioning to improve outcomes in alcohol-related harm the Department of Health has implemented the Alcohol Improvement Programme involving the following elements:

Early implementation programme

20 PCTs, from those with the greatest level of alcohol-related hospital admissions have become Early Implementer sites for the Alcohol Improvement Programme. The PCTs are supported with additional funding to allow them to lead the way in implementing the high impact changes.

Alcohol Interventions Improvement Centre

To support Local partners in reducing alcohol harm the Department of Health has developed the Alcohol Interventions Improvement Centre that has two main functions:

- **Alcohol Learning Centre** as a repository of tools, guidance and the practice taking place to tackle alcohol-related harm.
- **Improvement Support**, working through Regional Alcohol Offices – the programme provides advice and support to PCTs on a wide range of improvement activities.

Regional Alcohol Offices

The Regional Public Health Groups have been resourced to facilitate regional delivery of reduced alcohol-related hospital admissions and are establishing Regional Alcohol Offices or Regional Alcohol Managers who will be responsible for the link between Strategic Health Authorities, Government Offices, Local Authorities and the Department of Health.

National Support Team

The Alcohol Harm Reduction National Support Team will support PCTs and their partner organisations in areas with the highest rates of alcohol-related hospital admissions to review their commissioning and delivery systems for alcohol harm reduction and identify what improvements can be made.

Screening and Intervention Programme for Sensible Drinking (SIPS)

SIPS is a 2 year research programme led by the Institute of Psychiatry, University of London and Newcastle University, to provide additional evidence, support and improve implementation of alcohol identification and the delivery of brief advice.

1. About this guidance

The Vital Signs indicator VSC26 sits in the third tier of the NHS indicator framework and as such, prioritising action to tackle alcohol-related harm is a local decision for PCTs. However in 2008/9 roughly two thirds of PCTs had included the indicator as a priority in their local operating plans. The following guidance is designed to direct commissioners to the resources and good practice guidance, which will assist them in commissioning interventions to reduce the harm caused by alcohol in their local community. The guidance will help commissioners to appropriately identify needs and commission services in line with the commitment to patient choice and local priority setting encompassed by Commissioning for Health and Wellbeing⁵ and the competencies described in World Class Commissioning⁶.

Most of the resources described in this document have been brought together in the **Alcohol Learning Centre**⁷ a one-stop shop for data, tools and guidance to support local areas in reducing alcohol-related harm.

Primary Care Trusts (PCTs) are responsible for commissioning for health outcomes on behalf of their local population and are working towards the aspirations of World Class Commissioning. This document forms part of a suite of approaches in the World Class Commissioning programme designed to support the development of capability in PCTs. It offers ways to improve commissioning looking at each World Class Commissioning competency and all stages in the commissioning cycle.

5 *Commissioning Framework for health and well-being*, Department of Health, 2007, Gateway 7361

6 <http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm>

7 <http://www.alcohollearningcentre.org.uk/>

2. Background

*Safe. Sensible. Social. The next steps in the National Alcohol Strategy*⁸, published in June 2007, sets out the Government's agenda on alcohol misuse. This includes a focus on a reduction in alcohol-related violent crime, disorder and antisocial behaviour and a reduction in chronic and acute ill-health, with fewer alcohol-related accidents and hospital admissions measured by Hospital Episode Statistics (HES) data.

Recent strategic planning through World Class Commissioning has placed addressing alcohol-related admissions as a highly ranked local outcome priority having been selected by 75 PCTs. Prevention of alcohol-related harm is appearing as one of the 10 most frequently chosen outcome measures across England for PCTs. This local recognition of the impact of alcohol-related harm will begin to address the concerns expressed in the 2008 National Audit Office (NAO) report⁹ that *"local strategies are lacking, or inadequate, in many areas and service delivery is fragmented, with resources allocated based on an incomplete picture of need. Service provision has, as a consequence, varied widely, both in type and degree of provision"*.

Several local areas have conveyed the need for guidance around commissioning services to meet local alcohol-related need and this document is intended as supportive, good-practice guidance to assist PCTs in respect of the harm caused by alcohol misuse and, in doing so, to reduce alcohol-related hospital admissions.

8 *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*, Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport, 2007 Gateway 8079

9 *Reducing Alcohol Harm: health services in England for alcohol misuse*, National Audit Office, 2008

3. Why a focus on alcohol-related harm?

3.1 The case for change

The estimated £18 billion to £25 billion¹⁰ a year cost of alcohol misuse spans alcohol-related disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace and problems experienced by those who misuse alcohol and their families. For the NHS alone, the estimated financial burden of alcohol misuse is around £2.7 billion¹¹ in hospital admissions, attendance at A&E and in primary care. Alcohol-related illness or injury accounts for 863,000 hospital admissions per year. Recent studies suggest that alcohol treatment has both short and long-term savings and analysis from the UKATT Study suggests that for every £1 spent on treatment, the public sector saves £5¹².

Many of those injured as a result of alcohol-related crime and disorder are likely to present, in the first instance to A&E departments. In 2007/08, 22.6% of all attendances at major A&Es resulted in an admission, an estimated 13% of admissions via A&E are alcohol-related and 52% of all alcohol-related admissions come via A&E. There are also health impacts on victims of alcohol-related crime and disorder such as domestic abuse, assault or drink-driving and many who repeatedly commit alcohol-related crime and disorder may be involved in a pattern of drinking which could be increasing risks to their long-term health.

The impact of alcohol misuse is so widespread in local communities that large-scale action to reduce alcohol-related harm is likely to also have a positive effect on other priorities and targets by, for instance:

- improving liver health
- reducing the incidence of CHD, liver disease, hypertension and some cancers
- reducing teenage pregnancy and STI incidence

¹⁰ *Safe. Sensible. Social. – consultation on further action impact assessment*, Department of Health, 2008, Gateway 10209,

¹¹ *The cost of alcohol-related harm to the NHS in England*, Department of Health, 2008), Gateway 10277

¹² UKATT Research Team (2005). *Cost-effectiveness of treatment for alcohol problems: Findings of the UK Alcohol Treatment Trial*. *British Medical Journal*, 331:544–547.

- reducing the incidence of domestic violence
- reducing health inequalities.

There are links between high levels of youth alcohol consumption and other risk factors such as youth offending, teenage pregnancy, truancy, exclusion and illegal drug misuse, but the precise nature of this relationship is not fully understood¹³.

- Among 10–15-year-olds, being drunk once a month or more in the last 12 months increases the likelihood of offending
- Among 14–15-year-olds, those who have drunk in the last month are more likely to engage in sexual activity.

3.1.1 Alcohol and Health Inequalities

The most deprived fifth of the population of the country suffer two to three times greater loss of life attributable to alcohol; three to five times greater mortality due to alcohol specific causes; and two to five times more admissions to hospital because of alcohol than those in more affluent areas¹⁴.

The data are starting to identify effects of alcohol misuse in very specific groups, allowing for targeted activity:

- The most deprived lifestyle group – the Urban Challenged¹⁵ group – have four to fifteen times greater alcohol-specific mortality and up to ten times greater alcohol-specific admission to hospital
- New Starters – young, highly qualified but low income young people – are showing higher levels of harm (mortality, life lost and admission to hospital due to alcohol use) than would be expected from deprivation alone
- Those at highest risk of being admitted to hospital with a primary or secondary diagnosis that was linked to alcohol are men aged over 35 who work in an unskilled or manual field or are unemployed.
- Half of homeless people are dependent upon alcohol.

13 *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*, Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport, 2007 Gateway 8079

14 *Indications of Public Health in the English Regions 8: Alcohol*, Association of Public Health Observatories, 2007, page 6, paragraph 3.

15 The report “*Indications of Public Health in the English Regions 8: Alcohol*” uses “People & Places”, a geodemographic classification built by Beacon Dodsworth, in partnership with the Department of Civic Design at the University of Liverpool who created Super Profiles, using 2001 Census data.

- Psychiatric co-morbidity is common among problem drinkers – up to 10% for severe mental illnesses, up to 50% for personality disorders and up to 80% for neurotic disorders
- For women living in the most deprived areas, alcohol-related death rates are three times higher than for those living in the least deprived areas
- For men living in the most deprived areas, this is even worse: alcohol-related death rates are over five times higher than for those living in the least deprived areas.

Of particular interest to PCTs are:

- Excessive drinking is a major cause of disease and injury, accounting worldwide for 9.2% of disability-adjusted life years (DALYs) with only tobacco smoking and high blood pressure as higher risk factors¹⁶.
- The 2007/08 figures show that there were 863,000 NHS hospital admissions in England with either a primary or secondary diagnosis wholly or partly related to alcohol.
- Evidence suggests that rates of disease associated with alcohol are increasing: the most common alcohol-related cause of death, alcoholic liver disease, killed 4,160 people in 2005, an increase of 20% (from 3,464) since 2001.
- Months of life lost and mortality attributable to alcohol are typically increasing in the North East, North West and Yorkshire and The Humber, but decreasing or remaining static in the East of England, London and the South East.

Men who regularly drink more than 8 units a day and women who drink more than 6 units a day raise their risk of having various diseases, as shown in Table 1.

Table 1: Increased risks of ill health to harmful drinkers

Condition	Men (increased risk)	Women (increased risk)
Hypertension (high blood pressure)	Four times	Double
Stroke	Double	Four times
Coronary heart disease (CHD)	1.7 times	1.3 times
Pancreatitis (inflammation of the pancreas)	Triple	Double
Liver disease	13 times	13 times

Source: Anderson P. (2007) The scale of alcohol-related harm. (Unpublished) Department of Health.

¹⁶ World Health Organization (2001). Geneva: WHO; *World Health Report*

Because drinking is generally socially tolerated and because problems such as liver disease and high blood pressure may not show any symptoms until serious damage has occurred, the harm to health is often well established before intervention is made.

3.2 Trend in alcohol-related hospital admissions in England

All regions show an increase in rates of alcohol-related hospital admission over the period 2003–2007. The increases are greater in the West Midlands and London for both males and females than in other regions. Concern about the number of alcohol-related hospital admissions and the rising trend (around 73,000 per year over the five years to 2006–07) led the Department of Health to put in place a new national Vital Signs indicator VSC26 for the NHS from April 2008 that will measure change in the rate of alcohol-related hospital admissions. This signals a significant national commitment to monitor how well the NHS is tackling alcohol-related health harm.

Figure 1 – Trend in alcohol-related hospital admissions in England



The categories of *Hospital Episode Statistics* (HES) data chosen to make up the alcohol-related hospital admission indicators (VSC26/NI39) are considered to be sensitive to a range of alcohol misuse prevention and treatment interventions, and will form the basis for measuring the impact of local actions. Improved prevention and treatment interventions will be expected to have a clear impact on the rate of alcohol admissions.

3.3 The cost of alcohol-related harm to the NHS

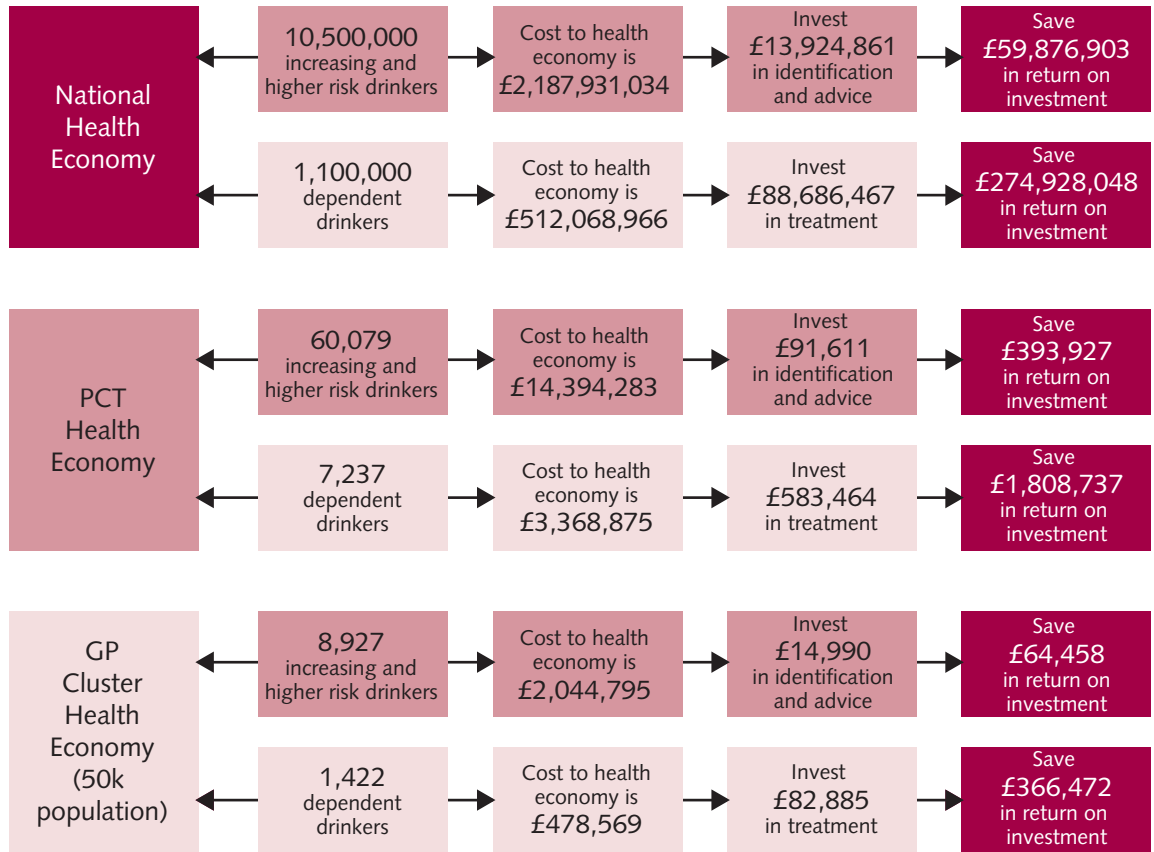
It is estimated that the annual cost of alcohol harm to the NHS in England is £2.7bn in 2006/7 prices. This is broken down as follows:

Cost Estimate (£m) (7.6 million people drinking at “increasing risk” levels, 2.9 million people drinking at “higher risk” levels)	
Hospital inpatient & day visits	
– Directly attributable to alcohol misuse	167.6
– Partly attributable to alcohol misuse	1,022.7
Hospital outpatient visits	272.4
Accident and emergency visits	645.7
Ambulance services	372.4
NHS GP consultations	102.1
Practice nurse consultations	9.5
Laboratory tests	N/A
Dependency prescribed drugs	2.1
Specialist treatment services	55.3
Other health care costs	54.4
Total	2,704.1

Source: “The cost of alcohol harm to the NHS in England: An update to the Cabinet Office (2003) study”:
DH July 2008

The figure below demonstrates the types of resource impacts that a PCT (based on an average PCT population of 350,000) or GP cluster (50,000 population) could expect from investing in alcohol-related harm. The levels of investment are illustrative based on average spend and do not reflect expectations.

Total population



4. Commissioning to improve the outcome for people at risk of alcohol-related harm

A reduction in alcohol-related harm will only be achieved through understanding and responding to needs. PCTs are responsible for identifying health need and commissioning alcohol health interventions. Local population needs will most effectively be understood across partnerships, thereby ensuring the full range of appropriate services are commissioned.

This section explores the important partnerships and commissioning actions to reduce alcohol-related harm. Specific approaches in commissioning have been identified as offering greatest effectiveness. These high impact changes are described below.

4.1 Commissioning for outcomes

Any partnership will need to commission outcomes. MoCAM¹⁷ describes the overall outcomes sought (to the individual, to others directly affected by their behaviour and to the wider community) and an improvement in the health and social functioning of the alcohol misuser. However, these goals are usually measured through progress towards measurable outcomes in the following domains:

- **reduction of alcohol consumption** – this may be an abstinence goal or a moderation goal
- **reduction in alcohol dependence**
- **amelioration of alcohol-related health problems** – such as liver disease, malnutrition or psychological problems
- **amelioration of alcohol-related social problems** – such as family and interpersonal relationships, ability to perform effectively at work, avoidance of criminal activity
- **general improvement in health and social functioning.**

¹⁷ *Models of care for alcohol misusers (MoCAM), Best Practice Guidance*, National Treatment Agency for substance misuse Department of Health, Gateway 5899

4.2 Delivery through Partnership

Local Strategic Partnerships (LSPs) – or Local Area Agreement (LAA) partnerships in two-tier areas – are best placed to plan a comprehensive, integrated and inclusive approach which takes into account all of the different ways alcohol impacts on local people and communities. The appropriate supporting structure to the LSP will oversee the full extent of partnership action and the PCT will need to show leadership and influence in each of the following:

Health and Well-being

Local authorities and PCTs share a responsibility to improve health and well-being. Local authorities and PCTs are required to produce a Joint Strategic Needs Assessment of the health and social care needs of their local population. In line with NAO findings the PCT will wish to consider including specific understandings of alcohol-related harm within the JSNA.

Crime and Disorder Reduction Partnership (CDRP)

The PCT is a statutory member (along with Local Authorities and Police) in the local Crime and Disorder Reduction Partnership. The partnership includes a requirement¹⁸ to carry out annual strategic assessments that assess the impact of alcohol misuse on crime and disorder and prepare a three year strategy for the reduction of crime and disorder and for combating substance misuse in the area. 'Substance misuse' explicitly includes alcohol. The plan is to be revised at the beginning of each year.

These CDRP strategic assessments will provide valuable information on local alcohol harms and combined with the access to the collective skills of partners they can be used to secure the most comprehensive and effective means of response. Plans to provide services for offenders and re-offenders can be developed as part of this partnership. These teams can use the full range of powers available to them to deal with irresponsible licensed premises and criminal and disorderly behaviour and provide the local infrastructure to support management of the night-time economy.

¹⁸ Strategic instrument SI 1830: The Crime and Disorder (Formulation and Implementation of Strategy) Regulations 2007.

Children's Trusts and Children and Young People's Strategic Partnerships

Children's Trusts and local Children and Young People's Strategic Partnerships, in association with the Drug and Alcohol Action Team, are responsible for addressing the needs of young people and their families where alcohol is a consideration. They may, for example, tackle issues such as the prevalence and impact of underage drinking, and take action to tackle alcohol problems that contribute to poor educational attendance and attainment or teenage pregnancies.

Economic partnerships

Whilst Local economic partnerships may focus on the economic benefits of the night-time economy, potential impact on this local economy from economic losses or impact of crime means the PCT can find the economic partnership a valuable vehicle in action against alcohol-related harm.

Drug and Alcohol Action Teams (DAAT)

Drug and Alcohol Action Teams are local partnerships of professionals from local authorities, PCTs and other public bodies such as, the police or probation service. In some cases, PCTs will deliver some of their responsibilities for commissioning alcohol interventions via DAAT commissioning teams.

In it's report the NAO identified that "PCTs have often looked to their local Drug and Alcohol Action Teams to take the lead in commissioning services to tackle alcohol harm, but these bodies focus primarily on specialist services for dependent users of illegal drugs and alcohol. They are not equipped to meet the needs of the much larger groups of 'hazardous' [increasing risk] and 'harmful' [Higher risk] alcohol misusers... ..Furthermore, many Drug and Alcohol Action Teams do not have the direct links with or experience in primary or acute (hospital) care to commission effective alcohol interventions in these areas."

Local Area Agreements

Since 2008, LAAs have become the central 'delivery contract' between central government and local government and its partners. LAAs provide the opportunity to work in partnership with local government to identify clear expectations for local partnerships to tackle alcohol-related harm. Alcohol is increasingly being reflected within LAAs with more local partnerships setting targets to reduce alcohol-related crime or hospital admissions.

Recommendations for commissioning through Partnerships:

JSNA element specific to alcohol-related harm:

Through collaboration between the relevant partners, develop the JSNA to specifically understand the needs of alcohol-related harm. Clarify the impact arising across agencies from alcohol-related harm and the known expenditure through prevention and treatment.

Set strategic priorities as appropriate

Agree the appropriate partnership response to the needs and determine any strategic priorities for alcohol-related harm.

Commission across the spectrum:

PCTs will want to determine how they will undertake a joined up commissioning approach which is resourced to a level that ensures needs assessment, strategic planning and implementation in contracting and performance review are all achieved. The approach and governance will need to interface with other PCT commissioning functions and attain optimum collaboration with the CDRP and DAAT. It is important to ensure the commissioning teams have the scope and skill to commission processes which support and identify people at risk from harm as well as those who are already experiencing harm and may require specialist services. Appendix 1 describes the full spectrum of understanding of the way people drink in England and will be useful to ensure the partnership has considered the full population risk.

Develop the necessary information sharing protocols and agreed data sources

Commissioners will benefit from building into contracts/SLAs specifications on data collection and sharing. This will ensure that relevant data are available for performance management and JSNA. Consideration should be given to data which will benefit other partners in their planning to reduce alcohol-related harm and monitoring progress of initiatives. Data sharing protocols will be important to support this work and provide public confidence on anonymity, data security and protection.

Tower Hamlets PCT: practice example

The DAAT, which is the lead commissioner for substance misuse in Tower Hamlets, has been strengthening its collaborative work. Tower Hamlets PCT prioritised prevention of alcohol-related harm in the Operating Plan for 2008/09 and has helped to mainstream substance misuse issues by linking these into core planning of commissioning in the PCT. Local work began on strengthening the Public Health role in commissioning through developing an Inner London Health Intelligence Unit across City and Hackney, Newham and Tower Hamlets PCTs. Public health now fully involved in the CDRP and the DAAT.

To strengthen the service response in alcohol-related harm the PCT identified the following priorities

- Overview & scrutiny review of young people & alcohol
- Alcohol LES
- Alcohol Social Marketing
- Re-tender of Enhanced Community Alcohol Service
- A&E diversion intervention
- Forthcoming alcohol NST Support visit
- Young People Alcohol Health Improvement Officer
- Alcohol Public Health Strategist

The PCT is also gaining a greater understanding of local residents through a health and lifestyle survey. This includes three questions around alcohol based on the on Audit-C screening tool. The survey has been undertaken by MORI and will report in June 2009. The PCT is currently developing a social marketing campaign directed mainly at adults.

Citysafe: practice example

In a partnership between local A&E departments, the police and Liverpool John Moores University, Citysafe has been promoting increased data sharing regarding alcohol-related assaults in the city. The data from A&E departments is helping Citysafe to target hotspot locations and bars. In turn, such activity is beginning to produce a reduction in the number of referrals to A&E departments. This package of initiatives has helped to reduce assaults, robbery and antisocial behaviour by over 28% in the city centre compared with last year. The overall figures represent the lowest in the centre for 10 years.

4.3 High Impact Changes

The Department of Health has 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 (Appendix 4).

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 first three High Impact Changes are necessary enabling actions that set the scene for success. The latter four changes are services and activities that can be commissioned that are calculated to impact most effectively on alcohol-related harm and reduce the rate of rise in alcohol-related admissions.

- **Improve the effectiveness and capacity of specialist treatment:** The evidence suggests that a dependent drinker costs the NHS twice as much as other drinkers and that the largest and most immediate reduction in alcohol-related admissions can be delivered by intervening with this group through the provision of specialist treatment. The UK Alcohol Treatment Trial (UKATT) shows that, over a 6-month period, specialist treatment delivered savings of nearly £1138 per dependent drinker treated – nearly 40% of drinkers showed a 'much improved' outcome (reduction in problem by 2/3 or more). We estimate that for every additional £1m invested in appropriate levels of accessible, evidence-based treatment, up to 1,200 alcohol-related hospital admissions could be averted.

The North American model developed by Rush (1990), regards an access level of 1 in 10 (10%) alcohol dependent individuals entering treatment per annum as a 'low' level of access, 1 in 7.5 (15%) 'medium' and 1 in 5 (20%) 'high'.

Recommendation: Ensure the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in the PCT area.

Implications for commissioning

Given the evidence of effectiveness, rapid impact on admissions and savings from specialist treatment the commissioners will need to ensure they have sufficient capacity and quality of services available to provide for specialist treatment for at least 15% of the dependent population. The review of service provision (described in 5.1.2) by the PCT can scope current capacity to match to the minimum recommendations. The estimation of dependent drinkers can be established using the dataset from the NWPHO as part of the JSNA (see 5.1.1).

*The Review of the Effectiveness of Treatment for Alcohol Problems*¹⁹ (NTA 2006) demonstrates there is a range of effective treatments to suit the variety of potential service users, with evidence indicating that those based on cognitive behavioural approaches offer the best chance of success. Whilst increasing risk and higher risk drinkers are likely to benefit from brief advice given by generic workers in almost any setting, dependent drinkers may require more intensive treatment given by specialist workers. Interventions of all kinds are only effective if delivered in accordance with their current description of best practice and carried out by a competent practitioner. Commissioners will need to ensure this evidence-based approach is secured through the contracting process described in section 5.2.2.

¹⁹ http://www.nta.nhs.uk/publications/documents/nta_review_of_the_effectiveness_of_treatment_for_alcohol_problems_fullreport_2006_alcohol2.pdf

Nottingham Drug and Alcohol Treatment Systems Review: practice example

Commencing in 2008, Nottingham conducted a review of their treatment services to ensure compliance with national guidance, relevance to local need and increased effectiveness of the treatment systems.

The first stage of the review has generated the general principles for a new model for the drug and alcohol treatment system. The proposed new treatment model aims to address these problems by:

- streamlining routes into treatment
- delivering interventions in line with clinical guidelines
- providing treatment options relevant to local need
- developing stronger more efficient care coordination
- maximising client choice
- developing integrated care pathways to create clear and effective pathways of care
- expanding alcohol interventions for hazardous and harmful drinkers

HubCAPP

Link: QTMX

www.hubcapp.org.uk/QTMX

For more information on this High Impact Change and further examples of practice, see Appendix 4.

- **Appoint an Alcohol Health Worker(s):** The Royal College of Physicians recommend that every acute hospital have an Alcohol Health Worker or an Alcohol Liaison Nurse to manage patients with alcohol problems within the hospital and liaise with community services. A study in Liverpool has indicated that this service saved 15 admissions or re-admissions per month and acted as a focus for other alcohol-related support.

Recommendation: Commission an adequate number of Alcohol Health Workers or Alcohol Liaison Nurses to work across the acute hospitals

Implications for commissioning

Given the possible effectiveness of this intervention, this could have a rapid impact on admissions and re-admissions.

The Royal Liverpool Hospital Lifestyles Team: practice example

The Lifestyles Team was set up when staff at the Royal Liverpool Hospital realised the size of the burden that alcohol-related attendances placed on the hospital. One third of admissions to intensive treatment units and 12% of attendances in the accident and emergency (A&E) department were directly attributable to alcohol. They found that employing an alcohol specialist nurse in the A&E department to assess patients prevented unnecessary admissions to the hospital and encouraged better patient education and links with other services. This service saved an estimated 150 admissions per year resulting in substantial cost savings to the hospital. Preventing the admission of as few as 30 patients could cover one year's salary for the alcohol specialist nurse. The scheme was also shown to improve clinical practice and patients' satisfaction and to increase the confidence and skills of nurses caring for these patients. Significant reductions in alcohol consumption by increasing-risk and higher-risk drinkers and reductions in the use of healthcare by dependent drinkers were also recorded.

HubCAPP**Link: TUL3**www.hubcapp.org.uk/TUL3

For more information on this High Impact Change and further examples of practice, see Appendix 4.

- **IBA – Provide more help to encourage people to drink less: Primary Care:** Department of Health commissioned research²⁰ describes how intervening with men aged over 35 who regularly drink over 50 units could reduce alcohol-related admissions nationally by 13,000 over three years; this group of drinkers is shown to contribute greatly towards alcohol-related hospital admissions. From April 2008 a Directed Enhanced Service (DES) was introduced which requires PCTs to provide alcohol identification and brief advice for all new adult registrants. DH estimates that this will avert 10,000 to 15,000 alcohol-related admissions nationally over a three year period. Some PCTs already plan to develop Locally Enhanced Service arrangements to expand the target group to include, for instance, all men aged 35-54

20 Anderson P. (2007) *The scale of alcohol-related harm*. (unpublished) Department of Health

Recommendation:

New registrants: Implement identification and brief advice as per the Directed Enhanced Service for all newly registered patients

At risk groups: Consider extending identification and brief advice coverage through a Local Enhanced Service in primary care to additional at risk groups such as men aged 35-54 or those patients on existing QOF registers.

Implications for commissioning

New registrants: The DES will run for two years from April 2008 and will reward achievement at the end of the financial year. Practices will be required to screen newly registered patients aged 16 and over using either one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaire to determine lower-risk, increasing risk, higher risk or likely dependant drinking. Following identification, the practice should deliver a brief intervention to those identified as drinking at increasing or higher-risk levels. Dependent drinkers should be considered for referral to specialist services. As part of performance monitoring (see section 5) PCTS can review Practices' audit results and will need to take into account the estimated impact on specialist services. The Primary Care Service Framework for Alcohol provides examples of practice for alcohol interventions and includes pro-forma care pathways²¹.

At risk group: Several PCTs have already found it beneficial to extend their coverage beyond new registrants to give greater coverage for those at those at greater risk. See example opposite.

21 www.primarycarecontracting.nhs.uk/204.php

Bolton PCT: practice example

In April 2008, Bolton PCT launched their alcohol Local Enhanced Service. The initiative is being piloted with 20 local GP practices for a six-month period, prior to it being rolled out across the area. This project aims for the majority of patients at each practice to be screened and provided with basic advice and information about alcohol consumption. Participant practices will also display information in waiting areas about alcohol awareness and local services.

Training for practices is being provided as part of the scheme. This comprises one day's training in behavioural change techniques and motivational skills followed by an additional half day on harmful and hazardous drinking, its impact on health, the alcohol screening tool and onward referral. For more information go to:

HubCAPP**Link: O4SA**www.hubcapp.org.uk/O4SA

For more information on this High Impact Change and further examples of practice, see Appendix 4.

A&E and specialist units (e.g. fracture clinics)

In 2007/08, 22.6% of all attendances at major A&Es resulted in an admission, an estimated 13% of admissions via A&E are alcohol-related and 52% of all alcohol-related admissions come via A&E. The existing evidence base describes a high likelihood of success for interventions delivered in A&E to susceptible patients. It is estimated that one nurse could avert c40 admissions per annum and deliver net savings to the NHS of c£67,000 (having covered estimated salary costs of c£60,000). This is based on an assumption that the case mix for the nurse would involve both planned (clinic appointments) and unplanned work (A&E based interventions). The current research programme (SIPS) is refining the tools and the brief advice interventions that are best offered in A&E.

Recommendation: Commission a specialist alcohol nurse linked to every accident and emergency unit where there is apparent local need to carry out brief advice.

Based on the evidence the PCTs may wish to consider interventions within A&E, fracture clinics and other targeted clinics. This will include training of staff and nurse provision within the department. Alcohol-related attendances can be broadly estimated by considering the 10 conditions most likely to be alcohol-related when presenting in A&E. These are described in the Paddington Alcohol Test (developed at St Mary's).

St Mary's Paddington: practice example

During attendance at St. Mary's accident and emergency department, medical and nursing staff use the Paddington Alcohol Test (PAT) to screen the alcohol consumption of any patients presenting with one of the "top ten" reasons for admission such as falls, collapse, head injury and other medical conditions which are most often associated with alcohol misuse.

For patients who screen as PAT+, referral is made (with the patient's agreement) to the A&E Alcohol Health Work session, which is operated by the Alcohol Nurse Specialist (ANS). During this session the ANS provides a patient-centred assessment of alcohol issues, discusses the impact of alcohol use with the patient and can offer further information or referral aimed at encouraging the patient to reduce their consumption where appropriate. The PAT process carried out by the A&E medic or nurse, also comes with brief advice about drinking,

HubCAPP

Link: GWAQ

www.hubcapp.org.uk/GWAQ

For more information on this High Impact Change and further examples of practice, see Appendix 4.

- **Amplify national social marketing priorities:** Department of Health and Home Office have together invested around £10m in high profile campaigns in 2008/9 and the national programme will continue to roll out until 2011. Local partners may wish to reinforce the national programme with local or regional activity, it will be important to ensure that messages are congruent with the national ones. Campaigns are a vital element of a multi-component strategy in support of other interventions.

Evidence is emerging that in addition to educational campaigns, targeted social marketing efforts aimed at higher-risk drinkers can reduce alcohol-related hospital admissions. Many people who drink harmfully, including dependent drinkers, are able to reduce the amount they drink without needing professional treatment. This is often achieved through self-help or support from family and friends. An important part of this is estimating how much they actually drink and planning how they can reduce this. There needs to be a wide range of ways in which people who want to reduce their drinking can seek help that is appropriate to their needs. These might include helplines, internet-based guidance and self-help or mutual aid groups.

The PCT may wish to develop complementary resources for people who want to reduce their alcohol consumption alongside those that may already exist for people seeking to lose weight or stop smoking, for example. By closely linking its social marketing and new kinds of support for harmful drinkers with the services provided by the local NHS, the PCT can encourage and support people who want to reduce or stop drinking in getting the kind of support or treatment best suited to their needs and motivations.

Recommendation: Commission social marketing activity which builds on the evidence, strategy and tools available through the national programme. Ensure this promotes the local available services response.

Department of Health/East Midlands: Social Marketing practice example

PCTs from East Midlands worked with the Regional Social Marketing Manager to develop a campaign targeting higher-risk drinkers in their area. Building on the lessons learned by the ongoing national alcohol social marketing programme, they launched a multi-media campaign combining direct marketing tailored for their area and locally-sourced advertising and PR.

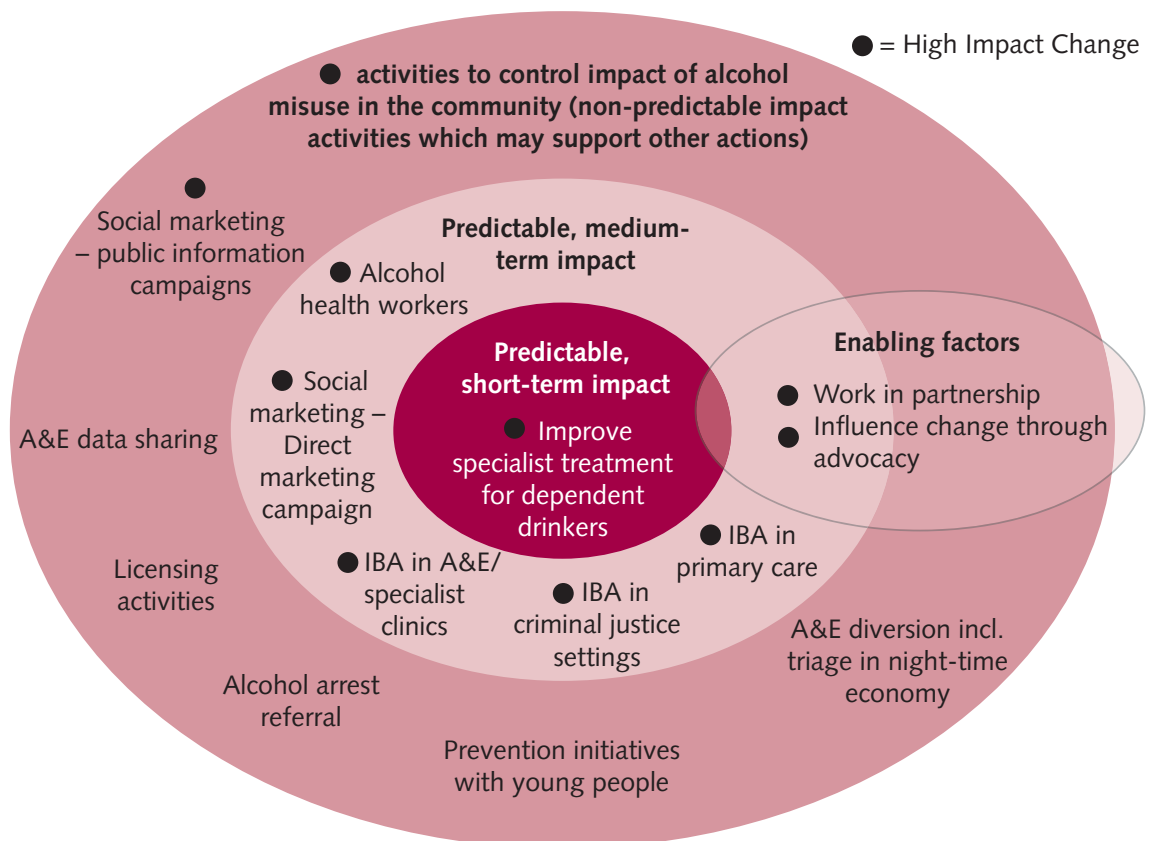
The direct marketing activity not only enabled a further roll out of “virtual IBAs” (see Appendix 4) but also showed where demand for information was coming from. The work is currently being evaluated and will be shared on the Alcohol Learning Centre’s social marketing pages.

For more information on this High Impact Change and further examples of practice, see Appendix 4.

Strategic implementation of High Impact Changes

Individual high impact changes will be less effective if applied in isolation and should be viewed as mutually reinforcing strands in a multi-component approach which need to be implemented in optimal combination, in line with local needs. Evidence also suggests that actions such as improvement of specialist treatment for dependent drinkers will have the most immediate and significant impact on alcohol-related admissions and that IBA in various settings can have a less immediate, but in the longer term, significant and building impact. There will be a number of actions that local areas will have in train, the impact of which are less predictable, due either to lack of evidence for their impact on alcohol-related admissions, or due to their not being targetted at those responsible for the most harm. Regional Alcohol Managers will be able to support PCTs in prioritising the combination of actions which are most likely to deliver the reductions in admissions that they have planned for their local area. The figure below shows the relative impact on alcohol-related admissions from the High Impact Changes and other alcohol-related actions that local areas might be implementing.

Local actions: relative impact on alcohol-related hospital admissions



5. World Class Commissioning competencies and the commissioning cycle

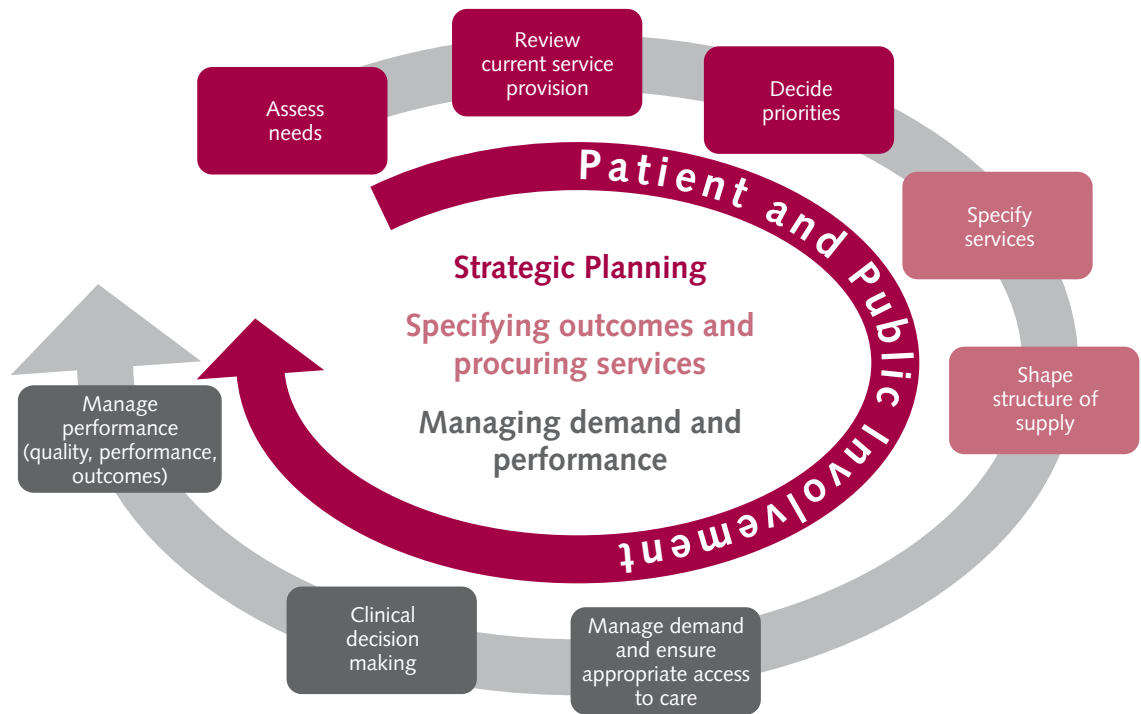
A set of World Class Commissioning competencies has been developed covering the knowledge, skills and behaviours expected to become world class, and an assurance system has been delivered to drive up performance and development in PCTs. PCTs and their partners could cross reference to these 11 competencies as they relate to their commissioning for alcohol services and identify any significant gaps.

The commissioning cycle is used in this section of the document, to identify appropriate actions to secure good health outcomes for interventions to reduce alcohol-harm.

There are three phases to the commissioning cycle covering:

1. Strategic planning: Understanding the need and service responses. Leading to a strategic commissioning plan and known priorities for action.
2. Specifying service outcomes and procuring services: Creating the service model to provide appropriate response and establishing the range of providers and underpinning contracts to ensure delivery.
3. Managing demand and performance: Holding the service providers to account for delivery, ensuring quality and user experience are all part of the review process.

The Commissioning Cycle



These phases will each be informed by each other. The success of providers in delivering the laid out service model will clearly inform future planning and strategic priorities. This section draws upon those areas of effective action for alcohol-related-harm outlined in section 4 and shows how these can be delivered in the commissioning cycle.

This section is supported by Appendix 3, which offers a resource reference for commissioners, describing the information and tools available. These are referenced according to each phase and action in the commissioning cycle.

This guide describes the tools and reference material, which will support the PCT through each phase of the commissioning cycle and related competencies. A checklist of key actions is offered at the end of each phase.

5.1 Phase1: Strategic planning

This phase covers needs assessment (JSNA), the review of current service provision and the comparison of these to inform the determination of priorities. This priority-setting process should culminate in the agreement of a strategic direction for delivery of alcohol interventions. Depending on the level of resources required and their impact, these plans may remain at the partnership planning level or may need to seek PCT Board approval. The priorities will flow into the overall PCT strategic plans, LSP and where relevant the LAA. The PCT will select the key outcomes to be monitored as a result of these strategic plans.

Each stage of the strategic planning cycle is strengthened by the engagement of partners. This will both enhance the process but maximise buy-in for any collective or subsequent partner action. The strategic planning process will need to be aligned with the overall PCT process to ensure the relative priorities from competing areas are all discussed in the PCT Board.

5.1.1 Assess needs

In the light of the recent NAO study on the NHS and alcohol "*Reducing Alcohol Harm: health services in England for alcohol misuse*"²², and the World Class Commissioning competence to provide leadership, PCTs will want to be clear on their own overriding responsibility for assessing need of their local population and meeting this for alcohol prevention and specialist treatment, even where commissioning for certain services may be delegated to partnership bodies such as Drug and Alcohol Action Teams.

In order to assess local needs in relation to alcohol-related harm PCTs and their partners will need to build a picture of local alcohol harm and its particular impact on the community. Local areas will need to understand, for instance, the relative levels of harm caused by alcohol-fuelled crime and disorder, alcohol-related chronic ill-health or domestic violence, etc. In order to begin to understand the types of services that can address local harms, commissioners will also need to understand the alcohol misuse make-up of the community i.e. approximate numbers of increasing-risk, higher-risk and dependent drinkers. This information will be integral to delivering the High Impact Changes described in section 4. Local partners will clearly wish to undertake surveys, stock-takes and capture the views of local communities and a number of resources have been developed to guide and support ongoing JSNA.

22 http://www.nao.org.uk/publications/nao_reports/07-08/07081049es.pdf

There is significant variation across the PCTs in relation to the health consequences of alcohol use linked to deprivation. Data analysis highlights variations across different areas and different groups within the population. Data should be disaggregated by ethnicity, disability, age and gender wherever possible, in order for PCTs to monitor both need and the impact of its commissioned services on the corresponding population groups. Drinking above the guidelines is more common in areas of high deprivation. The JSNA will seek to understand any internal and external variation.

There are indications that, as a group, offenders exhibit a higher incidence of alcohol-related problems than the general population, with 37% self-identifying as having current problems with alcohol²³. The majority have high social and health inequality indices, and do not ordinarily utilise primary healthcare services. Assessing the alcohol treatment needs of this group of the population as part of JSNA is assisted by the involvement of the Local Strategic Partnership

There are clear commonalities and overlaps between reducing alcohol-related crime and disorder and reducing alcohol-related hospital admissions and CDRP Strategic Needs Assessments may therefore be of use in informing JSNA.

To support the understanding of local alcohol harms in JSNA, the North West Public Health Observatory (NWPHO) has produced Local Alcohol Profiles for England covering a number of indicators ranging from binge drinking levels, through specific alcohol-related diseases and alcohol-related hospital admissions to crime attributable to alcohol, including violent crime and sexual offences. This also contains data on the prevalence of alcohol misuse in every PCT and Local Authority area, giving estimates of the numbers of increasing, and higher-risk drinkers. They show alcohol-related harms in relation to national averages. <http://www.nwph.net/alcohol/lape/> and <http://www.nwph.net/alcohol/lape/download.htm>

In planning to address gaps between local need and current service provision, commissioners will find Models of Care for Alcohol Misusers (MoCAM)²⁴ and the National Alcohol Treatment Monitoring System (NATMS)²⁵ of particular use. It is clearly important that interventions are implemented where and when they will be effective. Tools to segment the admitted populations and to create estimates of numbers of increasing-risk/higher-risk and dependent drinkers are described in appendix 3.

23 The OASys Data Evaluation & Analysis Team (O-DEAT) carried out an analysis of data drawn from over 120,000 Offender Assessment System (OASys) assessments in 41 probation areas between 1 April 2004 and 31 March 2005

24 *Models of care for alcohol Misusers (MoCAM)*, Best Practice Guidance, National Treatment Agency for substance misuse Department of Health, Gateway 5899

25 <http://www.ndtms.net/alcohol.aspx>

NHS East Lancashire Lifestyle surveys in the JSNA: Practice example

As part of the partnership alcohol strategy, NHS East Lancashire led on a Health Needs Assessment working group, involving Police, Probation, County Council, research and development, public health intelligence, and acute care commissioning. The aim of this work stream was to begin to plan better alcohol treatment services.

The lifestyle surveys that NHS East Lancashire had conducted in 2006 enabled a range of partner agency data to be compared. They were able to identify where health harms were the greatest, down to middle super output area (MSOA) and identify barriers to accessing services from what patients had told them. They were able to identify disadvantaged groups, for example no car/poor transport links and living in heavily rural areas.

The lifestyle survey reinforced the links between deprivation and poor health outcomes. It also identified more unusual trends, such as in more affluent areas, the self-reported alcohol consumption did not correspond with (was much lower than) the alcohol indicators.

One initial finding was that areas where alcohol related harms were high, people also reported poor access to healthcare, most notably in rural areas. The results are interim investment in Tier 2 services within primary care and other community-based settings.

Demonstrating commissioning competency for alcohol-related harm

<p>1. Locally lead the NHS Joint commissioning approach resourced to a level that ensures needs assessment, strategic planning and implementation in contracting and performance review are all achieved in conjunction with the relevant partnership groups.</p>	<p>3. Engage with public and patients People with, or at risk will help design and deliver plans. Local media support will complement national messages and raise individual aspirations and provide direction for improved health outcomes.</p>
<p>2. Work with community partners JSNA which demonstrates an understanding of the specific needs and outcomes for alcohol-related harm.</p>	<p>4. Collaborate with clinicians & professionals Mainstream services have the skills, experience and appropriate supporting materials to provide opportunistic and planned care. As a priority this should include GPs, A&E and fracture services.</p>

5.1.2 Review current service provision

The second stage of strategic planning phase is to develop understanding of how services are currently provided, assess their quality and identify any gaps which may need to be addressed through new initiatives and/or decommissioning. Particular emphasis should be placed on how well the current provision meets identified need. This requires drawing together a number of strands of data. This data will need to be benchmarked against national or, if more appropriate, cluster averages using each tier of the MoCAM framework.

Identifying and assessing current service provision

Local areas will already have services in place to address alcohol problems. These will broadly range from prevention, through low level support to specialist care-planned treatment and will be provided in a wide range of settings by the NHS, Local Authorities voluntary and private-sector partners. In order to help commissioners plan co-ordinated local systems of alcohol interventions the Department of Health and the NTA have provided the following guidance and support: (Details can be found in Appendix 2, the resource reference for commissioners.)

- Models of Care for Alcohol Misusers (MoCAM)²⁶
- National Alcohol Treatment Monitoring System²⁷
- The Hub of Commissioned Alcohol Projects and Policies (HubCAPP)²⁸.
- Alcohol Learning Centre website²⁹

The final step in establishing the baseline is to overlay the needs assessment with the analysis of the current pattern of provision to identify the key implications. These will vary widely PCT by PCT, but may include:

- A misalignment between those segments of the population that have the highest health needs and the existing pattern of investment
- Areas or services that have poor access to services or widespread patient dissatisfaction
- Elements of the known High Impact Changes (see section 4.3) missing in current service provision

26 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136806?IdcService=GET_FILE&dID=28613&Rendition=Web

27 <http://www.ndtms.net/alcohol.aspx>

28 <http://www.hubcapp.org.uk/>

29 www.alcohollearningcentre.org.uk

- Communities that have limited choice in the nature of services available
- Services not achieving basic quality standards

It is at this stage the key priorities for development for alcohol-related harm should be emerging. Once local programmes for reducing alcohol harm have been planned, local partners will be in a position to project the level of reduction on the baseline admissions trends. A commissioning tool has been developed to assist PCTs in calculating this, using the available evidence base and emerging data to more accurately establish admissions reductions and cost savings available from planned local investment. http://www.alcohollearningcentre.org.uk/_library/Alcohol_Ready_Reckoner_V1.xls

5.1.3 Decide Priorities: PCT strategic and operational plans

In line with the Operating Framework 2008/09³⁰ World Class Commissioning includes a requirement for every PCT to develop an overarching five year strategic plan, setting the PCT's vision, its priorities and how they will be delivered and an annual operating plan. The JSNA and service review process will inform this process. The priorities for commissioning interventions to reduce alcohol-related harm determined in the process outlined above will flow into the overall PCT strategic plans, LSP and, where relevant, the LAA.

The Equality Impact Assessment from World Class Commissioning³¹ reflects the criteria used to prioritise investment, and their application, need to be carefully considered. There is a risk that the considerable health inequalities experienced by particular groups or communities may not score as highly in the prioritisation process due to the size of the population or the lack of quantitative data with which to make a robust commissioning case. Conducting equality impact assessments of investment proposals could assist PCTs in demonstrating how the reduction of health inequalities has informed investment decisions.

The annual operating plan will set out in some detail what will be done in the coming year to implement its' strategy. A key element of the annual operational plan will be specifying the changes that the PCT has committed itself to in order to reduce alcohol-related harm. It will need to include the relevant performance targets and supported by effective project management.

30 The NHS in England: The operating framework for 2008/09, Department of Health, 2007, Gateway 9120

31 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091029

NHS East Lancashire Strategic planning alcohol: Practice example

Success through delivery and accountability – Save a Million Years of Life
 NHS East Lancashire devised a strategic plan to increase life expectancy, and quality of that extended life, through the delivery of evidence based interventions. One of these work streams is alcohol harm reduction.

The Save a Million Years of Life Programme consists of project management tools, with regular progress reporting, action plans and specific metrics. Within these tools are specifically designed performance management frameworks for service providers to feed forward progress to targets at each stage up to the health inequalities partnership board (HIPB) level. The HIPB consists of Police, Borough Council, PCT and voluntary sector representatives. The SMYL metrics are also mirrored in the Commissioning Strategic Plan, and some are included in the Vital Signs Operating Framework. This ensures sufficient support is available to meet the agreed project milestones and targets.

The alcohol work stream metrics consist of NHS, Police and partnership targets on alcohol harm reduction. These see steady increases in outputs year on year. Part of the Tier 2 services are based in criminal justice settings, through alcohol arrest referral and conditional cautions and the alcohol treatment requirement (ATR).

Demonstrating commissioning competency for alcohol-related harm

5. Manage knowledge and assess needs

Methodologies will be available to draw through qualitative information and seek the opinions of significant numbers of users of the services. MoCAM, Effectiveness review, NATMS, LAPE and ANARP will be driving commissioning. Evidence of stratification of patients at risk and trends in the outcomes data are indicators of the higher end of performance in this competency.

6. Prioritise investment

Investments will be linked to reasonable improvement in the health outcomes described in section 4.1. Commissioners will have a clear understanding of their expenditure on alcohol services and over time be able to quantify the effectiveness of this spend. They will use information provided from programme budgeting and other investment analysis to make commissioning and decommissioning decisions.

Checklist for Phase 1: Strategic planning

- PCT takes a leading role in JSNA and commissions alcohol interventions for the needs of the local population
- Identification of the capacity and capability to undertake a JSNA specific to alcohol-related harm
- Engagement of partners, service users, and those at risk, in the needs assessment process
- Agree strategic data needs and data sharing protocols to enable monitoring of the impact from all partners' actions on alcohol harm
- JSNA covering as a suggested minimum:
 - up-to-date Alcohol misuse prevalence data or prevalence surveys,
 - map of service provision in each tier
 - up-to-date information on service use
 - alcohol-related hospital admissions baseline
 - Informed by young people's substance misuse plans, CDRP strategic needs assessments, local surveys of service users and carers
- Understand the current service response and expenditure against known best practice in the prevention and treatment and determine how these may need to change
- Establish alcohol-related harm as a priority within the strategic plan where appropriate
- Describe the strategic approach to minimise alcohol-related harm and link into the LAA as appropriate
- Specify required outcomes and set priorities for action which enable the PCT to monitor impact on indicator ambitions at strategic level

Best practice outputs from Phase 1: all specific to alcohol-related-harm

Joint Strategic Needs Assessment
 Analysis of service provision and related expenditure
 Set of jointly agreed priorities for action
 Programme plan to deliver

5.2 Phase 2: Specifying service outcomes and procuring services

Informed by the strategic plan, the baseline mapping exercise and the ongoing involvement of patients, carers, clinicians and other local partners, the next stage will be to set out a clear, compelling vision of what the PCT wants alcohol services to look like in the future. This service model should seek to describe the appropriate service responses and be sufficiently detailed to facilitate selection of the range of providers and underpinning contracts to ensure delivery. Care pathways to support the service model will need to ensure handovers between service approaches and providers are fail-safe.

The PCT and partners will then have specified the outcomes required, described the preferred service model, assessed existing provision and determined what their gaps are. The PCTs will need to decide whether they will work with their existing providers to manage this gap or seek new options for provision. The commissioners need to seek appropriate means to new provision including competitive tender as appropriate. This will provide the PCT with its emerging market strategy for reducing alcohol-related harm.

Similarly the commissioners should now be clear if they have areas of non-evidenced, poor value for money or ineffective care which needs to be decommissioned. A clear decision making process will assist in the communication of required changes. As for any significant service changes the need for involvement will apply as per section 242(1B) of the NHS Act 2006 explained in recent guidance³².

Irrespective of type of provision, new or existing, the decision to commission services from a provider will need to be underpinned by effective and specific contracts. These will offer the level of detail to give assurance that effective practice will be provided and the service model delivered.

5.2.1 Specify services

In drawing up the service vision the commissioners will need to ensure they will drive the required outcomes. MoCAM describes the achievement of outcomes in alcohol-related harm in the following domains (shown in full in section 4 of this guide) these are likely to require differential service planning.

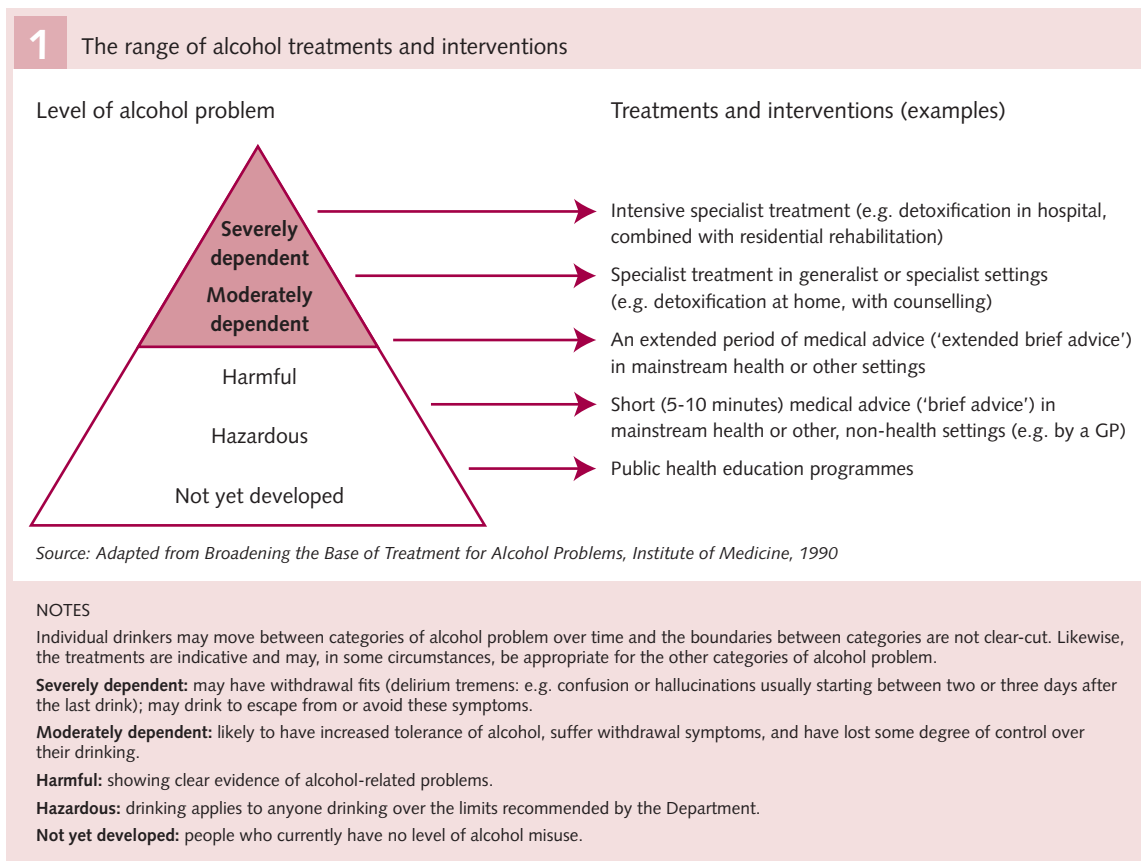
- reduction of alcohol consumption

32 *Real Involvement; working with people to improve health services*, Department of Health, Gateway 10546, 2008

- reduction in alcohol dependence
- amelioration of alcohol-related health problems
- amelioration of alcohol-related social problems – such as family and interpersonal relationships
- general improvement in health and social functioning.

Because alcohol dependence is a highly relapsing condition the service vision should encompass approaches that deliver maintenance of initial gains at appropriate intervals.

The PCT will need to commission the full range of services across the four tiers of the MoCAM framework. The diagram below outlines a range of example treatments the commissioner will be looking to evidence for the population.



The *Review of the Effectiveness of Treatment for Alcohol Problems*³³ was written to inform MoCAM and provides in depth information about interventions appropriate for different levels of alcohol misuse and their relative merits, based on the available evidence. Section 4 recommends a series of High Impact Changes which can be prioritised for commissioning to achieve the earliest and most effective outcomes. The commissioners as part of their inequalities review work in the JSNA will benefit from understanding any impact local service design has on access rates and using this to inform future service models.

The service model will seek to deliver the outcomes described in 4.1. As well as providing local services for dependent drinkers it is important that there are commonly understood care pathways between local capture points and specialist alcohol services and between tiers of treatment service. Guidance on the development of Alcohol Care Pathways will be available from the Alcohol Learning Centre in summer 2009.

33 http://www.nta.nhs.uk/publications/documents/nta_review_of_the_effectiveness_of_treatment_for_alcohol_problems_fullreport_2006_alcohol2.pdf

Respond/Surrey & Borders – Alcohol care pathways: practice example

The Respond community drug and alcohol service in Leatherhead, working closely with the primary care mental health teams with Surrey and Borders Partnership NHS Foundation Trust, agreed a joint working policy, procedure and care pathway for clients with mental health and drug or alcohol misuse problems in 2006. This was developed through an active collaborative process with a project lead and small project team. The intention was to improve access to appropriate care irrespective of whether clients initially presented with comorbid mental health problems or these problems were identified during the course of treatment in one or other of the services.

The care pathways were explicitly devised to help minimise the risk of:

- serial or poorly coordinated parallel treatment
- clients being referred unnecessarily between teams and
- client disengagement.

They were also each intended to help:

- encourage communication between services that enhances client care
- enhance opportunities for clinical supervision across services on specific cases
- promote a culture of joint assessment where appropriate and
- minimise barriers to treatment for vulnerable clients.

Detailed narrative policies and procedures accompany diagrammatic representations of the agreed care pathways, which also sit alongside an organisational chart showing the place of identified link workers.

The teams involved reported that the process of protocol development, the linked training activities and the clarification of communication paths, as well as the key role of named link workers, were key to the success of the final care pathways.

5.2.2 Shape the structure of supply

Given clarity around the service model and care pathways required, the Commissioner will seek to ensure sufficient range and quality of providers to create a comprehensive service response. A robust, flexible and diverse market serving people at risk of alcohol-related harm in all areas of provision will support high quality outcomes.

Effective choice will need to be offered through this range of services. The Principles and rules for Cooperation and Competition³⁴ lays on commissioners the requirement to commission services from the providers who are best placed to deliver the needs of their patients and populations. From April 2008, free choice of provider applies to routine elective services funded by the NHS. Outside of elective care services the PCT will need the evidence to demonstrate appropriate quality care and value for money. The PCT Procurement Guide for Health Services offers more guidance³⁵.

These guidance documents advise PCTs to make their decision on the approach or otherwise to market on a set of parameters linked to the nature of their gaps, the size and nature of the contract, the potential to improve services through contestability and local circumstances. The significant feature is the process for thinking through the gaps and how they might be addressed. The PCTs will need to decide whether they will work with their existing providers to manage this gap or seek new options for provision. The commissioners need to seek appropriate means to new provision including competitive tender as appropriate. This will provide the PCT with its emerging market strategy for reducing alcohol-related harm. The PCT and partners need to be able to demonstrate the rationale for their decisions as they inform local planning.

Encouraging the third sector to provide health services is an important aspect of competency 7. A considerable number of third sector agencies provides services tailored to specific communities or are managed by people from minority groups – or both. It is important the processes and criteria employed to identify potential delivery partners do not inadvertently screen out these smaller, not-for-profit organisations.

34 Principles and rules for Cooperation and Competition, DOH, 13 Dec 2007, Gateway 9244

35 PCT Procurement Guide for Health Services, DOH, 16 May 2008, Gateway 9915

The selection of providers supported by contracts and grants concludes this phase. Where alcohol-related harm is an element in a larger NHS or other provider contract, the contract will need to lay out the financial and other resources being made available by the commissioner specific to alcohol-related harm. The schedules will describe the outcomes, metrics and quality standards required from these resources.

Appropriate contract periods will determine how frequently the Commissioner will wish to reopen tendering processes for services. Contracts will be based around the national model contracts³⁶ or local tailored approaches where appropriate. The measurement of progress will feature in contracted service specifications. This will, over time be built into the standard contract. As contracts become more specific the commissioner will expect to see progress reported as part of the monthly Service Quality Performance Report described in the contract guidance and will detail performance against the Service Quality Performance Indicators.

It is likely that output measures will need to be devised alongside outcomes to measure progress. Examples could be:

- Numbers of contacts/triages/treated at tier 2
- Reduced Alcohol consumption (as recorded at triage and at discharge)
- Average number of sessions
- Average duration of treatment
- Did not attend rates DNA
- Numbers readmitted to service after 6 months
- User views of services
- Waiting times

Commissioners will find the National Alcohol Treatment Monitoring System (NATMS) useful for monitoring uptake of specialist treatment provision as it provides ongoing data on numbers in specific treatment services. The commissioner will wish to specify that services are underpinned by appropriate quality governance. Suggestions of useful resources are given in Appendix 3.

36 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091451

Demonstrating commissioning competency for alcohol-related

<p>7. Stimulate the market Robust, flexible and diverse responses through a market which demonstrates a range of services to prevent alcohol-related harm will be evidenced. Effective choice will be offered through this range of services. Market strategy and rationale.</p>	<p>8. Promote improvement and innovation Specific outcomes as per Quad, MoCAM, DANOS and Effectiveness review expected from providers will be an evidenced part of the contracting and procuring process. Metrics will be developed with providers that demonstrate reduction in alcohol dependency.</p>
<p>9. Secure procurement skills Provider economics knowledge (e.g. scale, finances and performance) and specific patient experience data will be demonstrated for each provider for alcohol-related harm. Commissioners will be involving service users and their families in decision making and monitoring.</p>	<p>also Collaborate with clinicians & professionals as earlier.</p>

Checklist for Phase 2: Specifying service outcomes and procuring services

- Ensure sufficient contracting and other capability to deliver prioritised actions
- Agree and publish a service vision supported by alcohol care pathways.
- Commission at minimum the recommendations from the high impact changes.
- Ensure a comprehensive and vibrant economy of service provision.
- Contract for services with clear service specifications including resources, quality measures and user feedback

Best practice outputs: all specific to alcohol-related-harm

- Service Vision
- Care pathways
- Market analysis including understanding of any gaps or areas for decommissioning
- Agreed approach and rationale to addressing any gaps/decommissions
- Contracts and grant agreements for all Providers with clear financial agreement, specifications, incentives and which are measurable.

5.3 Phase 3: Managing demand and performance

This phase involves delivering the agreed care pathways, regular monitoring of performance and intervening early when performance suggests that outcomes may suffer. This includes assessing delivery against particular standards and outcomes, reviewing agreed use of resources and reviewing whether service responses are targeted as effectively as possible against priorities.

5.3.1 Manage demand and ensure appropriate access to care

Section 4 made the case for ensuring capacity to meet the needs of at least 15% of dependent drinkers in the PCT. Approaches in primary and secondary care were also described to identify those who are identified as being dependent drinkers and would benefit from further support. The nature of alcohol-related harm is such that both ensuring patients can access the right services but also ongoing maintenance will be important components of success.

As has been previously described there are considerable inequalities evident for people with alcohol-related harm. Chapter 4 of the NTA³⁷ review of evidence considers the issues of specific service user groups and suggests means to address these through service design.

37 http://www.nta.nhs.uk/publications/documents/nta_review_of_the_effectiveness_of_treatment_for_alcohol_problems_fullreport_2006_alcohol2.pdf

It concludes

- *All services should aspire to be ethno-culturally competent as might be appropriate to their particular locality*
- *There is a trade-off between providing services for special groups that benefit from ease of shared identity and the creation of a therapeutic alliance, against generic services that offer greater choice and range of expertise*
- *Individuals from ethnic minorities tend to divide according to their degree of religious allegiance and there is a stronger case for novel ways of engaging ethnic minorities than for providing separate services*
- *With the exception of women who have been abused, women do well with mainstream services provided co morbidity needs are addressed.*
- *Significant co-morbidity with mental illness is also an issue for consideration.*

Commissioners will wish, as part of their EqIA, to understand how features of access such as location, language, timing and others are impacting on take up of services. The EqIA from World Class Commissioning³⁸ evidences significantly different levels of satisfaction with primary care services among minority communities compared to satisfaction levels as a whole. Commissioners when seeking the views of the local population on improvements to services, would benefit from disaggregating feedback – by ethnicity, disability and gender at least – to see whether satisfaction levels are improving across the board or just among certain communities.

5.3.2 Clinical decision making

The High Impact Changes (section 4.3) have been explicit about the evidence of impact from clinicians offering identification and brief advice in primary care, A&E and settings such as fracture clinics on individual alcohol-related behaviour. *The Primary Care Service Framework* offers guidance for making use of enhanced services for implementing this work in primary care.

38 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091029

Clinicians will need to be competent to deliver IBA and have received any necessary supporting materials to deliver effective services and make the right decisions for onward referral. The appropriate capacity will also need to exist in those services likely to receive specialist referral following assessment. Early Implementer PCTs have established training programmes and determined target numbers of clinicians to undertake training to ensure sufficient coverage.

5.3.3 Manage performance (quality, performance and outcomes)

A fundamental building block is to develop and implement a comprehensive approach to reviewing performance and supporting improvement. This will clearly set out the standards that the PCT expects which will in general fall into two areas:

- Minimum standards that must be met; a number of these will be contractual standards and failure to meet them will, in general, trigger a formal intervention by the PCT
- Aspirational or developmental standards to be worked towards; these will clearly set out what the PCT would like services to deliver, and will often be backed by clear development programmes

The comprehensive approach will develop a clear performance cycle, setting out what will happen, and when. This will require monitoring a set of performance measures to reach an objective and rounded view of performance. PCTs should prepare to invest in the necessary systems and expertise to enable effective identification and segmentation of their local populations by healthcare needs. Performance data should be disaggregated by ethnicity, disability, gender wherever possible, in order for PCTs to monitor the impact of its commissioned services on the corresponding population groups.

The final element in a comprehensive approach is a clear escalation regime, setting out what the PCT will do when performance slips below the agreed standard.

NHS East Lancashire – Project and performance review: Practice example:

NHS East Lancashire established a performance process to determine the most significant areas to improve outcomes. The process tracks performance metrics for NHS, Police and partnership targets on alcohol harm reduction delivered through service provision. Communication between commissioner and providers on progress is good, and providers are aware of the accountabilities they have for delivery through the Save a Million Years of Life Programme.

World Class Commissioning competency linkages

10. Manage the local health system

Commissioned services will be rigorously monitored in year. Metrics will be devised and used to track performance and actions taken where performance does not meet expectations.

11. Make sound financial investments

There will be clarity and transparency in the deployment of resources, including clear information on outcomes expected. New powers to enable health and local authority partners to work together more effectively came into force on 1st April 2000 and has since been replaced, for England, by Section 75 of the National Health Service Act 2006. Appropriate legal frameworks³⁹, will be explored to gain optimal flexibility and governance on resources. These arrangements were previously referred to as Section 31 Health Act flexibilities and cover lead commissioning, integrated provision and pooled budgets.

³⁹ <http://www.dh.gov.uk/en/Healthcare/IntegratedCare/Healthact1999partnershiparrangements/index.htm>

Checklist for Phase 3: Managing demand and performance

- Understand and meet clinicians' needs to manage demand
- A comprehensive performance review process specific to alcohol-related harm including proportionate interaction with Providers to ensure good provision
- Regular performance reporting
- Engagement of sufficient users and relevant stakeholders to give representative feedback in ongoing service review
- Feed outcomes of commissioning into the annual planning review cycle

Best practice outputs from Phase 3: all specific to alcohol-related-harm

- Clinician training and support materials
- Provider Performance management framework including escalation policy
- Routine process for performance management reports
- User feedback and other qualitative information to inform throughout the year and then to inform future years JSNA, commissioning and contracting round
- Minimum standards in contracts shown as delivered and progress demonstrable in aspirational standards
- Evidence that the PCT is moving towards improved outcomes

6. Conclusion

This document explores the commissioning cycle and the key actions in commissioning that will make a difference in preventing alcohol-related harm. Key stages in moving to World Class Commissioning have been illustrated as:

- PCT to take a leading role in JSNA and commission alcohol interventions for the needs of the local population
- Identification of the capacity and capability to undertake a joint strategic needs assessment specific to alcohol-related harm
- Engagement of partners, service users, and those at risk, in the needs assessment process
- Maximise partnership responses through appropriate level engagement into the planning infrastructure
- Agree data needs and sharing protocols to identify hotspots
- Understand the current service response and expenditure against known best practice in prevention and treatment and determine how these may need to change
- Establish alcohol-related harm as a priority within the strategic plan where appropriate
- Describe the strategic approach to minimise alcohol-related harm and link into the LAA as appropriate
- Specify required outcomes and set priorities for action which enable the PCT to monitor impact on indicator ambitions at strategic level
- Agree and publish the service vision supported by alcohol care pathways across all services
- Commission at minimum the recommendations from the high impact changes
- Ensure a comprehensive and vibrant economy of service providers
- Contract for services with clear service specifications including quality measures and user feedback
- Establish a comprehensive performance review process specific to alcohol-related harm
- Feed outcomes of commissioning into the annual planning review cycle

To support PCTs and their partners in commissioning to improve outcomes in alcohol-related harm the Department of Health has implemented the Alcohol Improvement Programme involving the following elements:

Early implementation programme

20 PCTs from those with the greatest level of alcohol-related hospital admissions have become Early Implementer sites for the Alcohol Improvement Programme. The PCTs are supported with additional funding to allow them to lead the way in implementing the High Impact Changes.

Alcohol Interventions Improvement Centre

To support Local partners in reducing alcohol harm the Department of Health has developed the Alcohol Interventions Improvement Centre that has two main functions:

- **Alcohol Learning Centre (ALC)** – is a one-stop shop where local partners can find guidance, data, tools and training resources to support them in implementing the high impact changes. It provides examples of solutions and innovation identified through local implementation, gathered through the experiences of the Regional Offices in working with local delivery partners and through various web fora. The ALC also contains the HubCAPP database on which local partners can showcase examples of practice that is underway around the country to tackle alcohol-related harm.
- **Improvement Support** – working through the Regional Alcohol Offices, the programme provides advice and support for groups of PCTs on a wide range of improvement activities such as learning sets, evaluation and outcome measurement, mentorship and arranging peer visits. This is in addition to facilitating national and regional workshops and events on key topic areas.

For further information visit www.alcohollearningcentre.org.uk

Regional Alcohol Offices

The Regional Public Health Groups (RPHGs) are establishing Regional Alcohol Offices or Regional Alcohol Managers, responsible for the link between Strategic Health Authorities, Government Offices, Local Authorities and the Department of Health. The Regions are resourced to facilitate regional delivery of reduced alcohol-related hospital admissions by providing ongoing support to local PCTs and their partners where reducing alcohol-related admissions has been prioritised. RPHGs have taken various approaches to providing this resource ranging from teams of staff to innovation schemes. All will be able to co-ordinate support for PCTs committed to reducing alcohol-related harm

National Support Team (NST)

The Alcohol Harm Reduction National Support Team will support PCTs and their partner organisations in areas with the highest rates of alcohol-related hospital admissions to review their commissioning and delivery systems for alcohol harm reduction and identify what improvements can be made.

The NST are invited by PCTs and will carry out a structured diagnostic visit that involves leaders, commissioners and those delivering services from the local organisations that contribute to alcohol harm reduction. The visit is followed up by a tailored package of support from the Regional Alcohol Managers.

The NST will liaise with and involve Regional Offices in planning visits and in providing follow up support.

Screening and Intervention Programme for Sensible Drinking (SIPS)

SIPS is a 2 year research programme led by the Institute of Psychiatry, University of London and Newcastle University, to provide additional evidence, support and improve implementation of alcohol identification and the delivery of brief advice (IBA). SIPS is testing educational and behavioural interventions to assist individuals to moderate their alcohol use to within sensible limits and avoid health and anti-social behavioural consequences. Interim reviews will help to develop and refine current tools and a final report will be available in Autumn 2009.

The SIPS research programme is being conducted through clustered, randomised clinical trials across:

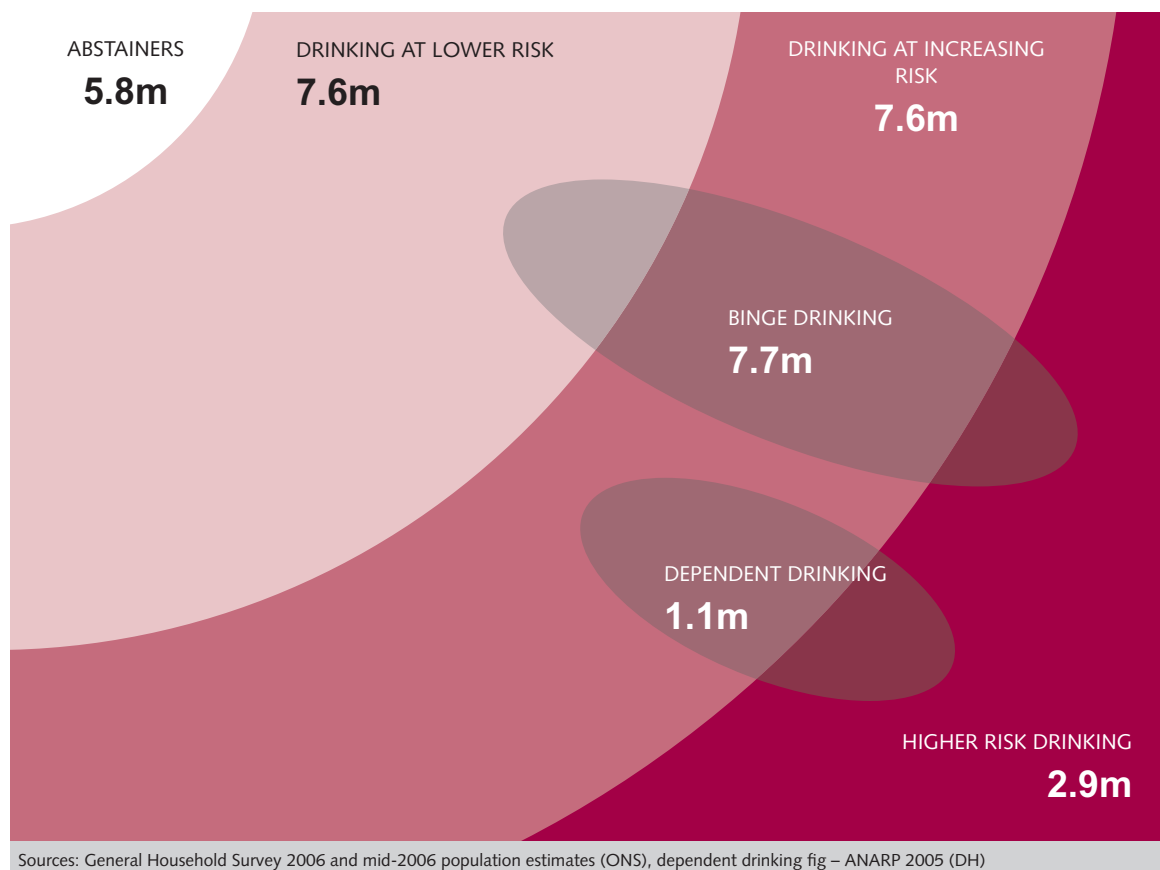
- Primary Care/General Practice
- A & E
- Criminal Justice – Probation Service

The research is designed to refine the evidence base for IBA by assessing:

- *Screening Approach*: What are the best identification tools and what is the most effective way to target screening in each of the settings?
- *Intervention Approach*: What are the most clinically effective and cost effective interventions e.g. simple brief advice, extended brief advice or self help literature?
- *Common Measures*: What are the best measures to allow comparisons?
- *Implementation*: What are the barriers and how can we best overcome them?
- *Roll-out*: If proven effective, what would be the best methods to facilitate roll-out nationally?

Appendix 1: Planning for the full population: see Section 4.2

The diagram below represents what data tell us about the way people in England drink



Lower Risk Drinking: This group (estimated around 24.8 million people) drink alcohol in line with the Government's recommended lower risk limits. The Government advises that women should not regularly exceed 2-3 units of alcohol per day and men should not regularly exceed 3-4 units per day for men. Preventive activity such as provision of information and advice can encourage lower risk drinking.

Increasing Risk Drinking: This group is the largest group of people misusing alcohol (estimated around 7.6 million people) and is made up of those who regularly drink over the recommended limits for lower risk drinking but are not regularly drinking at the higher risk levels. These drinkers might not currently be experiencing harm from their drinking but are at increasing risk of physical and mental ill-health and of being a victim of crime, contracting a sexually transmitted disease and, for women, being more likely to have an unplanned pregnancy. There are also risks to others such as aggression towards family members, general disorder, accidents and assaults.

Higher Risk Drinking: This group (estimated around 2.9m people) regularly drink well over the recommended limits. Higher risk drinkers are those men who regularly drink more than 50 units a week or regularly drink more than 8 units a day and those women who regularly drink more than 35 units a week or regularly drink more than 6 units a day. Although a smaller group than the increasing risk drinkers, this group is at a much greater risk of the wide range alcohol-related health harms and the consequent costs, and so effective preventive and treatment interventions can have a particularly powerful benefit in individuals who receive them.

Increasing and higher risk drinkers account for most of the costs (estimated £2.2bn) caused by alcohol-related harm to the health economy. This equates to approximately £14.4 million per PCT, which offers opportunities for a substantial impact from brief, preventive interventions aimed at this group.

Dependent Drinking: This group is relatively small (around 4% of the population or 1.1m people) Dependent drinking is identified in some increasing risk drinkers but is more prevalent in higher risk drinkers. Rather than being defined solely by intake, dependence is essentially typified by an increased drive to use alcohol and difficulty controlling its use, despite negative consequences. Dependent drinkers are more likely therefore to need, and benefit from, access to specialist alcohol treatment interventions at a range of intensity – both for management of the dependence and to reduce risk or costs of other serious health harms. Although only a minority of drinkers become addicted to alcohol, the 1.1 million people who are dependent drinkers cost the health economy twice as much per person as other drinkers. This equates to £512m nationally or £3.4m per PCT.

Binge Drinking: Spanning the lower, increasing and higher risk drinking groups binge drinkers are a group of people who have episodes of drinking during which they drink to intoxication or to get drunk. This is commonly defined for epidemiological purposes as women drinking more than 6 units in any one day or men drinking more than 8 units in any one day. They are at risk of some acute

health harms including accidents and they can contribute to other social harms in a local community.

NB The terms 'Lower Risk', 'Increasing Risk' and 'Higher Risk' are now used by the Department of Health, reflecting the level of risk incurred by drinkers as their consumption increases. These terms – lower, increasing and higher risk drinking – are more readily understood by the general public and reflect their current consumption and hence are more directly useful. These terms do actually correlate closely to the terms – sensible, hazardous and harmful – respectively used by the World Health Organisation, whilst not exactly the same.

Appendix 2: Resources reference for Commissioners

	Resources and recommendations	Tools for support
Phase 1 5.1.1 Assess needs	<p>Effective measures for Alcohol needs assessment</p> <p>Vital signs and the National Indicator Set The DH Vital Signs indicator VSC26 is included in the National Indicator Set (NIS 39) for Local Authorities and Local Authority Partnerships. The latter forms a key indicator, to be measured by HES data, for the Home Office led Alcohol and Drugs PSA 25⁴⁰ which focuses on the reduction of harm caused by alcohol, alongside the Home Office Safer Communities PSA 23⁴¹.</p> <p>World Class Commissioning national list There are two metrics within the world class commissioning national list to reflect alcohol:</p> <ul style="list-style-type: none"> • Rate of hospital admissions per 100,000 for alcohol related harm (this is also in tier three of the Vital Signs) • Deaths from chronic liver disease (directly standardised rates from chronic liver disease, including cirrhosis per 100,000 all ages) <p>These were chosen for inclusion in the world class commissioning assurance system to reflect the priority that PCTs might wish to give to alcohol locally. The first, is the more sensitive proxy measure for alcohol related harm at all levels across a community which aligns with the metric included in the Vital Signs.</p> <p>The second reflects an outcome measure specific to harm often caused by chronic alcohol misuse.</p>	<p>Directors of Public Health are encouraged to use the National Data Set from NWPHO, which can be found at http://www.nwph.net/nwpho/default.aspx or http://www.nwph.net/alcohol/lape/nationalindicator.htm</p> <p>A trajectory planning tool has been developed to help PCTs calculate local admissions trajectories to 2012 and so set baselines. This is also available on the NWPHO website http://www.nwph.net/alcohol/lape/NI39PlanningTool.xls</p> <p>DH and the NWPHO have produced guidance explaining the alcohol-related admissions dataset in more detail <i>Hospital admissions for Alcohol-related harm: technical information and Definition</i>⁴³ – provides a technical description of the methodology for the indicator</p> <p><i>Hospital admissions for Alcohol-related harm: Understanding the dataset</i>⁴⁴ provides guidance on how Alcohol-related hospital admissions are calculated.</p> <p>East Midlands Public Health observatory information resource on alcohol offers a range of sources of data http://www.empho.org.uk/Themes/alcohol/alcohol4.aspx</p> <p>Guidance for local partnerships on alcohol-related crime and disorder data, Home office development and practice report 6</p>

40 http://www.hm-treasury.gov.uk/d/pbr_csr07_psa25.pdf

41 http://www.hm-treasury.gov.uk/d/pbr_csr07_psa23.pdf

43 http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_086412?IdcService=GET_FILE&dID=169374&Rendition=Web

44 http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_086412?IdcService=GET_FILE&dID=169370&Rendition=Web

Resources and recommendations	Tools for support
<p>Alcohol-related admissions trends data DH will also provide admissions trend data for every PCT. These data will obviously indicate existing trends in alcohol related ill-health and provide a baseline against which PCTs can measure progress in tackling alcohol harm.</p> <p>Health and wellbeing measures There are now considerable data available showing the impact of alcohol on health and wellbeing. 36 indicators and 84 separate sub measures relating to implications – for individuals, the local community and the overall population – of alcohol use and its effects on health and wellbeing are comprehensively set out in the Chief Medical Officer's report, <i>Indications of Public Health in the English Regions, 8: Alcohol</i>⁴² published in August 2007.</p> <p>Baseline data on related indicators e.g. NI 41 Perceptions of drunk or rowdy behaviour as a problem, NI 115 Young People's alcohol use, NI32 Repeat incidents of domestic violence, NI 20 Assault with injury crime rate, NI 21 Dealing with local concerns about anti-social behaviour and crime by the local council and police.</p>	<p>http://www.homeoffice.gov.uk/rds/pdfs2/dpr6.pdf</p> <p>Segmenting admissions: In order to target services most effectively, PCTs and local partners may wish to use HES data to segment admissions populations using segmentation methodologies such as Health ACORN, MOSAIC,⁴⁵ etc in order to identify which types of alcohol harm are prevalent in particular communities. HES data are collected by The Information Centre. HES data on alcohol related admissions for every PCT are available on a quarterly basis from the NWPHO at www.nwph.net/alcohol</p> <p>Estimates of numbers of increasing risk/higher risk and dependent drinkers. The former will broadly speaking be susceptible to the lowest tier of intervention in MoCAM whereas the latter will be more likely to require specialist treatment described in tiers 2 – 4 of MoCAM depending on the severity of dependence. DH has developed a tool to predict likely need across the MoCAM tiers from NWPHO local prevalence figures. This tool is based on a Canadian modelling tool for specialist treatment developed by Dr Brian Rush, the applicability of which to UK services has not been tested. However, it may be of use when supported by local data on service usage, surveys and user and carer input. http://www.alcohollearningcentre.org.uk/_library/Rush_Model-Average_PCT_Spreadsheet.xls</p>

42 http://www.nwph.net/nwpho/publications/Alcohol_Indications.pdf

45 different types of population segmentation techniques are compared and contrasted in the Synthesis report: Population Targeting: Tools for Social Marketing. Dedman D, Jones A, Tocque K, Bellis MA (2006). www.nwpho.org.uk

	Resources and recommendations	Tools for support
5.1.2 Review current service provision	<p>Models of Care for Alcohol Misusers (MoCAM)⁴⁶ sets out best practice guidance for commissioning and delivering a 4 tiered framework for planning a system of alcohol interventions to meet local needs. By mapping locally assessed needs and existing services available against the 4 tiers detailed in MoCAM, gaps in both the range of interventions required and the level of service capacity available can be identified.</p> <p>The National Alcohol Treatment Monitoring System⁴⁷ (ROCR\OR\0072\002) was developed by the NTA to provide local commissioners with ongoing, detailed performance data on the provision of alcohol treatment in their areas including numbers in specialist treatment across MoCAM tiers 3 and 4. This information will help commissioners to see current services, access and capacity and will provide a way for ongoing monitoring of commissioned services and inform decisions on re-structuring of local treatment systems, re-commissioning and de-commissioning of services.</p>	<p><i>Models of Care for Alcohol Misusers (MoCAM)</i></p> <p><i>National Alcohol Treatment Monitoring System</i></p> <p><i>The Alcohol Needs Assessment Research Project (ANARP)</i></p> <p>It may be of use when planning interventions to know how other local areas are tackling alcohol related harm. As part of the Alcohol Improvement Programme DH has provided <i>The Hub of Commissioned Alcohol Projects and Policies (HubCAPP)</i>⁵⁰. The Hub highlights not only what projects exist but how they link to local and national strategies and meet priorities and indicators. The Hub also outlines how initiatives were commissioned, received funding, why alcohol was prioritised as an issue in the area and (where available) what the outcomes have been. The Hub aims to be a leading resource in sharing knowledge and practice across England particularly for those planning or funding new initiatives as it contains examples of strategies, contracts, SLAs, etc.</p>

46 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136806?IdcService=GET_FILE&dID=28613&Rendition=Web

47 <http://www.ndtms.net/alcohol.aspx>

50 <http://www.hubcapp.org.uk/>

Resources and recommendations	Tools for support
<p>Additionally The Alcohol Needs Assessment Research Project (ANARP)⁴⁸ DH – 2005 provided the first comprehensive national picture of alcohol related needs and availability of treatment. There was considerable variation in the level of service availability for people with alcohol problems across England that bore little relation to the variation in need within different regions. ANARP found that there is a large gap between the need for alcohol treatment and actual access to treatment with only approximately 1 in 18 (5.6%) alcohol dependent individuals accessing specialist alcohol treatment nationally per annum. In North America, an access level of 1 in 10 (10%) alcohol dependent individuals entering treatment per annum is regarded as a 'low' level of access, 1 in 7.5 (15%) 'medium' and 1 in 5 (20%) 'high'⁴⁹. Recommendation is to ensure the provision and uptake of specialist treatment for at least 15% of estimated dependent drinkers in the PCT.</p>	

48 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122341?IdcService=GET_FILE&dID=5841&Rendition=Web

49 Rush B, *A systems approach to estimating the required capacity of alcohol treatment services*, British Journal of Addiction, 1990, 85, 49-59

	Resources and recommendations	Tools for support
Phase 2 5.2.2 Shape the structure of supply	<p>Specifying services. Best practice guidance for the provision of substance misuse services exists which covers competency in the provision of interventions and organisational quality of providers these are:</p> <p>This will include but is not limited to Care Quality Commission standards for residential care settings from 2010 registration compliance assurance DANOS⁵¹ – The Drug and Alcohol National Occupational Standards tools which are of use to employers in designing roles and measuring performance of both specialist and non-specialist staff who deal with substance misusers. The effectiveness review identifies that therapist characteristics account for around 10–50% of the outcome variance so confidence that performance of specialist staff is understood by Providers is significant. QuADS – Quality in Alcohol and Drug Services⁵² (Alcohol Concern, DrugScope 2000):best practice guidance particularly relevant when considering the management and quality assurance mechanisms of alcohol treatment providers.</p> <p>MoCAM⁵³ sets out in detail, best practice quality criteria for providing an evidence-based alcohol treatment system.</p>	

51 <http://www.skillsforhealth.org.uk/page/competences/completed-competences/list/drugs-alcohol-danos>

52 *QUADS: Organisational Standards for Alcohol and Drug Treatment Services*. DrugScope and Alcohol Concern, SCODA. London, 1999

53 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136806?IdcService=GET_FILE&dID=28613&Rendition=Web

Appendix 3: Alcohol Social Marketing for England overview

The DH National Alcohol Social Marketing Strategy was initiated in May 2007 and is being developed according to National Social Marketing Centre guidelines. It does not offer a single solution, but represents a process towards an increasingly targeted, sustainable and holistic response based on building insight, continued evaluation and testing with an emphasis, always, upon *behaviour change*. Traditionally, public health campaigns have tended to focus on raising awareness rather than achieving quantifiable behaviour change. Increasing an audience's awareness can lead to changes in behaviour, but it can also have limited leverage – note, for example, the resilience of some smokers despite awareness of the risks. Rather than focussing on telling people what to do, social marketing aims to understand people's circumstances and motivations, discovering what influences their behaviour and designing responsive services and programmes.

The National Social Marketing Centre website contains a case study of the national alcohol social marketing strategy which breaks the programme down against the benchmark criteria for social marketing⁵⁴

Scoping and strategic development (May 2007 – November 2007)

A comprehensive research phase underpinned the development of the strategy. A scoping study was initially undertaken, drawing on ONS and other available public and commercial data to identify key insights. It found that there was a widespread lack of awareness about the potential health consequences of harmful drinking; government guidelines on sensible drinking levels; and how to apply these guidelines.

Ethnographic (qualitative) research was also commissioned to provide a detailed segmentation of hazardous and harmful drinkers accounting for discrepancies between claimed, perceived and actual behaviour, and to understand the attitudes and motivations driving higher risk drinking and the key barriers to reducing alcohol

54 <http://www.nsmcentre.org.uk/public/CSVView.aspx?casestudy=98>

consumption. This segmentation work identified nine broad “types” of drinker , providing insight into how to reach particular target groups and the likelihood of affecting change in each group.

Drawing on the above research, along with extensive expert and stakeholder consultation, an initial strategy has been developed. The DH social marketing alcohol strategy marks a journey, which began in uncharted territory.

Prior to launch:

- Few people understood what “a unit” was
- Most people had never been asked to consider how much they drink

In addition, drinking is an embedded part of the British culture, and there is a complex spectrum of stakeholder interests to be considered when seeking to reduce its consumption.

The main aims of the strategy are:

- To enable higher risk drinkers to understand why they should cut down
- And to provide the necessary support and information to help them to cut down

The strategy offers a national lead on this, allowing local commissioners and providers to use extensive research findings; segmentation tools; and products to inform their own local programmes.

Both the scoping and ethnographic reports, along with a PowerPoint summary of the national alcohol social marketing strategy, are available on-line at www.alcoholstakeholders.nhs.uk

Initial implementation (December 2007 – May 2008)

The initial strategy proposed a multi-faceted approach which would:

- Change the public-facing language used around alcohol to one based on risk
- Test the use of IBAs “virtually” via various channels to avoid placing a burden on the NHS
- Promote awareness and the employment of IBA among front-line healthcare practitioners

In May 2009, the national alcohol social marketing strategy was launched to coincide with the units campaign.. It included the following products:

- The *Drinkcheck* website: this is based on the World Health Organisation's AUDIT tool and takes users through a questionnaire which indicates their level of risk and gives them the opportunity to order a self-help booklet (see below)
- *Your Drinking & You* booklet: this was developed by alcohol-health experts, designed to assist people to cut down on their drinking by providing simple factual information and tips for cutting down
- *Drinkline*: the Drinkline telephone helpline service was strengthened and expanded, with additional training provided to advisors
- Fact sheets, wallcharts and handouts, as well as care pathway information and identification tools for GPs and Primary Care professionals delivering IBA

It was agreed with leading healthcare bodies and UK CMOs that the language used to discuss alcohol harm (which was based on scientific terms) was not easily understood by the public and agreement was reached to change the public-facing language to a risk-based vocabulary. This risk-based approach involved defining recommended guidelines around 'lower', 'increasing' and 'higher' risk behaviours. By doing so, it avoids more judgmental terminology (e.g. 'sensible drinker', 'problem drinker') and provides a more objective concept to attach to units.

Materials are available at www.alcoholstakeholders.nhs.uk

Drinkcheck is available at www.drinkcheck.nhs.uk or via units.nhs.uk

Acquisition pilot

Having tested the self-help pathway that was being developed, the team moved on to the next stage: acquiring 'new' harmful drinkers. A pilot to target drinkers in the North West was initiated in September 2008 and ran until December 2008. Key findings from the evaluation include:

- The cost per active response was £52 which is very low compared to other public health campaigns, e.g. smoking cessation
- Targeting was very accurate – responses were from the appropriate socio-economic groups, with an equal gender split
- Three creative routes were developed, using the 'risk' vocabulary for excessive drinking. The health risks pre-tested were cancer, liver/heart disease, and general ill health. Surprisingly, although cancer risk had tested as the strongest motivator of change in focus groups, it had the weakest response in the North West. General health, which tested most poorly in focus groups, came out top.

- Respondents tended to be those who were already concerned about their drinking. However, there was no “push” Above the Line (ATL) to coincide with the direct marketing (this is something being tested further with East Midlands – see below).
- The self-help booklet was highly-regarded, although the long term effects cannot yet be gauged at this stage but will be explored further in the next phase of activity.

Rolling-out the national strategy (January 2009 – onwards)

Customer Relationship Management (CRM)

CRM will strengthen the self-help pathway so that we will be able to develop a sustainable relationship with harmful drinkers and accompany them on their journey.

Department of Health is also continuing to explore solutions outside existing interventions to ensure a rigorous social marketing approach, feeding into a multi-faceted strategy that emphasises partnerships, including commercial, not-for-profit, and NHS.

Partnership, learning and development with the NHS – a two-way process

DH will work in partnership with PCTs, SHAs and other bodies throughout England to implement the strategy. In the first quarter of 2009 DH began working with a coalition of PCTs in East Midlands to use the national products (i.e. Segmentation, Direct Marketing and self-help pathway) to target their population, alongside a mix of centrally and locally-commissioned media services. Learning gained from this exercise will be used to help refine the products.

Work with the NHS will:

- embed social marketing best practice locally
- establish common evaluation processes to measure impact and contribution to PSA progress
- contribute to a knowledge management hub as part of the Alcohol Learning Centre to disseminate learning
- build a self-sustaining, quantifiable and innovative social marketing mechanism to reduce alcohol-related harm

A fully-integrated campaign

The Units campaign was developed to raise awareness and provide a common language with which to talk to people about their drinking. Alongside campaigns by Drinkaware (underpinned and shaped by Department of Health research) it has begun to shift public awareness and understanding of the risks.

From 2009 onwards, ATL and PR will be increasingly targeted and tailored to the priorities of the social marketing strategy. It is therefore expected to include an increasingly close partnership with the regional partners.

Alcohol Social Marketing Toolkit

DH has developed an alcohol social marketing toolkit *Alcohol Social Marketing for England: Working together to tackle higher risk drinking* which gives practical guidance on commissioning/managing local social marketing programmes based on the national research and tools and includes information on brand/creative guidelines; conducting primary research; overlaying the national segments with local data, etc. The toolkit is available on the Alcohol Learning Centre. http://www.alcohollearningcentre.org.uk/_library/Resources/SocialMarketing/Alcohol_SM_Toolkit.pdf

Appendix 4: High impact changes to reduce Alcohol-related harm

Introduction

Why High Impact Changes?

High Impact Changes have been extensively used across the NHS and local government to highlight practical measures that can be implemented at local level. This appendix identifies those which are calculated to have the greatest impact on health commissioned outcomes and suggests some actions which are calculated as being likely to have the best impact for areas where tackling alcohol-related harm has been identified as a priority. These are:

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

PCT commissioners, their partners and service providers have asked for guidance and help to target their work to reduce alcohol related harm. It is hoped that this practical guidance will answer this request.

A word of warning

The High Impact Changes for Alcohol presented in this document are linked. The temptation to see them as completely separate activities from each other would be the wrong approach. While changes 4 through 7 are supported by clear evidence of their impact, changes 1 through 3 are changes that set the scene for progress.

The first High Impact Change, **Work in partnership**, is a major building block for success as it is unlikely that progress on reducing alcohol harm at any level will be effective without good partnership working in place.

Change two, **Developing activities to control the impact of alcohol misuse in the community**, is everyone's business – the NHS because of the high cost of alcohol-related illnesses and alcohol-related hospital admissions, Local Authorities because of quality of life and community safety and the criminal justice system because of the link between alcohol, crime and public disorder. All partners need to use their existing powers to make the maximum impact on alcohol-related harm.

The latter four High Impact Changes are services and activities that can be commissioned with proven or emerging evidence of their effectiveness and direct impact on hospital admissions.

High Impact Changes explained

This appendix 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.

Each of the High Impact Changes is described in the following way:

- a description of what the change means
- a summary of the evidence that shows it is worth doing and
- a number of case studies that demonstrates how the High Impact Change has already been successfully implemented

Considerably more information and detail concerning most of the case studies included in this document are available from HubCAPP on the Alcohol Learning Centre. HubCAPP is the Hub of Commissioned Alcohol Projects and Policies commissioned by the Department of Health and run in partnership through Alcohol Concern. The Hub provides information on various projects, how they were commissioned and how they link to local and national strategies.

High Impact Change 1

Work in partnership

What does this mean?

PCTs and their local partners will wish to prioritise alcohol in relation to local need and co-ordinate action to maximise the impact on alcohol-related harm. They should investigate their alcohol-related needs within their Joint Strategic Needs Assessment (JSNA) and reflect their plans within the NHS Operational Plan using the Vital Signs alcohol indicator (VSC26) and the Local Area Agreement (LAA) indicator (NIS39). In order to work effectively in partnerships, partners must be agreed on a vision for the area. It is not enough for a vision to simply record the things that partners want less of (e.g. less crime and anti-social behaviour, fewer alcohol related injuries, fewer people dying prematurely, fewer alcohol problems). Partners should be able to describe what an area will look like at the end of their endeavours so that they can maximise the potential to work collaboratively and reduce the risk of becoming target-focussed and working in silos.

What is the evidence that this works?

Work by Tether, Robinson and colleagues (Tether and Robinson, 1986; Robinson et al., 1989) set out the rationale for co-ordinated action at local level. They argue for actions to shift the emphasis from individually oriented interventions to focus on policy-based interventions to initiate change at local community level.

The existence of multi-agency groups such as Crime and Disorder Reduction Partnerships (CDRPs) and Drug and Alcohol Action Teams (DAATs) offers opportunities to reduce alcohol related harm and co-ordinate local initiatives. However, it is important that these thematic groups are given a strong mandate from the principle partnership – usually the Local Strategic Partnership (LSP). It is important that Crime Reduction, Health and Regeneration (Transport and Planning) are all aware of the contribution that they can make to the alcohol harm reduction agenda.

References:

Robinson, D. Tether, P. and Teller, J. (1989) *Local Action on Alcohol Problems*. London: Routledge

Tether, P. and Robinson, D. (1986) *Preventing Alcohol Problems: A Guide to Local Action*. London: Tavistock

Case Examples

Brent Multi-agency Data Collection and Analysis: This project aims to collate multi-agency data from all partners working in the alcohol field in the borough of Brent. The data is collected from all partners, analysed and then disseminated back to the agencies involved to inform their planning and co-ordinate their response.

HubCAPP **Link: L2FS** www.hubcapp.org.uk/L2FS

Oxford Information Sharing Initiative: In March 2007, Oxford's John Radcliffe and Horton hospitals began delivering an information sharing initiative between their A&E departments and the local Crime and Disorder Reduction Partnership (CDRP). The project is part of Government Office South East's (GOSE) regional data sharing initiative that aims to build closer relationships between NHS and the CDRP.

HubCAPP **Link: VAU5** www.hubcapp.org.uk/VAU5

Hampshire Alcohol Intervention Commissioning Plan: The Alcohol Intervention Commissioning Plan consists of specified actions by various partners to ensure the delivery of alcohol brief intervention services and training in Hampshire throughout 2008-2009.

HubCAPP **Link: VPGS** www.hubcapp.org.uk/VPGS

High Impact Change 2

Develop activities to control the impact of alcohol misuse in the community

What does this mean?

Make use of all the existing laws, regulations and controls available to all the local partners to minimise alcohol related harm. Make use of the powers under the Licensing Act (2003) and the Violent Crime Reduction Act (2006). Use the Local Development Framework to 'design out' alcohol harm and enable planners to reject inappropriate proposals at an early stage. Manage the night-time economy to reduce alcohol harm.

What is the evidence that this works?

Citysafe, Liverpool's Community Safety Partnership (case below). This package of initiatives has helped to reduce assaults, robbery and antisocial behaviour by over 28% in the city centre compared with the previous year. The overall figures represent the lowest in the centre for many years.

Sheffield Community Safety Partnership has introduced a number of new initiatives to reduce violent crime (case below). In the period between April and October 2006, Sheffield saw a reduction in serious violent crime of approximately 30%.

References:

HM Government (2007) *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*. London: TSO.

Case Examples

Liverpool: Citysafe, Liverpool's Community Safety Partnership, has developed a web of interlinked initiatives to reduce the potential impact of alcohol-related crime and antisocial behaviour. The local partnership has developed Pub Watch and the Best Bar None schemes to promote good practice in the licensing trade. The Chamber of Commerce, the City Council, Merseyside Police and other partners have encouraged city centre pubs and clubs to be part of a radio link, which enables staff to share information about potential problems and to notify the police about incidents quickly. Taxi-marshalling schemes have also been introduced and have had positive effects, reducing potential flashpoints at the designated taxi ranks.

Citysafe has also funded two schemes as part of its prevention strategy. The first has been to deploy additional handheld metal detectors at pubs and clubs to discourage the carrying of knives and other offensive weapons. The scheme is being extended to include door supervisors. The second scheme promotes the use of polycarbonate glasses in bars and clubs. As part of the promotion, Citysafe is subsidising the difference in price between conventional glasses and the polycarbonate replacements. The scheme builds on the Crystal Clear programme, which aimed to reduce glass-related injuries and assaults. In September, following joint work involving the City Council, Citysafe and the police, a designation order for the city centre was obtained under powers contained in sections 12–14 of the Criminal Justice and Police Act 2001, to prevent alcohol consumption in public places. In a partnership between local A&E departments, the police and Liverpool John Moores University, Citysafe has been promoting increased data sharing regarding alcohol-related assaults in the city. The data from A&E departments is helping Citysafe to target hotspot locations and bars. In turn, such activity is beginning to produce a reduction in the number of referrals to A&E departments. This package of initiatives has helped to reduce assaults, robbery and antisocial behaviour by over 28% in the city centre compared with the previous year. The overall figures represent the lowest in the centre for many years.

Sheffield: Since joining the Home Office's TVCP, the Sheffield Community Safety Partnership has introduced a number of new initiatives to reduce violent crime, particularly in relation to the night-time economy. These include 'meet and greets' at key entry points to the city's night-time economy area. Police community support officers and the Council's City Centre Ambassadors mix with the public, providing community safety, advice on crime prevention and a high-profile presence. These officers also use questionnaires to gather information and intelligence from the public. Incidents are analysed weekly to produce an accurate picture of where, when and what offences are being committed. This allows the licensing team, trading standards officers, and the fire service to focus their checks and attention on premises that require action.

A city centre triage and help point has also been introduced, where members of the public can access treatment for minor injuries or advice. The South Yorkshire Ambulance Service and South Yorkshire Police also undertake joint patrols, therefore ensuring an improved service to the public. These initiatives have led to a reduced demand for ambulance services at peak demand times. Initial data suggests that this reduction is around 7% on both Friday and Saturday nights. A taxi-marshalling scheme at key locations within the city has also been launched and is proving a great success. It ensures that night-time revellers can get out of the city quickly and efficiently rather than becoming embroiled in disorder or violence.

St. Neots Community Alcohol Partnership Pilot Project: In September 2007, Cambridgeshire Trading Standards and the Retail of Alcohol Standards Group began a new initiative – a Community Alcohol Partnership (CAP) – to reduce alcohol-related disorder. They aimed to bring about a cultural change by improving information-sharing between off-trade retailers, the local police and Trading Standards officers. St Neots, a small market town in central Cambridgeshire with a population of 30,000 and a history of anti-social behaviour and youth-related disorder, was selected for the project. Over the life of the project St Neots saw a 42% reduction in anti-social behaviour, a 94% decrease in under-age people found in the possession of alcohol and a 92% decrease in alcohol-related litter at key hot spot areas.

HubCAPP **Link: YH5N** www.hubcapp.org.uk/YH5N

High Impact Change 3

Influence change through advocacy

What does this mean?

Find high-profile champions to provide leadership within partner organisations and a focus for action to reduce alcohol harm. This is never easy but a champion within the PCT, the acute hospital, Social Services, local authority, elected members, Probation, the Police and other partners can galvanize change and action. Champions can help build the case for local investment and potential savings to the NHS, the community and the public purse.

Particularly, identify a clinical champion who can influence and support positive changes in the attitudes and skills of those within health settings responding to, or caring for, individuals with alcohol-related problems.

What is the evidence that this works?

The Community Trials Project (Moore and Holder 2003) lists a number of key elements in making progress on alcohol harm:

- Community leadership
- Making local alliances
- Working with local politics
- Making the case for and seeking additional resources

Every acute hospital should have a named Consultant as their 'Alcohol Lead' from whatever acute specialty is pragmatic for that hospital. This individual should have time allocated within their weekly job plan. (Royal College of Physicians, 2001)

References:

Moore, R.S., and Holder, H.D. (2003) 'Issues surrounding the institutionalization of local action programmes to prevent alcohol problems. Results from a community trial in the United States', *Nordic Studies on Alcohol and Drugs*, Vol. 20, English supplement, pp. 41-55

Alcohol – can the NHS afford it? London: Royal College of Physicians, (2001)

Case Examples

St Mary's Hospital, London – Emergency Department (ED): Under the leadership of their Consultant, Professor Robin Touquet, all junior doctors and staff were trained to tackle alcohol misuse. They developed a screening tool specifically designed for their environment, the Paddington Alcohol Test (PAT). All patients presenting to A&E with one of the targeted conditions are screened for alcohol misuse. Patients who are drinking at increased or higher risk are offered the opportunity to return to the hospital the following day (or within a few days) to have a session with the A&E's Alcohol Health Worker. This worker is a trained nurse who carries out a more in depth assessment concerning the individual's lifestyle and alcohol use. The worker then delivers brief advice and education concerning the patient's use of alcohol.

HubCAPP **Link: GWAQ** www.hubcapp.org.uk/GWAQ

Professor Jonathan Shepherd in Cardiff pioneered work demonstrating that A&E departments are capable of collecting valuable data on patients attending as a result of alcohol use and working in partnership with local organisations such as police, social services, public health, industry representatives and local authorities to develop effective strategies for local intervention. The sharing of data across services to develop a full picture of premises and factors that are contributing to alcohol harms in a community has been shown to promote the development of community-based interventions that target specific premises and areas.

Derbyshire Violence, Alcohol harm, Licensing (VAL) Project: The project came about through a Police Inspector being seconded to Derbyshire DAAT and given a brief to research how violent crime could be reduced within Derbyshire. From his recommendations the 'Violence, Alcohol harm, Licensing' (VAL) meetings were set up.

HubCAPP **Link: SEVD** www.hubcapp.org.uk/SEVD

Bristol Hospital Based Alcohol Nurse Specialist: United Bristol Healthcare Trust (UBHT) appointed a full-time Alcohol Nurse Specialist (ANS) in October 2006. The full-time role was developed after a part-time pilot in the Hepatology Unit had proved cost-effective through a reduction in re-admission rates and had led to positive health outcomes.

HubCAPP **Link: QAM2** www.hubcapp.org.uk/QAM2

High Impact Change 4

Improve the effectiveness and capacity of specialist treatment

What does this mean?

Dependent drinkers represent a very high-risk group for alcohol-related hospital admissions. Providing evidenced based, effective treatment as well as increasing treatment opportunities for dependent drinkers may offer the most immediate opportunity to reduce alcohol-related admissions. Reviewing care pathways, access times and blockages into treatment offer opportunities to improve the local treatment system.

What is the evidence that this works?

Models of care for alcohol misusers (MoCAM) describes a four tier system of stepped care for alcohol misusers (DH, 2006)

The *Review of the effectiveness of treatment for alcohol problems* provides the evidence base for effective treatments (NTA, 2006)

McKenna *et al.* (1996) showed that alcohol dependent service users were more costly in terms of health costs than those with other levels of alcohol abuse – £1222 compared to £632 over a six month period in 1994 prices – and have poorer health.

The UK Alcohol Treatment Trial (UKATT) shows that, over a 6-month period, specialist treatment delivered savings of nearly £1138 per dependent drinker treated and reduce hospital stays (UKATT Research Team, 2005b).

25% of patients involved in the UKATT study had a successful outcome, reporting no continuing alcohol-related problems and 40% of patients reported being much improved, reducing their alcohol problems by 66% (UKATT Research Team, 2005a).

References

McKenna, M., Chick, J., Buxton, M., Howlett, H., Patience, D. and Ritson, B. (1996) The SECCAT Survey 1. The costs and consequences of alcoholism, *Alcohol and Alcoholism*, 31(96): 565–576.

Department of Health (2006). *Models of care for alcohol misusers (MoCAM)*. DH

National Treatment Agency (2006). *Review of the effectiveness of treatment for alcohol problems*. London: NTA

UKATT Research Team (2005a). Effectiveness of treatment for alcohol problems: Findings of the randomised UK Alcohol Treatment Trial (UKATT). *British Medical Journal*, 311, 541–544.

UKATT Research Team (2005b). Cost-effectiveness of treatment for alcohol problems: Findings of the UK Alcohol Treatment Trial. *British Medical Journal*, 331, 544–547.

Case Examples

Bolton Redesigned Alcohol Treatment System: After identifying a lack of integration and efficiency in the structure of local alcohol services, Bolton PCT and Bolton Council worked with local service providers to redesign the area's Alcohol Treatment System in 2007.

HubCAPP **Link: V3FO** www.hubcapp.org.uk/V3FO

High Impact Change 5

Appoint an Alcohol Health Worker

What does this mean?

Since their report in 2001, The Royal College of Physicians have advocated the appointment of a dedicated Alcohol Health Worker or an Alcohol Liaison Nurse in each major acute hospital, to work with a named Consultant/Senior Nurse Alcohol Lead, to provide a focus for:

- Medical management of patients with alcohol problems within the hospital
- Liaison with community alcohol and other specialist services
- Education and support for other healthcare workers in the hospital
- Implementation of case-finding strategy and delivery of brief advice within the hospital.

What is the evidence that this works?

Over an 18 month period, the intensive care management and discharge planning delivered by an Alcohol Liaison Nurse in the Royal Liverpool Hospital had been shown to prevent 258 admissions or re-admissions – about 15 admissions per month.

Economic analysis of such an appointment in a general hospital suggested that the post saved ten times more in reducing repeat admission than its cost.

References

Alcohol – can the NHS afford it? London: Royal College of Physicians, (2001)

Case Examples

Nottingham Alcohol Liaison Team: This team has been operational since March 2002. Based principally at the Queen's Medical Centre this patient-centred project works closely with local statutory and non-statutory healthcare, alcohol and drugs services as part of its inclusive and co-ordinated approach.

HubCAPP **Link: JIR3** www.hubcapp.org.uk/JIR3

Middlesbrough voluntary sector partnership: best practice example

An alternative to employing a nurse is to employ alcohol workers from the third sector to work within the A&E. In Middlesbrough the Albert Centre provides services in Middlesbrough James Cook University Hospital and is funded via the Safer Middlesbrough Partnership (SMP). The service is called the Primary Alcohol and Drugs Service (PADS) and has been running for over 12 months. The service is cost effective offering 2 full time (equivalent) PADS workers and part time administration support for around £73k. Employment of two staff provides enhanced capacity to see patients and allows for cover during sickness and holidays. The third sector workers are trained in 'talking therapies' and have motivational interviewing, CBT, counselling skills amongst others. They can offer a holistic approach covering all factors which may be affecting patients drinking behaviour such as housing, debt, bereavement, etc and can liaise with community based services, arrange appointments and advocate on behalf of the patient. The PADS workers also provide training to the doctors and nurses who rotate job roles at regular intervals. PADS workers visit wards where more chronic dependent drinkers are treated for medical conditions associated with their drinking; ensuring that community treatment services can prioritise patient follow up.

SMP have asked Teesside University to carry out a assessment /review of the effectiveness of the PADS service which will be completed in the summer 2009.

High Impact Change 6

IBA – Provide more help to encourage people to drink less

What does this mean?

Identification and Brief Advice (IBA) is opportunistic case finding followed by the delivery of simple alcohol advice (in the research literature, this is referred to as **Alcohol Screening and Brief Interventions**). These are effective interventions directed at patients drinking at increasing or higher-risk levels who are not typically complaining about or seeking help for an alcohol problem.

IBA can be effectively implemented in a number of settings including:

- Primary Care – targeted at increasing and higher risk groups
- A&E Departments – possibly with the use of Alcohol Liaison Nurses or Alcohol Health Workers

- Specialist settings – e.g. maxillofacial clinics, fracture clinics, sexual health clinics
- Criminal justice settings such as Probation and arrest referral schemes (evidence to support this setting is still emerging)

What is the evidence that this works?

There is a very large body of research evidence supporting IBA in primary care including at least 56 controlled trials (Moyer *et al.*, 2002). A Cochrane Collaboration review (Kaner *et al.*, 2007) provides substantial evidence for the effectiveness of IBA.

For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels (Moyer *et al.*, 2002). This compares favourably with smoking where only one in twenty will act on the advice given (Silagy & Stead, 2003). This improves to one in ten with nicotine replacement therapy.

Patients who received IBA in A&E made 0.5 fewer visits to the A&E during the following 12 months (Crawford *et al.*, 2004).

References

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Kaner E, Beyer F, Dickinson H, Pienaar E, Campbell F, Schlesinger C, Heather N, Saunders J, Bernand B. 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.

Moyer, A., Finney, J., Swearingen, C. and Vergun, P. (2002) Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment seeking populations, *Addiction*, 97, 279–292.

Silagy, C. and Stead, L.F. (2003) Physician advice for smoking cessation (Cochrane Review), in: *The Cochrane Library, Issue 4* (Chichester, Wiley).

Case Examples

Camden PCT: The Camden Local Enhanced Service (LES) is designed to support interventions which are known to be effective in reducing alcohol misuse. The Local Enhanced Service has been implemented in Camden GP Practices with input from the PCT Sensible Drinking Service and other Camden alcohol provider services.

The Camden Alcohol LES has three levels. Practices can choose to participate in only the lower levels or in all of them. Practices applying for the LES are expected to provide both lower levels as a minimum. The LES will be reviewed after the first six months of implementation.

HubCAPP **Link: 6IR5** www.hubcapp.org.uk/6IR5

NHS Stoke on Trent: Stoke has set out a framework for quality improvement in general medical practices, as an integral part of their Primary Care Strategy. The ultimate purpose of the initiative is to reduce health inequalities across the population of Stoke on Trent and improve health outcomes. It will incentivise general practice teams to strive for and attain aspirational standards that are set over and above contractual and statutory requirements and the quality and outcomes framework (QOF). The PCT will be providing support and development for practices to achieve exemplary standards of service and *high quality care for all*⁵⁵. The process is voluntary seeking continuing quality improvement year on year. The scheme, which covers all aspects of primary care, makes specific reference to preventing alcohol-related harm throughout. This ranges from looking at expected prevalence data on joining the scheme through to exemplary standards around identification and brief advice. The document, *Improving health outcomes: Setting aspirational standards in general medical practices in Stoke on Trent*, can be found at the following address and will be continuously updated as standards rise; <http://www.stokepct.nhs.uk/pdfs/890.pdf>

The Sheffield Identification and Brief Advice Training Project: This programme is designed to develop skills amongst a range of Tier 1 and 2 staff working face-to-face with increasing and higher risk drinkers, and enabling these staff to deliver opportunistic identification and brief advice in their communities.

HubCAPP **Link: QXDT** www.hubcapp.org.uk/QXDT

55 *High Quality Care For All: NHS Next Stage Review Final report*, Professor the Lord Darzi of Denham KBE, 2008, Gateway 10106, Cm7432.

Hampshire Brief Interventions Training: Since March 2007, Hampshire DAAT has provided alcohol IBA training to over 150 front line staff from a variety of organisations across the statutory and voluntary sector.

HubCAPP **Link: GWQU** www.hubcapp.org.uk/GWQU

Cornwall Brief Interventions Training: In November 2007, Cornwall & Isles of Scilly PCT employed a Brief Intervention Officer to set-up and deliver an IBA training package in the area. The role encompasses the co-ordination of training materials (including a website, leaflets and training resources) and the delivery and evaluation of training sessions in identification and brief advice to a range of organisations across Cornwall.

HubCAPP **Link: TL73** www.hubcapp.org.uk/TL73

Gloucestershire Alcohol Arrest Referral Scheme: In 1999, the Gloucestershire Drug and Alcohol Service (GDAS) and the Gloucestershire Constabulary launched the Alcohol Arrest Referral Scheme project (AARS). The scheme, the first of its type in the country, is not cell based and aims to minimise additional work for Custody Staff.

HubCAPP **Link: B2VC** www.hubcapp.org.uk/B2VC

Leeds Pharmacy Brief Alcohol Interventions: In 2006, professionals from Leeds PCT and Leeds Pharmaceutical Committee collaborated to launch this innovative research project. The intention was to investigate the feasibility of community pharmacists incorporating IBA for increasing and higher risk drinkers as a routine part of their public health role.

HubCAPP **Link: OFAT** www.hubcapp.org.uk/OFAT

High Impact Change 7

Amplify national social marketing priorities

What does this mean?

Social marketing is the systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, for a social good. For alcohol, the goal is to reduce alcohol-related hospital admissions by influencing those drinking at higher risk to reduce their use of alcohol to within lower risk levels.

PCTs and partners are advised to commission local social marketing activity which builds on the evidence, strategic framework and tools emerging from the national alcohol social marketing programme, such as direct marketing materials, wall charts and fact sheets for GPs, and the *Your Drinking & You* booklet.

What is the evidence that this works?

Evidence supporting social marketing exists in areas such as smoking, sexual behaviour and nutrition. But direct evidence concerning alcohol is still emerging. The alcohol social marketing strategy improves access to identification and brief advice through using marketing techniques to engage higher risk drinkers and nudge them toward lower risk drinking behaviour. It provides self-help support via the *Your Drinking & You* booklet. Other products and techniques are in the pipeline.

Case Examples – Social Marketing

East Midlands: PCTs from East Midlands worked with the Regional Social Marketing Manager to develop a campaign targeting higher risk drinkers in their area. Building on the lessons learned by the ongoing national alcohol social marketing programme, they launched a multi-media campaign combining direct marketing tailored for their area and locally-sourced advertising and PR. Coupons in local papers, mail drops and direct mail were used as routes to reach harmful drinkers.

The materials used in the trial encouraged drinkers to assess their own drinking and gave them reason to cut down. They were directed to the DrinkCheck website and also the Drinkline telephone helpline service to obtain a copy of the self-help booklet *Your Drinking and You*.

Case Examples – Educational and awareness raising campaigns

Brighton Alcohol Awareness Campaign: A month-long alcohol awareness campaign targeted at 16-24 year olds reinforcing the 'Know Your Limits' campaign. The centre piece was of a series of sensible drinking messages displayed on fifty paving slabs across the city centre's popular drinking areas.

HubCAPP **Link: VY1X** www.hubcapp.org.uk/VY1X

Buckinghamshire Sensible Drinking Campaign: Public awareness to highlight the importance of sensible drinking to 30 to 50 year old age group. The project involved the production and promotion of an advert entitled 'Gourmet Dining' which looked at the impact on the liver of exceeding the lower risk unit levels. The clip was released on YouTube and the DAAT website

HubCAPP **Link: KZLO** www.hubcapp.org.uk/KZLO

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Hampshire PCT
Ian Treasure, Alcohol Harm Reduction and Commissioning Manager, NHS East Lancashire
Kevin Wilson, Chief Executive Officer, The Albert Centre, Middlesbrough
Leeds PCT
Liverpool PCT
Marie-Carmen Burrough, Public Health Strategist, Tower Hamlets PCT
Middlesbrough PCT
Nottingham PCT
Oxford PCT
Sarah Ward, HubCAPP Manager, Alcohol Concern
Sheffield PCT
Sue Baker, Independent consultant
Stoke on Trent PCT
Surrey and Borders Partnership NHS Foundation Trust
Tower Hamlets PCT
Westminster PCT
Dr Zafar Iqbal, Deputy Director of Public Health, NHS Stoke on Trent

