

1. Portfolio

1.1 Abstract and Background

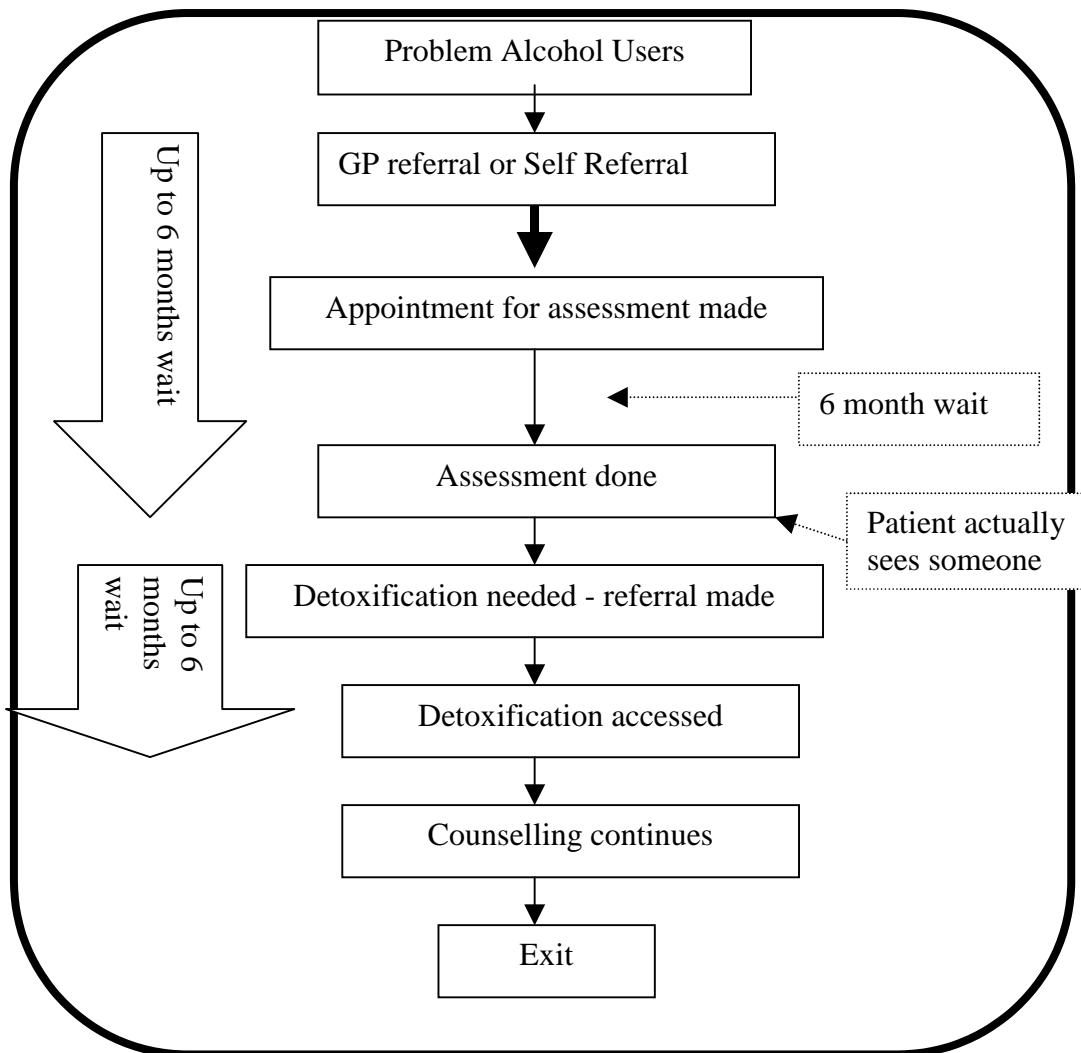
Blackpool is a seaside holiday resort in the northwest of England with a resident population of 150,000. Blackpool has the worst rates of alcohol related morbidity and mortality in England, and widespread deprivation as 6 of the 21 wards of residence are within the 10% most deprived nationally. Alcohol related morbidity and mortality is also concentrated in these wards of residence.

1.2 Obstacles to Overcome

The location of the alcohol service and waiting times to treatment were identified as the biggest blocks to service access. During 2004/05, the service received over 1,500 referrals but only treated 393 people. The waiting time was approximately 6 months to see a counsellor, and people would be expected to travel up to 5 miles to appointments. In addition, pathways were unclear as there were no services targeted at patient need, and there were waiting times at every point of the treatment journey.

Alcohol and Drugs Services (ADS) who deliver alcohol services in Blackpool, had expanded service capacity by using unpaid volunteers, as funding was very low. These volunteers delivered client centred counselling that takes up to 2 years, and carries a low evidence base for effectiveness in the treatment of alcohol problems.

The service model looked like:



1.3 New and Recent Schemes

This service redesign utilised the most recent evidence based practice in reducing alcohol related harm. This current scheme has been fully operational since January 2006.

1.4 How These Obstacles Were Overcome

The key areas for change were identified as greater points of access, reducing distance to treatment and reducing waiting times at all stages to create a functional pathway.

1.4.1 Greater Points of Access

Alcohol counselling surgeries in GP practices have been established across the town, offering 15 different centres where patients can access alcohol treatment.

1.4.2 Reducing Distance to Treatment

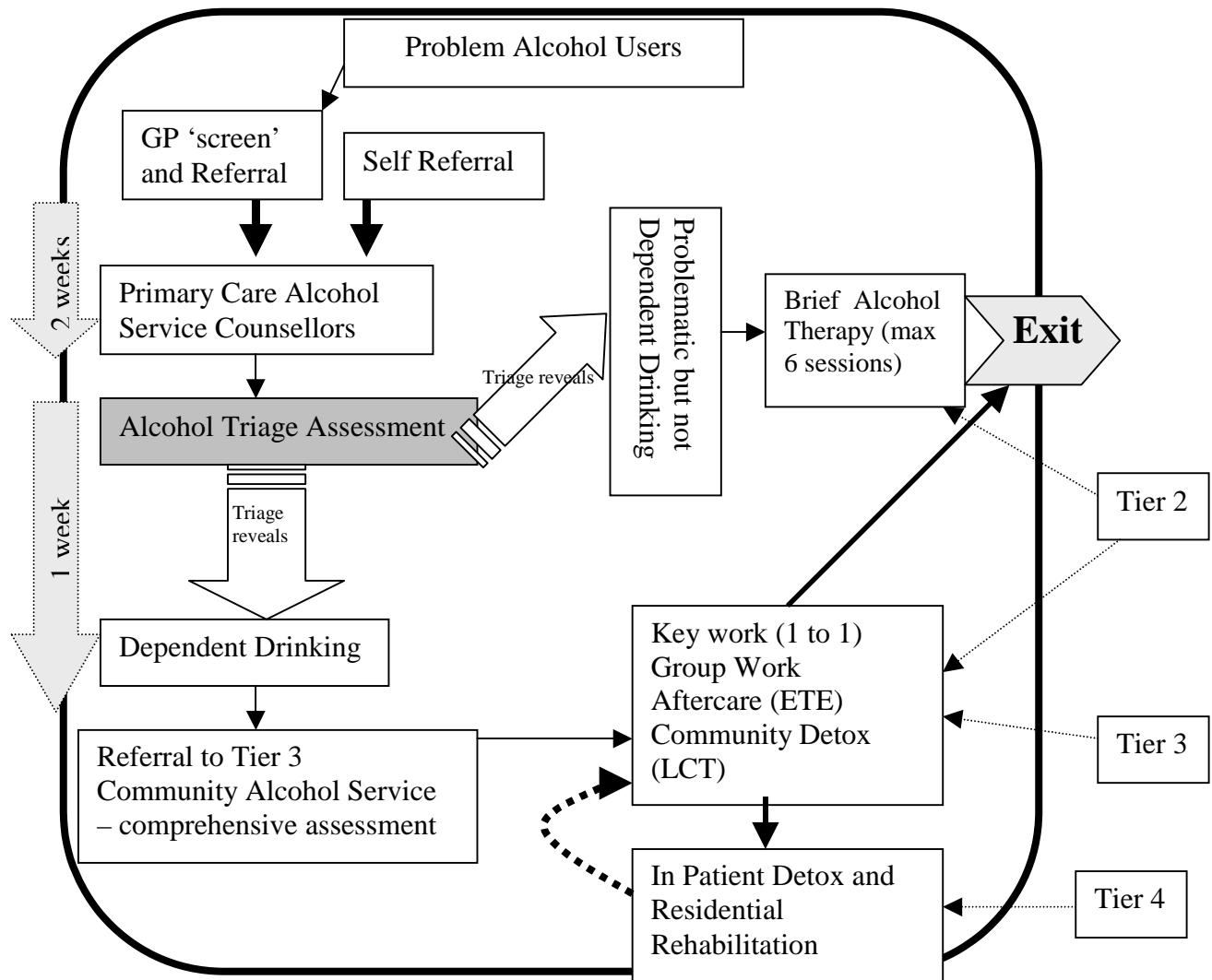
Patients can now see an alcohol worker at their local GP practice, where they can access a range of treatment interventions.

1.4.3 Reducing Waiting Times

Patients no longer have to wait more than two weeks for alcohol treatment.

1.4.4 Functional Pathways

Patients with a lower threshold of need can be treated in primary care and discharged, reducing the pressure on the structured treatment.



2. Impact

2.1 Have we met the needs of patients?

The needs of patients are met by a more efficient service, with shorter waiting times, and a removal of the stigma associated with going to alcohol treatment services. The improvement in meeting patient needs is clear when considering patient activity, they are;

- Waiting times were reduced from 6 months to 2 weeks
- Attendance rates increased from 25% to 60%
- Postcodes demonstrated that over half of those receiving treatment were from the six poorest wards
- Numbers completing Tier 2 and discharged was 40 and is now 200
- Numbers completing Tier 3 and discharge was 15 and is now 244
- Numbers completing Tier 2 being referred into Tier 3 was 400, and showed good referral pathways, plus good completion rates (244 out of 400)

The positive impact created service efficiencies further along the pathway, these were;

- Numbers completing community detox increased from 25 to 54 (116% increase)
- Numbers completing residential detox increased from 21 to 75 (257% increase)

2.3 Number of patients who have benefited to date

During 2006-2007 financial year, 1670 patients referred themselves into treatment, with 1250 accessing help through GP practices. Of those 1250, only 450 needed referral into structured treatment and detoxification.

2.4 Numbers who will benefit annually

It is anticipated that 1300 people per year will benefit from this service redesign, over three times the number that previously received services.

2.5 Impact on hospital admissions

We await the statistics on hospital in patient episodes. We expect to see a reduction in the rate at which alcohol attributed in-patient episodes are rising. We also expect to see a reduction in Length of Stay for alcohol-attributed conditions.

2.6 How the scheme impacts on local financial and human resources

The scheme has involved additional investment of £62,500 per annum, in addition to the £95,000 that was already invested. The impact on HR is mitigated as the services are delivered by a voluntary sector provider (ADS) within a service contract.

2.7 How the scheme fulfils the priorities of local primary care clinicians

The service has encouraged the referral of alcohol misusing clients into treatment by Primary Healthcare Workers, especially GP's, who had lost faith in the old system.

3. Innovation and Good Practice

The Innovation of the scheme can be seen in the new service model, with the creation of an easily accessible treatment system. Local accessibility in terms of capacity and waiting time are well above the national average. The scheme supports treatment progression (direction of travel) including re-integration into mainstream community services.

The findings of the UK alcohol treatment trials (UKATT, 2005) which later informed the NTA's "*Review of Effectiveness of Treatment for Alcohol Problems, 2006*" underpinned practice. Cognitive Behavioural Therapy, and Social Network Therapy replaced client centred counselling at Tier 3. Tier 2 centred around Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET). Both Tier 2 and Tier 3 services were given time-limited targets on length of treatment in each modality.

4. Planning for the Future

Blackpool PCT will continue the current investment in primary healthcare alcohol services to maintain this level of service.

The scheme is sustainable, as the funding is mainstreamed, and GP practices continue to support the scheme with access to treatment rooms.

The scheme's progress will be monitored by the Blackpool Alcohol Steering Group.

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