Public Health
England

Protecting and improving the nation's health

Adults – alcohol commissioning support pack 2018-19: principles and indicators

Planning for alcohol harm prevention, treatment and recovery in adults

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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Introduction

10.4 million adults in England (25%) drink at levels that increase their risk of health harm.[1] Of these, 595,000 adults are potentially in need of specialist treatment for alcohol dependence.[2] Addressing the harm caused by alcohol misuse is a priority for Public Health England (PHE). Alcohol is the leading risk factor for ill-health, early mortality and disability among men and women aged 15-49 years in the UK[3] and the harm from alcohol impacts on a range of other public health outcomes.

Alcohol is a causal factor in more than 60 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression.[4] Alcohol-related harms fall disproportionately on the poorest in society.[5]

The increase in risk for these conditions is greatest among those 1.9 million adults in England drinking at harmful levels (ie, in excess of 35/50 units per week, female/male). However, even increasing-risk drinkers (those regularly exceeding the lower risk guidelines) are at significantly increased risk of long-term conditions.[6]

Binge drinking can lead to injuries, anti-social behaviour and other societal harm. Alcohol misuse also causes losses to business and the local economy through absenteeism, poor performance and work-place accidents.

Alcohol causes harm to others. It is associated with family and relationship problems, and was a component in almost 18% of the assessments of children in need by children's social care in England during 2014/15.[7] Alcohol is a significant contributory factor in offences of violence[8] and disorder including domestic violence.

Given the range of harms and at-risk groups, evidence points to a multi-faceted and integrated response, aimed at individual drinkers at risk and whole populations. The OECD suggests that combining alcohol polices may create a critical mass effect, changing social norms around drinking to increase the impact on alcohol-related harm.[9] Effective local systems will be those that are coherently planned by local government, NHS and criminal justice partners to provide what is known to work in terms of effective interventions addressing the full range of drinking behaviours and harms to individual drinkers, families and communities. To support local government and its partners to review local structures and delivery arrangements and evaluate what works well to reduce alcohol-related harm, PHE has developed a system improvement tool: the CLeaR Improvement - alcohol.

Planning is key. To address the harm, costs and burden on public services from alcohol misuse, successful plans will be based on the assessment of local needs.

This document outlines key principles that local areas might consider when developing plans for an integrated system. These principles have indicators to help commissioners put them into practice.

1. Effective population-level actions are in place to reduce alcohol-related harms

Local evidence-based, population-level approaches reduce alcohol-related harm by control and influence over supply and marketing, coordinating community action, and utilising monitoring and surveillance data.[10]

What you will see locally if you are meeting the principle

Population-level approaches that support raising awareness and reducing the aggregate level of alcohol consumed and, therefore, lower the whole population's risk of alcohol-related harm.[11]

Indicators that will help you to establish whether you are following the evidence and best practices that support the principle

1.1. Local health improvement campaigns are planned, and are based on, and targeted at, identified needs in the local population.
1.2. The expected outcomes of these campaigns are understood, routinely evaluated and supported by the evidence base.
1.3. Where local alcohol social marketing campaigns are employed, they reflect and amplify national campaign messages[12] when appropriate.
1.4. The public health team actively contributes to the local vision for alcohol licensing as set out in the Statement of Licensing Policy (SLP) and works in effective partnership with the other responsible authorities.[13]
1.5. Local crime, health and social care data is used to map the extent of alcohol-related problems as part of licensing policy.[14]
1.6. Hospital and ambulance data is shared routinely to inform improvements in community safety and licensing activity.
1.7. The licensing authority can demonstrate how local licensing policies (including the use of tools and powers) have contributed to the successful management of the night-time and day-time economy.[15]
1.8. Optimal use is made of existing legislation to target the prevention of under-age sales, sales to people who are intoxicated, proxy sales to minors, non-compliance with any other alcohol licence condition and illegal imports of alcohol.
1.9. The partnership can demonstrate the impact of using voluntary and industry-led schemes to achieve the local vision to reduce alcohol harm.

2. There is large scale delivery of targeted brief advice

Targeted interventions aimed at individuals in at-risk groups can help make people aware of the harm and change behaviour, preventing extensive damage to health and wellbeing.

What you will see locally if you are meeting the principle

There is large scale delivery of identification and brief advice (IBA) to those at most risk of alcohol-related ill health. NICE recommends the delivery of IBA in all adult health, social care and criminal justice settings[16] and the focus on promoting the implementation of IBA in all primary and secondary healthcare settings is reiterated in recent PHE planning guidance developed to support local leaders working together across STP footprints.[17]

Indicators that will help you to establish whether you are following the evidence and best practices that support the principle

2.1 The partnership has an integrated plan that sets out the partners' agreed roles and responsibilities, including for workforce development, in rolling out IBA in a range of settings, and a system is in place to monitor this activity.
2.2 The services that deliver IBA collect, analyse and report data to demonstrate the level of delivery.
2.3 Local 'making every contact count' (MECC) activity includes evidence-based alcohol IBA.[18]
2.4 There are specific interventions to raise awareness of the harms of drinking for at-risk groups, such as pregnant women, older people and those with existing long-term conditions or mental health issues.
2.5 The NHS Health Check[19] programme, GP new-registrations procedures and the prevention CQUIN[20] include evidence-based alcohol IBA in line with regulations, contracts and guidance.
2.6 There is IBA delivery across a range of adult local authority services, criminal justice and healthcare settings.
2.7 There are clear pathways to specialist assessment for those who may be dependent and require structured treatment.

3. There are specialist alcohol care services for people in hospital

Specialist alcohol teams in hospitals reduce alcohol-related hospital admissions and improve quality of care, thereby saving money for the NHS.[21]

What you will see locally if you are meeting the principle

All district hospitals will have 7-day specialist provision for alcohol, in stand-alone teams or as part of a team with a wider remit, including drugs and/or psychiatric liaison.

Indicators that will help you to establish whether you are following the evidence and best practices that support the principle:

3.1 Specialist alcohol (and drug) care is available in all acute hospitals where this could have an impact.

3.2 Senior medical/nursing support and leadership is provided to the secondary care alcohol (and drug) service to ensure that their role and function is understood and appropriately utilised by partners in the system.

3.3 There are timely and effective care pathways between hospitals and community services to ensure the continuation of detoxification with psychosocial interventions outside of the hospital.

3.4 A range of services are working to actively support high-need, high-cost alcohol users and reduce frequent hospital attendances and admissions.

3.5 Hospital services collect data necessary to demonstrate service effectiveness, impact on patient care and value for money.[22]

4. There is prompt access to high quality, effective alcohol treatment that is recovery-orientated

Successful treatment and recovery is optimised by providing welcoming, easy to access and flexible services that cater for the needs of a broad range of people and problems. They reduce risk of harms, raise recovery-orientated ambitions and facilitate service users' progress towards recovery goals.

What you will see locally if you are meeting the principle

Treatment services that are evidence-based and which deliver the broad range of effective interventions sufficient to meet the needs of the local dependent population, ensuring:

All alcohol dependent adults have prompt access to a treatment system that has established care pathways with a range of health, social care, criminal justice and community agencies.

Tailored packages of psychosocial, pharmacotherapeutic and recovery interventions that are accessed by the target populations and deliver sustained outcomes for dependent drinkers.

Safeguarding practice is continuously monitored and regularly reviewed and reported on to ensure the safety of alcohol/drug users, their families and wider social groups.

The number of people successfully completing treatment is increasing and recovery from dependence is sustained.

Indicators that will help you to establish whether you are following the evidence and best practices that support the principle

4.1. The alcohol prevention and treatment system is integrated and configured to meet the needs of the local population across community, hospital and prison settings.

4.2. There is sufficient capacity in the treatment system to optimally address the needs of the estimated population of alcohol dependent adults in need of specialist treatment, and alcohol services are commissioned to target and treat dependent drinkers, wherever they are located in the community, responding appropriately to presenting risk.

4.3. Where the estimated rate of unmet need for alcohol treatment appears high when benchmarked against past performance or against local areas with similar needs, there is a plan to address this.

4.4. Explicit information governance and joint working agreements are in place across all services to promote effective care delivery and risk management through the routine sharing of information.

4.5. Alcohol treatment services in all settings offer evidence-based, effective recovery-orientated interventions in line with NICE guidance CG115,[23] CG100[24] and quality standards QS11[25] (including, where appropriate, quality statements 4, 5, 7, 8, 9, 10, 11, 13). Treatment interventions are appropriately tailored to levels of severity of alcohol dependence and complexity of need.

4.6. There are clearly defined and well-functioning care pathways between alcohol (and drug) services, mental health provision, criminal justice agencies as well as social care and safeguarding services (both children's and adult).

4.7. Pathways for alcohol dependent and increasing/higher-risk drinkers are jointly agreed, regularly monitored and reviewed by all relevant partners.

4.8. There is rapid access, appropriate assessment and care planning to support parents as well as and joint working with children and family services.

4.9. Links between domestic violence and alcohol misuse are considered in assessment care planning and reviews. There is joint working with (and effective pathways to) services for victims and perpetrators of domestic violence.[26]

4.10. Heavy drinkers with high levels of need who are frequent users of hospital and other local services are identified, assertively engaged and supported into appropriate treatment[27] through a co-ordinated multi-agency response.[28]

4.11. The recovery journey is initiated early and facilitated by access to a range of recovery support interventions and services such as peer support, mutual aid, family/parenting support, employment, training and housing.

4.12. All community treatment providers report data to the National Drug Treatment Monitoring System (NDTMS) and this data is analysed locally to inform improvements. Where structured alcohol treatment is provided in settings that do not report into NDTMS, such as by alcohol care teams, mechanisms are in place to feed data on this activity into local needs assessment and planning processes.

4.13. Alcohol treatment provider information systems comply with the NDTMS minimum data set and there is appropriate investment in IT systems to meet the clinical and NDTMS needs of providers where required.

4.14. Treatment providers have workforce plans that describe how specialist staff are trained and supported to ensure appropriate competence and supervision to deliver specialist interventions.

5. Commissioners work with partners to commission effective alcohol and drug treatment services

This section is relevant to drug and alcohol commissioning and is repeated in the adults alcohol/drugs commissioning support pack. In addition to the indicators set out below, commissioners and their partners will also need to comply with all relevant legislation, regulations and other statutory requirements as appropriate.

What you will see locally if you are meeting the principle

Effective integrated policies and commissioning of services that achieve positive outcomes for individuals, families and communities by:

- co-ordinated policies to promote less risky drinking and drug use, and to prevent harm
- effective partnership working between local authority-led public health, the NHS (clinical commissioning groups and NHS England health and justice commissioners), mental health services, Jobcentre Plus (JCP), Work and Health Programme (WHP) providers and adult social care, housing and homelessness agencies, children's services, criminal justice agencies and emergency services
- a commissioning system operating transparently according to assessed need
- improving connectivity between treatment providers and mutual aid organisations
- full involvement of service users and local communities, including through Healthwatch

More alcohol and drug misusers in treatment are supported into work by an effective partnership between the treatment and employability sectors. There is an integrated support offer involving greater support around training, education, voluntary work and general improvement of skills and work experience.

Alcohol and drug misusers have the best possible access to warm, safe and affordable homes, suitable for their needs in the community that local conditions will allow.

Indicators that will help you to establish whether you are following the evidence and best practices that support this principle

5.1. Embedding in local systems

5.1.1. There is an explicit link between the evidence of need and service planning within alcohol and drugs needs assessments, drug and alcohol commissioning strategies, clinical commissioning group strategy, and the joint health and wellbeing strategy.

5.1.2. Mechanisms are in place for reporting on alcohol and drugs to the health and wellbeing board, to the police and crime commissioner and to local safeguarding systems for vulnerable adults and children.

5.1.3. Public health commissioners have partnership arrangements with key agencies including clinical commissioning groups, clinical networks, NHS England health and justice teams, children's and adult social care and criminal justice agencies.

5.1.4. The integration of local authority and health planning to reduce alcohol and drugs harm has been supported by the introduction of place-based sustainability and transformation planning (STPs), across 44 geographic footprints.

5.1.5. Arrangements are in place for joint commissioning where there is a shared responsibility for commissioning and planning.[29]

5.1.6. A fully integrated system of health improvement, treatment and recovery for alcohol and drug misusers has been developed by a formal strategic partnership involving key stakeholders and agencies.

5.1.7. The general public, service users and staff in other services understand the alcohol and drug services available locally, the pathways between services and points of entry for drug and alcohol treatment.

5.1.8. Quality governance mechanisms assure the quality and safety of alcohol and drug treatment services and are embedded in public health systems.[30]

5.2. Needs assessment

5.2.1. The needs assessment includes a comprehensive section on the full spectrum of alcohol and drug-related harm and it acknowledges the impact of alcohol and drug work across the public health and NHS outcomes frameworks.

5.2.2. There is a shared understanding of the level of demand and need, based on a range of local and national data across a range of public services.

5.2.3. The following are identified locally:

- gaps in delivery of primary, secondary and tertiary prevention for alcohol and drugs
- the extent of drug treatment penetration and the rate of met need among the estimated population of adult dependent drinkers in need of structured treatment
- unmet need among specific populations for example, people with co-occurring mental health conditions or substance misusing parents
- the impact of services on health and wellbeing, public health and offending

5.2.4. Data is collected on alcohol and drug interventions provided in hospitals, primary health care and other settings, to inform needs assessment.

5.2.5. Levels of alcohol and drug-related admissions to hospital are analysed, to target interventions.

5.2.6. Specialist alcohol and drugs treatment data is monitored and analysed, to compare current treatment provision with need.

5.2.7. The latest prevalence data on alcohol and drug using parents and on children living in their households is used to consider the impact of parental alcohol/drug misuse within families and inform work with local services to address this need.

5.2.8. The local authority has worked with its partners to use PHE's CLeaR improvement – alcohol system improvement tool to review local structures and delivery arrangements and evaluate what works well to reduce alcohol-related harm.

5.2.9. The needs assessment uses a methodology such as asset-based community development to take into account the availability and potential development of existing community support networks and other local assets.

5.2.10. The needs assessment takes account of the needs of the local population including:

- children affected by parental drug or alcohol misuse
- those with poor mental health
- those (predominantly women and girls) vulnerable to alcohol and drug misuse as a result of domestic abuse, sexual assault, child sexual exploitation, or prostitution
- prisoners and continuity of care requirements for alcohol and drug-misusing offenders moving between custody and the community
- those with protected characteristics under the Equality Act 2010
- the carers and family members of alcohol and drug misusers
- those with co-occurring mental health and alcohol/drug use conditions.

5.2.11. A mutual aid self-assessment tool[31] has been completed as part of the needs assessment.

5.3. Finance

5.3.1. Investment is sufficient to provide a range of prevention, harm reduction and treatment services commensurate with the level of identified need.

5.3.2. Decision-makers have been enabled to understand the potential return on investment from alcohol and drug interventions and the possible cost of under-investment. Tools such as the Social Return on Investment Tool can help commissioners demonstrate the benefits derived from local investment.

5.3.3. Decision-makers understand the effectiveness and cost-effectiveness of their commissioned services and can identify ways of improving these where necessary. The Commissioning Tool is designed to help local areas understand and improve the cost-effectiveness of local treatment systems.

5.3.4. Commissioners can identify the total level of local investment by all partners who contribute to delivery.

5.3.5. There is close communication with finance colleagues to ensure that planned and actual expenditure on drug and alcohol prevention and treatment interventions is accurately reported to DCLG as part of required local authority financial returns. For help in disaggregating local substance misuse expenditure and estimating unit costs, commissioners can refer to the Commissioning Tool.

5.4. Effective commissioning

5.4.1. Commissioning is based on evidence-based guidelines, such as NICE guidance, for effective interventions in tackling alcohol and drug-related harm.[32,33,34,35]

5.4.2. There is an alcohol and drugs planning document that describes how best to meet local need, which clearly identifies:

- the level of demand
- existing strengths and assets and ways in which services can be commissioned to build on them
- finance and available resource.

5.4.3. Investment in alcohol and drug prevention, treatment and recovery is based on an understanding of expenditure, performance and cost-effectiveness.

5.4.4. Contracts for commissioned services specify the outcomes to be achieved and these outcomes are regularly monitored and reviewed.

5.4.5. Care pathways and services are geographically and socio-culturally appropriate to the people they are designed for.

5.4.6. Service users, their families and carers and people in recovery are involved at the heart of planning and commissioning. This is evident throughout needs

assessment and key priority-setting processes both for community and prison-based services.[36]

5.4.7. Commissioning functions are fit for purpose. There is sufficient alcohol and drug misuse commissioning capacity and expertise, including information management.

5.4.8. A workforce strategy and improvement plan ensures that commissioning staff are competent to commission safe and effective services.

5.4.9. Service specifications clearly indicate the level of professional competence required to deliver safe and effective services

5.4.10. The transfer of care is managed safely and effectively, when the contracted provider changes, with appropriate communication of patient information to enable seamless management of risks.

5.4.11. The commissioning strategy includes the formal evaluation of the range of alcohol and drug interventions.

5.5. Commissioning services for individuals in contact with the criminal justice system

5.5.1. Clear pathways are in place into assessment, treatment and support services for individuals in contact with the criminal justice system who have drug and/or alcohol problems and, where possible, consideration is given to the development of integrated pathways for individuals with co-occurring mental health and alcohol/drug use conditions.

5.5.2. Discussions have taken place with police and crime commissioners and NHS England health and justice commissioners and there is a collaborative approach to the commissioning of fully integrated services that effectively support and engage individuals as they move between places of detention and community settings.

5.5.3. Commissioners have engaged with their local National Probation Service and community rehabilitation company (CRC) to agree capacity for treatment interventions and the need for specific requirements for offenders subject to statutory supervision in the community and on release from prison.

5.6. Involvement with mutual aid significantly improves recovery from alcohol and drug dependency

5.6.1. There is a shared, locally developed vision of recovery where mutual aid is appropriately integrated with all alcohol and drug services including in-patient and residential treatment.

5.6.2. People in treatment have access to a range of peer-based recovery support options, including 12-step, SMART Recovery and other community recovery organisations.

5.6.3. Local services are encouraged to support service users to engage with mutual aid groups through the inclusion of specific requirements in their service specifications.

5.7. The home environment enables people to sustain their recovery

5.7.1. The housing needs of alcohol and drug misusers in the community, prison and residential treatment have been identified and are used to inform commissioning plans for housing, homelessness and housing related services.

5.7.2. The housing needs of alcohol and drug misusers and their families/carers (where appropriate) are assessed in a timely manner to prevent homelessness and/or to enable move-on to a suitable home.

5.7.3. Housing information and advice are readily available for everyone in treatment.

5.7.4. There is a range of housing options to meet different needs.[37]

5.7.5. Alcohol and drug misusers who are rough sleeping are able to access emergency accommodation and support.

5.7.6. The health needs of homeless alcohol and drug misusers have been identified[38] and these individuals are supported to access primary and other healthcare.

5.7.7. Front-line housing staff are trained to meet the housing and related needs of alcohol and drug misusers.

5.7.8. Policies and procedures for homeless alcohol and drug misusers support pathways into suitable accommodation on discharge from hospital or residential rehab, or on release from prison.

5.8. Getting a job can enable people to sustain their recovery

5.8.1. Joint planning arrangements are in place between treatment commissioners and providers and JCP and WHP leads to meet the employment, training and education (ETE) needs of the alcohol and drug misusing population.

5.8.2. Worklessness and employability strategies reflect the ETE needs of alcohol and drug misusers.

5.8.3. Commissioners incorporate ETE in their performance monitoring arrangements with treatment providers and providers address ETE in supervision for keyworkers.

5.8.4. JCP, WHP and treatment providers have agreed a process of joint working between agencies, including arrangements for three-way meetings and co-location.

5.8.5. Local single points of contact have been identified in JCP, WHP and all treatment teams and these details have been circulated.

5.8.6. There are employment champions in treatment teams, whose role it is to liaise with JCP and WHP, and to champion ETE.

5.8.7. Treatment providers, JCP and WHP routinely engage with local employers to make the case and address negative preconceptions and stigma about employing people with a history of alcohol or drug dependence.

5.8.8. Discussions about employability are introduced early on in treatment journeys, and commissioners and treatment providers continually review the extent to which the ETE agenda is prioritised in local recovery provision.

5.8.9. Treatment staff encourage clients to consider appropriate disclosure of their alcohol and drug misuse within JCP and WHP to facilitate tailored support.

5.9. Commissioning hospital-based alcohol and drug services

5.9.1. Services are in place to meet the needs of hospital patients who misuse alcohol or drugs.

5.9.2. There is a strategic understanding of how alcohol and drug services for people in hospital are part of the wider treatment system and awareness of the role they play in addressing need.

5.9.3. Patients leaving hospital and requiring further treatment and recovery support are encouraged to access community alcohol and drug services.

5.10. Young people, children and families

Note: there is a separate support pack for substance misuse by young people that should be read alongside the following indicators.

5.10.1. Treatment services follow the statutory guidance relating to section 11 of the Children Act 2004 and this is regularly audited using a standardised audit tool.[39]

5.10.2. Effective referral pathways and joint working arrangements are in place with children and family services where there are safeguarding issues and with local Troubled Families provision where alcohol or drug misuse is a factor.

5.10.3. Protocols have been developed between alcohol and drug systems, and children and family services in line with 'Supporting information for the

development of joint local protocols between alcohol and drug partnerships, children and family services'.[40]

5.10.4. Treatment services identify and address needs for parenting and family support at the 'early help' level as part of the care planning process.

5.10.5. The health and wellbeing board oversees the collation and analysis of data on parental alcohol misuse from a range of local services, as proposed by the Office of the Children's Commissioner.[41]

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