Alcohol Concern
Making Sense of Alcohol

AN AUDIT OF THE FOCUS ON ALCOHOL-RELATED HARM IN JOINT STRATEGIC NEEDS ASSESSMENTS, JOINT HEALTH AND WELL-BEING STRATEGIES AND CCG COMMISSIONING PLANS

Alcohol Concern

Alcohol Concern is the leading national charity working on alcohol issues. Our goal is to improve people's lives through reducing the harm caused by alcohol.

About Us

Alcohol Concern is a national charity working in England and Wales to influence alcohol policy and champion best practice locally. We support professionals and organisations by providing expertise, information and guidance. We are a challenging voice to the drinks industry and promote public awareness of alcohol issues.

This guide was written and researched by Alcohol Concern

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Lundbeck

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Foreword

In the last year our health service has undergone unprecedented and wholesale change. The shift in responsibility for health services from national to local bodies means that Joint Strategic Needs Assessments (JSNAs) should now be taking centre stage. Clinical Commissioning Groups (CCGs) and other local commissioning bodies should be looking to JSNAs for a clear assessment of the current and future health and social care needs of their local communities.

With increasingly tightened budgets and so many competing health concerns it was heartening to see that all the JSNAs audited for this report, and most Joint Health and Wellbeing Strategies (JHWSs) and CCG strategies reviewed, address alcohol in some form. What is worrying however is that for many alcohol received only a brief mention and not the 'comprehensive section on alcohol harm' that Public Health England recommends.

An estimated 1.6million people in England[1] – one in 20 adults – are dependent on alcohol and many more damaging their health by drinking at unsafe levels.

Harmful drinking is not always easy to spot because dependent drinkers don't always look like a stereotypical alcoholic; many dependent drinkers are employed, in stable relationships and raising families. Those who are at increasing and high risk levels of drinking also place a significant burden on the economy. It is thought that alcohol dependent employees miss around 11 million working days through alcohol per year[2] and between 780,000 and 1.3million children under 16 have parents whose drinking is classed as harmful or dependent.[3]

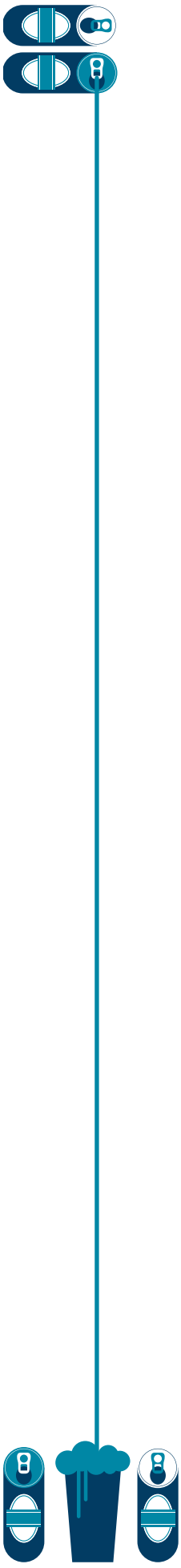
The reliance on hospital admissions data to assess local need, as found in this report, is a concern. While clearly an important indicator, hospital admissions do not tell the whole story and we believe that in some cases this had led to areas with lower hospital admissions rates giving less attention to alcohol services, leaving many lower risk yet still harmful drinkers without support.

The new local bodies must work together to take on joint responsibility for alcohol. Whilst this report found a great deal of cross-referencing between JHWSs, CCG plans and JSNAs in general, this was not the case when it came to alcohol.

Health problems and costs associated with alcohol misuse are rising year-on-year, with research increasingly showing clear links between harmful alcohol consumption and hypertension, cancer, stroke and other common illnesses. With the impact of harmful drinking being felt across so many conditions and at great cost to local health economies, responsibility must not be allowed to fall between the gaps of local bodies' remits.

Without clear prioritisation for both treatment and prevention services, alcohol dependence and the effects of harmful drinking will continue to exact a toll on people's lives and health at great detriment to the sustainability of the NHS and the ability of local health bodies to provide healthcare for their wider communities.

Eric Appleby
Chief Executive
Alcohol Concern



Executive summary

Alcohol Concern, with the financial support of Lundbeck, undertook an audit of the priority given to tackling alcohol-related harm in Joint Strategic Needs Assessments (JSNAs), Joint Health and Wellbeing Strategies (JHWSs) and Clinical Commissioning Group (CCG) plans across England. The audit considered the published documents from 25 local authority areas. Fifteen of the top 25 authorities in the country for alcohol-related harm were considered and 5 each from the middle and lowest ranked authorities. The choice of partnerships was based on Public Health England data on the rates alcohol-related hospital admissions and liver mortality.

The indicators reviewed were influenced by Public Health England's (PHE) Good practice in planning for alcohol and drugs prevention, treatment and recovery but also covered indicators of interest to the lead agencies.

Many positives emerged from this review. All of the JSNAs and JHWSs and the vast majority of the CCG plans addressed alcohol. However, the amount of attention varied greatly. Many of these suites of documents appeared unlikely to meet the PHE suggestion that JSNAs have a "comprehensive section on alcohol related harm". The degree of attention declined in the areas classified as medium and lower need in the NWPHO dataset.

40% of the JSNAs and 36% of JHWSs specifically identified alcohol as a priority, but those in the middle and lowest need areas were less likely to set it as a priority. In the high need areas which did not set alcohol as a priority, this was usually because they either did not have priorities or prioritised at a thematic rather than condition level.

All but one JSNA (24/25) contained some data on alcohol and the majority of CCG plans (21/34) showed clear evidence of need. While a variety of data sources are used across these documents, the greatest reliance was on LAPE data: usually hospital admissions data. It is important that local action plans are built on a wider dataset than hospital admissions alone. This could include prevalence data, treatment data, licensing information, crime figures as well as specific local research.

24 out of the 25 JSNAs addressed alcohol-related hospital admissions and this emphasis was repeated in the other documents. This highlights the benefits of national indicators; but a downside exists. Areas with lower national rankings for hospital admissions, morbidity and mortality in the LAPE data appeared to give less attention to alcohol in their suite of documents. However, this lower ranking is relative and almost certainly underplays the actual impact of alcohol in the area. Even the lowest risk areas in England will experience considerable harm from alcohol.

PHE guidance suggests that JSNAs reflect "need across the whole spectrum of harm". Only a few of these suites of documents clearly recognised that alcohol has a varying impact on different groups in the community. Moreover the range of groups considered was relatively small and groups highlighted by PHE such as prisoners and young women at risk of sexual abuse and exploitation were rarely considered.

The most commonly considered sub-group was young people. This may be viewed positively but it is important to ensure that the needs of young people are not over-emphasised in comparison with other groups, leading to the danger of inappropriately stigmatising young people as a major cause of alcohol related harm. The needs of the larger group of young people who are at risk because of parental drinking should also be considered.

In comparison, the needs of older drinkers (55+) who make up a large share of the burden on hospital services were less likely to be mentioned.

The degree of attention given to alcohol treatment and care pathways is hard to assess because no standard exists for judging whether it is adequate. Alcohol treatment was mentioned in the vast majority of JSNAs but far less attention was given to care pathways.

Key to the effectiveness of this strategic process is that the documents link together and reflect and reinforce the messages in each other. The majority of JHWSs and CCG plans cross-referenced to the JSNA and each other. However, they were less likely to cross-reference each other regarding alcohol and much less likely to reference alcohol or community safety strategies. Two examples of good practice were noted. Nottingham had a very well-coordinated suite of documents. Hampshire had also clearly worked well to link documents together in the challenging context of an area with four CCGs.

In general the high need areas addressed alcohol and across the two key plans all had some recommendations about alcohol. However, four high need partnerships did not have any recommendations about tackling hospital admissions. Seven did not have recommendations about IBA and the same number did not have recommendations about treatment. A focus on recovery, peer support and mutual aid is suggested by the PHE good practice guidance but was scarcely mentioned in any of the strategies.

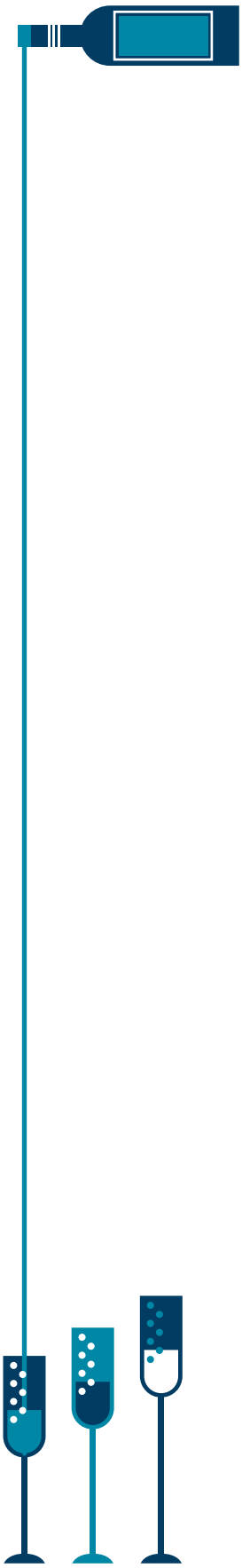
This does suggest a discontinuity between evidence and actions, particularly around hospital admissions, alcohol Identification and Brief Advice and treatment generally. It is important that the key bodies ensure that the degree of harm caused by alcohol is reflected by the priority or importance given to it in the documents and then by the actions or recommendations included.

A particular challenge in tackling alcohol misuse is to clarify where the lead responsibility lies for commissioning each element of the care pathway for drinkers. Inconsistency existed in the balance between the number and type of treatment and care recommendations in the JHWSs and the CCG plans in different areas. This process offers a real opportunity to clearly state the responsibility for the alcohol care pathway.

None of the JHWSs and only two of the CCG plans allowed the identification of the level of investment in alcohol although this was also true of investment plans generally.

The transfer of public health to local authorities creates a framework for making use of the opportunities offered by the licensing framework to tackle alcohol related harm. While this was reflected in some of the documents, it remains an underused approach, particularly reflecting on the use of powers such as late night levies.

Little evidence was found that the Public Health Outcomes Framework and NHS Outcomes Framework were driving the process with only 6 out of 25 JSNAs mentioning the outcomes frameworks. However, this is probably historical due to the recent advent of these structures.



Recommendations

1

Directors of Public Health should ensure that JSNAs contain a comprehensive section on alcohol related harm.

2

Directors of Public Health should ensure that JSNAs are built on a wider dataset than the LAPE data alone and hospital admissions specifically. This could include prevalence data, treatment data, licensing information, crime figures as well as specific local research.

3

Public Health England should note the obvious impact of the alcohol-related hospital admissions indicator and consider whether indicators around Identification and Brief Advice or treatment provision would further improve the local response.

4

Directors of Public Health should ensure that JSNAs consider the impact of alcohol on sub-groups within the local population e.g. different wards, ethnic and language communities, people with mental health problems, unemployed people, offenders, women who have been the victims of abuse.

5

Directors of Public Health should ensure that the needs of young people are not over-emphasised in comparison with other groups, leading to the danger of inappropriately stigmatising young people as a major cause of alcohol related harm. The needs of the larger group of young people who are at risk because of parental drinking should be considered.

6

Directors of Public Health should ensure that JSNAs specifically consider the needs of older drinkers (55+) who make up a large share of the burden on hospital services.

7

Directors of Public Health and CCG chairs should ensure that, in considering alcohol treatment, the strategic process considers the client's care pathway through treatment.

8

Directors of Public Health and CCG chairs should use the opportunity offered by this strategic process to clearly state the lead responsibility for each step of the alcohol care pathway.

9

Directors of Public Health and CCG chairs should ensure that, in and across all the key documents, the degree of harm caused by alcohol is reflected by the priority or importance given to it in the documents and then by the actions or recommendations included.

10

Directors of Public Health and CCG chairs in areas with lower national rankings for hospital admissions, morbidity and mortality in the NWPHO data should ensure that JSNAs, strategies and plans reflect the actual impact that alcohol is having not simply the lower ranking. In England even the lowest risk areas will have considerable harm from alcohol.

11

Directors of Public Health and CCG chairs should ensure that this process reflects and makes of use of the opportunities offered by the licensing framework to tackle alcohol related harm.

1
Introduction

1.1
Aim

The aim of this project was to:
Conduct an audit of the priority given to alcohol misuse in Joint Strategic Needs Assessments (JSNAs), Joint Health and Wellbeing Strategies (JHWSs) and Clinical Commissioning Group (CCG) plans across England.

The key questions to be considered in this audit were:

— To what extent is alcohol a priority in the various strategies?

— What aspects of alcohol related harm are addressed in these strategies?

— What evidence base is used?

— Does the degree of priority and attention given to alcohol match the identified level of need in the area?

— Do the various local strategies in an area link together?

Part way through this project Public Health England published *Good practice in planning for alcohol and drugs prevention, treatment and recovery - Public Health England – 2013.*[1] This is part of a suite of material provided to support JSNAs, JHWSs and CCG planning and contains prompts for commissioners and planners. These prompts were generally consistent with the questions already being asked in this research. Sections have, therefore, been included which measure the plans reviewed against the PHE guidance. The guidance is described in more detail in 1.5 below.

1.2
The areas chosen

The choice of partnerships whose strategies were audited was based on Local Alcohol Profiles for England (LAPE) data from the North West Public Health Observatory.[2] This presents data on a number of alcohol related indicators for each of the 326 local authorities in the country enabling them to be ranked in comparison with each other. The rankings for every authority for the rate of alcohol related hospital admissions and both the male and female rate of mortality from chronic liver disease were averaged to create a notional average ranking and the creation of a league table which orders the authorities with the highest rates to the lowest rates of harm across these three indicators.

15 authorities were chosen from the highest 25 authorities on the list - the element of choice was used to ensure that as many regions of the country were represented as possible. The chosen authorities were:

Chosen from top 25 local authorities

Top 25 local authorities	Region
Sunderland	North East
Blackpool	North West
Salford	North West
Islington	London
Wolverhampton	West Midlands
Sandwell	West Midlands
Rochdale	North West
St. Helens	North West
Manchester	North West
Hartlepool	North East
Wigan	North West
Liverpool	North West
Middlesbrough	North East
North Tyneside	North East
Nottingham City	East Midlands

A smaller comparative sample of five authorities each was chosen from the two sets of middle and lower need areas.

Chosen from middle 20 local authorities

Middle 10 local authorities	Region
Westminster	London
Bath & NE Somerset	South West
Cornwall	South West
Swindon	South West
North Lincs	East Midlands

Chosen from bottom 20 local authorities

Bottom 10 local authorities	Region
Wokingham	South East
Hertfordshire	South East
North Yorkshire	Yorkshire & Humberside
Hampshire	South East
Suffolk	Eastern

The JSNA, JHSW and CCG commissioning plan was identified for each authority along with the community safety strategy and any available local alcohol strategy. These were then subject to a comparative review.

From this point on all references to these authorities have been anonymised using a code. However, where we have identified good practice we have named the area involved. The code allocated is consistent throughout the document so that patterns can be identified.

1.3

Co-terminous CCG and HWB?

15 of the areas had co-terminous local authorities and CCGs. 5 were covered by multiple CCGs (Suffolk, N. Yorkshire, Hampshire, Hertfordshire and Manchester). Another 5 were part of a larger CCG area (Wokingham, Hartlepool, Middlesbrough, Nottingham, Sandwell). This means that a larger number of CCG plans were reviewed than JSNAs and JHWSs.

1.4

The strategic context – the role and purpose of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

Joint Strategic Needs Assessments (JSNA) were first introduced in 2007. However their effectiveness in addressing the health and wellbeing requirements of communities was enhanced by the establishment of health and wellbeing boards (HWBs) under the 2013 changes to the health care system.[3]

As a result, the Department of Health (DH) states that the JSNA has "moved centre stage and sits at the heart of local health improvement."[4] The Health and Social Care Act 2012 also introduced duties and powers for these health and wellbeing boards to develop Joint Health and Wellbeing Strategies (JHWSs).[5]

The DH states that the purpose of JSNAs and JHWSs is to: Improve the health and wellbeing of the local community and reduce inequalities for all ages.[6]

JSNAs are assessments of the current and future health and social care needs of the local community: these are needs that could be met by the local authority, CCGs, or the NHS Commissioning Board. JSNAs are produced by health and wellbeing boards, and are unique to each local area. The policy intention is for health and wellbeing boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities.[7]

They are not intended to be an end in themselves nor simply one-off documents. JSNAs and JHWSs are continuous processes, and are an integral part of CCG and local authority commissioning cycles. They should represent a continuous process of strategic assessment and planning. "The core aim is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, will be used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing."[8]

HWBs can decide for themselves when to update or refresh JSNAs and JHWSs. Local areas are also free to undertake JSNAs in a way best suited to their local circumstances and there is no template or format that must be used and no mandatory dataset to be included. However, JSNAs:

- Must assess current and future health and social care needs within the health and wellbeing board area,
- Cover the whole population, and
- Ensure that mental health receives equal priority to physical health.[9]

JHWSs are strategies for meeting the needs identified in JSNAs. As with JSNAs, they are unique to each local area, and no mandated standard format has been set.[10]

The DH says that JHWSs should: "explain what priorities the health and wellbeing board has set in order to tackle the needs identified in their JSNAs…This is not about taking action on everything at once, but about setting a small number of key strategic priorities for action, that will make a real impact on people's lives. JHWSs should translate JSNA findings into clear outcomes…"[11]

The third element of this new strategic framework is the Clinical Commissioning Group which has taken on many of the functions of the former Primary Care Trusts in commissioning and purchasing healthcare. Their decisions should be made in partnership with the HWB (of which they are key members) and informed by the JSNA and JHWS.

As a result ensuring that the local impact of alcohol is reflected in these documents will be a key part of developing a robust local and national response to alcohol related harm.

1.5

Evaluating the documents - Good practice in planning for alcohol and drugs prevention, treatment and recovery

In 2013 Public Health England published *Good practice in planning for alcohol and drugs prevention, treatment and recovery - Public Health England – 2013* .[12] This is part of a suite of material provided to support JSNAs, JHWSs and CCG planning.

These cover:

Strategic leadership and planning
Domain 1 Needs assessment and data
Domain 2 Finance
Domain 3 Pathways

Primary prevention
Domain 4 Population level actions

Secondary prevention
Domain 5 Targeted interventions

Hospital-based alcohol services
Domain 6 Hospital-based alcohol services

Tertiary prevention
Domain 7 Specialist treatment

The full suite of documents is available at: *www.nta.nhs.uk/uploads/goodpracticeinplanningforalcoholanddrugspreventiontreatmentandrecovery%5B0%5D.pdf.*
The key elements in the context of this report are also included at appendix 1.

The Alcohol stocktake self-assessment tool, which is the second part of the document, provides recommendations or prompts against which local areas can assess their response to alcohol-related harm, some of which apply to JSNAs, JHWSs and CCG plans. This report has pulled out those recommendations which relate to alcohol within the three documents and which can be judged by a review of published material. To these have been added a few which reflect themes included in the report but not directly set out as a prompt and a few which have been added by Alcohol Concern or the commissioners. The recommendations used are set out at the start of each section.

1.6

Methodology

The strategies and plans from each area were examined in their own right to determine both how, and how well, they addressed alcohol and whether this reflected the level of need in the area. However, an equally important question is whether the plans inter-relate. Is the significance accorded to alcohol in the JSNA reflected in the JHWS and the CCG's plans?

A separate chapter is devoted to each of the three main documents and then a fourth looks at the inter-relation between them. A subsequent chapter considers local alcohol strategies and community safety strategies. The section contains the recommendations.

1.7

Acknowledgements

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Mike would like to thank Emily Robinson at Alcohol Concern for her invaluable direction and advice.

The research – Joint Strategic Needs Assessment

2.1

Public Health England prompts

The JSNA addresses alcohol

1.1 The local JSNA includes a comprehensive section on alcohol-related harm that reflects need across the whole spectrum of harm and readily acknowledges the impact of alcohol work across the PHOF and NHSOF resulting in partnership collaboration and support.

Data

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

1.5 Local data on alcohol interventions provided in hospitals, Primary Health Care, and other settings is collected to inform needs assessment. (This might include data from: NHS Health Check, DES, LES (or equivalent), hospital services.)

1.6 The commissioners have analysed the local levels of alcohol-related admissions to hospital in order to target interventions. (Commissioners use analysis of alcohol-related admissions to identify in-need population groups so that appropriate, accessible services can be designed and located.)

1.7 The commissioners have analysed and monitored local specialist treatment data including specific breakdown by gender, age, postcode, condition, route of admission, repeat admission, etc. in order to compare current treatment provision with need.

Good practice in planning for alcohol and drugs prevention, treatment and recovery - Public Health England – 2013[13]

2.2

Does the area have an up to date JSNA?

All of the authorities reviewed (25/25) had JSNAs accessible via the internet. Because national guidance does not specify a particular style or structure, the JSNAs varied greatly. The majority were available as single PDF documents. However, a reasonable number were primarily web based. This makes direct comparison more difficult. The web based structures tend to have a huge array of content and it was hard to discover whether references to alcohol were to be found in some less obvious part of the website.

2.3

Other needs assessments

15 of the 25 areas had an identifiable separate alcohol or drugs and alcohol needs assessment.

Table 1: The number of partnerships with separate alcohol / drugs and alcohol needs assessments

All	Top 25	Middle 10	Bottom 10
15	10	4	1

2.4

Does the JSNA address alcohol?

All of the JSNAs addressed alcohol. However, the amount of attention devoted to alcohol varied from a page or less to over 100 pages. In the latter case a separate alcohol needs assessment was used as the alcohol section of the JSNA in a web based structure.

These proportions are misleading unless seen in the context of the overall size of the JSNA and this is virtually incalculable in the web based JSNAs. Nor is size the only factor. It can be argued that two pages in the main JSNA is a clearer statement of the importance of the subject than a large but separate alcohol focused document in a sub-section of a website.

2.5

Is alcohol identified as a priority?

In 10 out of the 25 JSNAs alcohol was clearly identified as a priority. 8 of these were top 25 areas with 1 each in the middle and bottom groups. The degree of priority ranges from 1 priority in 4 to 1 in 25.

Table 2: Examples of how alcohol fits into local priorities:

The Health and Wellbeing Board has chosen to focus in its strategy on four areas that underpin these priorities:

— Reducing the impact of child poverty

— Reducing cancer deaths

— Reducing the impact of alcohol

— Improving Mental Health

The priority themes of (the) JSNA:

— Mental Health and Wellbeing

— Alcohol

— Economy

— Get Active

— Learning

— Environment and Sustainability

— Stay Safe

2.6

Further analysis of the priority given to alcohol in JSNAs

15 areas had not set alcohol as a priority. At first sight this would seem inappropriate for the 7 authorities which were in the top 25 for alcohol related harm. However, in many cases the drafting of the document would not allow alcohol or any other "condition", albeit cancer, smoking or obesity, to be a priority.

Many JSNAs have process priorities. In some cases these are taken from the Marmot review, e.g. ensuring every child has the best start in life. Some of the JSNAs see themselves as an information resource and leave the setting of priorities to the Health and Wellbeing Board or Clinical Commissioning Group. The Department of Health guidance is clear that this is appropriate for JSNAs.

Further tests were applied to those seven high need areas which did not set alcohol as a local priority.

Firstly the seven JSNAs were divided into three categories which explain the lack of a priority:

— The JSNA did not have any priorities;

— The JSNA did not have disease or condition level priorities;

— The JSNA had disease or condition level priorities but these did not include alcohol.

Secondly, the research considers whether the JSNA demonstrated priority in other ways i.e.:

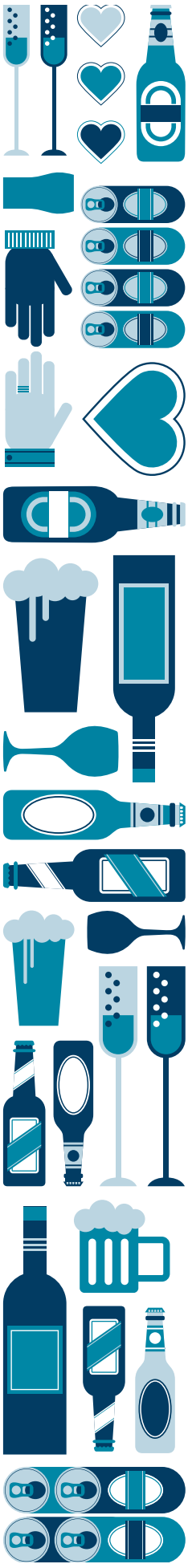
— It had recommendations about alcohol; and/or

— It gave significant attention to alcohol.

The analysis, set out below, shows that in all but one case the lack of priorities was a result of the way the JSNA was structured. All 15 of the JSNAs in the top 25 areas gave a reasonable degree of attention to alcohol.

Table 3: The role of alcohol in JSNAs in high need areas which do not have alcohol as a priority

Category	Area	JSNA
The JSNA did not have any priorities	H13	H13 had a web based structure which did not have specific priorities but has an alcohol JSNA with recommendations.
	H8	H8 did not have recommendations but it did have key messages about alcohol and attention was given to alcohol in the text
	H7	H7 did not have recommendations but it did give attention to alcohol
	H2	H2 did give alcohol attention and listed alcohol related key points for commissioners
The JSNA did not have disease or condition level priorities	H11	H11 had 6 high level priorities; alcohol was one of a number of issues identified under the healthier lifestyles priority. The report had no recommendations but significant attention was given to alcohol.
	H9	H9 used Marmot categories for its priorities alcohol was a subset of two of these – both concerned with young people. However there was also a separate alcohol JSNA.
The JSNA had disease or condition level priorities but these do not include alcohol	H1	The new web-based H1 JSNA had some key topics — Children's oral health — Childhood obesity — Healthy work and skills — Mental health and wellbeing — Falls — Heart disease But alcohol was not one of these. However, in its geographical sections alcohol did receive significant attention. These sections had points for commissioners to consider, which were the equivalent of recommendations, and these included alcohol.



2.7

Does the JSNA contain data on alcohol use and alcohol related harm?

All but one JSNA (24/25) contained some data on alcohol. The exception was a web based JSNA with a section on alcohol but as yet no content.

The data included was most commonly LAPE data which was either directly used or drawn on in all 25 JSNAs i.e. usually hospital admissions data. Next most common were national prevalence figures. However, some JSNAs used local data e.g. licensing figures, crime data or schools surveys and some referred to national research. Treatment data was not widely used despite the PHE guidance.

2.8

What themes do the JSNAs cover?

The research explored the range of alcohol-related themes covered in the JSNAs. The findings are set out in the two tables below.

Table 4: The alcohol related themes covered by JSNAs

	All areas	Top 25	Middle 10	Bottom 10
Social marketing/prevention	16/25	10/15	4/5	2/5
The need for tier 1 interventions such as Identification & Brief Advice	18/25	12/15	4/5	2/5
The impact of alcohol in hospital	25/25	15/15	5/5	5/5
Young people	21/25	11/15	5/5	5/5
Older people	10/25	5/15	4/5	1/5
Care pathways	9/25	6/15	3/5	0/5
Treatment	23/25	14/15	4/5	5/5
Crime and disorder	21/25	12/15	5/5	4/5
Licensing	13/25	8/15	3/5	2/5
Link to NHS / Public Health Outcomes	6/25	2/15	3/5	1/5
Mentions Public Health England	1/25	0/15	1/5	0/5

It is not possible to say that the degree of attention given to any one theme is inappropriate. This depends entirely on the local approach and interpretation of the data. For example, given the national priority around IBA it is a possible concern that over a third of JSNAs did not mention it. However, these were assessments of need rather than of services. The same point can be made about the lack of focus on care pathways.

The next table shows how many of these topics were addressed by each of the top 15 authorities.

Table 5: The alcohol related themes covered by each JSNA in the high need areas

	Social marketing	IBA	Hospital	Young people	Older people	Pathways	Treatment	Crime	Licensing
H1	●	●	●	●	●	●	●	●	
H2		●	●				●	●	●
H3		●	●	●	●		●		
H4	●	●	●				●	●	●
H5	●	●	●	●		●	●	●	●
H6	●	●	●	●	●	●	●	●	●
H7	●		●	●			●	●	
H8			●	●			●		
H9	●	●	●	●		●	●	●	●
H10	●	●	●	●		●	●	●	●
H11			●					●	
H12*	●	●	●	●			●		
H13*	●	●	●	●	●	●	●	●	●
H14		●	●				●	●	
H15	●	●	●	●	●		●	●	●

Again it is impossible to say that an area like H6 which covered all the themes had developed a better JSNA or will build a better response to alcohol. In the same way a JSNA like H11's, although, it covered only two of these themes still gave significant attention to the overall data on alcohol misuse.

It should be noted that JSNAs which had theme level priorities and, therefore, do not prioritise alcohol specifically are no different from other JSNAs in the attention they give to alcohol.

2.9

Does the JSNA have proposed actions or recommendations on tackling alcohol related harm?

JSNAs are not required to have an action plan or recommendations: they are a statement of the local situation. However, 13 of the 25 had recommendations related to alcohol. 9 of the top 15 had them, 3 of the middle 5 and 1 of the bottom 5.

Table 6: Example of JSNA alcohol recommendations

Extend diversionary and engagement activities in key areas in the borough to reduce youth alcohol related anti-social behaviour.
Increase/improve enforcement of licensing and trading standards intervention in areas with the highest levels of alcohol related crime and anti-social behaviour.
Continue to target known priority groups and identify additional priority groups at high risk of alcohol related harm as a focus for prevention activity.
Highlight the need for prevention of alcohol misuse across all age groups and ensure health promotion interventions are fully commissioned.
Develop a wide-ranging media and communications strategy utilising localised messages to create safe drinking messages for the wider population.
Further develop the case conferencing group for prolific street drinkers by ensuring that the most problematic street drinkers are identified and receive the support required to exit this lifestyle.
Review alcohol treatment services' capacity, including community detoxification provision.
Develop and evaluate a new service to address the needs (both treatment and aftercare) of high volume service users of acute hospital care for alcohol related causes to reduce unnecessary hospital admissions and emergency department attendances.
To advise and inform decision makers and the public of the positive impact to health of introducing a 50 pence Minimum Unit Price for alcohol.
Ensure adequate access to specialist alcohol at the point of need, in the community, custody and in hospital.

2.10

Treatment and care pathways

The attention given to alcohol treatment and care pathways through treatment was a specific focus of the research. This was hard to assess because no standard exists for judging whether the emphasis was adequate and the absence of a particular focus on treatment might be because existing local services were seen as a lower priority for development than IBA or alcohol liaison schemes. This research can only reflect the documents.

Table 7: Comparing the attention given to treatment and care pathways across the three sets of documents

		All	Top 25	Middle 10	Bottom 10
JSNA	Care pathways	9/25	6/15	3/5	0/5
	Treatment	23/25	14/15	4/5	5/5

8 partnerships included either alcohol treatment or pathways as priorities. 6 mentioned treatment and 4 mentioned pathways, 2 mentioned both. 2 of these pathway mentions focused on specific issues: one on families the other on liver disease.

2.11

Does the JSNA reflect the impact of alcohol on particular demographic or geographic groups e.g. BME communities, different wards or gender

17 of the JSNAs reflected that alcohol may have a different effect on particular groups. 7 of the top 15 reflected this, whereas all of the other 10 reflected this. Deprived communities were those most commonly identified. Dual diagnosis was also mentioned with regularity. Other groups included ethnicity, gender, unemployed people and Lesbian Gay Bisexual & Transgender communities.

The disparity between the number of times that the top 25 authorities and the lower need authorities reflected on the impact on different groups in the community is an interesting sidelight. It could reflect failings on either side. Are lower need authorities more likely to see alcohol problems as being about particular communities rather than the whole population or are high need areas failing to see the needs of particular groups because of the extensive generalised level of need? At this point this can be no more than speculation.

2.12

How JSNAs compare with good practice and other emerging themes

It is positive to note that all the JSNAs reviewed alcohol. As no absolute standard exists it is impossible to determine whether this represented "a comprehensive section on alcohol-related harm" as recommended by PHE. Considerable variation existed in the style and content and even in some high need areas the attention given to alcohol was relatively brief, therefore, many documents appeared unlikely to meet the PHE suggestion that there is a comprehensive section on alcohol related harm. Nonetheless, it is encouraging that alcohol was recognised.

Far fewer of the JSNAs can be said to reflect "need across the whole spectrum of harm". For example, some high need areas did not reflect young people's needs, older people or care pathways.

Little evidence was found that the PHOF and NHSOF were driving the process with only 6 out of 25 JSNAs mentioning the outcomes frameworks. This may be due to the recent advent of these structures.

The range of data used in the JSNAs was equally variable with some simply relying on the LAPE data and in particular hospital admissions data. However, there was little indication of more detailed analysis in most areas. Relatively few were using local treatment data.

The reliance on LAPE hospital admissions data is a concern. A recurring theme in this report is that the centrality of this indicator may be leading some areas with lower levels of admissions to interpret the data as a message that they have a low level of problems. This is a misinterpretation of the data – it implies only that they have a lower incidence of what remains a major national problem. For example, in the lower need areas (which have been defined using NWPHO data) only 2 out of 5 mention the need for alcohol identification and brief advice which NICE clearly advocate for rollout across the country irrespective of level of need.

On the other hand the degree of focus on the impact of alcohol on hospitals and hospital admissions does highlight the power of national indicators. Reducing the rate of rise in alcohol related hospital admissions was a former National Indicator and is a current Public Health Outcomes Framework indicator and has clearly raised the profile of this issue.

The imbalance between the attention given to young people's drinking and older people's drinking may be a cause for concern. A danger exists that drinking is seen as a problem of young people and young adults. This could be both stereotyping and lead to the real needs in older age groups being ignored. The attention given to older people in the JSNAs was certainly not in keeping with the growing concern about older people's drinking. However, again it is not possible to make absolute statements about whether this was appropriate.

It is also important to remember the needs of the larger group of young people who are at risk because of parental drinking.

The research - Joint Health and Wellbeing Strategies (JHWS)

3.1

PHE prompts

Investment

2.2 The partnership can identify the total level of local investment in alcohol harm reduction by all partners who contribute to delivery.

Has the commissioning strategy accounted for any changes in the funding allocated for alcohol and for drugs? (Page 6 commissioning principles)

Appropriate care pathways & treatment

3.3 Care pathways and services are geographically and socio-culturally appropriate to those for whom they are designed.

Are the following fully identified:

— gaps in delivery of primary, secondary and tertiary prevention for alcohol and drugs

— the extent of drug treatment penetration and the alcohol 'prevalence service utilisation ratio'

— the impact of services on health and wellbeing, public health and offending? (Page 6 commissioning principles)

IBA

5.1 The JHWS clearly indicates that the partnership has an integrated plan that sets out the agreed roles and responsibilities of partners, including workforce development, to roll out Identification and Brief Advice (IBA) in a range of settings with a system in place to monitor activity.

Frequent hospital attenders

6.5 There is a range of services to support and reduce the number of frequent hospital attenders.

Other themes

— Is recovery addressed in the plans? (General theme e.g. 6.4)

— Do the plans identify the importance of peer support and mutual aid? (General theme e.g. 7.8)

— Does the needs assessment take into account the availability and potential development of existing community support networks and other local assets, using a methodology such as asset-based community development? (Page 6 commissioning principles)

— Does the local needs assessment take account of the needs of women and young girls vulnerable to substance misuse (for example, those subject to domestic violence or sexual assault, or involved in prostitution, or with poor mental health)? (Page 6 commissioning principles)

— Does the local needs assessment take account of the needs of prisoners and continuity of care requirements for substance misusing offenders moving between custody and the community? (Page 6 commissioning principles)

Good practice in planning for alcohol and drugs prevention, treatment and recovery - Public Health England – 2013[14]

3.2

Does the Health and Wellbeing Board have a JHWS?

The study identified JHWSs from 24 of the 25 authorities. The missing area's strategy was still under development.

Table 8: The number of partnerships with JHWSs

All	Top 25	Middle 10	Bottom 10
24	14	5	5

As with the JSNAs, these strategies did not conform to a prescribed style, were of varying length and had significant differences in the way they approached topics.

3.3

Does the JHWS or action plan cover alcohol?

Every JHWS reviewed covered alcohol. The degree of coverage varied with the size and overall approach of the strategy. Some of the strategies were very brief documents; in general they were not as large as the JSNAs.

3.4

Is alcohol identified as a priority?

9 of the JHWSs identified alcohol as a priority. The degree of priority varied from 1 out of 3 to 1 out of 21.

Table 9: The number of JHWSs which identify alcohol as a priority

All	Top 25	Middle 10	Bottom 10
9	7	1	1

Table 10: Sample JHSW priority statements

Sample priority statement including alcohol

The proposed actions have been scored against a prioritisation framework developed by the Health and Wellbeing Board. The top nine actions focus on three priority outcomes:

— Alcohol related admissions and mortality

— Cardiovascular disease mortality

— Child poverty

Sample priority statement excluding alcohol

In order to achieve our vision for the future, the Health and Wellbeing Board has agreed the following broad priorities:

— Getting the youngest people in our communities off to the best start

— Educating, informing and involving the community in improving their own health and wellbeing

— Moving more health provision into the community

— Providing the best treatment we can to people in the right place and at the right time

— Turning round the lives of troubled families

— Improving people's mental health and wellbeing

— Bringing people into employment and leading productive lives

— Enabling older people to keep well and live independently in their community

As with JSNAs, further tests were applied to those seven high need area JHWSs where alcohol did not have a clearly stated priority.

In contrast to the JSNAs, all of the JHWSs should have, and did have, a set of priorities. Therefore, the only question was whether the JHWS used high level rather than disease or condition level priorities or whether any of the JHWSs had disease or condition level priorities but did not include alcohol.

In every case the lack of a specific alcohol priority was the result of priorities being set at a level beyond the disease or condition.

The table below shows whether each of the 7 JHWSs gave significant attention to alcohol. Section 3.5 looks at the recommendations in each strategy in more detail.

Table 11: The attention given to alcohol in JHSWs where alcohol is not a priority

Area	JHWS content	Alcohol recommendations?
H1	8 high level priorities. The strategy mentioned alcohol but not extensively.	Yes
H3	3 high level priorities each of which had 3 sub themes – alcohol was not mentioned. The document mentioned the alcohol strategy and makes 4 other mentions of alcohol.	Yes
H6	3 high level outcomes. The strategy significantly referenced alcohol	Yes
H9	Uses Marmot priorities and made limited mention of alcohol.	Yes
H11	High level priorities. The role of alcohol was included under one of them and its role was recognised.	Yes
H13	High level priorities. Alcohol was mentioned but this is a very brief, six page document	No
H15	High level priorities. Alcohol was mentioned four times in 17 pages.	No

3.5

What themes do the JHWSs cover?

As with the JSNAs the research explored the range of alcohol-related themes covered in the JHWSs. The findings are set out in the two tables below.

Table 12: The alcohol related themes covered in the JHSWs

	All areas	Top 25	Middle 10	Bottom 10
Social marketing/prevention	10/24	6/14	3/5	1/5
Tier 1 interventions such as IBA	6/24	5/14	0/5	1/5
Hospital alcohol work	18/24	12/14	4/5	2/5
Young people	11/24	6/14	4/5	1/5
Older people	4/24	2/14	2/5	0/5
Care pathways	1/24	1/14	0/5	0/5
Treatment	9/24	8/14	1/5	0/5
Crime and disorder	12/24	6/14	4/5	2/5
Licensing	7/24	5/14	2/5	0/5
Link to NHS / Public Health Outcomes	11/24	8/14	3/5	0/5
Mentions Public Health England	2/24	2/14	0/5	0/5

The next table shows how many of these topics were addressed by each of the top 15 authorities with strategies available.

Table 13: The alcohol related themes covered in each of the high need JHWSs

	Social marketing	IBA	Hospital	Young people	Older people	Pathways	Treatment	Crime	Licensing
H1			●	●			●		
H2			●	●				●	
H3			●					●	
H4	●	●	●	●	●	●	●		
H5	●	●	●				●	●	●
H6	●	●	●	●			●	●	●
H7	●	●	●		●		●	●	●
H8	●	●	●	●			●	●	
H9			●	●					●
H11			●				●		●
H12*									
H13*									
H14	●		●				●		
H15*			●						

**These documents are deliberately brief.*

Regarding specific themes in the PHE guidance: recovery was mentioned in only one JHWS, peer support and mutual aid were not mentioned in any of the strategies. The asset based approach was mentioned in strategies but not specifically in the context of alcohol.

3.6

Recommendations about alcohol and the themes they cover

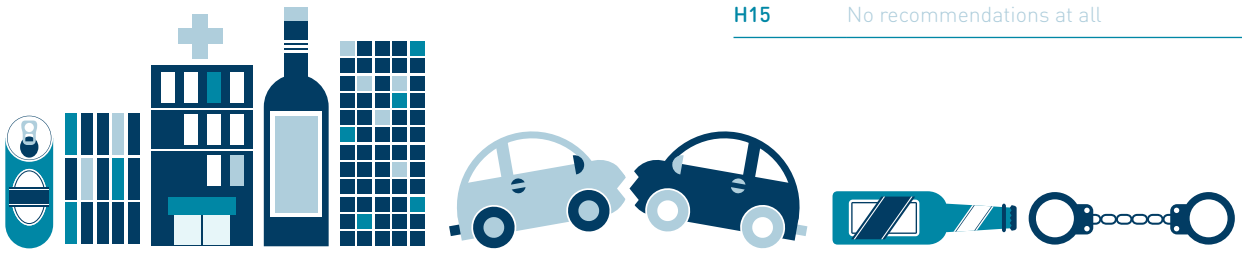
Of the 14 high need area JHWSs, 6 did not have formal recommendations or actions at all. Some were in development, others had more detailed priorities but not at the level of recommendations or actions. The following table is a summary of the themes covered by the existing recommendations. The subsequent table shows how the recommendations were distributed between the high need partnerships.

Table 14: The alcohol related themes covered by the recommendations of the high need JHSWs

Recommendation	No. of JHWSs
Better strategic framework	5
IBA	5
Hospital admissions	5
Licensing	4
Treatment and care pathways	4
Crime and disorder	2
Minimum unit price	2
Social marketing	2
Engage the community	1
Families	1

Table 15: The alcohol related themes covered by the recommendations in each of the high need JHSWs

H1	Pathways for families to alcohol services Better partnership
H2	Hospital admissions
H3	No recommendations at all
H4	Social marketing IBA Pathways between services
H5	IBA Referral Pathways Hospital admissions Safer neighbourhoods Licensing Minimum unit price
H6	IBA Hospital admissions Better partnership re treatment Licensing
H7	Crime and disorder Licensing Minimum Unit Price
H8	Engage the community Social marketing IBA Hospital pathway Better partner ship working and investment
H9	Lifestyle service for alcohol Treatment Licensing Partnership working
H10	No plan
H11	Hospital admissions Healthier Policies Treatment services
H12*	No recommendations at all
H13	No recommendations at all
H14	No recommendations at all
H15	No recommendations at all



3.7

The impact of alcohol on particular groups

Only three JHWSs (one in each need group) identified the impact of alcohol on particular groups. The groups included: deprived communities (2x), ethnicity and dual diagnosis (1x each). The specific groups mentioned in the PHE guidance: prisoners, young women at risk of sexual abuse and exploitation were not mentioned in any of the JHWSs reviewed.

3.8

Investment

None of the JHWSs allowed the identification of the level of investment in alcohol although this was also generally true of all health themes.

3.9

Conclusions - Do the JHWSs meet the standards and other emerging themes?

While a comprehensive JSNA is important, it is more crucial that alcohol is targeted for action in the JHWS and the CCG plan. Given that alcohol is primarily a responsibility of Public Health, the JHWS is the most crucial document.

At this point it appears that there was a disconnect between the assessment of need, the priority and the level of action in the documents reviewed.

Every JHWS covered alcohol and 9 of the JHWSs identified alcohol as a priority. None of the strategies in the high need areas made recommendations without having one concerning alcohol.

However, the selection of recommendations had some surprises.

— Work in hospital was a recurring theme in the JSNAs. The bias to hospital related alcohol work was also very noticeable in the JHWSs. This re-emphasised the success of the national indicator. However, it was not so obviously reflected in the recommendations. It may be argued that a range of community interventions will impact on admissions. It may also be that this theme was seen by the HWBs as the responsibility of the CCGs.

— The roll out of IBA also received surprising little attention given its national strategic importance.

— Treatment may also be argued to have been subject to relatively few recommendations compared to its presence in the JHWSs. More areas mentioned social marketing than treatment.

— The use of licensing powers was clearly under-developed as a lever in these strategies.

— The PHE guidance recommended a focus on recovery, peer support and mutual aid but these were scarcely mentioned in any of the strategies.

Again the concern can be expressed that the areas with lower level of need identified in the NWPHO data were giving significantly less attention to alcohol. This raised the question of whether the lower ranking was reducing the attention given to alcohol.

The PHE guidance suggests attention is given to the needs of a number of groups within the population of risky and dependent drinkers. This aspect received very little attention. The specific lack of attention to alcohol problems among older people was quite marked.

4

The research – Clinical Commissioning Group Commissioning Plans

4.1

PHE prompts

As both the JHWS and the CCG plan are action plans, the prompts set out in 3.1 above are applicable to the CCG plans.

4.2

The CCGs

The 25 local authority areas reviewed were covered by a total of 35 CCGs. These were biased in number towards the lower need areas which tended to be large rural counties with multiple CCGs.

Table 16: The distribution of CCGs between the three groups of authorities

All	Top 25	Middle 10	Bottom 10
35 CCGs	16 CCGs	5 CCGs	14 CCGs

4.3

Does the CCG have an identifiable commissioning plan?

34 of the 35 CCG areas covered had an identified commissioning plan. The missing plan was from a high need area.

4.4

Does the CCG commissioning plan clearly address alcohol?

30 of the areas had a commissioning plan which clearly covered alcohol.

Table 17: The distribution of CCGs which have a commissioning plan covering alcohol

All	Top 25	Middle 10	Bottom 10
34	16/16	4/5	10/13

4.5

Is the CCG plan based on clear evidence of need?

21 of these plans showed clear evidence of need.

Table 18: The distribution of CCGs which have a commissioning plan with evidence of alcohol related need

All	Top 25	Middle 10	Bottom 10
21	12/16	1/5	10/13

4.6

Is alcohol identified as a priority?

8 CCGs identified alcohol as a local priority, all of these were in the high need areas.

Table 19: Sample CCG plan priority statements including alcohol

Sample priority including alcohol

"This (plan) is driven by "the big six" causes of death – infant mortality, coronary heart disease, alcohol related mortality, respiratory disease mortality, lung cancer and stroke."

Our organisational priorities are:

- Improve early detection and management of long term conditions
- A sustainable local health economy
- Reduced childhood obesity and alcohol related admissions
- Increased access to health education for patients, public and professionals
- System Reform of Urgent Care and Mental Health illness
- A holistic approach to care closer to home
- To develop the CCG team and individuals
- Community Resilience

As with the JSNAs and the JHWSs further tests were applied to those high need CCG areas in which alcohol did not have a clearly stated alcohol priority. By definition these strategies were targeted at driving action, so alcohol could be set as a priority.

It can be argued that CCGs are not primarily responsible for alcohol; that this responsibility lies with public health and it is true that the mainstream funding for alcohol services is now a Public Health responsibility.

Table 20: Sample CCG statements re Public Health responsibility for alcohol

> Support Public Health wherever possible in delivering essential prevention and health awareness/ self-check programmes, as well as initiatives to tackle smoking, obesity, and alcohol and drug misuse.
>
> We will continue to work with our public health colleagues to address the following public health issues:
>
> Alcohol - A new service to support patients who frequently require acute care related to alcohol will be developed. This service will aim to reduce alcohol related healthcare issues by working proactively with patients who have an identified need.

The research looked at how the high need area CCGs without an alcohol priority addressed the topic in their plans.

Table 21: How high need area CCGs which did not set alcohol as a priority addressed it in their plans

H2	H2 had three disease level priorities: COPD, CVD & dementia.	Alcohol was a sub-theme under these headings.
H5	H5 had disease level priorities but the strategy made it clear that its role was to support the city council which leads on alcohol.	The importance of alcohol was clearly identified.
H6	The primary care strategy did not have alcohol as a priority. It had high level outcomes .	Alcohol was mentioned three times under the high level outcomes.
H13	It was not identified as a CCG priority but this was in the context of local joint commissioning arrangements.	Its local importance was clearly recognised.
H14	It was neither a workstream nor a strategic outcome (these were not disease level).	It was a target under the Health and Well-being workstream and alcohol's role was recognised.
H1	Alcohol was not a specific priority but the Public Health role was recognised.	Alcohol received significant attention and actions were identified.

4.7

What themes does the CCG strategy cover?

As with the other documents the research explored the range of alcohol-related themes covered in the CCG plans. Again this question is more important than in the context of the JSNA because these plans drive action. The findings are set out in the two tables below.

Table 22: The alcohol related themes covered in CCG plans

	All areas	Top 25	Middle 10	Bottom 10
Tier 1 interventions such as IBA generally	8/35	5/17	1/5	2/13
Tier 1 interventions such as IBA in primary care	11/35	7/17	1/5	3/13
Hospital alcohol work	25/35	15/17	4/5	6/13
Young people	3/35	1/17	2/5	0/13
Older people	2/35	1/17	0/5	1/13
Care pathways	5/35	1/17	0/5	4/13
Treatment	8/35	5/17	1/5	2/13
Link to NHS / Public Health Outcomes	23/35	10/17	5/5	8/13
Mentions Public Health England	8/35	4/17	2/5	2/13

This analysis provides a very graphic illustration of the bias towards alcohol work in the hospitals. The CCGs are not responsible for the majority of alcohol interventions but it can be argued that they have a role in both hospital related work and IBA in primary care. The disparity between hospital work and IBA was very noticeable.

The following table shows the alcohol related themes covered in the high need areas.

Table 23: The alcohol related themes covered in the CCG plans of each high need area

	IBA generally	IBA primary care	Hospital	Young people	Older people	Pathways	Treatment
H1	●	●	●				●
H2			●				
H3	●	●		●			●
H4			●			●	●
H5			●				
H6		●	●				
H7			●				
H8			●		●		
H9							
H11	●		●				●
H10		●	●				
H12			●				●
H13	●	●	●	●		●	●
H14			●				
H15	●	●	●				

NB. To maintain anonymity the one high need area with multiple CCGs has had the three sets of recommendations collated into a single row.

Regarding themes in the PHE guidance: recovery was mentioned in only one CCG plan as was peer support and mutual aid. The asset based approach was not mentioned specifically in the context of alcohol.

4.8

Recommendations in the high need area CCG plans

15 of the 17 high need CCG plans reviewed had alcohol related recommendations. This was a higher proportion than the JHWSs. The following table is a summary of the themes covered by these recommendations. The subsequent table shows how the recommendations were distributed between the partnerships and provides a little more detail on the themes.

Table 24: Key alcohol related themes covered by the recommendations of the high need CCG plans

Theme	No. of plans
Reducing hospital admissions	7
Treatment services	5
Increase IBA	4
Pathways for drinkers	2

Theme	No. of plans
Maternal and ante-natal	2
Developing joint commissioning arrangements	2
Social marketing	1
No plan found	1

Table 25: The alcohol related themes covered by the recommendations in each of the high need CCG plans

H1	Reducing hospital admissions Treatment services Alcohol liaison & IBA in A&E Increase IBA Health Visitors with specialist alcohol knowledge
H2	Tackle alcohol in A&E Pharmacy IBA
H3	IBA in primary care Harmful and dependent drinkers in primary care
H4	Treatment services Pathways for drinkers Social marketing
H5	Support partnership programme to tackle alcohol misuse
H6	
H7	Reducing hospital admissions
H8	Recommendations existed but not about alcohol –this was deemed a public health role
H9	
H10	Reduce alcohol related hospital admissions Ante-natal care
H11	Developing joint commissioning arrangements Hospital admissions
H12	IBA Reducing hospital admissions Treatment services
H13	Better integrated commissioning of treatment
H14	Reduce alcohol related hospital admissions IBA
H15	Reduce hospital admissions relating to alcohol.

4.9

The impact of alcohol on particular groups

The specific groups mentioned in the PHE guidance: prisoners, young women at risk of sexual abuse and exploitation were not mentioned in any of the CCG plans reviewed.

4.10

Investment

Only two CCG plans provided any data on the level of investment in alcohol although one of these was out of date and the other was only partial information about one aspect of the alcohol treatment system.

4.11

Conclusions - How the CCG plans compare with good practice and other emerging themes

30 of the areas had a commissioning plan which clearly covered alcohol and all of those in the high need areas addressed the theme. 21 of these plans showed clear evidence of need and 8 set alcohol as a priority, all in the high need areas. In those high need areas which do not set it as a priority it usually receives significant attention.

Perhaps surprisingly, 15 of the 17 high need CCG plans reviewed had alcohol related recommendations. This was a higher proportion than the JHWSs.

It was noticeable that hospital work was the theme that received the most attention in the documents. It was mentioned in 15 of the 17 high need areas but only seven recommendations focused on it. Treatment and IBA had a slightly lower degree of attention in the recommendations.

The lower need areas again gave less attention and priority to alcohol, and were less likely to recommend work on nationally recommended themes like hospital interventions or IBA.

5

The whole picture - how the three documents inter-relate

5.1

PHE prompts

Linking the documents together
1.2 Needs assessment, the local commissioning strategy, CCG strategy and Joint Health and Wellbeing Strategy (JHWS) demonstrate an explicit link between evidence of need and service planning. (There is clear congruity between all documents from needs assessment to strategic planning.)

5.2

The linkage between the documents

The above sections have looked at the documents in isolation. This is possibly inappropriate because they should link together and jointly drive action. This section reviews whether and how the linkage is happening.

5.3

Do the documents reference each other?

The tables below shows whether the JHWS and the CCG plan reference each other, the JSNA, the local alcohol strategy and the community safety strategy. It also notes whether the mention is specifically to do with alcohol.

Table 26: The proportion of JHWSs that reflect other strategies and other strategies re alcohol

JSNA	16% of JHWSs did not mention JSNA at all	52% of JHWSs mentioned the JSNA but not re alcohol	32% of JHWSs mentioned the JSNA re alcohol
CCG Plan	20% of JHWSs did not mention CCG plan at all	60% of JHWSs mentioned the CCG plan but not re alcohol	20% of JHWSs mentioned the CCG plan re alcohol
Alcohol Strategy	60% of JHWSs did not mention local Alcohol Strategy at all	NA	40% of JHWSs mentioned the alcohol strategy
Community Safety Strategy	60% of JHWSs did not mention CSS at all	32% of JHWSs mentioned the CSS but not re alcohol	8% of JHWSs mentioned the CSS re alcohol

Table 27: The proportion of CCG plans that reflect other strategies and other strategies re alcohol

JSNA	12% of CCG plans did not mention JSNA at all	56% of CCG plans mentioned the JSNA but not re alcohol	32% mentioned the JSNA re alcohol
JHWS	8% of CCG plans did not mention the JHWS at all	64% of CCG plans mentioned the JHWS but not re alcohol	28% of CCG plans mentioned the JHWS re alcohol
Alcohol Strategy	92% of CCG plans did not mention local Alcohol Strategy at all	NA	8% of CCG plans mentioned the alcohol strategy
Community Safety Strategy	84% of CCG plans did not mention CSS at all	4% of CCG plans mentioned the CSS but not re alcohol	12% mentioned the CCG plans re alcohol

The full dataset is in appendix 2 and this shows that there is a decline in the references to alcohol in the lower need areas.

5.4

Good practice

Two examples of good practice were noted. Nottingham had a very well-coordinated suite of documents. Hampshire had also clearly worked well to link documents together in the challenging context of an area with four CCGs.

5.5

How the three documents in the high need area reflect alcohol

The table below shows how the three key documents, JSNA, JHWS and CCG commissioning plan, in each high need area reflected alcohol using the following code:

- Alcohol addressed
- Alcohol not addressed but due to the structure of the document e.g. no priorities at all
- Alcohol not addressed but could have been
- Documents not completed

Table 28: Comparing the attention given to alcohol across the three documents in each of the high need areas

	JSNA			JHWS			CCG Plan		
	Priority	Mention	Recommen-dations / action	Priority	Mention	Recommen-dations / action	Priority	Mention	Recommen-dations / action
H1	■	●	●	■	●	●	■	●	●
H2	■	●	●	●	●	●	■	●	●
H3	●	●	●	■	●	■	●	●	●
H4	●	●	●	●	●	●	●	●	●
H5	●	●	●	●	●	●	■	●	●
H6	●	●	●	■	●	●	■	●	■
H7	■	●	■	●	●	●	●	●	●
H8	■	●	■	●	●	●	●	●	■
H9	■	●	●		●	●	○	○	○
H10	●	●	●	○	○	○	●	●	●
H11	■	●	■	■	●	●	●	●	●
H12	●	●	●	●	●	■	●	●	●
H13	■	●	●	■	●	■	■	●	●
H14	●	○	○	●	●	■	■	●	●
H15	●	●	●	■	●	■	●	●	●

5.6

The combination of recommendations

It can be argued that it is unimportant whether the CCG plan or the JHWS sets an alcohol related priority as long as one of them is accepting the responsibility. The table below shows the combination of recommendations across the JHWS and the CCG plan. The non-shaded recommendations are in the JHWS and the shaded are in the CCG plans.

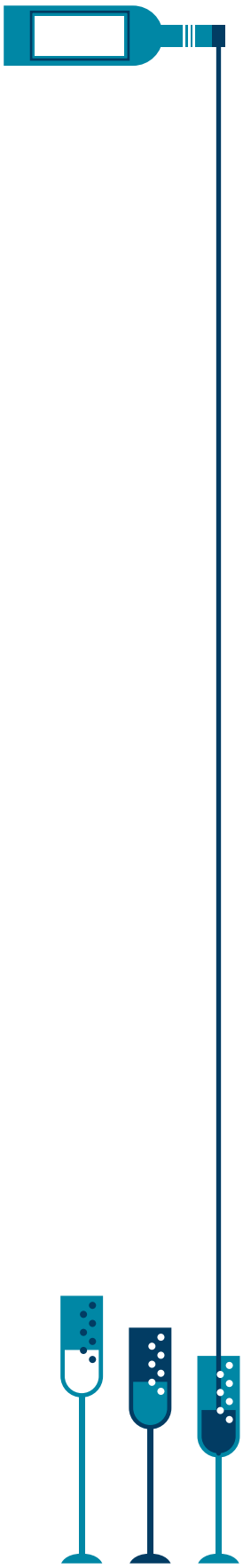


Table 29: The JHWS and CCG alcohol recommendations in each of the high need areas

	JHWS recommendations	CCG recommendations
H1	Pathways for families to alcohol services Better partnership	Reducing hospital admissions Treatment services Alcohol liaison & IBA in A&E Increase IBA Health Visitors with specialist alcohol knowledge
H2	Hospital admissions	Tackle alcohol in A&E Pharmacy IBA
H3	No recommendations at all	IBA in primary care Harmful and dependent drinkers in primary care
H4	Social marketing IBA Pathways between services	Treatment services Pathways for drinkers Social marketing
H5	IBA Referral Pathways Hospital admissions Safer neighbourhoods Licensing Minimum unit price	Support partnership programme to tackle alcohol misuse
H6	IBA Hospital admissions Better partnership re treatment Licensing	
H7	Crime and disorder Licensing Minimum Unit Price	Reducing hospital admissions
H8	Engage the community Social marketing IBA Hospital pathway Better partnership working and investment	Recommendations exist but not about alcohol. This is deemed a public health role
H9	Lifestyle service for alcohol Treatment Licensing Partnership working	
H10	No plan	Reduce alcohol related hospital admissions Ante-natal care
H11	Hospital admissions Healthier Policies Treatment services	Developing joint commissioning arrangements Hospital admissions
H12	No recommendations at all	IBA Reducing hospital admissions Treatment services
H13	No recommendations at all	Better integrated commissioning of treatment
H14	No recommendations at all	Reduce alcohol related hospital admissions IBA
H15	No recommendations at all	Reduce hospital admissions relating to alcohol.

The following table summarises the attention given to treatment and care related issues in the JHWS and CCG plan in each area using the following code:

- Theme mentioned and recommendations included
- Theme mentioned and but no recommendations included
- Theme not mentioned
- Documents not available

Table 30: Do the JHWS and CCG have alcohol recommendations regarding, hospital admissions, IBA and treatment in each of the high need areas

	JHWS	CCG
H2	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H3	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H7	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H12	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H13	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H5	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H4	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H11	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H15	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H6	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H8	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H9	Hospital	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H10	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H14	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment
H1	Hospital admissions	Hospital admissions
	IBA	IBA
	Treatment	Treatment

Four high need area partnerships have no published recommendations and seven have no recommendation about IBA with the same number having no recommendations about treatment.

5.7

Conclusions

The majority of JHWSs and CCG commissioning plans cross-reference to the JSNA and each other. However, they were less likely to cross-reference each other regarding alcohol and much less likely to reference alcohol or community safety strategies. The best two areas were Nottingham and Hampshire which each had a clear suite of documents which interlinked and/or cross-referenced

In general the high need areas addressed alcohol and across the two key plans all have some recommendations about alcohol. However, four high need partnerships did not have any recommendations about tackling hospital admissions. Seven did not have recommendations about IBA and the same number lacked recommendations about treatment.

6

Other strategies – The local alcohol strategy / Crime and disorder strategy

6.1

Does the area have an alcohol strategy / drugs & alcohol strategy / Crime and disorder strategy?

17 of the local authority areas reviewed had an identified alcohol or alcohol and drug strategy.

Table 31: The number of partnerships with an identified alcohol strategy

All	Top 25	Middle 10	Bottom 10
17	11	3	3

Crime and disorder strategies were identified from 19 of the 25 areas. These all covered alcohol to varying degrees.

Table 32: The number of partnerships with an identified crime and disorder strategy

All	Top 25	Middle 10	Bottom 10
19	12	4	3

6.2

What themes do the strategies cover?

Table 33: The themes covered by partnership alcohol strategies

	All areas	Top 25	Middle 10	Bottom 10
Social marketing/prevention	17/25	11/15	3/5	3/5
Tier 1 interventions such as IBA	17/25	11/15	3/5	3/5
Hospital alcohol work	17/25	11/15	3/5	3/5
Young people	17/25	11/15	3/5	3/5
Older people	7/25	4/15	1/5	2/5
Treatment	17/25	11/15	3/5	3/5
Crime and disorder	17/25	11/15	3/5	3/5
Licensing	14/25	9/15	2/5	3/5

Table 34: The themes covered by partnership crime and disorder strategies

	All areas	Top 25	Middle 10	Bottom 10
Social marketing/prevention	7/25	5/15	1/5	1/5
Tier 1 interventions such as IBA	3/25	2/15	0/5	1/5
Hospital alcohol work	8/25	5/15	2/5	1/5
Young people	11/25	8/15	2/5	1/5
Older people	0/25	0/15	0/5	0/5
Treatment	12/25	7/15	4/5	1/5
Crime and disorder	19/25	12/15	4/5	3/5
Licensing	15/25	10/15	3/5	2/5

7

Recommendations

1

Directors of Public Health should ensure that JSNAs contain a comprehensive section on alcohol related harm.

2

Directors of Public Health should ensure that JSNAs are built on a wider dataset than the LAPE data alone and hospital admissions specifically. This could include prevalence data, treatment data, licensing information, crime figures as well as specific local research.

3

Public Health England should note the obvious impact of the alcohol-related hospital admissions indicator and consider whether indicators around Identification and Brief Advice or treatment provision would further improve the local response.

4

Directors of Public Health should ensure that JSNAs consider the impact of alcohol on sub-groups within the local population e.g. different wards, ethnic and language communities, people with mental health problems, unemployed people, offenders, women who have been the victims of abuse.

5

Directors of Public Health should ensure that the needs of young people are not over-emphasised in comparison with other groups, leading to the danger of inappropriately stigmatising young people as a major cause of alcohol related harm. The needs of the larger group of young people who are at risk because of parental drinking should be considered.

6

Directors of Public Health should ensure that JSNAs specifically consider the needs of older drinkers (55+) who make up a large share of the burden on hospital services.

7

Directors of Public Health and CCG chairs should ensure that, in considering alcohol treatment, the strategic process considers the client's care pathway through treatment.

8

Directors of Public Health and CCG chairs should use the opportunity offered by this strategic process to clearly state the lead responsibility for each step of the alcohol care pathway.

9

Directors of Public Health and CCG chairs should ensure that, in and across all the key documents, the degree of harm caused by alcohol is reflected by the priority or importance given to it in the documents and then by the actions or recommendations included.

10

Directors of Public Health and CCG chairs in areas with lower national rankings for hospital admissions, morbidity and mortality in the NWPHO data should ensure that JSNAs, strategies and plans reflect the actual impact that alcohol is having not simply the lower ranking. In England even the lowest risk areas will have considerable harm from alcohol.

11

Directors of Public Health and CCG chairs should ensure that this process reflects and makes of use of the opportunities offered by the licensing framework to tackle alcohol related harm.

Appendix 1 – Relevant prompts from the alcohol self-assessment stocktake: *Good practice in planning for alcohol and drugs prevention, treatment and recovery - Public Health England – 2013*[15]

1.1 The local JSNA includes a comprehensive section on alcohol-related harm that reflects need across the whole spectrum of harm and readily acknowledges the impact of alcohol work across the PHOF and NHSOF resulting in partnership collaboration and support.

1.2 Needs assessment, the local commissioning strategy, CCG strategy and Joint Health and Wellbeing Strategy (JHWS) demonstrate an explicit link between evidence of need and service planning. (There is clear congruity between all documents from needs assessment to strategic planning.)

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

1.5 Local data on alcohol interventions provided in hospitals, Primary Health Care, and other settings is collected to inform needs assessment. (This might include data from: NHS Health Check, DES, LES (or equivalent), hospital services.)

1.6 The commissioners have analysed the local levels of alcohol-related admissions to hospital in order to target interventions. (Commissioners use analysis of alcohol-related admissions to identify in-need population groups so that appropriate, accessible services can be designed and located.)

1.7 The commissioners have analysed and monitored local specialist treatment data including specific breakdown by gender, age, postcode, condition, route of admission, repeat admission, etc. in order to compare current treatment provision with need.

2.2 The partnership can identify the total level of local investment in alcohol harm reduction by all partners who contribute to delivery.

Has the commissioning strategy accounted for any changes in the funding allocated for alcohol and for drugs?
Page 6 commissioning principles

3.3 Care pathways and services are geographically and socio-culturally appropriate to those for whom they are designed.

5.1 The JHWS clearly indicates that the partnership has an integrated plan that sets out the agreed roles and responsibilities of partners, including workforce development, to roll out Identification and Brief Advice (IBA) in a range of settings with a system in place to monitor activity.

6.5 There is a range of services to support and reduce the number of frequent hospital attenders.

Are the following fully identified:

- gaps in delivery of primary, secondary and tertiary prevention for alcohol and drugs
- the extent of drug treatment penetration and the alcohol 'prevalence service utilisation ratio'
- the impact of services on health and wellbeing, public health and offending?
  Page 6 commissioning principles

Is recovery addressed in the plans? **General them e.g. 6.4**

Do the plans identify the importance of peer support and mutual aid?
General them e.g. 7.8

Does the needs assessment take into account the availability and potential development of existing community support networks and other local assets, using a methodology such as asset-based community development? Page 6 commissioning principles

Does the local needs assessment take account of the needs of women and young girls vulnerable to substance misuse (for example, those subject to domestic violence or sexual assault, or involved in prostitution, or with poor mental health)?
Page 6 commissioning principles

Does the local needs assessment take account of the needs of prisoners and continuity of care requirements for substance misusing offenders moving between custody and the community?
Page 6 commissioning principles

The references to the other documents in the JHWSs and CCG plans

The plan/strategy is addressed regarding alcohol
The plan/strategy is addressed but not regarding alcohol
The plan/strategy is not addressed at all

	JHWS	CCG Plan
H1	JSNA but not re alcohol	JSNA but not re alcohol
	CCG but not re alcohol	JHWS but not re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy but not re alcohol	Community safety strategy
H2	JSNA re alcohol	Too brief
	CCG but not re alcohol	Too brief
	Alcohol strategy	Too brief
	Community safety strategy but not re alcohol	Too brief
H3	JSNA but not re alcohol	Too old
	CCG but not re alcohol	Too old
	Alcohol strategy	Too old
	Community safety strategy but not re alcohol	Too old
H4	JSNA re alcohol	JSNA re alcohol
	CCG but not re alcohol	JHWS re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy
H5	JSNA re alcohol	JSNA but not re alcohol
	CCG re alcohol	JHWS latter re alcohol,
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety re alcohol
H6	JSNA re alcohol	JSNA re alcohol
	CCG re alcohol	JHWS re alcohol,
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy
H7	JSNA but not re alcohol	JSNA but not re alcohol
	CCG but not re alcohol	JHWS re alcohol,
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy
H8	JSNA re alcohol	JSNA re alcohol
	CCG but not re alcohol	JHWS re alcohol,
	Alcohol strategy	Alcohol strategy
	Community safety strategy re alcohol	Community safety strategy
H9	JSNA but not re alcohol	NA
	CCG re alcohol	NA
	Alcohol strategy	NA
	Community safety strategy re alcohol	NA
H10	NA	JSNA but not re alcohol
	NA	JHWS re alcohol,
	NA	Alcohol strategy
	NA	Community safety strategy
H11	JSNA re alcohol	JSNA but not re alcohol
	CCG	JHWS re alcohol,
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy re alcohol
H12	JSNA but not re alcohol	JSNA re alcohol
	CCG but not re alcohol	JHWS but not re alcohol,
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy
H13	Very brief document	JSNA re alcohol
	Very brief document	JHWS re alcohol,
	Very brief document	Alcohol strategy
	Very brief document	Community safety strategy
H14	JSNA but not re alcohol	JSNA re alcohol
	CCG re alcohol	JHWS but not re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy but not re alcohol	Community safety strategy
H15	JSNA re alcohol	JSNA but not re alcohol
	CCG but not re alcohol	JHWS but not re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy

	JHWS	CCG Plan
M1	JSNA but not re alcohol	JSNA but not re alcohol
	CCG	JHWS but not re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy re alcohol	Community safety strategy
M3	JSNA but not re alcohol	JSNA but not re alcohol
	CCG but not re alcohol	JHWS but not re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy
M5	JSNA but not re alcohol	JSNA but not re alcohol
	CCG re alcohol	JHWS but not re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy but not re alcohol	Community safety strategy
M4	JSNA but not re alcohol	JSNA but not re alcohol
	CCG but not re alcohol	JHWS but not re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy but not re alcohol	Community safety strategy but not re alcohol
M2	JSNA but not re alcohol	JSNA but not re alcohol
	CCG but not re alcohol	JHWS but not re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy re alcohol

	JHWS	CCG Plan
L2	JSNA but not re alcohol	Both CCGs mention JSNAs but no link to alcohol
	CCG but not re alcohol	Both CCGs mention JHWS but no link to alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy
L4	JSNA	JSNA but not re alcohol
	CCG but not re alcohol	JHWS but not re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy
L5	JSNA re alcohol	4 CCGs mention JSNAs of which 2 link to alcohol
	CCG but not re alcohol	3 CCGs mention JHWS one specifically re alcohol
	Alcohol strategy	3 CCGs link to alcohol strategy
	Community safety strategy	Community safety strategy
L1	JSNA but not re alcohol	JSNA in all 4 CCGs but only one re alcohol
	CCG but not re alcohol	JHWS mentioned ain all 4 CCGs but not re alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy but not re alcohol	Community safety strategy
L3	JSNA but not re alcohol	JSNA mentioned in one of two CCGs but not alcohol
	CCG but not re alcohol	JHWS mentioned in one of two CCGs but not alcohol
	Alcohol strategy	Alcohol strategy
	Community safety strategy	Community safety strategy

References

1 Good practice in planning for alcohol and drugs prevention, treatment and recovery - Public Health England – 2013

2 www.lape.org.uk – Reference to whole website

3 Joint Strategic Needs Assessment: A springboard for action - Local Government Group - April 2011 – page 2 column 1 second paragraph

4 Joint Strategic Needs Assessment: A springboard for action - Local Government Group - April 2011– page 6 column 1 first paragraph

5 Department of Health - Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – 2013 – page 4 first paragraph specifically but this is the theme of the whole document.

6 Department of Health - Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – 2013 – page 4 – 4th paragraph

7 Department of Health - Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – 2013 – page 6 first paragraph of section 3.2

8 Department of Health - Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – 2013 – page 4 4th paragraph

9 Department of Health - Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – 2013 – page 7 last paragraph

10 Department of Health - Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies – 2013 – page 8 first paragraph of section 3.3 at foot of page

11 Department of Health - Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies - 2013 – page 9 2nd paragraph

12 Good practice in planning for alcohol and drugs prevention, treatment and recovery - Public Health England – 2013

13 Good practice in planning for alcohol and drugs prevention, treatment and recovery - Public Health England – 2013 – all numbered sections refer to the numbered table on page 22ff

14 Good practice in planning for alcohol and drugs prevention, treatment and recovery - Public Health England – 2013 – all numbered sections refer to the numbered table on page 22ff / non-numbered sections refer to either Page 6 commissioning principles or particular numbered sections in the document – these are referenced individually and specifically in the text.

15 Good practice in planning for alcohol and drugs prevention, treatment and recovery - Public Health England – 2013 – all numbered sections refer to the numbered table on page 22ff / non-numbered sections refer to either Page 6 commissioning principles or particular numbered sections in the document – these are referenced individually and specifically in the text.

Alcohol Concern
Making Sense of Alcohol

Lundbeck