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▶ Supporting partnerships to reduce alcohol harm: key findings, recommendations and case studies from the Alcohol Harm Reduction National Support Team.

[UK] Department of Health, Health Improvement, National Support Teams.
[UK] Department of Health, 2011.

When the English Department of Health's alcohol policy support team visited local areas, they found an improving but often muddled and uncoordinated attempt to improve public health through alcohol-related interventions which lacked consistent commitment.

Adapted abstract National support teams were established by the Department of Health from 2006 to support local areas – including local authorities, primary care trusts and their partners – to tackle complex public health issues more effectively using the best available evidence. By undertaking intensive 'diagnostic' visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten teams provided intelligence, support and challenge to local areas to help them achieve better public health outcomes. The programme finished in March 2011.

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

They undertook more than 480 visits to local partnerships and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work.

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

support, either at the time of reporting, or as part of follow-up activity.

This document describes the work of the Alcohol Harm Reduction National Support Team. The team formed part of the Department of Health's Alcohol Improvement Programme, and followed a similar methodology to the other public health national support teams.

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

Section two provides an analysis of the findings of the team during these visits and outlines the common recommendations made to areas to accelerate their progress in reducing alcohol-related harm. This section has been developed to allow local authorities and their partners to understand fully the areas of particular challenge as they manage the transition to alcohol being embedded within their new public health responsibilities. This section also highlights examples of good practice identified by the team during the visits.

Section three uses case studies to illustrate the experience of areas visited by the team. These outline key recommendations made by the National Support Team, follow-up support provided and describe the impact this had in the area.

The following text from section two explores the most common themes to emerge in order to describe:
- the main issues the team identified during visits;
- common recommendations.

Strategic arrangements

'Vision', 'strategy and performance', 'local leadership', and 'organisational & partnership arrangements' are frequently occurring themes contained in National Support Team reports. All but one of the analysed reports contained recommendations about strategy and performance. Recommendations about organisational and partnership arrangements were made in 80%, vision occurred in 70%, and local leadership in over half during 2009/10.

Vision, strategy & performance

The National Support Team found that many areas did not have a clear shared vision for reducing alcohol-related harm and that alcohol strategies were often out of date or being rewritten. Where areas did have a vision, or a strategy, this did not always reflect a partnership approach. In several cases, one or two individuals had developed the alcohol strategy in isolation and key partners were not actively engaged in the development or delivery of the strategy. Consequently, partners did not always fully understand either their contribution to meeting the desired outcomes or recognise how their organisation could contribute to reducing alcohol-related harm. Many partners had not recognised the importance of embedding the reduction of alcohol-related harm in their own strategic or operational plans.

The team therefore recommended that areas agree a clear vision, aim and objectives for

their strategies, so all partners understood what they should be trying to achieve and were clear about the contribution they could make to realising the vision.

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

Where delivery plans were in place, the absence of SMART objectives [Click here for explanation] made it difficult for them to monitor whether their planned actions delivered the desired outcomes. Several areas' delivery plans did not: reflect local needs; include specific targets; or align the plan's outputs to alcohol strategy objectives.

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

- a three-year action plan with specific milestones;
- detailed SMART objectives;
- named designated operational leads responsible for delivery;
- sufficient resources to deliver the plan;
- performance indicators to monitor progress.

Organisational and partnership arrangements

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

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

In many cases, the team recommended that areas review structures and governance arrangements to provide a clearer structure that held partners to account for the joined-up delivery of the alcohol strategy. Similarly, in many cases they recommended reviewing the terms of reference and membership of alcohol strategy groups. Arrangements do not necessarily need to be based around an alcohol strategy group. Some areas had effective governance arrangements based on other partnership groups and structures.

In some areas, the National Support Team recommended the identification of a dedicated

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

Local leadership

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

Identifying champions to influence change through advocacy and drive the agenda is a 'High Impact Change'. The National Support Team therefore recommended that areas identify designated champions, including clinical and elected member champions. The team also suggested that the role of these champions should incorporate acting as advocates providing leadership in their organisation to promote initiatives to reduce alcohol-related harm.

Commissioning

Recommendations about commissioning were included as priority actions in 70% of visit reports. Three sub-themes figured prominently:

- the need to improve commissioning structures and processes;
- ensuring that commissioned services are fully integrated;
- the need to improve contract management and performance management of providers.

Commissioning structures and processes

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

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

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

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

Where commissioning did not appear to be needs-led, the team recommended that areas

assess local service provision and capacity against local need and focus on populations among whom interventions are likely to have the greatest impact on reducing hospital admissions.

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

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

Ensuring that commissioned services are fully integrated

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

In visits undertaken by the National Support Team during its first year of operation, the team frequently highlighted the discrepancy in many areas between the lack of resources allocated to alcohol programmes and the priority afforded to alcohol in their local area agreements and primary care trusts' strategic plans. More recently, as the financial position of many primary care trusts and local authorities began to change, the team focused on recommending interventions that reduce the rate of hospital admissions and release cost savings elsewhere in the system. The team highlighted the likely cost-benefits of those interventions in its recommendations.

Contract monitoring and performance management of providers

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

Data

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

Needs assessment

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

Many of the strategic data and information documents the team saw did not enable partners to make decisions or inform commissioning. These included: alcohol needs assessments, joint strategic needs assessments and strategic intelligence assessments. The National Support Team therefore recommended that when areas undertake such assessments they:

- include a wide range of data sources from relevant partner organisations;
- use language that is widely understood amongst partners;
- spell out how an organisation's core activity might have an impact on a particular phenomenon;
- provide advice about targeting for maximum gain;
- provide evidence-based suggestions of input (or options appraisal).

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

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

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

Rate of hospital admissions per 100,000 for alcohol-related harm

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

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

- undertake a detailed analysis of their data;

• communicate their findings to ensure all partners understand the target and the contribution they can make to reducing alcohol-related admissions.

Areas with large and diverse minority populations, or rapidly growing or transient populations, were keen to point out their deviation from the national norm and the implication that the rate of hospital admissions per 100,000 for alcohol-related harm data was not representative or possibly relevant. Some areas also reported that they felt coding practices in their acute trusts were affecting their rate of admissions. However, few areas were able to support their assertions with evidence. Consequently, the team made recommendations to encourage areas to investigate these claims further to support commissioning intentions.

Patients repeatedly admitted to hospital for conditions related to alcohol

The National Support Team challenged areas to make their analyses relevant so they can be used to inform commissioning. In particular, using data to target populations among whom an intervention will have the most impact. Often areas had only analysed depersonalised hospital data. Therefore the team recommended that areas look to other data sources to identify individuals repeatedly admitted for alcohol-related conditions and target interventions accordingly.

Alcohol treatment services

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

In the first 6–9 months of visits, the team found wide variations in specific alcohol treatment provision across tiers 1–4, against a background of historical low-level provision. Whilst some areas had been successful in identifying resources for alcohol and were developing provision based on identified need, others were facing challenges in identifying resources with no clear understanding of the needs of the population and the treatment provision required. Often, alcohol services were a bolt-on to established drug services with little clarity on service level agreements, resources and capacity. Many areas were in the process of disentangling large block contracts with mental health trusts. 'Early implementer' areas were mainly using the additional funding through the programme to improve treatment and were at various stages in this process.

After the initial 6–9 months of visits, the team began to see more consistency in approaches to alcohol treatment development, the redesign of alcohol treatment systems and tendering becoming more common.

Analysis of all alcohol treatment and intervention recommendations from visits highlighted the three most common sub-themes:
• developing a fully integrated treatment system across tiers 1–4, including a clearly defined model and treatment pathways;
• developing primary care alcohol interventions, including the development of the Directed Enhanced Service or Local Enhanced Service;
• developing/reviewing alcohol interventions within the acute hospital.

Developing a fully integrated treatment system across tiers 1–4, including a clearly defined model and treatment pathways

The National Support Team found in most areas there was a need to bring together service provision to form an integrated alcohol treatment system, as opposed to separate silos of provision with undeveloped connections between each component. In some areas, work had already started on this, but often the team found confusion over the intended treatment system model and a lack of clear pathways. More often than not there was confusion about access points, and identification tools were being used inconsistently. In other areas, whilst some tiers of provision were developed, other tiers, especially tier 1 and 2,

were either absent or largely undeveloped. Additionally, areas frequently expressed their concerns over the capacity of the system to cope with estimated drinking levels in the population.

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

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

- mapping existing pathways to identify blocks to access, throughput and transitional fallouts;
- navigating the system through the medium of clearly identified and published pathways (for all treatment interventions and priority population groups);
- describing entry points and routes, dependent on the needs of individuals.

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

Developing primary care alcohol interventions, including the development of the Directed Enhanced Service or Local Enhanced Service

The National Support Team found a wide variation in the provision of primary care alcohol interventions. Whilst most areas were implementing the Directed Enhanced Service,

some had not developed a robust performance framework for the service or had not developed further alcohol services in primary care beyond this service. Some areas had developed a Local Enhanced Service or were planning to do so. The delivery of identification [including screening] and brief advice in primary care varied greatly from well-implemented and monitored systems to inconsistent ad hoc delivery. Some areas had invested in primary care support functions to assist in the development of interventions.

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

Developing /reviewing alcohol interventions within the acute hospital

During visits, the team found many areas had introduced alcohol liaison posts in emergency department and acute hospital wards, and other areas were planning this development. There were frequently issues with the coverage of the alcohol liaison service out of hours and covering leave, with usually only one or two post-holders covering the service.

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

We found blocks to progress centred on the lack of engagement from acute hospital trusts and lack of formal hospital champions. A few areas were using the contract with the acute hospital to embed identification and brief advice in the hospital through the use of Commissioning for Quality & Innovation indicators and Health Gain Schedules, whereas other areas had not considered this. In order to take hospital-based alcohol services forward, the team usually made a series of recommendations, including:
- the introduction of a multi-agency steering group to oversee and coordinate developments;
- identifying senior clinical and operational champions within the hospital to assist in implementation;
- the use of diversion schemes to reduce alcohol-related emergency department attendances;
- establishing a system for identifying and targeting high impact users;
- developing pathways from hospital into specialist alcohol services;
- use of Quality & Innovation and Health Gain Schedules in contracting.

Last revised 09 April 2011

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