

Purpose

This report sets out a template for use in preparation of the work programme for each of the Health and Wellbeing Board's ten interventions. The template is designed to;

- Create clarity on the desired impact of each intervention and on the specific roles of partners in delivering the intervention.
- Make explicit the shifts in ways of working that will allow partners to deliver the intervention.

The planning template

I. Reality

What's the current reality?

What is currently working well?

- 3 distinct commissioning projects in Lancashire. In collaboration with PCT's in unitaries, commissioners in each locality are already engaged in negotiating alcohol liaison scheme implementation with PCT /CCG funders, community service providers, hospitals and other stakeholders. Local schemes are bespoke depending on need and circumstance and not 'one size fits all'.
- Public Health Network Alcohol Programme Manager assists coordination and collaboration through the Lancashire Alcohol Network. LAN input influences effective collaborative working across partnerships at district and County levels.
- Evidence base for alcohol liaison intervention is strong ie NICE(ref). Data for alcohol related hospital admissions is reliable and Lancashire Alcohol JSNA, 2012 (Ref)has highlighted increasing trend in rate of alcohol related hospital admission. Costs estimates of alcohol impacts to health have been identified by OurLife (ref).
- Partners involved in alcohol harm reduction partnerships have identified alcohol impacts as a priority.
- Evidence of alcohol liaison outcomes based on 'invest to save' principles is strong. (NWCEO's ref) Locality business cases predicated on this.

What is getting in the way of partners achieving desired impacts?

- Consistency and commitment for sustainable funding for alcohol liaison nurse resources. N Lancs has some specific funding, East has improvised a resource and Central has no specific resources committed.
 - QIPP proposals have not been able to demonstrate to PCT's actual savings from alcohol liaison due to lack of reliable data and cost/benefit analysis tools. PCT QIPP investment
-

criteria has been largely based on cost saving prediction and hence reluctance to fund.

- Generally, hospitals and urgent care centres lack screening processes to identify alcohol related conditions on presentation and staff lack awareness and training to recognise issues and deliver information and brief advice (IBA).
- Significant progress has already been made in discussing liaison services with partners. However, the need for this service requires constant re-enforcement with colleagues across acute trusts to ensure that a partnership approach to service implementation can be achieved.
- Lack of effective clinical pathways between hospital, primary care and community services to reduce repeat attendance and admission by 'frequent flyers'.

Where are the gaps in service delivery that really matter?

- Equity of access to alcohol liaison across Lancashire ie Central no liaison, NL only at BVH, East at RBH. The lack of equitable service delivery across Lancashire impacts on re-admissions and the long term prognosis for patients with chronic conditions caused or exacerbated by alcohol.
- Alcohol related condition screening and identification in hospitals and primary care Urgent Care Centres is poor. Low level of professional awareness of alcohol screening tools and IBA techniques. However, some developments are being taken forwards in Central Lancashire.
- Lack of effective and consistent referral and clinical pathways between hospital, GP and community services.

What are the issues and opportunities that must be addressed if we are to make a breakthrough? i.e. what really matters?

- Engagement with senior management in strategic health planning and acute hospital trusts to influence and lead the implementation of alcohol liaison as a means to health improvement and reducing associated costs to health services and other partners.
 - Successful business cases for investment proposals to funding organisations e.g. PCT's/CCG's and PHL to access sustainable resources for alcohol liaison.
 - Opportunity to publicise JSNA findings and evidence base for intervention impacts.
 - Provision of alcohol awareness, identification and brief advice training for appropriate staff.
 - Identify and agree 'best fit' liaison model and target groups ie dependent drinkers (frequent flyers) or dependent + increasing risk or universal whole patient group approach.
 - Identify robust data systems and cost benefit tools to demonstrate effectiveness and outcomes.
-

2. Results

What does success look like?

2.1 Longer-term impact

What will be the 3 to 5 year impact of the intervention?

- Reduction in the rate of increase of alcohol related hospital admissions and A&E repeat attendances.
- A reduction in the number of alcohol specific re-admissions and A&E representations within 30 days.
- A reduction in bed days associated with managing acute alcohol withdrawal (AAW)
- Improvement in Lancashire Alcohol Profiles for England (LAPE) across Lancashire 12 districts.
- Improved quality of care for people admitted to hospital for alcohol specific and alcohol related conditions.
- Reduced health service utilisation (pre and post intervention) by patients supported by the alcohol liaison service.
- Improved treatment pathways between hospital, primary care and access into community treatment services
- Skill development within the acute sector workforce through training in identification and brief advice and management of AAW.
- A reduction in alcohol fuelled violence and aggression against hospital staff.

What are the longer-term measures of success?

- Contribute to a reduction in the rate of increase of alcohol related hospital admissions
 - Contribute to reducing demands on partner services from alcohol related issues.
-

2.2 Impact in the year ahead

What specific goals will the intervention achieve in the next year?

- Identify resources that facilitate implementation of an agreed model for alcohol liaison services to be established in all acute hospitals with a catchment serving Lancashire residents including aligning contracts with unitary PCT's. Explore potential to establish liaison cover for primary care out of hours and urgent care.
- Produce service specifications based on the identified target groups for local projects.
- Agree contracts for establishing alcohol liaison with acute hospitals including service mobilisation.
- Establish robust data collection and monitoring systems for evaluation
- Produce referral and clinical pathways between hospital, GP and community services appropriate to each locality.
- Deliver training programmes aimed at increasing alcohol awareness and skills in Identification and Brief Advice for 'front line' hospital staff.

What are the specific measures of success for the year ahead?

- How will the Health and Wellbeing Board know that the intervention has achieved its goals?
-

-
- Sustainable resources are identified to facilitate alcohol liaison service provision.
 - Alcohol liaison established equitably in all A&E and acute hospital settings in Lancashire by September 2013.
 - Alcohol liaison established in Urgent Care Centre and Out of Hours primary care services where appropriate and resources available.
 - Effective clinical pathways are established between hospital, primary care and appropriate community services.
 - Lead officers will produce quarterly progress reports on key deliverables for H&WB responsible members for programme monitoring and feedback to the Board.
-

3. Response

What needs to happen to ensure partners achieve better results?

3.1 Shifts in the way that partners deliver services

-
- How must partners work to ensure that the 'priority shifts' are applied and the intervention is effectively implemented?
 - Partners need to promote awareness of the impacts that alcohol has on services and the benefits of alcohol liaison as a harm reduction intervention to prevent ill health and reduce demand for services.
 - Partners need to commit to engagement in the work programme and contribute to the implementation of alcohol liaison as a priority objective.
 - Partners need to communicate openly regarding barriers to achieving objectives.
 - Partners need to commit to pathways and joint working to delivering accessible services within hospital and community settings to improve the experience of moving between primary, hospital and social care.
 - Partners need to commit to training and raising awareness for frontline staff to facilitate identification of alcohol harms, adopting screening tools for identification, delivering information and brief advice and pathways for signposting.
 - Influence of HWB/CCG's to promote planning priorities
-

3.2 Programme of work

-
- Who needs to be involved to develop, commission and deliver the intervention?
 - Public Health Lancashire (interim PCT locality commissioners & LAN/LDAAT)
 - CLASS on behalf of CCG's (interim acute trust commissioners and allied support e.g.finance, performance etc)
 - Acute Trust managers
 - Primary care service managers
 - Community treatment service managers
 - Leverage from HWB/CCG's
 - What are the 'milestones' for the Task Group in the year ahead?
 - Where required, resubmit QIPP proposals to funding groups for alcohol liaison resources and/or consider shifting existing health resources to prevention and early
-

interventions.

- Engage all key stakeholders in planning alcohol liaison services as per 3.2 above.
- Develop locality implementation plans including; agreement of liaison model and target groups, specification and performance management indicators, and provider mobilisation plans including staff recruitment and agreed commencement date.

-
- What are the specific activities to be carried out by each partner?
 - Awareness raising and engagement of partners to develop local implementation plans. (Commissioners/partners)
 - Business case(s) worked up and submitted to funding groups (NHS Commissioning)
 - Negotiate potential for resource shift with partners and providers ie acute trusts'
 - Negotiate contracts with acute trusts including finance, service model, performance management framework etc. and ensure service equity across Lancashire (commissioners NL/CL/EL in collaboration with unitaries as required and provider stakeholders)
 - Provider mobilisation including recruitment of staff , protocols and pathways, staff training. (providers)
 - Develop referral and treatment pathways between hospitals, primary care and community treatment services and signposting to other partners. (all)
 - Achieve full implementation of service and evaluation (all)
-

Appendix I
Priority shifts in the ways that partners deliver services

- | |
|---|
| <ul style="list-style-type: none">● Shift resources towards interventions that prevent ill health and reduce demand for acute and residential service |
| <ul style="list-style-type: none">● Build the assets, skills and resources of our citizens and communities |
| <ul style="list-style-type: none">● Promote and support greater individual self-care and responsibility for health; making better use of information technology and advice. |
| <ul style="list-style-type: none">● Commit to delivering accessible services within communities; improving the experience of moving between primary, hospital and social care. |
| <ul style="list-style-type: none">● Make joint working the default option; pooling budgets and resources to focus on priority outcomes, commissioning together on the basis of intelligence and evidence; sharing responsibilities for service delivery and combining services in the most effective way; sharing risk. |
| <ul style="list-style-type: none">● Work to narrow the gap in health and wellbeing and its determinants |