



## Primary Care Contracting

### Primary Care Service Framework: Alcohol Services in Primary Care

- This 'enhanced service' framework should be read in conjunction with the **supportive statements for commissioning** on the Primary Care Contracting website – 33H[www.pcc.nhs.uk/204.php](http://www.pcc.nhs.uk/204.php) – and the **additional supportive notes** at the end of this document. A **complementary suite of practical resources** is also available on this website to support commissioners, providers and other stakeholders with local service design and development. These additional practical tools or pointers have all been successfully used to improve the health of people with alcohol problems and have been shared by PCTs and providers of primary care alcohol services. Primary Care Contracting is grateful for all those organisations that were willing to share their learning across the NHS.
- This document provides examples of good practice around alcohol services in primary care and can be adapted and used as a basis for an enhanced service via a schedule within a local primary care contract or Service Level Agreement. This will hopefully avoid duplication of effort and speed up the commissioning process. It would be appropriate to adapt or include local information in the relevant sections. Legal advice or support for local contractual arrangements may need to be considered.
- NHS Primary Care Contracting kindly requests feedback from PCTs or Practice Based Commissioners following implementation of this Framework via the brief feedback questionnaire on their website – 34H[www.pcc.nhs.uk/204.php](http://www.pcc.nhs.uk/204.php). This will assist in its on-going development and sharing of good practice across the NHS.
- The Department of Health and NHS Primary Care Contracting would like to thank all those individuals, departments and organisations who have contributed to the development of this Primary Care Service Framework as well as Steering Group members. In particular, we are grateful to the Drug and Alcohol Action Team at Nottinghamshire County Teaching PCT and The Woodlands Practice, Ashfield. Thanks also go to Dr Jeff Anderson of Primary Care Unlimited – 35H[www.primarycareunlimited.com](http://www.primarycareunlimited.com) – for coordinating the development of this Framework.

## Primary Care Service Framework: Alcohol Services in Primary Care

- 1. Purpose of this Primary Care Service Framework**

The purpose of this Primary Care Service Framework is

  - to equip commissioners, providers and practitioners with the necessary background knowledge, service and implementation details to safely deliver support for alcohol interventions in primary care.
  - as a means of improving the health and quality of life of people whose health may be compromised by their use of alcohol by providing patient-centred, systematic and on-going support.
  
- 2. Period of Service**

For example:

This service will run for a period of twelve months from 1<sup>st</sup> April 2008 – 31<sup>st</sup> March 2009 (extended subject to satisfactory annual review).
  
- 3. Scope and Definition of Service**

The Primary Care Service Framework is open to male and female adult patients aged 18 and over who are **drinking to hazardous and harmful or dependent levels**.

The information contained within this Framework can be used to commission and provide services at these recognised levels. To help identify which information is relevant to which level of service, the Framework has been coded:

  - (A) – Hazardous and Harmful drinking** – where screening and brief advice are normally appropriate
  - (B) – Dependent drinking** – where more extended, specialist services are normally appropriate

This Framework for service commissioning and provision should not be confused with (and sits outside of) essential and additional GMS or PMS services already provided and current Quality and Outcomes Framework (QOF) indicators.

It is open to all types of providers with an interest in improving health for example, GP practices, Community Pharmacists, community and specialist nurse-led services, voluntary and third sector, Local Authority, the independent sector or other alternative providers. This will depend on the ability of the provider to ensure the appropriate health services are delivered by appropriately qualified practitioners.

For services for dependent drinkers, this Framework may achieve more success through an integrated and community based model, making best use of joint commissioning approaches and networks of provision. It can be provided either at individual practice level, or on a locality or PCT basis.

#### 4. Parties to the agreement

*Insert names of any accountable individuals and organisation details.*

#### 5. Background

Hazardous and Harmful drinking creates a huge burden on the health (and wider public sector) system both in terms of the cost of treating alcohol related diseases and the impact on hospital and primary care demand. Often patients continue to be treated for problems such as high blood pressure, depression or anxiety without ever having the contributing factor of alcohol addressed. If Hazardous and Harmful drinking is identified and brief advice is offered, it could lead to a reduction in future alcohol related health problems, which could save on treatment costs. This could decrease pressure on the NHS through a reduction in repeat admissions and consultations. For every £1 spent on alcohol services it is estimated that £5 will be saved across health and the wider public services.

Hazardous and Harmful drinking is associated with a wide range of problems, including physical health problems such as cancer and heart disease. In addition, alcohol is involved in a wide range of other social and health issues such as offending behaviors, not least domestic violence; suicide and deliberate self-harm; child abuse and child neglect; mental health problems; and homelessness.

Those with additional and co-existing problems, including people with mental health problems, people with learning disabilities, some older people, and some with social and housing problems, may be particularly vulnerable. They may have complex needs that require more intensive or prolonged interventions, even at lower levels of alcohol use or dependence. Complex problems may also include difficulties that have significant impact on others, such as domestic abuse, whether as victim or perpetrator.

The evidence base indicates that much of this harm is preventable. The introduction and development of comprehensive integrated local alcohol intervention systems considerably benefits hazardous, harmful and dependent drinkers, their families and social networks, and the wider community.

The National Treatment Agency's *Review of the Effectiveness of Treatment for Alcohol Problems* (2006) showed that opportunistic brief interventions delivered to hazardous and harmful drinkers in primary healthcare are effective in reducing alcohol consumption to low risk levels. The public health impact of widespread implementation of brief interventions in primary healthcare is potentially very large. Additionally, the effects of brief interventions persist for periods up to two years after intervention and perhaps as long as four years. Booster sessions may be necessary to maintain the effect for longer periods of time, although more research is needed on the longevity of the effects of brief interventions.

However, the review also found that most healthcare professionals have yet to incorporate screening and brief interventions for hazardous and harmful drinking into their routine practices with GPs in particular tending to miss most hazardous and harmful drinkers presenting to their practices.

*'Safe, Sensible, Social – The next steps in the national alcohol strategy'* (2007) reviews progress since the

publication of the *Alcohol Harm Reduction Strategy* (2004) and the *Choosing Health* (2004) white paper and outlines further national and local action to achieve reductions in alcohol-related ill health and crime.

About 26% of all adults in England, which equates to approximately 7.1 million people, are drinking at hazardous or harmful levels. A further 1.1 million people are showing signs of alcohol dependence. With 63% of all adults visiting their GP during the course of a year, primary care offers a unique opportunity to identify harmful and hazardous drinkers and intervene early to bring down the level of risk identified.

Annually, alcohol-related diseases account for 1 in 26 NHS bed days (around 2 million) and 1 in 80 NHS day cases (around 40,000) with up to 35% of all A&E attendance and ambulance costs (around £0.5 billion) being alcohol related.

*Models of Care for Alcohol Misusers (MoCAM, 2006)* provides best practice guidance for local health organisations and their partners in delivering a planned and integrated local intervention system for adults affected by alcohol. It promotes the use of the stepped care model, which is defined as 'the least intrusive and expensive intervention that is likely to be effective as the first line of treatment'. MoCAM informs this Primary Care Service Framework as it develops the notion of integrated local treatment 'systems' and the tiered framework of provision. It describes key quality criteria for the commissioning and provision of services as well as the interventions and specific treatment options that could be commissioned.

It is expected that MoCAM will be used by PCTs working in partnership with local commissioning groups and local service providers. The purpose will be to develop and build integrated systems to meet the needs of local people whose alcohol use maybe harmful and requires intervention or treatment, benefiting them, their families and communities. This process should also be informed by service user input.

Finally, the second generation *Local Public Service Agreements* (2007) which underpin Local Area Agreements (LAA) focus on how local public sector partnerships can impact on improvement of health for local people. Agreements may have local variation but many areas may choose to focus on setting targets to reduce alcohol related hospital admissions. Local Strategic Partnerships can play an increasing role in the development of local community strategies for improvement, which will provide much of the basis for identifying the priorities for improvement locally that are reflected in the local PSA.

For the first time, a national target for alcohol has been established which commissioners and providers should be aware:

- To reduce the trend in the increase of alcohol related hospital admissions (PSA 25)

To support this PSA, the NHS has developed an indicator for Operational Plans. This indicator monitors the rate of hospital admissions per 100,000 for alcohol related harm (Vital Signs Tier 3, NI 39).

## 6. Summary of Local Need

*Commissioners should outline or reinforce a summary of local health and social care or service need drawn from a Joint Strategic Needs Assessment, Local Strategic Partnership agreements and local alcohol strategies, in conjunction with Local Authority partners. Suggested options to include here can be found in the additional notes below.*

## 7. Service Objectives and Intended Health Outcomes

Joint working between service providers is critical to achieving the following list of service objectives and intended health outcomes for the local population and contribute to the national objective of reducing the rate of alcohol-related hospital admissions:

- To improve the identification, assessment and intervention offered to people at greater risk of alcohol morbidity through the primary care setting, particularly those drinking to hazardous and harmful levels.
- To provide quicker access to early assessment of potential alcohol related harm, early intervention and timely referral to specialist help for those who show signs of dependence on alcohol
- To reduce consumption levels in people who are drinking at hazardous, harmful or dependent levels.
- To improve the health outcomes of people who are drinking at hazardous, harmful or dependent levels by improving the management of physical and mental well-being and clinical co-morbidities.
- To provide further choice of interventions for people who are drinking at hazardous, harmful or dependent levels closer to home and outside of a secondary care setting.
- To ensure better value for money through effective commissioning of primary care services for people who are drinking at hazardous, harmful or dependent levels by maximising the impact of any screening, brief interventions and onward referral processes.

## 8. Service Outline

### Key

**(A)** - information more relevant to provision of services for **hazardous and harmful** drinkers

**(B)** - information more relevant to provision of services for **dependent** drinkers

*Note – the information provided for each service level is a guide and is not exclusive. It may be relevant to targeted or wider service provision. The level of*

To support service provision, a selection of **key principles** to inform local modelling include:

- Effective intervention is often brief **(A)**
- Early screening and intervention of the target population (hazardous and harmful drinkers) is critical **(A)**
- In most cases, for those not responding to brief advice, motivational enhancement therapy should be the first treatment intervention of stepped care **(A)(B)**
- Comprehensive (and holistic) assessment of patients needs is desirable **(B)**
- Care-planned interventions to meet need (even if treatment is short in duration) **(B)**
- Provision of a range of interventions to meet patient need is usually required, which broadens practitioner skill base **(B)**
- Evidence based interventions require a trained and competent workforce **(A)(B)**

**For hazardous and harmful drinkers (A), providers should consider all of the following:**

*any commissioned service, and thus the information used, will need to be determined locally.*

1. Nominate a lead clinician to take responsibility for coordinating service provision among their own teams. This person should be supported by other primary care professionals such as more specialist alcohol workers if necessary.
2. The recommended screening tests are the Fast Alcohol Screening Tool (FAST) or AUDIT-C. Detailed guidance is available from [www.druglibrary.stir.ac.uk/documents/fastmanual.pdf](http://www.druglibrary.stir.ac.uk/documents/fastmanual.pdf). In practice, identification may be opportunistic through a number of sources such as review of all chronic disease management contacts, new patient registrations or routine health checks, following up A&E attendances or referral from an outside agency.
3. For those patients identified as positive on the screening test and therefore drinking to hazardous or harmful levels, administer the full AUDIT tool. The exact AUDIT score should be recorded in the GP system using the Read codes provided (see Suite of Supportive Resources).
4. For those who score 19 or below on AUDIT, provide brief and up-to-date alcohol consumption and behaviour change advice as well as self-care opportunities on how to reduce consumption and harm. (Recommended examples of self-care support materials are highlighted in Section 9. below).
5. Provide written health promotion material and information for all patients on community and voluntary sector support if they should desire to seek this support.
6. The recommended brief intervention is the basic 5 minutes of advice used in the WHO clinical trial of brief intervention in primary health care. In the UK, the University of Newcastle had refined this into a programme called *How Much Is Too Much?*

Note - Brief interventions are targeted at those drinking at hazardous and harmful levels but not requiring treatment for alcohol dependence, and based on a reduction in alcohol consumption to within sensible limits. Advice and information is expected to be appropriate and relevant to the needs of diverse populations and literacy levels and, where relevant, written information is available in a number of languages. Interpreters should be used where required and in doing so it is strongly recommended that interpreters used have had basic alcohol misuse awareness training.

**For those requiring treatment for alcohol dependence (B), providers should:**

7. Develop and produce of an up-to-date patient register recorded in the GP system using the Read codes provided (see Suite of Supportive Resources) which identifies patients as dependent drinkers. These patients will normally have a full AUDIT score of 20 or more.
8. Produce a written and comprehensive care plan for all service users attending the 'open access' service. Any care plan will be tailored to the clients' needs and circumstances, following discussion with them, and will need to respond flexibly to clients' problems.

9. Where prescribing is necessary, such as for community detoxification, dosing regimes should follow according to a SADQ score (Severity of Alcohol Dependency Questionnaire).
10. Referral to the local alcohol specialist support service, in primary care if this pathway exists, or to secondary care services such as a NHS Community Alcohol Team. Some areas may be served by specialist alcohol services located in the voluntary sector and consideration should be given to providing information on local self help groups (such as Alcoholics Anonymous or similar).
11. Develop an effective service which is inclusive of all stakeholders and supports effective service integration. This includes:
  - working with families and carers affected as a consequence of alcohol misusers
  - developing sustainable partnerships between agencies involved in the care of alcohol misusers
  - supporting responsive information transfer to assist integrated service provision.

## 9. Support for Self Care

Providers should be in a position to identify those individuals **(A)(B)** who would benefit from additional support for self care and enable these individuals to access the four main areas of self care - Skills and Education; Information; Tools and Devices; Self Care support networks. Additional detail around support for self care can be found at [www.pcc.nhs.uk/204.php](http://www.pcc.nhs.uk/204.php) in a parallel Primary Care Service Framework, and also [www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/DH\\_4128529](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Longtermconditions/DH_4128529) on the Department of Health website.

## 10. Location of Service

*Commissioners will need to re-assure themselves that any service is provided from premises that are fit for purpose in a modern way and address issues of service user needs and uptake, particularly in communities with poor health outcomes. Details should be included here.*

## 11. Integrated Governance

Clinical Governance arrangements must be proportionate to the service provided and comply with any local expectations or requirements of the commissioner.

Any commissioned service must meet all national standards of service quality and clinical governance including those set out in Standards for Better Health (updated April 2006 [www.dh.gov.uk](http://www.dh.gov.uk)). These core and developmental standards of provision are designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The seven domains are safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, the care environment and public health. Compliance with relevant NICE guidance such as for the diagnosis and management of epilepsies in adults and children in primary and secondary care ([www.nice.org.uk](http://www.nice.org.uk)) is also required.

At present, however, there is no NICE guidance available for the commonly used specific treatments for

alcohol dependency (**B**) (such as disulfiram) – and in the absence of such guidance other sources may be utilized (such as those provided by the Scottish Intercollegiate Guidelines Network) (SIGN 2003).

**Professional competency, education and training** - All staff involved in delivering assessments, key-working, care planning and (most significantly) structured psychosocial interventions for dependent drinkers (**B**) must have an appropriate level of competence to deliver these services and training must be updated regularly in response to changes. The Provider will ensure staff hold, or are committed to work towards, achieving competence in the following **Drugs and Alcohol National Occupational Standards (DANOS)**. Further details of these standards can be found in the supportive notes accompanying this document.

All practitioners should prescribe within their own level of competence as defined by *Roles and Responsibilities of Doctors in the provision of treatment for drug and alcohol misusers* (RCGP & RCPsych 2005) and the Department of Health's '*Drug misuse and Dependence - guidelines on clinical management*' (1999). The service is required to be compliant with Quality in Alcohol and Drugs Services (QuADS, 1999) organisational standards.

The Department of Health has commissioned the development of a web-based modular training programme for GPs. This will be developed by 'E-Learning for Health' and will include training around patient identification, providing screening and delivering brief interventions in primary care. This resource will be available Summer 2008.

**Patient, public and staff safety** – Providers will be required to demonstrate that evidence based clinical guidelines are being used. Providers should have in place appropriate health and safety and risk management systems and that premises standards are met. They should also ensure that any risk assessments and significant events are both documented and audited regularly and outcomes of these implemented. Services should comply with national requirements for recording, reporting, investigation and implementation of learning from incidents. Further details can be found on the National Patient Safety Agency website [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

The provider of this service is also required to have in place effective policies and procedures which promote the well being and safety of service users and staff. Providers should ensure safe staffing capacity at all times and staff should be able to demonstrate that they have participated in organisational mandatory and update training, for example infection control, manual handling, risk assessment as required.

**Information management** – Practices should each have local policies in place that describe access to medical records by local Substance Misuse Services and Alcohol Dependency Service employees.

Any communications strategy or provision should be coherent with and follow local policies and the Department of Health Code of Confidentiality, local child and adult protection procedures, and should outline the mechanisms to safeguard patient information when shared within an integrated service. Furthermore,

accurate clinical coding is vitally important to capture enough information about a person who misuses alcohol to ensure better planning and monitoring of health inequalities.

**Clinical audit and review** – Providers will be required to demonstrate their coordination of and involvement in regular inter-professional and inter-agency meetings and regular clinical audit of the service interventions and outcomes such as drug therapies or well-being and behaviour changes. This audit can be carried out by extracting data using the Read codes provided in the Suite of Supportive Resources.

**Patient and Public Involvement** - Providers will be required to demonstrate active engagement with patients and local communities in commissioning and developing services, self care plans or in supporting patients to utilise self care opportunities. Providers should demonstrate how systematic patient feedback is being used to shape and improve services. Involving family carers and supporters will help deliver the components within this service specification. Local Involvement Networks (LINks), the voluntary sector and patient advocacy organisations are all further mechanisms to seek active involvement in service planning, delivery and monitoring.

**Equality and Human Rights** - Delivering good quality care will require organisations to demonstrate competence in identifying and taking action on inequality and also needing to engage with communities that have not found accessing public services easy. Undertaking Equality Impact Assessments (EQIAs) is a specific legal obligation, and conducting EQIAs and using the evidence to create a meaningful dialogue with communities (especially seldom heard from groups) is central to effective commissioning and service provision. This will create an evidence-based approach. As a minimum, core standard C7e of *Standards for Better Health* stipulates “healthcare organisations should enable all members of the population to access services equally and offer choice in access to services and treatment equitably”. To assist this process, organisations may wish to refer to ‘Creating a Disability Equality Scheme: a Practical Guide for the NHS’ - [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4139666](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139666).

**Managing complaints** – Responsive protocols and procedures should be in place for managing patient complaints. These should be available in ‘easy read’ format so they are accessible to people with limited communication skills. Complaints should be reviewed at regular intervals and learning from these shared and applied as appropriate to ensure that services are continually improved.

**Continuous quality improvement** – a set of indicators should be selected or developed and then agreed which defines the key quality requirements of the service. The service should also identify how it uses these measures and others to ensure that the quality of the service is continuously improved.

## 12. Information management/requirements

### Key

Information needs may be different depending on the scale of service provision at PCT-wide, locality or individual practice level and for the level of treatment intervention. The following describe a selection of key quality requirements and measurable indicators which will be used to demonstrate service effectiveness and

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provider performance. As far as possible, data collection should be undertaken at the patient contact point by using Read/SNOMED codes recorded in the GP system using the Suite of Supportive Resources.

Providers should consider the following:

- The number and percentage of patients drinking at hazardous and harmful levels in the practice population seen in last 15 months **(A)(B)**
- The number of patients who have been screened using FAST or Audit-C in the last 15 months **(A)(B)**
- The number of patients with a positive FAST or Audit-C score and full AUDIT assessment in last 15 months **(A)(B)**
- The number of patients who have a full AUDIT score recorded in the appropriate AUDIT category **(A)(B)**
- The number of patients given brief advice intervention in the last 15 months **(A)**
- The number of patients with a full AUDIT score of 20 or more who have been referred to specialist alcohol misuse services in the last 15 months **(B)**

Regular monitoring of patient outcomes and service performance should also be undertaken by the provider. PCTs may wish to aggregate and compare data (in the form of rates e.g. 1000 registered adult patients). The Spider evaluation tool developed for dependent drinkers **(B)** by Alcohol Concern offers some useful indicators such as:

- **Consumption reduction:**

Abstinence from alcohol; Near abstinence from alcohol; Reduction in consumption

- **Physical/Psychological health:**

Improvement in physical health (such as reduction in hypertension or increased Type 2 diabetes stability); Deterioration in physical health; Improvement in psychological health; Deterioration in psychological health; Reduction in sexual health risk

- **Social functioning/Life context:**

Improvement in employment status; Fewer working days missed; Improved personal relationships; Improved family relationships; Domiciliary stability improvement; Reduction in binge drinking.

### 13. Service Monitoring and Evaluation

Service providers will need to demonstrate the effectiveness of the service to commissioners possibly at regular times during the year and, at the least, on an annual basis. This will need to be provided to the commissioners in an annual report, which will inform any annual review process or meeting. The process by which this evaluation is achieved can also be used to show the outcomes of the service to other key stakeholders such as patients and family carers. Service evaluation should be built in from the commencement of any service and should cover, as a minimum, the following areas:

**Service Activity** – Volume of work against any agreed activity levels and distance from profile, capacity, needs and demand analyses, workforce arrangements, real time referral data to other care pathways or appropriate agencies recorded in the GP system using the Read codes provided in the Suite of Supportive Resources.

**Clinical Outcomes** – Regular analysis and interpretation of clinical outcomes data as well as regular analysis and interpretation of PPA data for prescribing.

**Quality and Governance** – Quality criteria will need to be established (in agreement with commissioners) and measured with standards needing to be met on a continual basis. Results of clinical audits will be used to inform service provision during the year. EQIA data should be used to underpin local integrated service provision.

**Patient Experience** – Patients views on their experiences and satisfaction levels will need to be measured through an on-going, systematic process to test whether the service is engaging with patients, family carers and supporters in a way that supports them. Different and innovative approaches to obtaining these views and experiences will be necessary. These processes should also be stratified where possible to show any differential impact on disadvantaged groups (e.g. Black and Minority Ethnic groups, deprived groups, males, females etc) and any resultant service changes (planned or achieved) should be highlighted. Separate analysis and interpretation of national and local patient satisfaction surveys for those with alcohol problems may also be necessary.

**Value for Money** – Cost effectiveness or ‘best value’ analyses of the primary service outcomes in relation to comparative costs of hospital activity or those services providing equivalent quality of care. Such measures could include attendance rates, waiting times, length of stay. Other possible analyses include: - Prescribing costs; benefits of increase in social capital and active citizenship; Staff and non-staff costs of running the service; Capital costs etc.

#### 14. Funding

There will be no fixed or nationally agreed price for this service. Commissioners and providers may wish to access alternative funding mechanisms, such as local programme budgeting along the whole patient pathway, and should agree funding which is reflective of the level of service to be delivered locally and could include:

- Basic funding for achieving minimum requirements within the service specification
- Additional funding or financial incentive for delivering specific local patient outcomes
- Indication of national benchmark prices if available.

#### 15. Contract Management

*The name and contact point of the contract manager of both the commissioner and provider should be given*

*here. Any specific local arrangements for contract management should also be stated.*

## **16. Review, variation and re-commissioning process**

A number of important contractual design and management issues will be followed throughout the period of the contract. In particular:

- Formal review of the service will be on-going and will inform the end of year service review process which will be used to determine if service is to be extended or de-commissioned.
- Any in-year contract variations will be discussed and agreed by both parties and will be included as additions to this Primary Care Service Framework.
- Following the review the commissioner will decide whether the service has been effective, including whether it is addressing the needs of disadvantaged groups with high needs. If not, the commissioner will discuss with the provider any formal escalation or recovery plan with realistic timeframes for delivery.
- Appropriate notice periods and termination procedures will be agreed by both parties.

Both parties may wish to seek legal advice before agreeing any formal contractual arrangements resulting from this Primary Care Service Framework.

## **17. Signatories**

*Signatures from both parties as those accountable for the agreement*

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## Additional supportive notes to assist the implementation of the Primary Care Service Framework: Alcohol Services in Primary Care

### *Commissioning 'business case' and Value for Money*

- Commissioning this Primary Care Service will have a significant impact on the availability of commissioning resources locally. Hospital admissions have significantly increased over the last decade. Around 1 million of these admissions relate to men aged between 35 and 55 which represents around 5% of all admissions annually. Alcohol accounts for 1 in every 26 NHS bed days at peak times. Up to 70% of attendances at Accident and Emergency during peak times on the weekends are related to alcohol, with 35% of all A&E attendances related to alcohol in some way. Under Payment by Results, an emergency admission for the first 22 days would currently generate a cost of £2273. Additionally, for every 100 patients attending A&E with an alcohol related problem, at least 31 new patients will be seen in outpatients attending 144 appointments over an 18 month period.
- A WHO study estimated that the cost-effectiveness of brief advice for hazardous and harmful drinking is approximately £1,300 per year of ill-health or premature death averted. This is nearly equivalent to the cost-effectiveness of smoking cessation interventions which is about £1,200 (Hutubessy *et al*, 2003).
- Studies from the US have shown that the costs of delivering simple alcohol advice were outweighed by the benefits with \$56,263 in benefits generated for every \$10,000 in intervention costs at 1994 price levels (Fleming *et al*, 2000).
- DH commissioned research describes how offering brief advice with men aged 34-74 who drink over 50 units per week could reduce alcohol-related admissions by 13,000 annually. 36% of male alcohol-related hospital admissions occur in middle-aged men who consume more than 50 units/week, about 200,000 admissions annually. A brief advice programme would, on average, reduce the consumption of a man drinking 50 units/week to 42 units/week (15% reduction). A reduction of 50 units/week to 42 units/week will reduce the relative risk of alcohol-related conditions by some 14%, the attributable fractions by some 12%, and the absolute risk of lifetime alcohol-related death by some 20%.
- Commissioners should also be aware of the wider savings which would be realised through support for self care as described in a complementary Primary Care Service Framework. This can be found on the NHS Primary Care Contracting website [www.primarycarecontracting.nhs.uk/204.php](http://www.primarycarecontracting.nhs.uk/204.php)

### *Practice Based Commissioning (PBC) sign off*

- PCTs and Practice Based Commissioners should be aware that business case proposals for the provision of this Primary Care Service will need to meet the full requirements of any local service delivery plan and authorisation process. This may well be at PCT Board level or any delegated panel. For proposals that pertain to the provision of services for a wider population, consideration as to further engagement and sign off with the SHA may be necessary.
- The Commissioning Framework (Department of Health, July 2006) highlights how commissioners should follow EU best practice principles when considering competitive procurement of local services. This does not necessarily mean open tendering processes should be adopted in every case. The Department of Health would not normally expect tendering where practices currently under GMS/PMS contracts could provide services as a means of extending patient choice.

- The Commissioning Framework for Health and Well Being consultation document (Department of Health, March 2007) emphasises the key role practice based commissioners play in more effective commissioning by shifting to more personalised services, promoting health as well as preventing the causes of ill health and working with key partners to achieve improved health outcomes overall. For more information visit [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_072604](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604)
- PBC resources can also be obtained from the Department of Health [www.dh.gov.uk](http://www.dh.gov.uk) and NHS Primary Care Contracting [www.pcc.nhs.uk](http://www.pcc.nhs.uk). PBC guidance can be found at [www.dh.gov.uk/assetRoot/04/14/15/64/04141564.pdf](http://www.dh.gov.uk/assetRoot/04/14/15/64/04141564.pdf)

#### *Contracting for the service*

- Category **(B)** services should be considered as an 'enhanced service'. As such, the full range of providers and primary care contracting flexibilities should be considered, including GMS, PMS, PCTMS, APMS, and community and voluntary organisations. Once an appropriate provider has been selected, the appropriate contracting route should be adopted. Additionally, providers may wish to sub-contract part or all of the service provision. This should be made clear throughout the contract implementation process.
- NHS Primary Care Contracting has developed a simple guide for potential providers of services such as this Primary Care Service [www.pcc.nhs.uk/3.php](http://www.pcc.nhs.uk/3.php). This guide has been developed further by the NHS West Midlands.
- Additional programmes have been developed to support commissioning and contracting of services in primary care. These include World Class Commissioning (WCC) and the Framework of External Support to Commissioners (FESC). Details of these programmes can be found on the Department of Health website – [www.dh.gov.uk](http://www.dh.gov.uk)

#### *Incentivising provision*

- The Commissioning Framework in July 2006 [www.dh.gov.uk/assetRoot/04/13/72/30/04137230.pdf](http://www.dh.gov.uk/assetRoot/04/13/72/30/04137230.pdf) emphasised the options open to commissioners to support new local providers of services by offering additional quality incentives or use of local primary care premises or pump-priming loans. However, the Kings Fund has described some of the considerations when developing local incentives. For instance, introducing new providers into the local health economy may improve service quality and efficiency but this may be at the expense of service responsiveness, provider collaboration and sustainability of services. Also care must be taken to develop better access to services without generating extra demand within the local health system which increases pressure on other services.

#### *Summary of local need*

- Local demographic information along with a broad public health profile may need to be considered and made explicit. Specific details of morbidity and mortality levels, other health and well being data and condition-specific data, health inequality data and ethnicity profile are also important and should be included if available. It is essential to clarify that this service is a priority identified in the Local Delivery Plan for either the PCT or the local PBC group. The North West Public Health Observatory can provide a breakdown of key public health information for each PCT area. More information can be found at [www.nwpho.nhs.uk](http://www.nwpho.nhs.uk).

- Additional relevant information should also be considered for inclusion such as recent service user feedback, current service staffing levels and competencies, local partnership arrangements, and any expected changes to local need.

#### *Patient Pathways*

- With the help of *Nottinghamshire Drug and Alcohol Action Team* and *The Woodlands Practice, Mansfield*, a comprehensive **Alcohol Care Pathway in Primary Care** has been developed to accompany this Primary Care Service Framework. It provides a quick reference guide to commissioners and providers around brief **(A)** and extended **(B)** levels of service. The key elements of the pathway include screening and assessment, interventions, information flows, and entry-exit points. This is available to download at [www.pcc.nhs.uk/204.php](http://www.pcc.nhs.uk/204.php)
- *Map of Medicine* provides a detailed pathway for the diagnosis of suspected alcoholic liver disease – [www.mapofmedicine.com](http://www.mapofmedicine.com)

#### *Referral criteria to the service (through a standardised referral form)*

- PCTs and provider can agree a number of referral criteria into the extended primary care service for patients requiring treatment for alcohol dependence **(B)**. Referrals should be received on a standardised referral form providing information about the patient/client. Acceptance of patients into the extended primary care service could be determined by one or more of the following factors:
  - There are minimal complicating factors
  - There are Mild/Moderate severity of alcohol problems
  - Home Detoxification is requested
  - There are no known child care issues
  - There are minor/no mental health problems
  - There are minimal social problems
  - Patient has stable lifestyle
  - Patient in reasonable physical health.

More complex cases should be referred to secondary care services.

#### *Suite of Supportive Resources (can be downloaded from the PCC website – [www.pcc.nhs.uk/204.php](http://www.pcc.nhs.uk/204.php))*

- A selection of practical resources have been developed by commissioners and providers across the country and are relevant to services for hazardous and harmful drinkers as well as dependent drinkers **(A)(B)**. Each resource is acknowledged by organisation. These include:
  - **Alcohol Care Pathway in Primary Care** – NHS Primary Care Contracting

- **'How Much Is Too Much'** simple and extended brief intervention and screening tools and includes a clinicians guide and posters, – Newcastle University and Gateshead PCT - [www.ncl.ac.uk/ihs/news/item/?brief-interventions-alcohol-and-health-improvement](http://www.ncl.ac.uk/ihs/news/item/?brief-interventions-alcohol-and-health-improvement)
  - **Risk assessment form** – Torbay PCT
  - **Full patient pathway diagram/flowchart for all Tiers 1-4** – Blackpool PCT
  - **FAST 'how to administer it'** – Salford PCT
  - **One-pager summary of MoCAM tiers** – Camden PCT
  - **Service evaluation table based on MoCAM tiers (One pager) of each service across the city** – Newcastle PCT
  - **Severity of Alcohol Dependence Questionnaire (SADQ)**
- **Other recommended website resources available at a national level include:**
    - [www.nhs.uk/units](http://www.nhs.uk/units) - to identify and give advice to people drinking at higher risk (ie harmful) levels. It includes a questionnaire based on AUDIT. Respondents whose answers indicate that their drinking is putting them at increased or higher risk, (ie hazardous or harmful levels) are invited to register to receive more information, in the form of a self-help booklet.
    - [www.nhs.uk/alcoholstakeholders](http://www.nhs.uk/alcoholstakeholders) - support to different stakeholders
    - [www.hubcapp.org.uk](http://www.hubcapp.org.uk) – a hub of commissioned alcohol projects and policies
    - [www.apho.org.uk/resource/links.aspx](http://www.apho.org.uk/resource/links.aspx) - APHO represents a network of 12 public health observatories (PHOs) working across the five nations of England, Scotland, Wales, Northern Ireland and the Republic of Ireland. We produce information, data and intelligence on people's health and health care for practitioners, policy makers and the wider community.
    - [www.nwph.net/interoperability/nwpho/search\\_index.aspx?instr=Alcohol](http://www.nwph.net/interoperability/nwpho/search_index.aspx?instr=Alcohol) – includes up-to-date statistics on Alcohol.

#### *Involving patients and the public*

- The White Paper 'Our Health, Our Care, Our Say' made it clear that patients and the public would be firmly placed at the centre of NHS and social care services, with a stronger local voice. Following this, the Department of Health has published a framework for creating stronger public engagement in the development of health and social care services [www.dh.gov.uk/assetRoot/04/13/70/41/04137041.pdf](http://www.dh.gov.uk/assetRoot/04/13/70/41/04137041.pdf). This will develop with patients and the public having more involvement in service planning processes where possible including design of individualised care plans and choice of services as well as involvement in decision-making processes and service evaluation mechanisms at both provider and commissioner level.
- Local Involvement Networks (LINKs) are new ways for people who use health and social care services to have their say in how they are planned and run. LINKs replace Patient and Public Involvement Forums. There will be a LINK in every local authority area and are closely linked to Overview and Scrutiny Committees. They will be a network of people, organisations or groups representing a diverse range of views and ideas and a host organisation will be responsible for setting up a LINK and giving practice support. There is now a regular LINKs Bulletin produced in 'easy read' format on the Department of Health website – [www.dh.gov.uk](http://www.dh.gov.uk). Further details about LINKs can also be found on the newly developed National Centre for Involvement – [www.nhscentreforinvolvement.nhs.uk](http://www.nhscentreforinvolvement.nhs.uk)

### *Skill mix and partnership opportunities (A)(B)*

- A commitment to funding local training courses is critical to help staff develop a full set of competencies across the health and social care workforce. One PCT organised a 3-day rolling training programme to cover core elements of service delivery such as Brief Interventions, using a screening tool, and providing effective advice and information. This costs the PCT around £10,000/annum.
- The Department of Health are currently developing an e-learning module to support the provision of brief interventions for GPs dealing with hazardous and harmful drinkers which will be available Summer 2008.
- Where there is a need to develop the GP with Special Interest role for more dependent drinkers, it is important to be aware of new guidance and regulation procedures published by the Department of Health. This will mean greater adherence to any new special interest competency framework and more formal special interest accreditation of new practitioners. [www.dh.gov.uk](http://www.dh.gov.uk)

### *Definitions and Patient Classification (A)(B)*

- The recognised low risk levels of alcohol consumption are: *For men* – not regularly drinking more than 3 to 4 units of alcohol per day and *For Women* – not regularly drinking more than 2 to 3 units per day. However, less frequent sessions of heavy drinking/binge drinking - more than 8 units of alcohol at any one session for men, and 6 units for women – is also hazardous.
- The World Health Organization (WHO) defines hazardous use of a psychoactive substance, such as alcohol, as ‘a pattern of substance use that increases the risk of harmful consequences for the user... In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user.’ Hazardous drinkers are drinking at levels over the sensible drinking limits, either in terms of regular excessive consumption or less frequent sessions of heavy drinking. However, they have so far avoided significant alcohol-related problems. Despite this, hazardous drinkers, if identified, may benefit from brief advice about their alcohol use.
- The WHO International Classification of Diseases (ICD-10) defines harmful use of a psychoactive substance, such as alcohol, as ‘a pattern of use which is already causing damage to health. The damage may be physical or mental.’ This definition does not include those with alcohol dependence. Harmful drinkers are usually drinking at levels above those recommended for sensible drinking, typically at higher levels than most hazardous drinkers. Unlike hazardous drinkers, harmful drinkers show clear evidence of some alcohol-related harm. Many harmful drinkers may not have understood the link between their drinking and the range of problems they may be experiencing.
- Alcohol dependence is defined as a compulsion to drink; experiencing of withdrawal symptoms if intake is reduced or stopped and persist in using alcohol despite clear evidence of harm; continued use of alcohol despite recurrent negative (social, psychological and/or physical) consequences; evidence of physical dependence including the need to take increasing amounts for the same effect (tolerance); negative physiological symptoms when alcohol consumption ceases (withdrawal); inability to stop drinking/compulsion.
- Developing a simple, **tiered** model of care may help to clarify appropriate levels of patient intervention and support within the resources available. This approach may allow commissioners and strategic partners to identify gaps in service provision or opportunities for service re-design whilst allowing providers to target different population cohorts across the local community.

*Read Coding and e-templates for GP practices*

- The Department of Health has commissioned the development of a new suite of Read Codes and GP system electronic templates. Current accepted Read Codes include:

<u>Concept</u>	<u>Action</u>	<u>4 BYTE</u>	<u>V2</u>	<u>V3</u>	<u>SCT</u>
Single alcohol screening questionnaire	Added for April 2008 Release	38D2.	38D2.	XaORO	335781000000108
Fast alcohol screening test	Already exists	388u.	388u.	XaNO9	303471000000106
Alcohol use disorders identification test	Added to earlier versions for April 2008 release	38D3	38D3	XM0aD	273265007
Referral to specialist alcohol treatment service	Added for April 2008 release	8HkG.	8HkG.	XaORR	335851000000105
Brief intervention	Not added				
Additional practice-based intervention	Not added				

- Further codes will be released in October 2008 which will update or replace the codes above.

*DANOS Standards (B)*

- Drugs and Alcohol National Occupational Standards (DANOS) standards include -

*For those delivering **Tier 1** services should achieve:*

- AA1 Recognise indications of substance misuse and refer individuals to specialists
- AF1 Carry out screening and referral assessment
- AH10 Carry out brief interventions with alcohol users
- AB2 Support individuals who are substance misusers
- AB5 Assess and act upon immediate risk of danger to substance misusers
- AB2 Support individuals who are substance users.

*For those delivering **Tier 2** interventions should achieve, in addition to the above:*

- AF2 Carry out assessment to identify and prioritise needs
- AG1 Plan and agree service responses which meet individuals' identified needs.

### *Health Inequalities*

- There are massive differences in the health consequences of alcohol use between richer and poorer local communities across all regions of England. For instance, the CMO report (November 2007) states that:
  - The most deprived fifth of the population of the country suffer two to three times greater loss of life attributable to alcohol; three to five times greater mortality due to alcohol-specific causes; and two to five times more admission to hospital because of alcohol than the more affluent areas.
  - The inequality ratio between measures of health in the poorest fifth compared with the richest fifth of the population is always greater in males than in females. Thus men are suffering greater inequalities related to alcohol use than women.
  - The poorest local authorities (those with the highest measures of multiple deprivation) also tend to have the highest recorded levels of health and social outcomes related to alcohol use: crime, anti-social behaviour orders, teenage conceptions, chronic liver disease, incapacity benefit claimant rates and unauthorised school absences.
- A more detailed look at inequalities between different communities has been undertaken by comparing alcohol-related measures across different lifestyle groups. These use geography and behavioural information to classify people by where and how they live and reveal remarkable differences between the rich and the poor whilst also highlighting particular communities that have additional alcohol issues:
  - The most deprived lifestyle group 'Urban Challenge', who are typically unemployed, low-income older smokers, have four to fifteen times greater alcohol-specific mortality and four to ten times greater alcohol-specific admission to hospital than the most affluent groups.
  - Whilst most lifestyle groups tend to show levels of alcohol-related harms in line with the level of deprivation experienced in their location, one group, 'New Starters', always shows higher levels of harm than would be expected from deprivation alone. These areas are characterised by young, highly qualified but not very well off people. Since they are already experiencing significantly high levels of mortality, life lost and admission to hospital due to alcohol use their location and prevalence in local communities should be used as a warning sign to authorities of where alcohol-related issues are likely to worsen in the future.
- Reducing the gap in infant mortality across social groups, and raising life expectancy in the most disadvantaged areas (the Spearhead areas) faster than elsewhere are the focus for the 2010 health inequalities Public Service Agreement target. Effective, pro-active action to tackle health inequalities at local level by commissioners, providers, practitioners and other stakeholders will be key to meeting the target. To understand more about the Equalities and Human Rights agenda in the NHS, the Department of Health has recently published a useful guide for NHS Boards – [www.dh.gov.uk/assetRoot/04/14/13/71/04141371.pdf](http://www.dh.gov.uk/assetRoot/04/14/13/71/04141371.pdf).
- With any provision of service, consideration must be given up front to the impact on inequalities in health which may result from service outcomes. This Primary Care Service provides an opportunity to narrow the inequalities gap by providing services not only to the mainstream population but also those in disadvantaged groups with poor health outcomes. Provision of this Primary Care Service should consider, where possible, outreach services by practitioners which offer a more flexible approach to ensure all groups in the population have good access to services. Twenty-two local pilot examples which reinforce this approach have recently been published by the Department of Health in 'Communities for Health: Learning from the Pilots' (February, 2007) – [www.dh.gov.uk/assetRoot/0414/32/25/04143225.pdf](http://www.dh.gov.uk/assetRoot/0414/32/25/04143225.pdf).

- The first Local Authority Health Profiles covering the whole of England have been produced by Public Health Observatories and will be updated every year. These profiles, which can be used by both local authorities and the health service, are designed to show where there are important problems with health or health inequalities to help target action to improve the health of local people. The profiles can be accessed at [www.communityhealthprofiles.info/](http://www.communityhealthprofiles.info/)
- Commissioners may also wish to consider looking at the profile of their local population against the Health Poverty Index [www.hpi-org](http://www.hpi-org) or the inequalities reports compiled by the London Health Observatory [www.lho.org](http://www.lho.org) to help them understand the impact this service may have on local population health.
- Further help in this area can be obtained from the National Support Team for Alcohol at the Department of Health which will be operational from September 2008. It will focus on the top 20-50 PCTs for alcohol related hospital admissions and will visit about 18 PCTs per year.
- Links to Health Literacy through support for self care and using health as a useful means of educating local people.