



Alcohol Improvement Program in the East of England

A summary of regional work April 2008 to March 2011

FINAL DRAFT v5.2

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Acronyms

AIP	Alcohol Improvement Programme
AUDIT-C	Alcohol Use Disorders Identification Test Consumption
CQUIN	Commissioning for Quality and Innovation
DCSF	Department for Children Schools and Families
DAAT	Drug & Alcohol Action Team
DH	Department of Health
CSPs	Community Safety Partnerships
ED	Emergency Department
ERPHO	Eastern Region Public Health Observatory
GO	Government Office
IBA	Identification and Brief Advice
LAA	Local Area Agreements
NI	National Indicator
PCT	Primary Care Trust
QIPP	Quality Innovation Productivity Prevention
RADG	Regional Alcohol Development Group
RAM	Regional Alcohol Manager
RASG	Regional Alcohol Steering Group
RDPH	Regional Director of Public Health
SHA	Strategic Health Authority

i. Executive Summary

The three year Alcohol Improvement Programme (AIP) was established in April 2008 by the Department of Health (DH) to help reduce alcohol related health and social harm.

This paper summarises the work carried out across the region to reduce alcohol related harm in the East of England between April 2008 and March 2011. It encompasses the key findings and learning from work taking place in the region. In addition, it provides a summary of how performance has been monitored, the tools and guidance available to assist local areas and a description of the networks and mechanisms (including QIPP) that have helped to support the work which has taken place.

In term of the key outputs:

The DH have provided several rounds of regional funding, PCTs bid for funding and an outline of the projects that were funded and the findings of any evaluation are provided in section 5.1.

Section 5.2 focuses on Identification and Brief Advice (IBA), opportunistic case finding followed by the delivery of simple alcohol advice. These are evidence based, effective interventions directed at patients drinking at increasing or higher risk levels that are not typically complaining about or seeking help for an alcohol problem.

Further DH funding was directed towards the recruitment of Alcohol Health Workers. Various models of delivery have been developed in local areas and further information can be found in section 5.3. These posts are thought to be key locally in improving access to appropriate services and working towards a reduction in alcohol related hospital admissions, length of stay and readmissions however further work is required locally in evaluating the service they provide and the impact seen.

Research from Wales identifies that Emergency Departments (EDs) can contribute to violence prevention by working with and sharing data with local Community Safety Partnerships (CSPs). This data, and the contributions of consultants in CSP meetings, has been shown to enhance the effectiveness of targeted policing, reduce street violence, and reduce overall A&E violence related attendances. The aim is to have data sharing systems set up in all ED departments across the region. In April 2011, a Specialist Nurse post was established to provide consultancy and expert advice to support implementation of ED data sharing in the East of England.

A number of recommendations are made for local areas:

- To ensure that comprehensive evaluation is built into the planning and delivery of any proposed or existing intervention in order to inform future decision making.
- To continue to build the evidence base in terms of the delivery of Identification & Brief Advice (IBA) and the role of alcohol health workers. Ensuring that systems are in place to enable local assessment of their effectiveness, including their cost effectiveness.
- To continue progress on Emergency Department (ED) data sharing, and sustaining this where it exists. Ensuring good partner engagement and essentially communicating how the data helps to inform local management of alcohol related problems back to ED departments.
- Maintain a network or forum of local alcohol leads across the region to help ensure service delivery is based on the best available evidence, that good practice is shared and that improvements are made to continuously improve service quality.

1. Scope

This paper summarises regional work carried out to reduce alcohol related harm in the East of England between April 2008 and March 2011. It encompasses the key findings and learning from both directly commissioned work and other work taking place in the region. It includes:

- Alcohol development funded projects (phase 1 & 2)
- Identification and Brief Advice (IBA) training and roll out
- Alcohol health workers funded as part of health programmes funding in 2010/11
- Emergency Department Data sharing (local implementation of the Cardiff Model)
- Alcohol National Support Team (NST) Visits in the region
- Work by the Eastern Region Public Health Observatory (ERPHO)
- Regional conferences
- Regional Alcohol newsletter
- The Big Drink Debate
- Local case studies

2. Background

The three year Alcohol Improvement Programme (AIP) was established in April 2008 by the Department of Health to help reduce alcohol related health and social harm. Alcohol related hospital admissions across the NHS were used as a measure of this harm. The measure is defined as a reduction in chronic and acute ill health caused by alcohol, resulting in fewer alcohol related accidents and hospital admissions than otherwise projected from 2008/09 baseline (derived from trend data spanning the last five years of admissions).

The objectives of the programme were to:

- Support capacity and capacity building in local areas to ensure sustainable improvement in interventions to reduce alcohol related harm.
- Collate and disseminate evidence, data, tools and guidance to support the NHS and local partners
- Produce guidance on the key enablers and activities for change.
- Work with regions to ensure that local learning and innovation is shared nationally.

Later this also involved delivering on the Quality Innovation Productivity Prevention (QIPP) agenda and making efficiency savings available from improved alcohol services.

Components of the alcohol improvement programme include:

- Regional Alcohol Managers (RAMs), providing linkage between Government Offices (GO) for the regions RDPH and DH, assuring local delivery and performance monitoring and provide regional and local advocacy and championing. The East of England RAM (Melvin Hartley) took up post in February 2009 and left this post in August 2010.
- Alcohol Learning Centre: An on line resource which disseminated national, regional and local information and resources to support PCTs and wider NHS delivery
- Hub of Commissioned Alcohol Projects and Policies (HubCAPP) and online resource of local alcohol initiatives.

- Early Implementer Sites, nationally 20 PCTs were selected from those that faced the highest challenge. None of these PCTs were within the East of England.

The AIP also developed a number of tools and guidance documents to assist PCTs and their partners, these are outlined in Appendix 1. Within this guidance, the Department of Health identified key actions that PCTs can take which will most likely have the highest impact on reducing alcohol related harm and admission. These High Impact Changes are outlined in the DH paper, Signs for Improvement and are to:

1. Work in partnership
2. Develop activities to control alcohol misuse
3. Influence change through advocacy
4. Improve effectiveness and capacity of specialist treatment
5. Appoint alcohol health worker
6. IBA provide more help to encourage people to drink less
7. Amplify national social marketing priorities

3. East of England Regional Alcohol Programme infrastructure and governance

The national alcohol strategy 'Safe. Sensible. Social' (June 2007) set out areas for government action on legislation, problematic drinkers and promoting sensible drinking. It was the role of the regional tier of government to ensure a comprehensive approach to reducing alcohol harm across its population, particularly in 'hotspot' localities and amongst communities and groups experiencing the greatest problems.

In December 2007, the SHA Board approved the final version of *Improving Lives: Saving Lives*, a strategy for the NHS in the East of England. With respect to alcohol it acknowledged that excess alcohol consumption is of relevance to several of the pledges, and that a focus on safe alcohol consumption is required to support delivery of the strategy. A paper "Reducing alcohol related harm" was later presented by the RDPH in March 2008 which demonstrated the links between alcohol harm reduction and delivery of the Improving Lives, Saving Lives pledges. This paper set out a governance structure and a programme of work.

A Regional Alcohol Steering Group (RASG) was established to provide strategic oversight and direction of the programme, programme delivery was managed through a Regional Alcohol Delivery Group (RADG) supported by five task and finish groups. See figure 1 below.

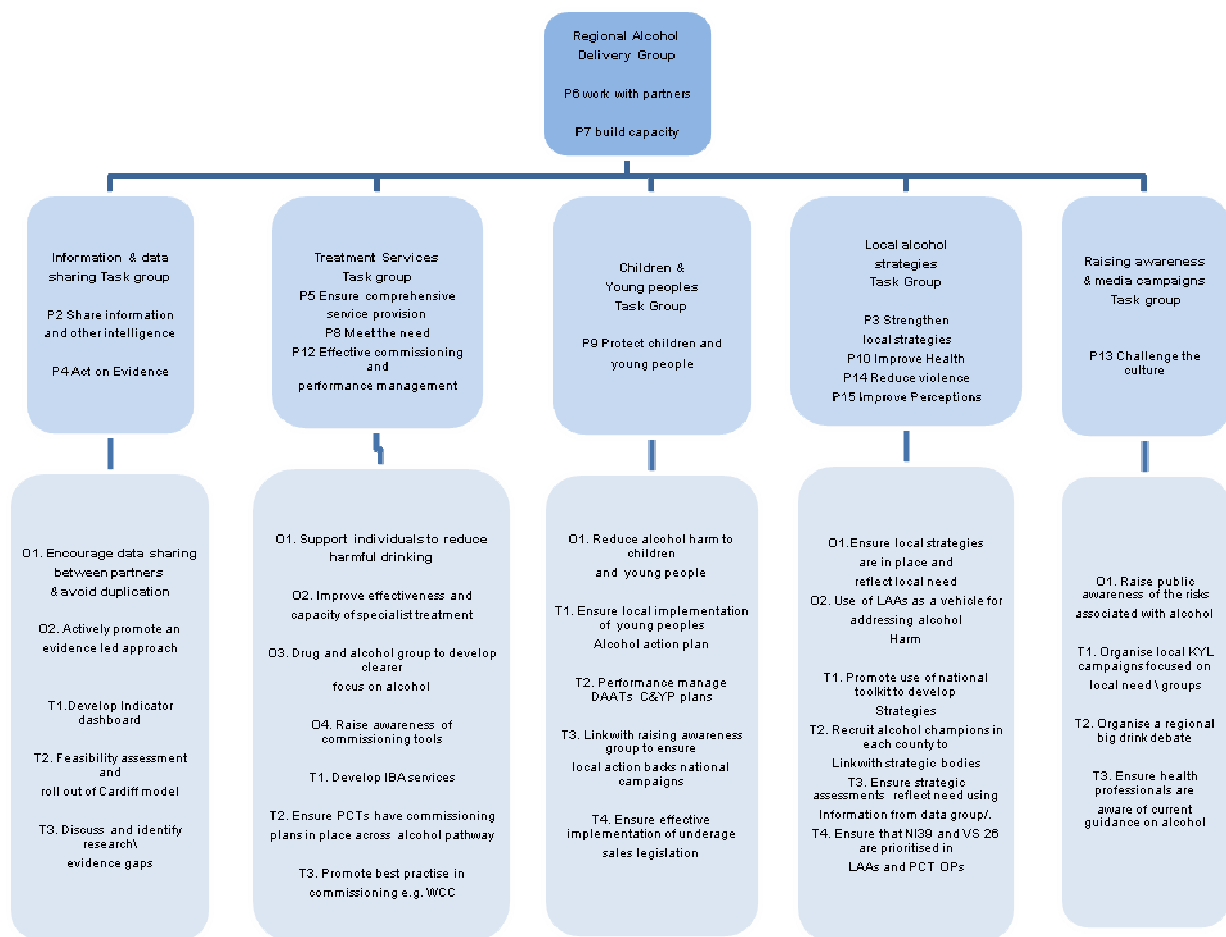
The alcohol work plan for the East of England 2009 -2011 (Appendix 2), set out a framework to advice the RASG on some clear key priorities with the overall aim to minimise the health harms, violence and antisocial behaviour associated with alcohol while ensuring that people are able to enjoy alcohol safely and responsibly. The RADG was tasked by the RASG to deliver the alcohol work programme and advise the RASG on progress and risks to delivery.

The RADG met frequently, its members were senior offices drawn from key partner agencies including PCTs, Acute Trusts, the Police, the Ambulance Trust, Government Office, National Offender Management Service and the trade. The role of the RADG was to oversee the Alcohol Improvement Programme action plan. The group had the following aims:

- To provide strategic regional oversight and coordination during the implementation and development of strategic delivery of alcohol strategies with each locality
- The group should serve as a conduit for effective communication between key partners/ stakeholders organisations
- The group will be responsible for the strategic oversight and management of a defined and agreed delivery plan.

The RADG oversaw the delivery of the National Alcohol Strategy in the region and ensured the effectiveness of the work of the departments and organisations represented by focussing on the areas of risk and areas of success. In addition, they identified and disseminated good practice. A number of working groups reported into the RADG as outlined in figure 1 below. These working groups focused on the priority areas outlined in the East of England Regional Alcohol Plan 2009-2011: treatment, awareness, young people, crime and justice and information.

Figure 1 Regional Alcohol Delivery Group Structure



Key: P = Priorities, O = Outcomes, T = Tasks

4. Performance Measures

The monitoring of performance was primarily through National Indicator NI20 (assault with injury crime rate) NI39 (reducing alcohol related hospital admissions) and NI41 (perceptions drunken/rowdy behaviour), all seen as key Local Area Agreement (LAA) indicators for alcohol by the

Home Office, although NI39 is also a key DH indicator matching up to Vital Signs Indicator VS26 measuring changes in the rate of alcohol related hospital admissions. All LAAs, apart from Bedfordshire and Cambridgeshire chose to include at least one of these in their 'up to 35' set of priority indicators.

NI115 (Substance Misuse by Young People) which is a DCSF indicator includes alcohol and is also important for LAAs.

In addition work was undertaken by ERPHO to provide analytical support on alcohol related information and performance metrics, please see section 5.6.

5. Outputs

5.1 Alcohol Development funded projects (phase 1 & 2)

The DH provided regional funding to support the implementation of the High Impact Changes to reduce alcohol related hospital admissions. Invitations were sent out to PCTs within the Eastern Region to apply for alcohol harm reduction development funds.

The selection criteria for those involved are:

- A commitment to reducing alcohol related admission, with an expectation that any PCT applying for funding are to include the VSC26 target based on the expected outcomes of the project
- A clear plan of action based on an assessment of local needs and the range of high impact changes
- A plan to evaluate the impact of interventions and treatments
- A willingness to participate in learning sets and other supportive activity
- A willingness to disseminate what is learned to others

The bids were assessed by two independent reviews based on their objectives, how the project was identified, whether they followed the High Impact Changes, what outputs and outcomes they envisaged and their monitoring and evaluation proposals. Each application needed to show clearly defined objectives, outputs and outcomes. Further detail on each of the funded projects is provided in table 1.

Table 1: Alcohol Development Fund Projects

PCT & Contact	PROJECT DETAILS	AWARD	High Impact Changes							Summary of Outcomes
			1	2	3	4	5	6	7	
Phase 1 2008/09; 2009/10										
Bedfordshire Jackie.golding@Bedfordshire.nhs.uk Sarah.pacey@Bedfordshire.nhs.uk	Research building capacity and deliver IBA using train the trainer, staff awareness, public awareness, evaluation	£45,000								58 people trained in IBA and 15 in train the trainer. Delegates from a wide range of settings, Police, mental health services, practice nurses, advocacy services, drug agencies, health champions, local polish support centres and staff at HMP Bedford. Primary care staff also trained from all 5 GP consortia in Autumn 2010. Awareness campaign started in October 2010 and ran for a year. Three sided approach to the campaign, 1) to raise awareness of IBA and the staff who are trained, 2) new alcohol message/information 3) where to find help. Aims of evaluation to include impact of public awareness, staff awareness and brief interventions
Cambridgeshire (DAAT) Susie Talbot DAAT Coordinator	County Alcohol Harm Reduction Coordinator, leading the work on the multi agency county alcohol strategy	£20,000								Countywide coordinator appointed to implement Alcohol Harm Reduction Strategy. Encouraging working in partnership, influencing change through advocacy, develop local activities to control alcohol misuse. The post also assisted in the delivery of the Community Alcohol partnerships across the county with the aim of reducing alcohol related harm amongst young people in Cambridgeshire. The Post holder left post December 2010
Cambridgeshire (Trading Standards) Nikki.pasek@Cambridgeshire.gov.uk	Evaluation of St Neots Community Alcohol Partnership	£10,000								Completed, interim report received full report August 2010 Providing an assessment of the implementation and progress of the Community Alcohol Partnerships (CAP) in St Neots and Cambridge. The aim of CAP to bring a cultural change by improving information sharing between off trade retailers, the local police and Trading Standards Officers.

PCT & Contact	PROJECT DETAILS	AWARD	High Impact Changes							Summary of Outcomes
			1	2	3	4	5	6	7	
										Findings that CAP approach may be particularly effective in small well defined communities where the main problem is clearly identified as underage drinking. The extent to which proxy purchasing (particularly parental supply of alcohol) is addressed may warrant further development and the linking of CAP approaches with the broader issues associated with underage drinking (eg young people's health and welfare services) may also be beneficial to a wide range of local agencies.
South East Essex Andrea.Atherton@See-pct.nhs.uk Glyn Halksworth, Southend DAAT	Delivery of IBA in primary care, community and A&E	£49,200								Alcohol screening and brief interventions trainer targeting work on those areas of deprivation and within the 18-24 aged population. Engagement made with Clubwatch and night-time economy group with a view to improve partnership working.
Peterborough Nikki.Griffiths@peterboroughpct.nhs.uk	A&E alcohol link workers and probation project	£20,000								Probation Project: Establishment of walk in sessions, resources and referral criteria. Commitment from probation to implement alcohol screening for all offenders. Initially limited uptake was experience despite anecdotal evidence of the level of need within probation. This work has now been mainstreamed, supported by training in screening for Offender Managers. For information on A&E Link workers please see phase 3 in this table
Suffolk Amanda.jones@suffolk.nhs.uk	Nurse specialist in West Suffolk hospital working on enhanced pathways and specialist	£46,636								Analysis identified a gap in alcohol service provision within the Acute Trust with a estimation that at least 10% of the inpatient population at any one time have an alcohol related problem. 6 month reports received showing gradual reduction in

PCT & Contact	PROJECT DETAILS	AWARD	High Impact Changes							Summary of Outcomes
			1	2	3	4	5	6	7	
	treatment for in patients									admissions however data for previous years to aid comparison is not available.
Mid Essex Jenny Wheeler Eric Pudaloff	Prison health trainers delivering IBA to other prisoners	£6,500								Project completed and independently evaluated. Evaluation included, information review, before and after surveys, and focus groups. Please see section 5.10 Alcohol and Offenders
Phase 2 2009/10										
North East Essex emma.bishton@northeastessex.nhs.uk	Part time nurse specialist targeting inpatients and A&E and outpatient referrals	£25,000								Alcohol Specialist Nurse started work in May 2010 at Colchester Hospital, the majority of referrals seen through the Emergency Assessment Unit. Training A&E staff in IBA in September 2010. Please see section 5.3.
Norfolk Jocelyn.pike@norfolk.nhs.uk	Extending the alcohol team in A&E by making specialist nurse fulltime and adding an admin support worker	£43,000								Staff started work in May 2010 strengthening the new acute alcohol liaison team at Queen Elizabeth Hospital Kings Lynn. Some savings identified in terms of shortening bed stays. Improved partnership working with community alcohol services, increased knowledge among hospital staff, joint working with the mental health liaison team increased use of AUDIT with A&E.
West Essex Paula.Clugston@westessexpct.nhs.uk	Extending the hours of the Alcohol Worker in A&E	£6,500								Worker started within A&E at Princess Alexander Hospital on 2 August 2010 please see section 5.3
Luton Glynis.allen@luton-pct.nhs.uk	IBA workers in probation service and in Bedford Prison	£35,000								IBA worker employed to work with probation clients and to train staff. Trained probation staff and delivering interventions in probation, police cells and bail hostels. The workers also provides sessions in police cells to people arrested on alcohol related charges.

PCT & Contact	PROJECT DETAILS	AWARD	High Impact Changes							Summary of Outcomes
			1	2	3	4	5	6	7	
Phase 3 2010/11										
Peterborough Nikki.Griffiths@peterboroughpct.nhs.uk	Enhancing links between acute hospital (A&E/EAU) and community services	£20,000								<p>Piloted a range of activities to strengthen links between A&E and other departments with Drinksense's community based service programmes. Focused on 1) establishing link workers in both Drinksense and A&E 2) A&E data, screening and referral, 3) increasing hospital staff knowledge of community based alcohol services and their confidence in making referrals 4) peak time attendance at A&E 5) Information for patients and staff 6) Fortnightly clinics in the Hepatology Department, alongside the acute liver disease outpatients clinic. With limited resources, Drinksense were keen to make most effective use of capacity to deliver a wide range of supporting systems. A number of Drinksense staff were deployed using a range of skills rather than a single liaison nurse. This developed a system of relationships between specialist alcohol services and hospital staff.</p> <p>Following the first year evaluation was undertaken to gauge the impact of the pilot on strengthening links between A&E and community based services. The headline results from consultation with staff and stakeholders included: 43% respondents said their awareness of Drinksense community services had increased, with 57% responding that they knew how to refer. 60% responded that they found the presence of a Drinksense working in A&E at peak times useful. 33% reported an increased confidence in referring to alcohol services, suggesting further scope for staff training. 67% respondents felt that they would be more inclined to screen for alcohol if they knew they could signpost to a dedicated onsite clinic.</p>

5.2 IBA training and roll out

Identification and Brief Advice (IBA) is opportunistic case finding followed by the delivery of simple alcohol advice. These are effective interventions directed at patients drinking at increasing or higher risk levels that are not typically complaining about or seeking help for an alcohol problem. There is a large body of research evidence supporting IBA in primary care including at least 56 controlled trials which found that 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 and Stead 2003).

In an 18 month period between February 2009 and August 2010, 206 people across the region were funded by regional funding to undertake IBA training. Of those trained, 139 were Improving Access to Psychological Therapies (IAPT) workers. The aim of offering this training was to enable local tier 1 workers to identify problem drinkers and make appropriate interventions. The course objectives included:

- To apply knowledge of alcohol unit system in the calculation of overall individual consumption
- To use and interpret the AUDIT and FAST alcohol screening tools in order to assess presence or degree of alcohol dependence
- To communicate effectively and confidently with service users about their alcohol use, based on a respectful and non-judgmental approach
- To impart alcohol related knowledge such as long term health implications and short term physical/psychological/behavioural effects of alcohol in an effective and non-judgmental way that supports change
- To identify and make appropriate referrals to local support mechanisms for those experiencing problems with alcohol
- To provide information about the various treatment and support options available for alcohol users.

Figures 1 and 2 provide the results of evaluation forms completed by 152 attendees, over nine of the events held. The overwhelming response was very positive, with the majority of participants indicating that the training met the objectives outlined above.

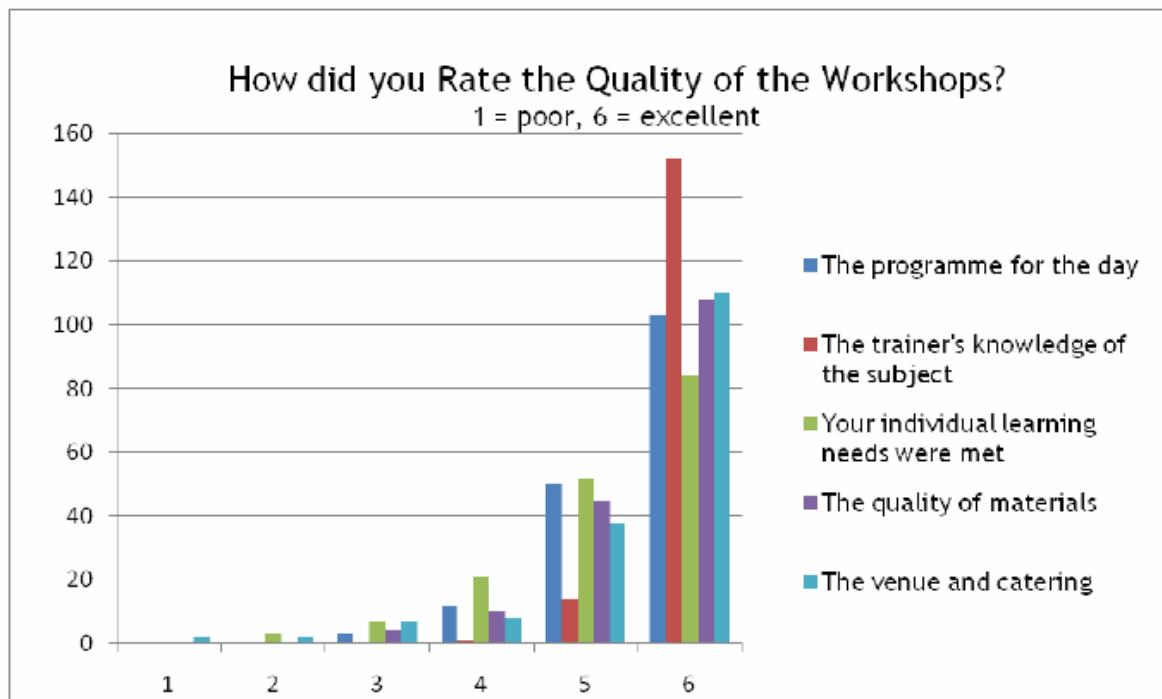
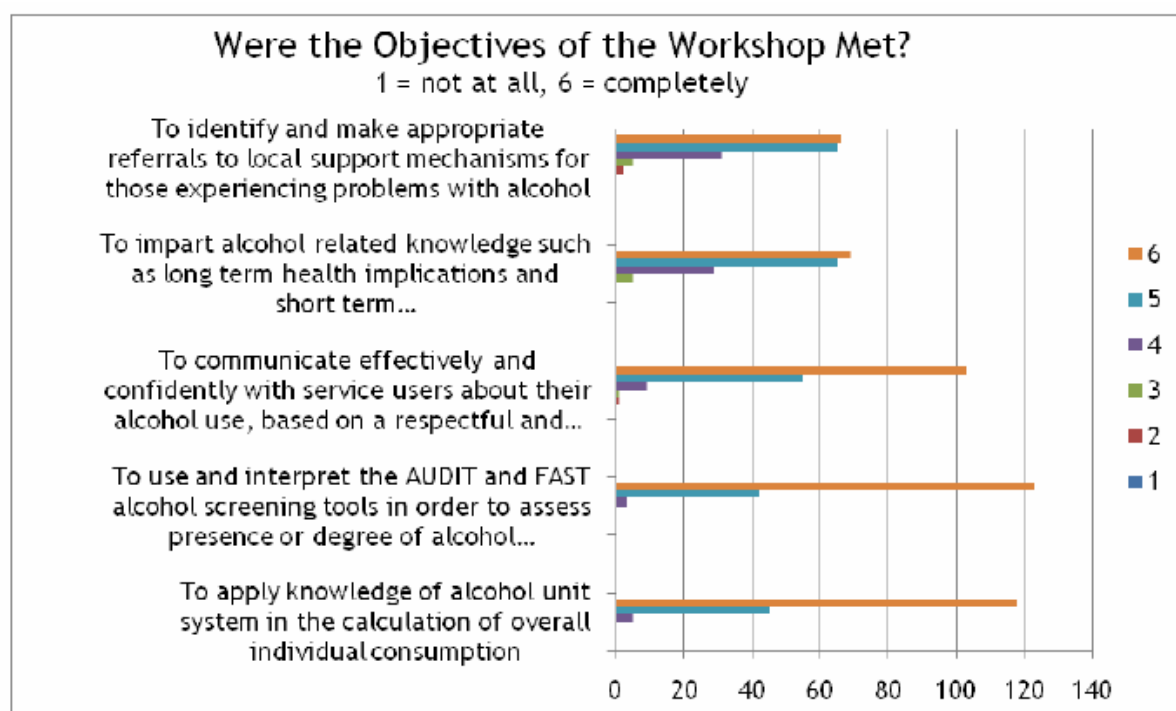


Figure 2 Evaluation Findings



Source: Alasdair Cant & Associates Evaluation Report

In addition, train the trainer IBA events were held in four locations across the region; Harlow, Stevenage, Ipswich, and Huntingdon. 44 people attended in total, from a range of professional groups including those from local authorities, health and the Criminal Justice Service. The aim was to enhance participants' competence and confidence in running a brief interventions training session.

12 months after the training, in July 2011 a survey was sent to all those who attended the train the trainers events. The response rate was poor but from the small sample who replied (n=5), all agreed or strongly agreed that the course had equipped them with the skills to deliver IBA training to others. 3/5 had delivered the training to others and of those who had delivered training, they had trained in total between 50 – 77 individuals.

One train the trainer event also took place focusing on offender health and delivery of IBA within the prison setting. Further information on this and the Chelmsford Prison pilot can be found in section 5.10 on Offender Health.

In addition, a number of local areas have funded further IBA training delivered to a variety of professionals including criminal justice, housing association and homelessness workers and those working with victims of domestic abuse. **Thurrock Community Safety Partnership** funded additional Alcohol Brief Interventions for clients attending their local Open Access Service whether or not they engage with the treatment service for further 1:1 support.

In **North East Essex**, IBA is mainstreamed in primary care with activity funded entirely through PCT funding and some of the training funded by Essex DAAT. In 2010 34 GP practices signed up to a Local Enhanced Service (LES) for the provision of IBA.

In **Bedfordshire** a further 358 were trained, again from a cross-section of agencies. The aim to introduce IBA to a broad spectrum of front-line staff that come into contact with those who could be potentially at risk with their alcohol consumption. External evaluation was undertaken and despite the relatively poor response rate the conclusions and recommendations drawn from the evaluators included:

- The finding that training was useful to those individuals trained on a personal level as it heightened their awareness about their own drinking.
- It was suggested that older people become a priority group for delivery of IBA, particularly those in sheltered accommodation or those who are isolated.
- It was suggested that paid carers would benefit from the training as they often shop for their client and are possibly in a position to identify potential issues.
- To continue to evaluate, monitor and report IBA delivery in a clear and robust way.

Further training sessions are scheduled, including train the trainer sessions. There will be a 6-month progress report relating to these new sessions followed by a 12 month evaluation. The plan is to follow up everyone that attends the courses to have a more comprehensive understanding of outcomes.

LOCAL CASE STUDY: Binge Packs, Hertfordshire

Binge Packs are pocket sized packs containing information around alcohol misuse and where to get help. These packs are given to individuals after receiving a brief intervention or as a standalone intervention. Each pack is tailored to the audience that the packs are given to. There is also an alcohol questionnaire for individuals to take and fill in themselves.

The number of packs given out in Accident and Emergency is monitored quarterly as are the number of enquiries for services as a result of receiving a Binge Pack. From January – March 2011 443 Binge Packs were given out and 19 people contacted services purely as a result of picking up a Pack.

Distribution of the Binge Packs is a target that is included in the service specification for Brief Interventions and targets have been achieved each quarter.

Glenda Lee, Hertsreach Dacorum Tel: 01442 240 879

Kate Phillips, Hertfordshire County Community Safety Unit Tel: 01438 843 150

5.3 Alcohol Health Workers

12 PCTs across the region received funding for an alcohol health worker as part of the region health programmes funding in 2010/11. These posts have since been established or in the process of being recruited to. Alcohol Health Workers are key locally in improving access to appropriate services and working towards a reduction in alcohol related hospital admissions, length of stay and readmissions due to alcohol related issues.

Some examples of local initiatives are provided below, drawing on the models in place in North East Essex, Hertfordshire, West Essex, Bedfordshire and West Suffolk. Information on the model in Peterborough is available in table 1.

An alcohol liaison nurse service has been established within the local general hospital for **North East Essex (CHUFT)**. The purpose of the service is to provide:

- Assessment, intervention and referral/signposting onwards for patients admitted to hospital with conditions related to consumption of alcohol.
- Training to hospital staff on IBA and on alcohol issues and services in general
- An 'alcohol champion' within the hospital to raise the profile of alcohol-related harm and how to address it

The referral process is now established and being refined and embedded. Widespread use of AUDIT-C is encouraged and now developing, in particular within the Emergency Assessment Unit. Patients who are AUDIT-C positive (i.e. score 5+) are referred to the alcohol nurse who completes AUDIT and undertakes intervention and support as required.

Referrals made to the service include those for patients with previous contact with local services (either as current or prior patients), and those with no prior history of engagement with alcohol services. The service and referral mechanisms have been able to accommodate both patients not previously known to consume to harmful or dependent levels and those known (likely to be dependent drinkers) but often poorly engaged with alcohol services previously.

For the 8 months from May to December 2010, referral data is as follows;

- 168 referrals (43 females and 125 males) Of these:
- 95 (57% had prior contact with North East Essex Drug and Alcohol Service (NEEDAS))
- 82 (49%) were aged between 36 and 55.

32 (19%) of patients came from wards associated with the highest risk of high-risk drinking in the PCT area (according to the DH social marketing segmentation tool).

The service has been in place since May 2010. It was initially part funded through regional funding but has been mainstreamed, and forms part of the QIPP plan for NHS North East Essex (alongside mainstream delivery of IBA in primary care, referred to in 5.2).

Ongoing developments include:

- Internal awareness raising of the issues with the view to include alcohol into the CQUIN from 2012.
- Developing links with the A&E alcohol worker pilot. This is a separate and part-time service (also provided by NEEDAS) being piloted from May-December 2011 focusing on delivery of IBA within A&E and on identifying and supporting “frequent flyers”. However it is expected that both services will work together to maximise referrals to the specialist nurse, uptake of IBA training and awareness of alcohol issues within the hospital.

In **Hertfordshire** there is a locally funded Alcohol Liaison Nurse who works at **Watford General hospital**. This post works closely with the existing Brief Interventions (BI) workers who are based in A&E and they share clients as appropriate. The BI worker will conduct an assessment on an individual before determining if they would need to see the Alcohol Liaison nurse if admitted.

In **West Essex**, an alcohol health worker is in post focusing on reducing the impact of drinking amongst patients at the **Princess Alexandra Hospital Accident and Emergency department** (and specific hospital wards) as identified by the Accident and Emergency (A&E) alcohol data sharing audit and providing alcohol brief advice and intervention.

The alcohol health service produces a quarterly newsletter. This seeks to inform staff of the progress of the service and encourages them to participate and refer into the service. In addition the service is promoted throughout the hospital both to patients and staff. Alcohol referral packs are available and there are designated referral points. Alcohol information is also available at these points for use by clinicians to offer their patients, as well as for staff.

An integral aspect of the effectiveness of the alcohol health service has been to try to promote alcohol service awareness among hospital staff and stimulate and open communication pathways, a number of information workshops have been held to achieve this. There is genuine commitment to see the alcohol health service firmly established throughout the hospital, incorporated into the everyday running of a busy hospital and to offer this service to all hospital attendees with alcohol related health concerns and injuries.

The alcohol health service has link workers throughout the hospital. They offer themselves voluntarily while others have been invited to become link workers and take part. We have link workers (service champions) in Psychiatry, A&E consultancy, nursing and administration, currently there are nine link workers in total. Their role is vital in developing the ‘alcohol service ownership’ concept.

In **Bedfordshire** Alcohol liaison workers (ALW) will work with patients attending General Practice, A&E, out-patient clinics and those admitted to wards. These patients will be assessed by trained members of the Acute and Primary Care teams for alcohol misuse using the AUDIT screening tool. Patients whose score indicates hazardous or harmful drinking will be offered an appointment with the ALW, who will carry out a more in-depth assessment of the patients' lifestyle and alcohol use. Where appropriate the ALW will undertake brief advice, extended brief interventions or refer on to specialist alcohol services, including dual diagnosis services or other wrap around support services e.g. housing, benefits advice etc.

The objectives of this Tier 1/2/3 service are:

- To identify people drinking outside of sensible drinking limits early
- To provide advice, assessment, planning and interventions for patients with alcohol related problems
- To facilitate access to support, treatment and care via an agreed single point of contact and appointment system
- To provide alcohol related advice and information
- To carry out assessments of client needs and, when required, facilitate referral onwards to Tier 3/4 services, linking with other services within the agreed care plan, if the client has one
- To provide brief and extended brief interventions, designed to help clients reduce or stop drinking
- To provide low level support for family members and carers affected by someone else's drinking

NHS Suffolk commissioned an alcohol liaison support worker post at the West Suffolk Hospital in December 2009. A year on, a report by NHS Suffolk examined the work carried out at the West Suffolk Hospital accident and emergency department to screen for alcohol intake at attendance to the department. The report identified the outcomes, measured against the objectives set at the start of project:

- Screening of agreed target group using PAT (Paddington Alcohol Tool) or similar.
- Training and education of qualified nurses and junior doctors to use agreed screening tool i.e. PAT.
- Develop a data base of activity of client group as per agreed parameters
- Undertake monthly documentation audits to demonstrate compliance with PAT screening
- Work with key staff to develop alcohol services at the West Suffolk Hospital

Since the start of the alcohol liaison support worker and the Alcohol Liver Disease Specialist Nurse the identification and proactive management of patients affected with alcohol problems has seen the following benefits:

- Improved inpatient pathway for patients.
- Improved Discharge arrangement for patients.
- Improved support for patients and families and sign posting to external agencies on discharge.

- A reduction in clinical incidents related to alcohol patients having acute withdrawal problems, particularly out of hours. In the past nursing teams had often utilised the rapid physical intervention team with this client group.
- There has also been a reduction in police call outs involving these patients.
- Reduced critical care admissions for this client group.

The main limitation identified in the report is the need to maintain an adequate data base. The evaluation was based on findings for the first five months of the screening work as data was only available for this time. The data that was available was also fairly limited and was quantitative only. No qualitative data had been collected.

A specific evaluation is planned to take place in the autumn 2011, across the region with the aim of evaluating the impact of the alcohol health workers that have been appointed as a result of the regional funding.

5.4 Data Sharing (The Cardiff Model)

Research from Wales identifies that Emergency Departments (EDs) can contribute distinctively and effectively to violence prevention by working with Crime and Disorder Reduction Partnerships (CDRPs) now replaced with Community Safety Partnerships (CSPs) and by sharing, electronically wherever possible, simple anonymised data about precise location of violence, weapon use and day/time of violence. These data, and the contributions of consultants in CSP meetings, enhance effectiveness of targeted policing significantly, reduce licensed premises and street violence, and reduce overall A&E violence related attendances - in Cardiff, by 40% since 2002.

Workshops were held and designed so that partners in each force area can work together to deliver the implementation of “the Cardiff model” of ED data collection and sharing. Where it was already happening the workshop helped improve the systems in place and improve knowledge and skills.

Dr Adrian Boyle, Consultant in Emergency Medicine at Addenbrookes co-authored the new College of Emergency Medicine guidance on data sharing and is leading the work with clinical colleagues across the region.

The College of Emergency Medicine guidance advocates that data about the location of assault, time and date of incident and the type of weapon used should be collected by hospital receptionists and shared each month in anonymous form with the local police crime analysts. The process can lead to impressive reductions in the number of people requiring emergency department treatment following assault.

The guidance is notable in that it advocates that there is no need for an information sharing protocol between hospitals and the police. The guidance is available on the College of Emergency Medicine website at

www.collemergencymed.ac.uk/CEM/Clinical%20Effectiveness%20Committee/Guidelines/Clinical%20Guidelines/default.asp

In April 2011, a Specialist Nurse post was established to provide consultancy and expert advice to support implementation of ED data sharing in the East of England. This post is based at Cambridge University Hospital Foundations Trust and will be overseen through the Office of the Acting Regional Director of Public Health (East of England). This role will:

- a. Provide advice on the appropriate IT and staff training to ensure that there is an electronic collection system for aggregating data and collecting the agreed minimum dataset;
- b. Produce protocols that govern data safety and transfer, and also the management of patients who are identified as vulnerable/at-risk. This will require a degree of regular scrutiny by local staff and the necessary follow-up of cases deemed to require additional attention beyond immediate treatment;
- c. Co-operate, participate with and input expertise to the providers who are delivering data sharing workshops to the South East and East of England SHAs. This also includes contributing to the development of training resources;
- d. Establish good relations with Children's and Adult Social Services to enable referral of any cases which raise issues of child protection or domestic violence. Where possible, collation of referral activity is desirable;
- e. Development of materials and co-ordination of the provision of training to other healthcare staff on violence prevention;
- f. Participate in and contribute to relevant regional and national committees and working groups.

The term of the post is 12 months and a report of progress against outcomes will be completed at 6 and 12 months. The expected outcomes of the post will be:

- a. Development and maintenance of a high quality A&E data sharing function in all East of England EDs;
- b. Promotion of an integrated multi-agency response to community violence to prevent repeat presentations in East of England EDs;
- c. Expert support function for general nurses and doctors involved in assessing patients who have experienced assault and provide specialist education to the all EDs in the East of England engaged in data sharing;
- d. Strong linkage between data sharing implementation and increased referral to alcohol, domestic violence and child protection functions in all EDs;
- e. Specific input to develop policies, procedures, training and documentation to support data sharing;
- f. An improvement in the detection and reporting rates of knife violence in the EDs through developing the professional skills and competencies of all ED staff.

As of June 2011, out of a total of 18 Acute Trusts across the region, four A&E departments have full implementation of the CEM guidelines with Community Safety Partnership and further 8 are data sharing but not fully compliant with the CEM guidelines or are actively in the process of implementing data sharing.. 6 A&E departments have yet to establish a local system.

The issue of sustaining data sharing once a system has been established was acknowledged as being common to many trusts at a workshop involving regional leads at the Department of health on 28th June 2011. Best practice to ensure sustainability discussed at the workshop included:

- Relationships between A+E and CSPs, on a name-to-name basis, developed and fostered
- Regular contact between the acute trust and the police to demonstrate outcomes of data sharing – real life interventions which have been put in place as a result of data sharing

- Champions for data sharing within trusts who have sufficient level of influence e.g. lead consultant or nurse, reception manager
- Advocacy of health role in community safety – developing a narrative around the effectiveness and importance of data sharing
- Ensuring regular electronic collection of the basic data elements to an acceptable level of quality, before additional data items are added to the list
- Acknowledgement that data does not to be 100% complete to be useful

In the East of England, building on the work of the A&E Specialist nurse, the Centre for Public Innovation have been commissioned to provide data sharing workshops and an e-learning package. The workshops will focus on trusts which have not yet fully implemented data sharing, targeted to their particular needs.

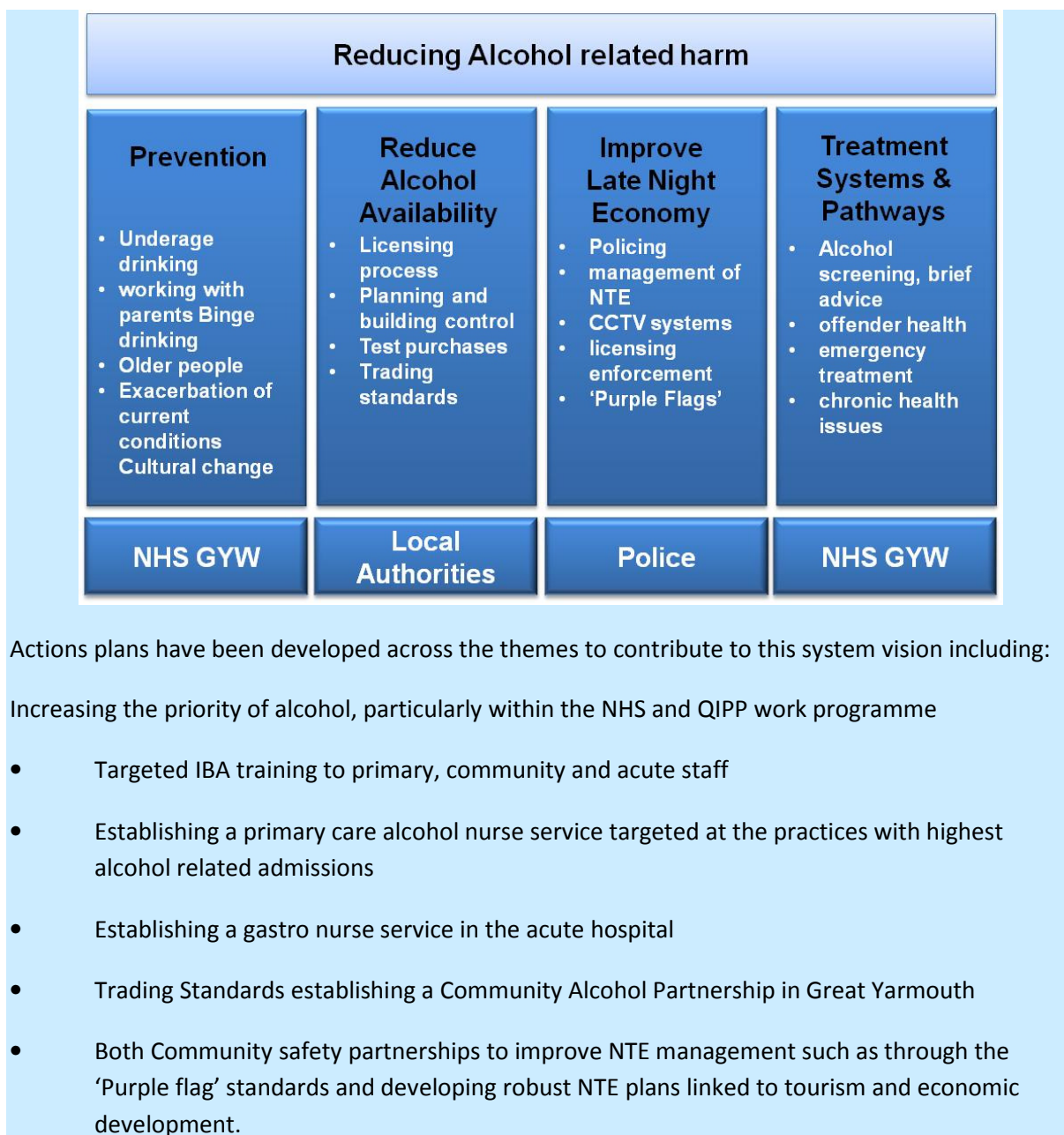
LOCAL CASE STUDY Healthy Places Healthy Lives, NHS Great Yarmouth & Waveney

Naji Darwish, Head of Strategy & Delivery Tel: 01502 719886 Email: naji.darwish@nhs.net

NHS Great Yarmouth and Waveney was selected as a pilot site and chose alcohol as the focus of this initiative due to shared priorities with partners, significant alcohol related demands on public services and emerging health need. Over the course of 2010 a series of planning and strategy development events brought together the public sector to identify the individual and shared challenges in reducing alcohol related harm. Partners included Children services, Norfolk and Suffolk Drug and Alcohol Action Teams (DAT), NHS commissioners, Licensing Authorities, Trading Standards, Police, Local Authorities and the Offender Management Service.

This discussion was informed by an in-depth analysis of benchmarking and costs for alcohol related harm, specific to the Great Yarmouth and Waveney area. Alcohol related harm costs Great Yarmouth and Waveney at least £40 million per year including £24 million in violent crime, £9 million in hospital admissions and £3 million to ambulance services

Partners developed and agreed a shared system model and strategy to reduce the harm caused by excessive alcohol consumption. This covered four themes, with a lead agency / partnership identified and interdependencies managed by LSPs.



5.5 National Support Team (NST) Visits

NSTs 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. The Alcohol Harm Reduction NST formed part of the Department of Health's Alcohol Improvement Programme. By undertaking extensive, 'diagnostic' visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

5.5.1 Peterborough NST Visit June 2009

The NST highlighted a number of strengths in local commitment, partnership working and progress on addressing alcohol harm reduction. Including:

- Multi Agency health and Young People's clinics in schools, with input from Drinksense

- An Integrated model in development for alcohol treatment across the Criminal Justice system
- A Comprehensive Domestic Abuse policy, programme and implementation
- Joined up night-time economy approach involving all the Regulatory Services

The Priority Areas identified:

- Identifying senior and middle level designated champions in each partner organisation, where they do not currently exist. Identifying clinical champions would also be beneficial
- Building on the work already carried out in the alcohol strategy where the beginnings of a needs assessment are included, the recommendation to undertake a full alcohol needs assessment, covering all aspects of the alcohol harm reduction agenda, to inform the development of a new multi agency alcohol strategy, that is owned and driven by the GPP
- Consideration of identifying an officer who can perform a co-ordinating function to oversee action across the partnership and drive the implementation of the strategy. This could be a joint PCT and PCC post
- All commissioned services need to be routinely monitored and evaluated to assess quality and outcomes, in particular their impact in reducing alcohol related hospital admissions
- We commend your intention to undertake further analysis of your NI 39 data. This should include breaking down the indicator by gender, age, ethnicity, condition, geography, to understand the reasons for the significant increase between 2006/7 and 2007/8 and to inform the strategy
- The evidence base suggests that provision of an Alcohol Liaison Nurse to work with dependant drinkers in the hospital would avert 172 admissions per year, with a cost benefit of £145k. The NST strongly recommend you develop a business case for this function.

5.5.2 South East Essex NST Visit November 2010.

The NST identified a number of strengths in South East Essex relating particularly to the commitment in the area to address alcohol related harm and the strong partnership working in place. They noted good progress in addressing alcohol related harm reduction. Potential good/innovative practice included:

- SOS Bus held in high regard by wide range of partners
- Operation Staysafe in both Southend and Essex County involves a wide range of partners including young people’s substance misuse services
- Effective use of the neighbourhood management project ‘Turning Tides’ to support alcohol work and engage vulnerable populations
- Community Safety Unit have pro-active relationship with the on-trade in Southend through Clubwatch and Night Time Economy Group (NTEG)

The Priority Areas Identified:

- Bring partners together to agree the footprint for the alcohol strategy(s)
- Undertake an audit to ensure you fully understand the total levels of investment in the alcohol agenda, as distinct from drug related investment
- Interrogate Secondary Uses Service (SUS) data in order to identify the most common types of alcohol related admission and frequent flyers to inform commissioning and target services
- Reconfigure alcohol services to ensure that you have an integrated model from Tiers 1 to 4
- Establish an alcohol liaison service for the hospital

5.5.3 Key Findings from all NST visits

Since 2009 the NSTs have systematically assessed the types of recommendations made in order to identify the common issues emerging. Systematic coding of the priority recommendations for each visit report identified the following common themes:

- Strategy and performance
- Alcohol Services
- Organisational/Partnership Arrangements
- Commissioning
- Vision
- Data
- Local leadership

For more information please refer to DH (2011) Alcohol Harm Reduction NST; Supporting Partnerships to reduce Alcohol Harm: Key Findings, Recommendations and Case Studies from the Alcohol Harm Reduction NST, DH. London.

5.6 ERPHO Work

The East of England Public Health Observatory (ERPHO) is commissioned by the Department of Health to provide public health analytical support to the East of England to support the delivery of its public health programmes.

An Alcohol Information Analyst was appointed on a fixed term contract for a period of 12 months. The role was appointed in order to provide specialist analytical support for the analysis of alcohol-related health data at a regional and sub-regional level for the East of England. During this time, ERPHO produced a dashboard of alcohol-related indicators utilising a variety of information sources e.g. ambulance data, Hospital Episode Statistics (HES), National Drug Treatment Monitoring System (NDTMS) and crime statistics from across the region to provide reports of results at regional and sub-regional level.

Further information can be found at

http://www.erpho.org.uk/topics/alcohol/alcohol_dashboard.aspx

5.7 Regional Conferences

In February 2008 a conference launching the Alcohol improvement Programme took place at Robinson College starting an annual cycle of events.

5.7.1 April 2009 Newmarket

174 delegates from across the region and beyond attended. Health, criminal justice, licensing, voluntary sector and local and central government were all represented. The main aims of the conference were:

- To share the headline results of The Big Drink Debate
- To disseminate best practice through headline speakers and workshops
- To share ideas and learning on alcohol harm reduction
- To encourage networking and meet other professionals in the field

Speakers covered social marketing, pre-loading, families and alcohol and corporate social responsibility.

5.7.2 May 2010 Stoke by Nayland

140 people attended from across the region. The day received very positive feedback, the venue and facilities were highly commended as were the main speakers. The debate in particular proved to be a popular feature, this house believes that the government should introduce minimum pricing per unit as a means of reducing the consumption of alcohol. Arguing for was Dr Paul Cosford Regional Director of Public Health and against Mark Baird, Corporate Social responsibility Manager, Diageo GB.

5.8 Regional Alcohol newsletter

Three regional alcohol newsletters were published during 2009 and 2010. These provided a range of stakeholders with news, updates and articles about the alcohol harm reduction work taking place around the region.

5.9 Big Drink Debate

The Regional Big Drink Debate concluded at the end of March 2009. The aim was to gather information on people's attitudes and behaviour surrounding alcohol, especially in relation to:

- Drinking behaviour and levels of consumption
- Impact of drinking on health and wellbeing
- The packaging, marketing and sale of alcohol
- Societal impact of alcohol

In addition, to raise awareness and encourage public engagement on the issue of alcohol and health.

Headline Results for the East of England included:

- 6869 participants responded, all aged over 18
- Nine in ten people, 93% drink alcohol at least once or twice a year and nearly six in ten (59%) drink alcohol every week
- Nearly a third drink more than the recommended weekly limit (RWL)
- Two thirds of those who drink over the RWL described themselves as only moderate drinkers
- 60% don't recognise the fact that their intake is harmful to health
- Respondents, major concern about their drinking were about developing alcohol related problems, putting on weight and spending too much money
- 70% believe that people should drink nothing before driving
- 90% feel that schools should provide advice on sensible drinking

Detail on the Big Drink Debate can be found at

<http://www.erpho.org.uk/viewResource.aspx?id=20277>

Information from the Big Drink Debate was provided to PCTs by being incorporated into the Alcohol Dashboard put together by ERPHO, see section 5.6.

LOCAL CASE STUDY: 'Turn around Charlie' Hertfordshire

Jane Holton, Young People's Substance Misuse Team Hertfordshire County Council.

Tel: 01438 843 879

Turn around Charlie is an interactive theatre session around alcohol and risk taking which is aimed at year 9 and 10 students. It has taken place across 10 secondary schools and extended schools consortia throughout Hertfordshire.

The sessions take place over 1 hour and 30 minutes and allow opportunity for discussion and questions from Young People. The session aims to show what happens once you enter the criminal justice setting and the unintended outcomes of drinking too much alcohol.

A total of 1340 students participated in this event. An evaluation form was completed at the end of each play. In total 90% of students felt they now understood that consuming alcohol can lead to risk taking and 92% felt they had learnt new facts about alcohol. 70% of students felt that they identified violence as the main risk factor when consuming alcohol. Teachers answered that the play was informative and the right pitch for year 9's and complimented the PHSE programme.

The session achieved on not enforcing stereotypes and using 'positive social norms' messaging. The highlighting the amount of young people that don't drink and also incorporating the key priorities in the Children and Young People's plan.

5.10 Alcohol and offenders work

An Offender Health Trainer Pilot Scheme started in **Chelmsford Prison** in the summer of 2009. Evaluation of this initiative was undertaken by an external evaluator. The evaluation involved interviewing eight prisoners who had been trained as IBA Health workers, six of whom had delivered IBA sessions. In addition, all IBA sessions that had been delivered to a client were surveyed, 53 IBA sessions in total, between 28 July 2009 and the 14 December 2009.

From the survey results, it became clear that IBA training was received positively. There was a good level of self awareness about prisoner's own need for alcohol information. There was a mix of those for whom the information was new, and those who needed to refresh their knowledge. Everybody reported that they learnt something new

Key findings from the evaluation were that:

- The IBA OHT initiative has been successful overall
- Ongoing support for a prisoner after an initial IBA session is needed quickly and with a clear pathway
- Health trainers need continued support to be effective
- Peer group are often in denial about alcohol use
- Some frustration exists at lack of opportunity to deliver the IBA training
- The IBA OHTs have greater self confidence and continue to use their skills with their friends in more informal settings than the training
- Becoming an IBA OHT gives the individual greater resolve in tackling their own drinking

An overarching theme was recognising the challenges of making this kind of initiative work in a prison environment. Keeping up the momentum is difficult as the opportunities to deliver an IBA are sporadic and constrained. Because the target group has only recently entered the prison system, conversations about use of alcohol, as with other substances, was often felt unwelcome. This is before taking into account the unpredictable nature of some prisoners' daily regimes, which can mean too much or too little movement within the system. All of these factors work against the 'less

formal interactions' as described by one prisoner, which are the most powerful in terms of behaviour change.

The evaluation also found that there are limitations due to the prison environment, the expectations of individuals and the level of support available. The support available was the critical common thread. In discussion with those who deliver the sessions, they valued the Prison Healthcare lead's encouragement and support, and to some extent depend on it. This support is directly linked to the prisoners' motivation and personal effectiveness in delivering the IBA sessions.

In response to the question about where the IBA training might be improved, where answers are given, there is a desire to do more, suggestion given were:

- Delivering IBA encounters to the wider prison population
- Receiving updates and refresher sessions
- Receiving direct and in depth information about the actual experiences of problematic drinking.

NHS Bedfordshire is in the process of commissioning an Alcohol Arrest Referral and Outreach Service to reduce alcohol related offences and alcohol related harm for adults aged 18 years and over within Bedford Borough. It will provide a service to those referred following an arrest of a trigger offence and provide an outreach service for offenders i.e. follow up appointments and to other criminal justice settings i.e. Courts, prison, probation. The main contact point with the offender will be in the police custody suite.

6. Quality, Innovation, Productivity and Prevention (QIPP)

The Quality, Innovation, Productivity and Prevention (QIPP) programme is about ensuring that each pound spent is used to bring maximum benefit and quality of care to patients. QIPP is working at a national, regional and local level to support teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements.

In the East of England an Improving Healthy Lifestyles QIPP work stream was developed which included reducing alcohol related harm as a core component. The basis of Improving Healthy Lifestyles work stream is to make practical steps to reduce the burden of acute and long term conditions through combined and comprehensive action to increase the number of people in the east of England who follow the four healthy lifestyle behaviours of not smoking, drinking alcohol within the recommended daily limits, being physical activity and eating a healthy and balanced diet. Research studies have shown that people who follow these four healthy behaviours can expect to live for 14 years longer than those who follow none of these. Healthy life expectancy, the number of years we live without disability or long-term illness, is also increased in people following a healthy lifestyle. The work stream includes actions to reduce alcohol related harm. This focuses on training in delivering brief advice, developing commissioning tools, alcohol health workers in acute trusts and data sharing between emergency departments and local community safety partnerships (CSPs).

7. Conclusions

This paper summarises the work taking place across the East of England between April 2008 and March 2011 focused on tackling alcohol related harm.

It briefly describes a range of local and regional interventions, where available presenting the evaluation findings of these initiatives, together with sharing good practice and learning. The aim to help shape the delivery, implementation and evaluation of future initiatives in the region.

8. Recommendations

A number of recommendations are made for local areas:

- To ensure that comprehensive evaluation is built into the planning and delivery of any proposed or existing intervention in order to inform future decision making.
- To continue to build the evidence base in terms of the delivery of IBA and the role of alcohol health workers. Ensuring that systems are in place to enable local assessment of their effectiveness, including their cost effectiveness.
- To continue progress on ED data sharing, and sustaining this where it exists. Ensuring good partner engagement and essentially communicating how the data helps to inform local management of alcohol related problems back to ED departments.
- Maintain a network or forum of local alcohol leads across the region to help ensure service delivery is based on the best available evidence, that good practice is shared and that improvements are made to continuously improve service quality.

Appendix 1: Tools and Guidance

The AIP developed a number of tools and guidance documents to assist PCTs and their partners including:

- Local Routes: Guidance for developing Alcohol Treatment Pathways (DH 2009).
- Signs for Improvement: Commissioning Interventions to reduce alcohol related harm (DH 2010), within this document the DH identified a number of high impact changes.
- Ready Reckoner, which aims to assist PCTs to select interventions to reduce alcohol related admissions in the short term by calculating the likely costs benefit of alcohol health workers, delivery of IBA and increasing the proportion of dependent drinkers receiving treatment.
<http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/Datatools/?parent=5113&child=5109>
- System Dynamic Modelling Tool, can be used by PCTs to help in planning local implementation strategies. The model tests the impact of introducing three of the established high impact changes in relation to alcohol – IBA in primary care, alcohol health workers, and specialised services.
<http://www.tawileh.net/anas//files/downloads/papers/Alcohol-Misuse.pdf?download>
- The Alcohol Harm Reduction Partnership Progress (AHRPP) tool <http://ahrpp.alcohollearningcentre.org.uk/userAccount/logon> is designed to be used by PCTs and their partners to help them assess progress across local partnerships in improving their ability to reduce incidence of harm related to alcohol misuse. The tool reflects many of the themes that would usually be covered during NST visits and allows partnerships to identify strengths and areas for improvement.
- Alcohol Related Admissions Trend Data provides quarterly and annual admission trend data for every PCT against each of the conditions which are significantly (>20%) attributable to alcohol.

- The Local Alcohol Profiles for England (LAPE) <http://www.nwph.net/alcohol/lape/> are available through the North West Public Health Observatory. The profiles contain 23 alcohol related indicators for every local authority and 24 for every primary care trust in England. Key indicators in healthcare, criminal justice, benefits claimants, drinking patterns and life lost due to alcohol are used in combination to identify and map those areas experiencing different overall levels of alcohol related harms.
- The National Alcohol Treatment Monitoring System (NATMS) <http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/NATMS/> is part of the National Drug Treatment Monitoring System (NDTMS). It provides reports and statistics regarding tier 3 and tier 4 treatment services for clients who are resident in England and whose primary problematic substance is alcohol. Monthly reports include a brief summary of statistical indicators nationally and for each SHA, PCT and service provider. More detailed quarterly 'purple' reports include figures around waiting times, modalities of treatment and patterns of referral and discharge among various other indicators.
- The alcohol learning centre is a national resource for alcohol harm reduction activity www.alcohollearningcentre.org.uk at the time of writing the ongoing maintenance of this website is unclear and it therefore may not be updated in the future.



EAST OF ENGLAND REGIONAL ALCOHOL PLAN 2009 – 2011

Introduction

Alcohol can play an important and positive role in society. It can also cause moderate to severe health problems and dependency, as well as contributing to antisocial behaviour; crime and disorder.

The national alcohol strategy, 'Safe. Sensible. Social' (June 2007) sets out areas for government action on legislation; problematic drinkers and promoting sensible drinking. Local strategies are seen as an important part of the delivery chain, and should form part of wider Crime and Disorder Reduction Partnership strategies (CDRP) by April 2008.

Aim

It is the role of the regional tier of government to ensure a comprehensive approach to reducing alcohol harm across its population; particularly in 'hotspot' localities and amongst communities and groups experiencing the greatest problems.

This alcohol work plan for the East of England sets out a framework to assist the Regional Alcohol Steering Group (RASG) on some clear, key priorities.

The overall aim of the work plan, in line with the national strategy is to:

'Minimise the health harms, violence and antisocial behaviour associated with alcohol while ensuring that people are able to enjoy alcohol safely and responsibly'

Alcohol improvement Programme (AIP)

"The Alcohol Improvement Programme (AIP) was established in April 2008 by the Department of Health to help reduce Alcohol-related Hospital Admissions (ARHAs) across the NHS. The objectives include:

- Support capacity and capability building in local sectors to ensure sustainability and growth for change.
- Collate and disseminate evidence and learning to support PCTs in delivering against Vital Signs indicator VSC26 to reduce the rate of increase in alcohol-related hospital admissions as measured by Hospital Episode Statistics (HES) data.
- Produce guidance on the key enablers and activities for change.
- Ensure that advice and guidance which has the most impact on ARHAs is developed with regional input to support regional implementation. "¹

The AIP has provided the region with 3 year funding from 2008-2011 to assist in the work to help reduce alcohol related hospital admissions. Some of this funding has been used to create a Regional Development Fund to pilot projects. The projects all apply one or more of the 7 High Impact Changes which the Department of Health has identified as key actions that Primary Care Trusts (PCT's) can take which will make the highest impact on reducing alcohol related harm and admissions

These High Impact Changes are

-Work in partnership

· Develop activities to control alcohol misuse

¹ <http://www.alcohollearningcentre.org.uk/About/LearningCentre/AIP>

- Influence change through advocacy
- Improve the effectiveness and capacity of specialist treatment
- Appoint an Alcohol Health Worker
- IBA - Provide more help to encourage people to drink less
- Amplify national social marketing priorities

1.STRATEGY	2. TREATMENT	3. AWARENESS	4. YOUNG PEOPLE	5. CRIME & JUSTICE	6.INFORMATION
RPH	RPH	SHA	NTA /DCSF	SSC	Erpho
Anne McConville	Simon How	Hazel Thomson	Rick Andrews Hannah Woodhousee	Tim Hedges	Hannah Walford
Priorities					
P1 develop governance	P5 Ensure comprehensive service provision	P11 Raise awareness	P9 protect children & young people	P14 reduce violence	P2 Share information and other intelligence
P3 Strengthen local strategies	P8 Meet the need	P13 Challenge the culture		P15 Improve perceptions	P4 Act on evidence
P7 Build capacity	P10 Improve health				
	P12 effective commissioning and performance				

	management				
P6 Work with partners	P6 Work with partners	P6 Work with partners	P6 Work with partners	P6 Work with partners	P6 Work with partners
FUNDING					
Cambridgeshire St Neots CAP	Bedfordshire South East Essex Suffolk Peterborough	Bedfordshire	South East Essex St Neots CAP	Peterborough Mid Essex/ Norfolk	ERPHO
HO NTE				Peterborough	
CSF YCAP			Peterborough + Southend		

No	Action	Outcomes	Lead Officer	By when?
1.	STRATEGY – delivering a clear coherent regional alcohol programme			
1.1 HIC	Carry out regional review in all PCT areas using agreed checklist. Prepare report on best practice, identified gaps and next steps – also identify HICs in place and planned	Increased knowledge of current picture with gaps identified for action and improvement	Melvin Hartley	Dec 09

1.2	Review Governance, structure and reporting arrangements of the Regional Alcohol Programme	Revised streamlined structure, clear lines of communication	Melvin Hartley	May 09
1.3	Encourage each local authority area to develop and implement local alcohol strategies (top and 2 nd tier)	Each area has a local strategy and action plan	Tim Hedges	Mar 10
1.4	Maintain links to other public health programmes – obesity, tobacco, physical activity to enable cross cutting initiatives	Coordinated activity across public health	Simon How	ongoing

No	Action	Outcomes	Lead Officer	By when?
2.	TREATMENT – reducing the harm to health caused by alcohol misuse			
2.1	Facilitate the development of treatment services so they are provided across the range of tiers with clearly defined pathways between them in each PCT area	Each PCT has a set of services across tiers 1-4 for alcohol	Simon How	ongoing

HIC				
2.2	Encourage the development of IBA across services in primary care, hospitals and in the community (including through IAPT)	New IBA services are created and sustained in a variety of settings	Melvin Hartley	ongoing
HIC				
2.3	Provide tools and training for effective commissioning of alcohol services in line with DH guidance and World Class Commissioning	Commissioning of needs based services in each area across all tiers.	Simon How	Dec 09
HIC				
2.4	Provide and encourage the provision of training in IBA and Train the trainer courses	Training is delivered in IBA, extended IBA and train the trainer IBA	Melvin Hartley	Mar 11
HIC				

No	Action	Outcomes	Lead Officer	By when?
3.	AWARENESS			
	– increasing awareness of the harms of alcohol misuse			
3.1	Develop and implement an internal (NHS & statutory partners) Communications strategy that will promote and raise awareness of the alcohol improvement programme including Conference 2010, newsletter, website	Increased knowledge and understanding of alcohol harm across partners	Hazel Thomson	2010

HIC				
3.2	Share results of The Big Drink Debate at Regional, PCT and LA level with a view to the development of targeted campaigns based on findings that will influence public behaviour and attitudes about alcohol including Know Your Limits, Units, and other nationally led social marketing initiatives	Increased knowledge and understanding of alcohol harm in the community	Simon How	June 09 ongoing
HIC				
3.3	Work with Employers including the NHS, to develop workplace policies that encourage sensible drinking, help with legal issues, treatments services and alcohol related issues	Employers have introduced or improved their workplace policies	Neil Wood	ongoing
HIC				
3.4	Alcohol champions and identified lead commissioners for alcohol misuse services in each local area and PCT respectively	Each area has an identified champion and commissioning lead	Melvin Hartley	Dec 09
HIC				

No	Action	Outcomes	Lead Officer	By when?
4.	YOUNG PEOPLE – reducing under age drinking and alcohol related harm among young people			
4.1	Treatment services for young people are provided with targeted screening and	Each PCT has a clear range of services for young people	Rick Andrews	ongoing

HIC	early intervention especially with vulnerable young people	including transition pathways to adult care		
4.2	Promote the practice of partnership working to tackle under age drinking and illegal sales to under 18s	Each CDRP/county has taken action to tackle under age sales	Tim Hedges	ongoing
4.3	Ensure Tier 1 universal education on alcohol – healthy schools, curriculum based alcohol education	Improved education programmes in and out of school on alcohol harm	Ruth Brown	ongoing
4.4	Run workshop(s) for education – best practice, tools and techniques for raising awareness of alcohol misuse and so provide clear accessible information for young people	Workshop successfully held and attendees act on learning Increased knowledge and understanding of alcohol harm amongst young people	Melvin Hartley	Mar 10

No	Action	Outcomes	Lead Officer	By when?
5.	CRIME & JUSTICE – reducing the impact of alcohol misuse on the community			

5.1 HIC	Develop IBA in criminal justice settings including police, prison and probation	New IBA services are created and sustained in a variety of settings	Melvin Hartley	ongoing
5.2 HIC	Drink driving – i) gather data on alcohol related accidents and ii) target action accordingly	Increased understanding of alcohol related accidents and coordinated action taken in response	Melvin Hartley	December 09
5.3 HIC	Co-ordinated strategies to tackle and reduce alcohol related violent crime in public places (NTE) in identified CDRP areas	Each CDRP has a plan to tackle public place alcohol related violence	Tim Hedges	March 10
5.4 HIC	Engage with the Domestic Violence Forums via regional meetings to ensure programmes include alcohol related responses.	Each DVF to consider the impact of alcohol on DV and have in place appropriate responses	Gaynor Mears	ongoing

No	Action	Outcomes	Lead Officer	By when?
6.	INFORMATION - using information to intelligently help reduce the harm caused by alcohol misuse			

6.1	Relevant training opportunities be made to service providers including a workshop on data sharing	Training offered and workshop run with attendees acting on learning	Melvin Hartley	Dec 09
6.2	Gather data on the extent of alcohol related incidents and encourage the undertaking of coordinated action	Annual strategic assessments reflect all partners data and intelligence	Tim Hedges	Nov 09
6.3	Documented routine sharing of assault data between A&E departments and CDRPs as per the Cardiff model. Partnership actively using the data to target problems.	Each A&E is regularly sharing depersonalised data with CDRP partners	Melvin Hartley	Mar 10
6.4	Employ an Information Analyst for the Alcohol programme – Provision of data analysis, interpretation and presentation, develop dashboard and assist in the creation of alcohol service needs assessment tool for commissioners	Dashboard created and shared with partners	Hannah Walford Karen Mole	July 09