States of Jersey

A Proposed New System for Health and Social Services

Healthy Lifestyles: Alcohol Pathway

Scheme-level Outline Business Case (OBC)

Version 2.0

13 June 2012

This document

Purpose of the Outline Business Case

The Green Paper, *'Caring for each other, caring for ourselves'*, was produced in May 2011. Following public consultation, eight service areas were selected for early service development in 2012 – 2015. Sustaining Acute Services was identified as being 'Business As Usual', and was removed from the OBC list, therefore, seven OBCs have been produced.

Each proposed service change has been developed robustly, with full involvement from stakeholders. Working groups have used an Outline Business Case (OBC) template when discussing and developing the service changes, in order to ensure that all relevant aspects have been considered. The template incorporates guidelines from the UK Government's website on Business Cases as well as the template on the Treasury & Resources website.

Once approved, each OBC will be progressed to Full Business Case (FBC) – this is anticipated to be by Autumn 2012. The FBC will provide detail on the service change, including detailed timescales and action plans for implementation. Service implementation commences once the FBC has been approved and fund secured from the Medium Term Financial Plan, which is due to be agreed in late Autumn 2012.

Structure of this document

This Outline Business Case presents the elements of service change that must be considered in order for plans to be robust, stakeholders to be fully engaged, and risks to be managed effectively.

The case for change for healthy lifestyles and alcohol is presented, building from the case for change in the Green Paper. The linkage with the HSSD strategic principles and with the relevant services' strategies is clearly identified. The outcome of the Green Paper consultation, and in particular the views of stakeholders received during the consultation period have been presented where applicable, in recognition of the importance of these views.

The OBC then outlines the proposed service change, and the elements thereof, for example, the impact on workforce, on costs and on service delivery / quality.

Indicative costs and benefits are outlined. Some rounding adjustments have been made. All costs are presented at prices relevant to the each year, to ensure that the full cost of the proposals is understood. Costs and benefits which are quantitative and qualitative, short and long term and relevant to patients / service users / carers / families, clinicians and the public have been considered.

Implementation considerations are then presented, including stakeholder engagement and communication, key risks and issues for both the implementation period and for the full service delivery.

Revision history

Version	Date	Author	Description
0.02	21.11.11	Andrew Heaven	Second Draft needing Financials to add in
0.003	02.11.11	Andrew Heaven	Third Draft following KPMG changes to OBC structure
	03.11.11		Fourth – Sixth Draft – Post IT Recovery
0.007	14.11.11	Andrew Heaven	Seventh – Final
0.11	30.11.11	Scott Maslin	Generic updates
0.12	02.04.12	Andrew Heaven	Revised Financials
0.13	05.04.12	Andrew Heaven	Revised Financials
1.0	20.05.12	Rachel Williams	Final review and revision
1.1	12.06.12	Andrew Heaven	Final review and revision
1.2	13.06.12	Andrew Heaven	Final review and revision with SRO comments
2.0	13.06.12	Rachel Williams	Finalisation

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Abbreviations and Definitions

Abbreviation	Definition
BI	Brief Intervention
DETOX	Medically Assisted Withdrawal
FBC	Full Business Case
HSSD	Health And Social Services Department
IAPT	Improved Access to Psychological Services
MTFP	Medium Term Financial Plan
NICE	National Institute for Clinical Excellence
OBC	Outline Business Case
PSSRU	Personal Social Services Research Unit
SUI	Serious Untoward Incident

1 Executive Summary

1.1 Introduction and background

In common with jurisdictions and countries across the world, Jersey faces substantial current challenges in ensuring the availability of high quality health and social care for its citizens within a financially affordable sum. The KPMG technical document and the Green Paper, both published in May 2011, demonstrated that health and social care services in Jersey are at a crossroads. Existing capacity is due to be exceeded in some services in the near future, the elderly population is rising disproportionately and almost 60% of the medical workforce is due to retire in the next 10 years.

In early 2011 the vision for health and social care in Jersey was agreed. This clearly stated that services must be safe, sustainable and affordable.

The public consultation on the future of health and social services in Jersey concluded on 22 August 2011. Since that time, a Working Group has been considering the service changes that are required urgently; this Outline Business Case is a result of that process.

1.2 Strategic Context

Complex problems require governments to act in an integrated way. There is now a better understanding of what policies need to be in place to give the best chance of reducing the current levels of harm caused from alcohol[12]. For example international best practice highlights the need for countries to have a consistent approach to alcohol fiscal policy, a robust licensing law and easily accessible health services. When deployed in conjunction with other considered measures such as education, drink drive legislation, commercial communications a fully integrated approach to alcohol policy can have the desired effect.

1.2.1 The case for change

Islanders have high alcohol consumption - an average of 25 units a week for every person over 16 years[3]. A clinical audit in 2008 identified just over 250 alcohol-related emergency admissions, to the Emergency department with 28% being discharged within 24 hours and 11% requiring admission with length of stay > 11 days[4].

The JASS survey 2010[5] reported that approximately 11,000 people would meet the criteria for an intervention to reduce their alcohol consumption (7,300 for a brief intervention and 3,700 for intensive treatment).

Published best practice[6] indicates that 20% of dependent drinkers should be using alcohol services. In Jersey only 9% of dependent drinkers are accessing services.

1 World Health Organisation (Europe): 2009: Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm: World Health Organisation Regional Office.
2 Anderson.P & Baumberg.B: 2006: Alcohol in Europe, A Public Health Perspective, a report for the European Commission: Institute of Alcohol Studies
3 Medical Officer of Health Report: 2009: Our Island Our Health: Public Health Department
4: Dr Y Arshad, Dr A Luska, Dr P Schinie, Dr V Patel: 2010: The Burden of Alcohol Misuse: Clinical Audit Department
5 Jersey Annual Social Survey: 2010: States of Jersey Statistics Department
6 Alcohol Concern 2010 Making Sense of Alcohol

Currently, the strategic approach to alcohol being pursued by the States of Jersey does not appear to be consistent with international guidance, especially with regard population-level measures such as increasing the cost of alcohol, reducing accessibility and limiting alcohol promotion. In addition, more work needs to be done to improve health services and health promotion relating to alcohol, most notably:

- Ensuring a consistent approach to alcohol screening within Primary Care or secondary care, despite recent audit figures showing Jersey has the second highest rates for admissions due to alcohol when compared with UK regions.
- Reducing high rates of emergency detox within the hospital. This type of detox carries more risks for the service user and is 2.5 times more common then a community detox.
- Increasing capacity to provide support and counselling within the Alcohol and Drug Service.
- Investing in prevention. Personal Social Health Education in schools is not a compulsory part of the curriculum. The Healthy Schools Programme remains a voluntary for schools and not a minimum standard.

The missed opportunities for prevention and early intervention creates pressure on hospital services. Currently, Emergency Department and inpatient hospital beds, are regularly used for interventions that could be delivered and managed in the community. Treating alcohol related conditions is costly. In 2010 (using local activity figures and PSSRU costings) it is estimated that the hospital spent approximately £2 million on alcohol attributable conditions per annum[7][8]. Furthermore, Social Security Department estimate that in 2010 alcohol-related benefit payments totalled £353,870.

Anecdotal evidence also suggests that nursing staff feel under-equipped to address alcohol issues. As a result there is limited uptake of screening by hospital staff which is evidenced in the low number of referrals to the Alcohol and Drug Service from the Hospital.

1.3 Service Objectives for Healthy Lifestyles (Alcohol)

The current Alcohol and Drugs Service provide specialist community detox and relapse prevention and also an alcohol liaison service within the hospital. Staff also support clients with drug misuse problems.

The revised alcohol pathway will be based on NICE guidance[9][10] and other key documents. It will support a consistent approach to addressing alcohol misuse, through a pathway for addressing alcohol misuse, developed in consultation with clinicians and patients. The aim is to:

- Improve the identification and treatment of alcohol misuse.
- Increase access to alcohol services toward 20% in three years Encourage more people to proactively seek information to help themselves and others to drink sensibly

7 Estimated average Hospital activity is based methodology developed by Personal Social Services Research Unit at the University of Kent on behalf of Department of Health

8 Estimates of hospital activity related to attributable and specific fractions were generated from methodologies developed by North West Public Health Authority

9 Guidelines on Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence Volume 1 -3: NICE

10 Public Health Guidance 24: (2010): Alcohol-Use Disorders; Preventing the Development of Hazardous and Harmful Drinking: NICE

- Improve the timely use of health services
- Increase the number of people being supported sooner to reduce their alcohol consumption before any crisis or long lasting damage occurred
- Increase the number of severely dependent drinkers taking up community detox programmes in the community.

These service changes will be underpinned by an Alcohol Strategy.

The pathway comprises:

- Self Care / Guidance - A citizen's portal will provide information and signposts to further help. Media campaigns and targeted social marketing will be prioritised early. Evidence based programmes targeting those at risk would complement the existing generic information currently provided as part of the local PSHE Curriculum in schools
- Screening and Case Finding - Validated tools to screen for alcohol misuse are well known and well developed. Primary Care (GPs and Pharmacists) could deliver screening to provide early detection of alcohol related problems and could regularly review their practice populations to identify high risk individuals. Key gateways into the hospital (Emergency Department, Day Surgery, Outpatients, Emergency Admissions Unit and Gastroenterology) will screen opportunistically in key target audiences. A care bundle approach will be used to ensure patients are not repeatedly assessed but are offered appropriate interventions.
- Brief and Extended Interventions - once screening has been completed practitioners will offer brief advice and / or will refer to specialist services. Rapid response to referrals post screening will be achieved through increasing the capacity of the Hospital Alcohol Liaison Service and ensuring expertise is built into the future IAPT services.
- Community Detox / Relapse Prevention - Increasing the amount of screening will lead to an increase in the number of alcohol dependent patients identified for community detox. A consistent referral route will be implemented, which will enable capacity to be better utilised and will increase the amount of detox completed in the community. On completion of a detox, relapse prevention programmes will help support the client and family to adapt and maintain abstinence, thereby reducing the risk of readmissions and alcohol related morbidity. These programmes are delivered in groups by a multidisciplinary team. They address psycho-social elements of treatment and care.

Benefits include:

- Demonstrable behaviour change as a result of targeted social marketing
- Increased awareness across key stakeholders e.g. teachers, police
- Increased brief and extended intervention from targeted screening and case finding Early identification and intervention of alcohol related conditions
- Increased choice
- Reduced pressure on hospital, with reduced admissions and length of stay
- Improved understanding of how broader policy initiatives on pricing and access to alcohol influence demand
- Greater integration of services, particularly with Primary Care and Third Sector
- Leadership and operational guidance from professional champions

1.3.1 The Financial Case

The recurrent revenue cost for this OBC by 2015 (at 2015 prices) is £530,000.

Implementation costs total £52,000 over the period 2013-2015.
The service will require an additional 6.80 FTE.

As a result of the planned investment it is anticipated that an estimated annual cost containment of £264,000 (by 2015) could be achieved, which comprises (by Q2, 2015):

- Reduction in the number of admissions to the General Hospital with alcohol related conditions
- Reduction in the number of clients requiring Detox in the General Hospital

1.3.2 Implementation Actions and Timescales

	2012				2013				2014				2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Public Consultation Alcohol Strategy																
Agree alcohol related activity in QIF																
Commissioning priorities																
Establish Citizen's Portal																
Create leadership team																
Roll out pathway in Hospital																
Alcohol Liaison Nurse recruitment																
Workforce development																
Recruit to Community Alcohol Detox																
Begin brief / extended interventions in Primary Care																
Strengthening Families Programme																
Alcohol specific School Prevention Programme																

1.4 Stakeholders, risks, issues, dependencies and enablers

1.4.1 Stakeholders

The OBC was produced by a Working Group comprising Dr Susan Turnbull (SRO), Andrew Heaven (OBC Lead), Claire Farley (HSSD Public Health), Marie Leeming (HSSD Adult Mental Health Services), Michael Gafoor (HSSD Alcohol & Drug Service), Jane Finlay (HSSD Alcohol Drug Service), Dr David Bailey (General Practitioner), Dr Miguel Garcia-Alcaraz (HSSD Consultant Psychiatrist), Jason Wyse (Silkworth Lodge), Vanessa Furness (HSSD Alcohol & Drug Service), Sarah Barry (HSSD Alcohol & Drug Service), Dr Christina Montes (HSSD Adult Mental Health Service), Jill Birbeck (HSSD Health Intelligence), Ian de la Cour (HSSD Finance Department) Ann Kelly (HSSD Children's Services), plus external advisor: Dr Julia Sinclair, Consultant Psychiatrist

Stakeholders to be engaged as the OBC develops into an FBC include Michael Gafoor (HSSD Alcohol & Drug Service), Jane Finlay (HSSD Alcohol Drug Service), Dr David Bailey (General Practitioner), Jason Wyse (Silkworth Lodge), Chris Dunne (Director Adult Services), Ann Kelly (HSSD Children's Services) and representatives from the Shelter Trust, Primary Care Body and Alcoholics Anonymous.

1.4.2 Risks and Issues

Key risks and issues include:

- Low GP participation in screening if not suitably incentivised
- Failure to assemble senior clinical team to jointly lead the pathway
- Failure to provide the necessary skills and expertise for IAPT practitioners to deliver brief / extended interventions
- Recruitment and retention of appropriate staff
- Staff reticence to develop new ways of working or models of care, and/or to engage with individuals who have alcohol issues, provide brief advice and refer on
- There is no existing containment strategy for drunk and incapable vulnerable people.
- Existing hospital workforce are reluctant to discuss alcohol issues with patients

1.4.3 Dependencies

- The endorsement of the Draft Alcohol Strategy
- Revision of the Alcohol Licensing Law
- Third Sector provision

1.4.4 Enablers

The development of health lifestyles (alcohol) will require workforce training, development and ongoing support. IN addition, the Social Security Department review of short-term incapacity allowance will consider replacing this benefit with a statutory requirement for employers to pay sickness pay. Primary Care legislation and payment systems are also enablers to new ways of working.

1.5 Next steps

- Continue engagement with stakeholders, including Third Sector and Primary Care
- Develop detailed service specification, impacts, outcome measures and metrics
- Consult the public on the proposed Alcohol Strategy
- Work with the Primary Care Commission and Primary Care Body to agree payment and incentivisation (QIF)
- Complete the Full Business Case, including developing detailed service design.

2 Introduction and background

2.1 A Global challenge

Every health and social care system is experiencing similar challenges:

- Demographic change is dramatically increasing demand on all health and social care systems.
- Technological advances are allowing efficiency and quality improvements but also creating major new costs.
- Societal change is altering the relationship between services and service users, professionals and the public and between the state and individuals.
- Increasing regulation in health and social care is increasing quality but also reducing freedom to act atypically.
- Service ethos is shifting from treatment to prevention and promoting independence.
- Health, social care and Third Sector partners and multi-agency teams need to work closely with one another and with patients, service users and carers to provide tools and evidence-based services aimed at managing demand, promoting health and wellbeing, ensuring equality of access and protecting / safeguarding vulnerable people. Our aspiration is to enable people to be cared for in the most appropriate place, living as productive and independent lives as possible.

2.2 The Challenge for Health and Social Care in Jersey

Jersey is experiencing many of the same challenges as all other health and social care systems internationally, but it also has some unique challenges.

A small island

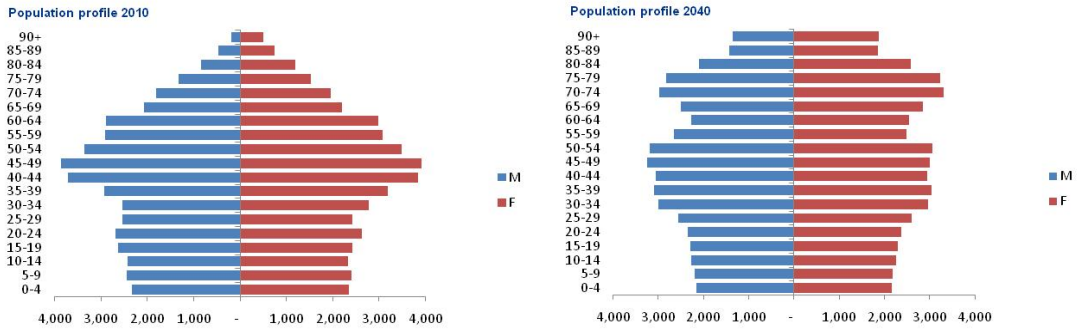
In normal circumstances our population of just under 100,000 would be considered too small to support comprehensive acute hospital services and very specialist social care services – this would normally be provided for a population of over 250,000. However, geographical isolation and infrequent but material travel difficulties mean that providing a significant level of acute and emergency services locally is essential, and that it is desirable to provide local care packages for people with complex needs.

Accordingly, the unit cost of delivering hospital and social services in Jersey is higher compared with systems serving larger populations. This is because the fixed costs of key services such as Accident and Emergency, intensive care, and secure residential accommodation, which are still necessary to support relatively low levels of activity. This, along with the cost of living (including the cost of land and buildings) in Jersey leads to an additional funding “premium”, which increases unit costs. Secondly, it can produce vulnerable services due to workforce models, particularly in the medical workforce, which are relatively light, highly reliant on very small numbers of individuals and where the achievement and maintenance of specialist skills is difficult given relatively low patient numbers.

2.2.1 Demography

Given immigration controls the population of Jersey is rising only slowly. But it is ageing rapidly. Over the 30 years from 2010 to 2040 the numbers of residents over 65 is projected to rise by 95%; in the period to 2020 the increase is projected to be 35%. This demographic change will create a huge surge in demand for health and social care services which will overwhelm the current capacity of the existing services.

Fig 1. Demographic change in Jersey



Within 5 years, the current numbers of hospital beds, operating theatres, residential and nursing care beds and other key community services will be inadequate to meet demand. These services therefore need to be expanded, supplemented and/or changed urgently to ensure that services can be safely and sustainably provided for the growing elderly population.

2.3 Strategic Principles

The vision of services which are safe, sustainable and affordable was distilled into a set of strategic design principles in late 2010. These were developed by stakeholders across health and social care, and ratified by Ministers:

- Create a sustainable service model – efficient, effective, engaging the public in self-management and with consistent access and thresholds
- Ensure clinical/service viability – overcome the challenges of low patient volumes, delivering high quality care and minimising risk
- Ensure financial viability – reduce the impact of diseconomies of scale, with value for money, an understanding of the costs of care in Jersey and robust procurement
- How should we fund health and social care? – establishing a charging model that incentivises care and cooperation
- Optimising estate utilisation – ensuring the estate is fit for purpose and utilised to maximum efficiency
- Workforce utilisation and development – supporting and utilising the workforce to the best of their abilities
- Clinical governance – sustaining a culture of safety, learning and transparency
- Use of business intelligence - with robust data to support decision making based on fact, and including patients and the public in service design and decision making

Service principles and assertions:

- Social care and health should be integrated as seamlessly as possible on a service user's/patient's life journey, with teams of social care, home care, medical, nursing, occupational therapy, psychology and other staff working together, working with the third sector and private sector providers
- Integration will be supported by an organisational and professional mindset that puts people first and at the centre of decision making about their care package, and ensures that needs drive services and not the reverse, to improve emotional, social and health wellbeing.

- Single, integrated care pathways, single assessment and a move towards personalisation and needs driven care will provide choice and empowerment. At present, complex services are provided by a multiplicity of providers, teams and professionals with different referral and access points, assessment frameworks, eligibility criteria and pathways. Simplifying and standardising the current range of approaches will improve co-ordination, providing a holistic, streamlined service which provides support, enablement and choice of care setting for older people and support for their carers.
- Services should be planned and delivered within partnerships brining together all sectors of our Islands community and economy
- Where appropriate, service provision should move away from residential care and institutionalisation within social care towards an increase in community provision to allow service users to integrate and lead independent and productive lives as much as possible.

2.4 Stakeholders and public opinion

Between November 2010 and April 2011 a number of stakeholders were interviewed to ascertain their views on the future for health and social care. The key themes were:

- The development of an overall strategic plan as an overarching context for the development of the above is essential. This should address any changes required in the structure of services and relationships between them, as well as future funding mechanism to ensure the changes in service provision required will be delivered
- There is a groundswell of appetite for change
- Considerable scope exists for improvement in the coordination, collaboration and communication between different services and service providers
- Some gaps in service provision exist
- Elements of the operational infrastructure would benefit from strengthening. This includes improved mechanisms for data collection and distribution, recruitment and retention of key staff, and improvement and better use of estate

2.5 Results of the Green Paper consultation

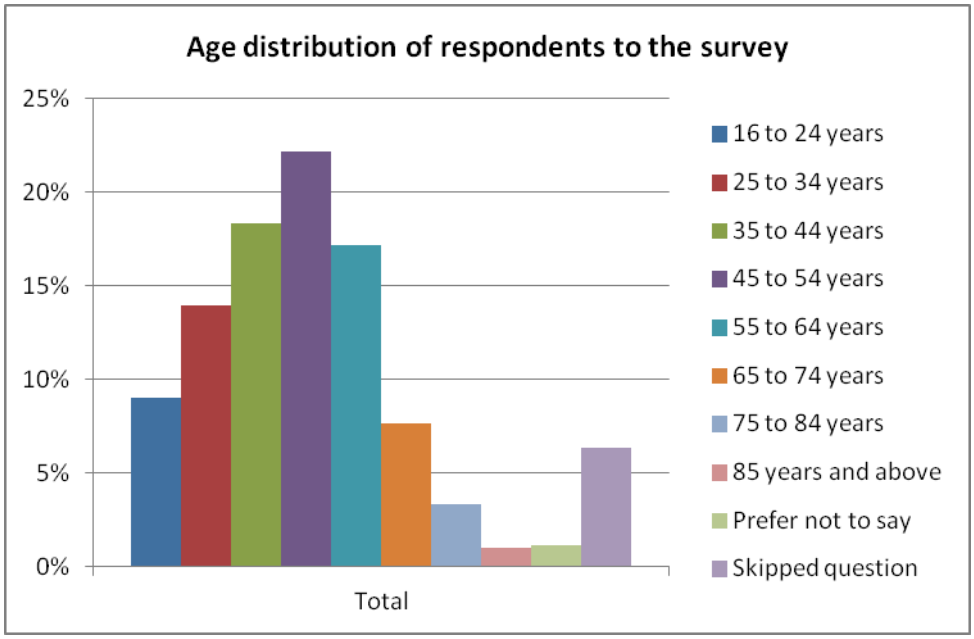
Between May and August 2010 HSSD consulted on the Green Paper 'Caring for each other, Caring for ourselves'. More than 1,300 Islanders responded to the consultation. The response was overwhelmingly in favour of redesigning health and social services so that they continue to be safe and affordable for the future (86%), and many respondents included detailed comments and viewpoints.

The Green Paper sought views on three scenarios for the future of health and social care:

- Scenario One: "Business as usual" – services continue to be provided in the same way and through the same structures as in 2010; spending increases to meet growing demand.
- Scenario Two: "A small increase in funding" – the funding allocation does not increase. Services have to be prioritised within this budget and many services will be subject to 'means testing' or will be stopped.

- Scenario Three: “A new model for health and social care” – prioritised changes to service delivery, to ensure health and social services are safe, sustainable and affordable and are able to meet projected increases in demand.

Responses were received from across all age groups. 69% of responses were received from individuals; 17% from organisations, such as Family Nursing and Home Care, dDeaf Awareness Group and Mind Jersey. More women than men responded.



Responses

The overwhelming message from the consultation was the positive views of Islanders about their health and social services. The majority of the respondents believe it is very (81%) or fairly important (16%) to continue providing a wide range of health and social care services on island. The remaining questions elicited the following responses:

- The majority find it very important (82%) or fairly important (16%) that in future these services are free, or affordable, and available to all.
- The vast majority of people (90%) agreed that “The States should ensure that preventing ill health is as important as curing ill health”. Some people felt that a large benefit could be gained from this area in the long term, whilst others were not sure whether this would be possible.
- Mixed views were received regarding having “responsibility for your own health” – whether this was for longer waiting times or increased charges for people who choose not to look after their own health. In particular, there were concerns about “self-inflicted” injuries or illnesses. Some respondents argued that it was not always possible for everyone to look after themselves and that vulnerable, ill or disabled individuals should not be disadvantaged.
- Most respondents agreed that “People should be able to live in their own home for as long as possible, providing they have the right health and social care support from the States of Jersey, the Third Sector and parishes.
- The vast majority of people (90%) agreed that “Instead of going to a hospital doctor or GP, I would be happy to be seen by a nurse, a pharmacist or other care

professional, for appropriate minor procedures such as measuring blood pressure or monitoring my diabetes."

- Most respondents said they would welcome qualified nurses working with GPs to free up their time, but others were not in favour of nurses doing what they considered to be the work of a GP. Some respondents commented that the GP system in Jersey was already very efficient and they were concerned about damaging patient-GP relations, and others were concerned about the cost of Primary Care to individual patients.
- Respondents also indicated that off-island travel was acceptable for some treatments. Some respondents would rather not have off island treatment, whilst others felt that going away for care to be inevitable on a small island like Jersey. Respondents also expressed views on whether patients should travel off island to see a doctor, or whether doctors should visit Jersey to treat patients.
- Professionals working together to deliver better integrated care was important, but some respondents noted that Jersey's charities should receive more funding and support.
- The vast majority of respondents thought that health and social care should be accessible and affordable, if not free, to all. However, there was a range of views about who should fund this care, and how.
- The need for affordable care was often stressed, and many respondents felt payment and funding needed to be explored in more depth.
- Most respondents said that those who cannot pay should still enjoy high quality health and social care. Opinion was then split about whether the amount of free care available for each person should be capped, with respondents expressing concern about the costs of care for people with long term illnesses and whether they would be able to pay.
- Some respondents commented that if health and social care was capped, for some conditions or for all, this should be means tested. However, others disagreed with means testing and felt that if someone had worked all their lives, they should have as much right to free care as others.
- Some respondents felt it would be fair that those who had lived in Jersey all their lives received free access to treatment – but that people who have not paid into the system should not enjoy the same benefits.
- According to many respondents, significant numbers of people visit the Emergency Department rather than seeing a GP because there is a charge associated with the GP, while a visit to the Emergency Department is free. The majority agreed that if a charge applied to visit the Emergency Department for treatment of a minor condition, they would be more likely to go to see their GP. Many also suggested that GP consultation costs should be reviewed at the same time as Emergency Department costs.
- Many respondents felt that there are opportunities to improve current system. Suggested ways to improve efficiency included reducing bureaucracy in health and social services, improving communication between organisations and bringing in more third party and profit making organisations to provide care.

2.6 Development of the Outline Business Case

This Outline Business Case (OBC) presents the case for change for the alcohol pathway. It explains, within the context of current and future safety, sustainability and

affordability and against the strategic principles agreed by Ministers in late 2010, the reasons why 'do nothing' is not an option.

The OBC was developed by a Working Group between August and November 2011. Between November 2011 and March 2012, significant work was undertaken with Treasury to ensure that financial projections are within an indicative cost envelope and sufficiently detailed and accurate for the Medium term Financial Plan submissions in Summer 2012.

The OBC outlines the preferred priorities that have been identified by the Working Group in connection with the proposed new service being introduced, referring to the three Scenarios outlined in the Technical Document and Green Paper. It presents an outline cost/benefit analysis of the options.

The OBC then outlines the features and timescales of the proposed service changes and assesses the potential impact against a range of factors, including workforce, cost and quality.

This OBC has been prepared by Andrew Heaven, Head of Health Improvement, with Susan Turnbull, Medical Officer of Health as Senior Responsible Officer, after consultation with service providers, Third Sector organisations, service users and carers.

3 The Preferred Option

3.1 The Service Case

International evidence

Modern approaches to alcohol misuse have moved away from episodic management often characterised by periods of time where the patient was not in contact with any services. Best practice emphasises the maintenance of periods of wellness, with rapid support provided when exacerbations occur. For example in Manchester the Mental Health and Social Care Trust have developed an integrated pathway which is multi agency and is consistent with this model. Similar initiatives can be seen in other regions.

Despite excellent individual practice, local alcohol services do not appear as consistent with national guidelines and models as they could be: For example there are:

- No consistent approaches to alcohol screening within Primary Care or secondary care, despite recent audit figures showing Jersey has the second highest rates for admissions due to alcohol when compared with UK regions.
- High rates of emergency detox within the hospital. This type of detox carries more risks for the service user and is 2.5 times more common then a community detox.
- Only limited capacity to provide psycho- social support and counselling within the Alcohol and Drug Service.

3.2 Current Services in Jersey

Islanders have high alcohol consumption - an average of 13.9 litres of pure alcohol each, per year (the UK consumes 11.2 litres). This equates to 26.7 units a week for every person over 16 years[11].

The JASS survey 2010[12] reported that approximately 11,000 people would meet the criteria for an intervention to reduce their alcohol consumption. Of those around 7,300 would require a brief intervention or extended interventions whilst a further 3,700 would require intensive treatment for their alcohol dependency.

Published best practice[13] indicates that 20% of dependent drinkers should be using alcohol services. Below 10% is considered to represent a poor level of access. Currently Jersey has approximately 7% of its dependent drinkers accessing services.

High levels of alcohol consumption lead to increased health risks and increased demand on health and other statutory services[14][15][16].

Clinical services that already identify and treat alcohol related problems are mainly based in Primary and Secondary Care. Specialist support to these services is provided by the Alcohol and Drugs Unit based at Gloucester Lodge.

[11] Medical Officer of Health Report: 2009: Our Island Our Health: Public Health Department
[12] Jersey Annual Social Survey: 2010: States of Jersey Statistics Department
[13] Alcohol Concern 2010 Making Sense of Alcohol
[14] World Health Organisation: 2010: Effectiveness and Cost Effectiveness of Policies and Programmes to Reduce the Harm Caused by Alcohol.
[15] Institute of Alcohol Studies: 2006: Alcohol in Europe, A Public Health Perspective. A Report for the European Commission.
[16] The Academy of Medical Science: 2004: Calling Time, The Nations Drinking as a Major Health Issue:

Different types and models of social and psychological support are provided by range third sector organisations. These include services which provide residential based support such as;

- Shelter Trust currently offer a 'Drunk and Incapable Unit' which has four single units which are available 24/7 for those people who are in crisis and still drinking. This capacity is essential to continue to offer a place of safety that is appropriate and a diversion away from a hospital environment. The Trust also offer other accommodation to clients as part of a tiered recovery out of homelessness.
- The Jersey Addiction Group runs a registered 12 bedded residential centre at Silkworth Lodge and Margaret House. It is commissioned by H&SS to provide residential relapse prevention beds.

There are also a range of community based support groups which can be accessed locally, including:

- Alcoholics Anonymous - group support towards abstinence
- Al-Anon - a support group for the relatives and friends of alcoholics.

There are a number of challenges:

Service design principle	Challenges of the current services
Create a sustainable service model	• Pressure on acute services - Over 250 alcohol-related emergency admissions in 2008, with 28% being discharged within 24 hours and 11% requiring admission with length of stay > 11 days • During 2008/9 the hospital had a higher rate of alcohol attributable admissions compared to other regions[17] • During 2008/9 Jersey experienced 30-50% more deaths then would be expected from chronic liver disease than England and Wales[18] • Approximately 200 hospital based alcohol detox in 2010, plus 50 community detox • Logistical challenges for the hospital during Friday, Saturday 7pm – 12am from intoxicated people presenting in the Emergency Department • At least 97 service users used the Drunk and Incapable Unit provided by the Shelter Trust in one year • Anecdotal evidence suggests that Nursing staff feel under-equipped to address alcohol issues. As a result there is limited uptake of screening and referral to the Alcohol and Drug Service from the Hospital • Only 7% of dependent drinkers are in contact with alcohol services - best practice is 20% • Social Policy does not address the high level of alcohol consumption at a population level, e.g. price, access and promotion • Population-wide messages about safe drinking levels are confusing with only minimal resources available to promote safe drinking • Alcohol Licence Law (1973) is out of date and not fit for purpose e.g. it does not acknowledge the harm caused by alcohol and in so doing reduces opportunity for prevention • Personal Social Health Education in schools is not compulsory; the Healthy Schools Programme is voluntary • School education on alcohol is predominantly knowledge based. There are limited targeted evidence-based programmes which include parental involvement, which could be effective in delaying drinking

17 Jersey Public Health Department: 2012: Health Profile – Jersey 2008/9: Public Health Intelligence Unit
18 Jersey Public Health Department: 2012: Health Profile – Jersey 2008/9: Public Health Intelligence Unit

Service design principle	Challenges of the current services
Ensure Clinical/service viability	• Anecdotal evidence suggests that Nursing staff feel under-equipped to address alcohol issues • Limited visibility of alcohol advice provided in Primary Care • Services are predominantly hospital-based • Limited integration of Third Sector providers within a pathway • Limited opportunistic alcohol screening and co-ordination across health and social services for the treatment and management of patients with alcohol misuse • Limited scope for therapeutic interventions whilst an individual is intoxicated, as the overriding need is to provide a place of safety. This can result in an admission
Ensure financial viability	• On average a hospital detox costs c£2,500. A community detox costs c£570. It is estimated that 250 detox were completed in 2010, 200 of which were completed in a hospital setting[19] (at a total cost of c£500k. It is likely that a proportion of current hospital detox could have been completed in a community setting • In addition to Alcohol Detox activity, the hospital treats a growing number of alcohol attributable diseases Based on 2010 figures and Personal Social Services Research Unit costings it is estimated that the hospital spends approximately £2 million on alcohol attributable conditions per annum[20][21] • The Social Security Department estimates that in 2010 there were 63 alcohol specific individual claims for benefit; 20,713 payment days at a cost of £353,870 • Silkworth lodge receive an annual grant of £222,200 from HSSD for providing 8 residential alcohol rehabilitation beds as part of a relapse prevention programme

[19] Detox activity taken from existing Alcohol Liaison Service and Adult Mental Health Service. Unit costs developed by H&SS Finance Department
[20] Estimated average Hospital activity is based methodology developed by Personal Social Services Research Unit at the University of Kent on behalf of Department of Health
[21] Estimates of hospital activity related to attributable and specific fractions were generated from methodologies developed by North West Public Health Authority

Service design principle	Challenges of the current services
Optimising estate utilisation	• Current lack of integrated planning for alcohol related services in community settings puts pressure on the hospital • Clinical audit shows that over 250 alcohol-related emergency admissions in 2008, with 28% being discharged within 24 hours and 11% requiring admission with length of stay > 11 days • Service activity estimates that 200 hospital detox episodes in 2010, of which a proportion of these will be presenting as an emergency
Workforce utilisation and development	• No senior clinical champion • A common view that alcohol misuse is a specialist area • Anecdotal evidence suggests generic nursing staff feel under-equipped to address alcohol issues
Clinical governance	• Anecdotal evidence of unwarranted variations in prescribing during alcohol detox, both in the community and hospital setting • Alcohol is regularly part of a patient's clinical condition but its identification, treatment and management are unlikely to be being addressed adequately due to unclear pathway for onward referral • No clinical champion • No consistent, evidence-based pathway • Limited service integration and joint working • Limited co-ordination and communication • Limited visibility of services provided and outcomes achieved in Primary Care • Limited visibility of services provided and outcomes achieved by Third Sector providers
Use of business intelligence	• Primary Care activity data (treatment, diagnosis, brief interventions) regarding alcohol related conditions is either unknown or difficult to estimate • Limited service level reporting on alcohol across acute services • Underreporting of alcohol on death certificates due to stigma means that attributable mortality is likely to be an underestimated

3.3 Description of Service

The aim is to increase access to alcohol services from the current level of 9% towards 20% by 2015[22]

Alcohol services will be based on two principles; prevention and early intervention.

NICE guidance[2324] and other key documents have been used to develop the pathway, and existing provision and activity have been reviewed in order to assess the future capacity required.

There will be a move away from episodic including emergency management and towards an approach akin to chronic condition management, which has an emphasis on maintaining wellness and responding quickly to acute exacerbations.

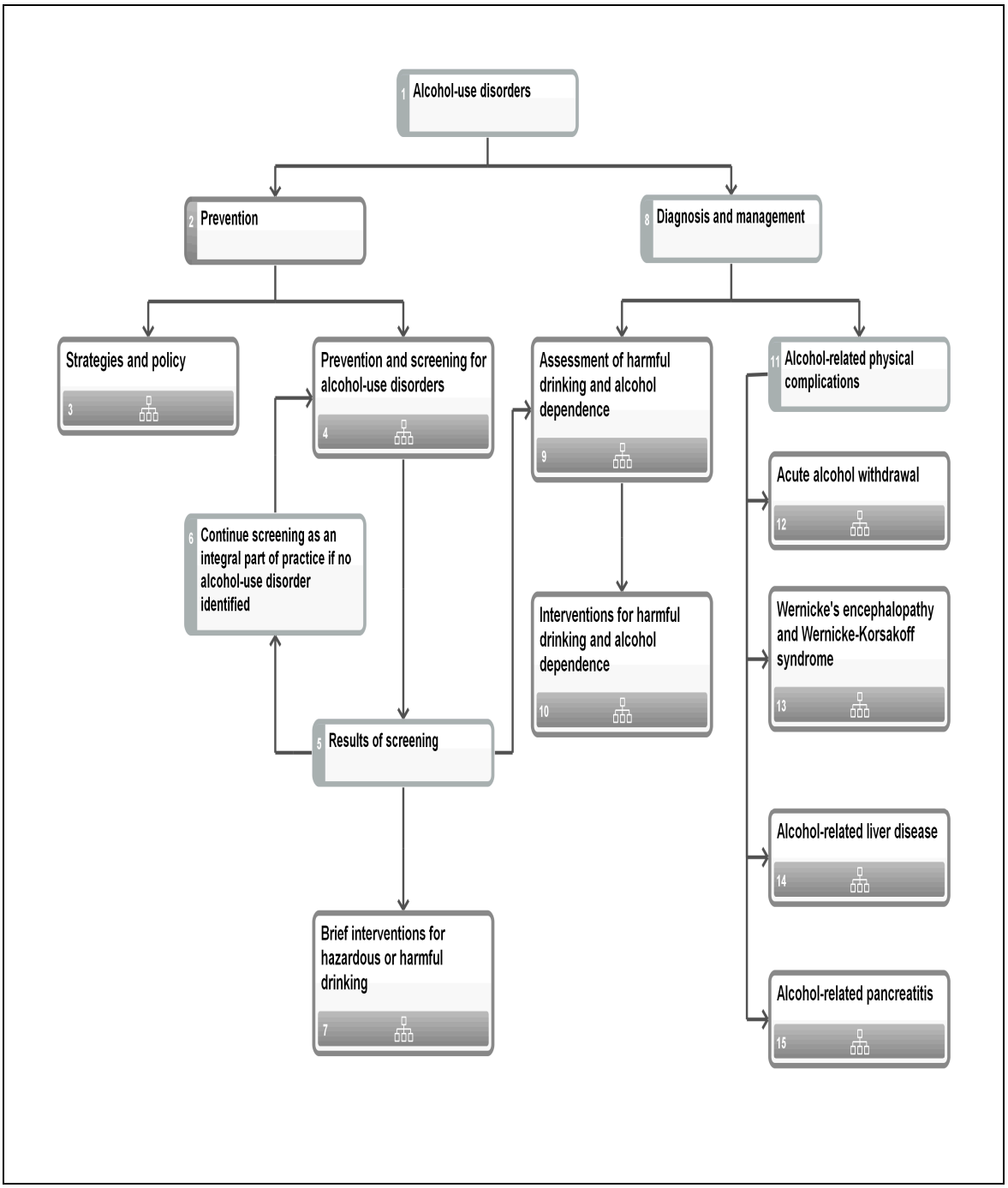
The alcohol pathway places an emphasis on a collaborative and consistent way of working by those practitioners and services that have a part to play in responding to alcohol misuse. The interventions are informed by the evidence base, and the capacity of services outlined is informed by local health intelligence and/or national projections.

This will lead to a more effective and efficient response to reduce harm caused by alcohol. It will also produce wider social and economic benefits, for example by improving community safety through reduced antisocial behaviour, domestic violence and alcohol related road traffic incidents

Establishing an alcohol pathway will require extending the role of some key stakeholders who would provide both a coordinating and leadership role. Development of the pathway and future commissioning will be informed by improved activity data and analysis provided by the Public Health Intelligence team.

[22] Rush,B: (1990) A systems approach to estimating the required capacity of alcohol treatment services: British Journal of Addiction: (85) p49 – 59:
[23] Guidelines on Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence Volume 1 -3: NICE
[24] Public Health Guidance 24: (2010): Alcohol-Use Disorders; Preventing the Development of Hazardous and Harmful Drinking: NICE

Summary of Alcohol Pathway



3.3.1 Self Care / Guidance

Awareness raising and information: Individuals will be supported to make informed choices about their alcohol consumption. Information and education material regarding alcohol consumption and associated risks will be provided through a variety of communication channels and will format on areas such as fitness, exercise, and nutrition and other risk factors e.g. alcohol and smoking. The citizen's portal will provide appropriate self help information and signposting. It will include clear referral points to assist families and carers in seeking professional help, support and advice in a timely and appropriate manner.

Media campaigns and targeted social marketing will be included in the citizen's portal, but will be initiated ahead of the portal's development and launch.

Branded materials ill be developed, which will also be used by universal services as part of a guided self-help programme.

Targeted Prevention: The pathway will include two evidence based targeted prevention and early intervention programmes:

- Aimed at year 8 children, and would complement the existing PSHE curriculum
- Familial intervention, working with children who are known to misuse alcohol and have been in contact with police, parish and police services.

3.3.2 Screening and case finding

Community health and social care services and Primary Care practitioners, including GPs and Community Services such as Community Contraceptive Services and Brook will be asked to extend their services to screen and offer brief advice, as well as to provide onward referral to specialist community services. This screening will be targeted at groups who are at risk initially.

General Practitioners could be incentivised to profile and casefind patients within their practice population. The GP will follow a protocol (which forms part of a wider alcohol pathway), for administering subsequent interventions. This will include handing out alcohol related materials, providing brief advice and/or referral to the alcohol liaison team for extended interventions and other levels of support.

Key gateways into the hospital (Emergency Department, Day Surgery, and Outpatients, Emergency Admissions Unit and Gastroenterology) will screen opportunistically for alcohol misuse in key target audiences. A care bundle approach will be used to ensure patients are not repeatedly assessed but are offered appropriate interventions as they pass through different parts of the hospital service. Practitioners will provide brief interventions or onward referral depending on the outcome of screening.

Fundamental to all the activity described is the ongoing training and support for professionals. Cascade models of training will keep staff informed and supported in the delivery of the pathway. A lead GP will ensure an ongoing programme of CPD is available, in order to support GPs to participate effectively in the pathway.

3.3.3 Brief and Extended Interventions

Increasing the capacity of the Alcohol Liaison Service working in the hospital and ensuring expertise is built into the future IAPT services working in the community will help to provide a rapid response to referrals:

Alcohol Liaison Services (Hospital): At risk patients attending the Emergency Department will be screened using a validated tool. This will be supported by an enhanced nurse-led alcohol liaison team. Emergency Department practitioners will follow a protocol (which forms part of a wider alcohol pathway), for administering subsequent interventions, including alcohol related self help materials, providing a brief advice and/or referral on to the hospital alcohol liaison team.

Alcohol Liaison Services (Community): Patients who are identified as requiring extended interventions following screening in the community will be referred to the IAPT team. This team will provide structured short term interventions aimed at reducing the patient's alcohol consumption. If identified as dependent, individuals will be referred to community detox and relapse prevention team for ongoing management.

3.3.4 Community Detox and Relapse Prevention

Currently residential-based relapse prevention programmes are offered by Silkworth Lodge. These are not appropriate for everyone, and a wider choice will be developed.

The increased screening across primary, community and secondary care will lead to an increased number of alcohol dependent patients identified who will need community detox.

On completion of a detox, relapse prevention programmes will help support the client and family to adapt and maintain abstinence, there by reducing the risk of readmissions and alcohol related morbidity.

A community based multidisciplinary team will provide expert advice, treatment and relapse prevention programmes to support dependent and harmful drinkers in order to prevent hospital readmission and reduce alcohol related morbidity.

The team will support an enhanced programme of community detox and relapse prevention. These programmes will be delivered in groups and address psycho-social elements of treatment and care, including specific cognitive behavioural therapy. Social care support will also be provided.

By developing a more consistent referral route through the pathway existing capacity can be better utilised and more detox completed in the community. In addition, the team will include one HCA, providing dedicated low level support to the small number of users who consistently use emergency hospital services. A 'Strengthening' Families Programme' Coordinator will focus on early intervention for the young people who frequently use health services as a result of alcohol misuse.

It should also be noted that Silkworth Lodge are in the early planning stages of planning a community detox unit.

3.3.5 Activity Impacts

The table below summarises the estimated impacts on activity across the pathway[25]. The demand is based on approximately 12,000 people in the local population who would benefit from an intervention to reduce their alcohol consumption. Of these, approximately 4,000 people within the drinking population are estimated to be alcohol dependent and would benefit from specialist medical intervention. In addition around 4,700 would require a brief advice whilst a further 3,300 would require an extended intervention.

The table below estimates different levels of activity resulting from an integrated (pathway) approach to alcohol. The explicit intention is to increase access to alcohol services for harmful and dependent drinkers whilst also providing early intervention and guidance to those drinking at increased risk.

Service	Activity Impact
Self Care / Guidance	• Citizens portal receive over 4,000 unique visits for alcohol advice and guidance by 2015
Brief and Extended Interventions	• Brief advice offered to 2,000 individuals p.a across the pathway by 2015 • Extended interventions offered to 1,000 individuals in a primary care setting p.a by 2015
Community Detox / Relapse Prevention	• Reduce the number of individuals requiring repeated hospital detox by 2015 • Complete above 200 community detox a year by 2015. • Reduce alcohol and substance misuse behaviour problems during adolescence for 100 high risk families with children who misuse alcohol by 2015

3.3.6 Workforce Impacts

The table below summarises the estimated workforce impacts:

Service	Staff	Number	Comment (e.g. timing)
Leadership	Director of Alcohol and Drugs Service Consultant Nurse General and Acute Consultant time GP Lead	No change 1.2 FTE	In post GP and consultant time equivalent to 1 session a week backfill
Strengthening Families Project	Project worker	0.5 FTE	Evidenced based programme. Programme could be delivered by third sector

[25] Activity impact are informed by JASS 2005 and 2009 surveys which asked about alcohol consumption and GP attendance in the last year

Self Care / Guidance	Coordination	-	Specific content developed by key stakeholders
Screening and Case Finding	Existing Primary Care Capacity	-	GP existing capacity, QIF used to develop and incentivise activity.
Brief and Extended Interventions	Nurse GP practice based interventions will be provided by IAPT practitioners	1 FTE -	In hospital to promote brief interventions and assist with extended interventions and detox and to provide ward based alcohol specific coaching and training Workforce capacity to deliver extended interventions is contained within IAPT advanced practitioners.
Community Detox / Relapse Prevention	Nurse Practitioner[26] Social Worker HCA Admin support	2 FTE 0.6 FTE 1 FTE 0.5 FTE	Case management for detox, relapse and prevention, plus support and supervision of IAPT practitioners To support clients with multiple admissions Strengthening Families Programme'
Analysis	Data Analyst	-	0.5 FTE not included in this OBC – included as part of the IT & Informatics Cross Cutting workstream
TOTAL		**6.8 FTE**	

3.3.7 Infrastructure Impacts

Estates: Whilst no costings are included within this OBC it is acknowledged that the current premises used by Alcohol and Drugs Department are sub-optimal. The service would be considerably enhanced by new fit for purpose accommodation.

Information Technology: A robust Public Health intelligence system will be required to collate and analyse population level information. Establishing a GP central server will enhance this process.

Citizen Portal: From 2014, health and social care professionals, children, parents and families will access information via a citizen's portal. The citizens' portal will enable care to be designed by the individual and care professional, based on the individual's needs and, where appropriate, they choices.

[26] One nurse would develop special interest in young people

Commissioning: A more robust process and performance management process will need to be developed regarding existing Service Level Agreement. This will ensure that investment is securing value for money.

3.3.8 Service Delivery Benefits

Anticipated Benefits would include:

- Reductions in alcohol consumption in key target audiences. Young adults, particularly women are more likely to be drinking harmfully then other groups[27]
- Delay the onset and frequency of drinking of children in Yr 10 – currently and estimated 91% of children who have tried alcohol by the age of 14
- Reduction in repeat admissions and pressure on hospital beds
- Reduction in Emergency Department presentations
- Reduction in the number of patients with a length of stay > 10 days
- More consistent approach to medication during the detox period
- Reduction in alcohol-related criminal activity
- Improved access to a wider range of services, particularly in community settings and in Primary Care. These locations can be less stigmatising
- More informed lifestyle changes
- Support to Primary Care
- Support to Third Sector organisations
- Earlier identification of at risk drinking
- Clinical leadership, focus and support

3.3.9 Anticipated risks

Anticipated risks include:

- Reticence to change the service model, pathway or approach
- Reticence to provide screening and brief intervention
- Staff lack of confidence and / or knowledge, skills and experience
- Misalignment of incentives for Primary Care
- Lack of agreement from Third Sector providers regarding commissioning and provision – including outcome measure and metrics
- Lack of health intelligence on alcohol related activity. Demand may be under/over estimated, and this may lead to recruiting an inappropriate number or skill mix
- Limited alternatives to hospital out of hours (particularly on Friday and Saturday nights)

3.3.10 Dependencies and interactions

Continued commitment is required from the States of Jersey to adopt a population-wide alcohol strategy with clear objectives to reduce consumption. This, along with strong leadership and support from across health and social services, including Primary Care and the Third Sector, are essential dependencies.

Interactions exist with:

- IAPT Service - extended interventions following opportunistic GP screening will be delivered by IAPT practitioners who will also be delivering psychological therapies for mild and moderate depression and anxiety
- Existing Third Sector service providers:

[27] Number taken from JASS 2010 Survey

  - Shelter Trust currently offer 'Drunk and Incapable Unit' accommodation for those people who are in crisis and still drinking. This capacity is essential to continue to offer a place of safety that is appropriate and a diversion away from a hospital environment
  - Shelter Trust also offer more long term accommodation which are used by clients with alcohol problems and dependency and are progressing toward independent living
  - The current Service Level Agreement with Silkworth Lodge provides for 8 residential relapse prevention beds to be provided per annum
  - Silkworth Lodge are in the early stages of planning a community detox unit. The type of capacity that this type of facility should be considered further at FBC stage when more details are developed
- HSSD Business Plan 2012
- States Strategic Plan
- Medium Term Financial Plan
- Health and Social Services White Paper

Workforce:
Anecdotal evidence indicates that some professionals are reticent to provide alcohol screening and brief advice. This partly stems from a lack of knowledge and understanding, and partly because these services are seen as 'specialist'.

All professionals who may come into contact with dependent drinkers and at risk individuals will need to understand the alcohol pathway.

Clinical leadership, training and support will be required for all staff.

Estates:
As noted above, there are limited estates enablers for the new pathway.

Commissioning:
Robust mechanisms to monitor and quality assure the activity across the pathway will need to be in place so that performance and unwarranted variation can be addressed. Outcome measures and metrics will be agreed as part of the FBC process.

Population-level data collection will assist in identifying future need.

Strong commissioning, with clear objectives will be supported by accurate, timely data regarding service delivery and value for money.

Primary Care:
GPs are pivotal to screening, case finding, brief advice and the ongoing support of individuals who are dependent drinkers or at risk. This includes young adults and their families.

Metrics and payment mechanisms will need to be agreed for Primary Care. This may inform negotiations for a new Quality Improvement Framework.

IT:

Completing the GP Central Server Project is a key enabler to the alcohol pathway. It will allow monitoring of the uptake of screening and brief interventions across GP practices and will provide measurable anonymised population level data on morbidity.

The citizen's portal is also critical to increasing awareness and ensuring fast, easy access to information and signposting of services.

Informatics:
As noted above, population-wide information such as morbidity, mortality and needs will be important to commissioning.

Outcome measures and metrics will be agreed as part of the FBC, and will be collected, analysed and reported in order to assess the quality and value for money of services.

Legislation:
The Jersey Licensing law (1973) is scheduled to be reviewed and updated. This is necessary in order to help drive a reduction in alcohol consumption.

3.4 Financial Case

3.4.1 Revenue costs

The total additional recurrent cost for Healthy Lifestyles (Alcohol) increases to £530,000 by 2015.

The revenue cost is estimated to be:
2013 - £300,000
2014 - £435,000
2015 - £530,000

Implementation costs total £52,000.

Summary costs 2013 -2015	2013	2014	2015
	£'000	£'000	£'000
Implementation Costs	37	13	2
Recurrent revenue costs	300	435	530
Capital costs	-	-	-
TOTAL	337	448	532

6.80 FTE will be required to implement the changes proposed.

3.4.2 Revenue savings

An estimated cost containment of £129,000 will be achieved in 2014, with £264,000 by 2015. The cost containment estimates do not take into account of the wider benefits to the economy or other Departments that are associated with reducing alcohol consumption.

Evidence from the Quality Improvement Prevention Programmes[28] [29] in the UK suggests that on average there is a 5% reduction in hospital admissions for alcohol related activity. It is estimated that the current spend on alcohol specific and alcohol attributable admissions is approximately £2million a year. The forecast cost containment taken from the average 5% reduction is estimated at £52,000 in 2014 and £106,000 in 2015.

Evidence would support a modest reduction in hospital detox activity. Although the precise number is difficult to identify as some patients will require a hospital environment due to other health conditions. Any future revenue savings would be based on the average cost of community detox at £570 versus a hospital detox at £2,500.

In the longer term, further benefits can be expected from reductions in the long term damage caused by alcohol e.g. liver cirrhosis. Further work will be undertaken at FBC to understand the local impact of specific conditions on hospital activity.

3.4.3 Capital costs

None identified

3.4.4 Funding

It is likely that there will be a range of existing and new sources of funds which would support service development in this area. For example the Quality and Improvement Framework could incentivise GP activity, existing Service Level Agreements may be revised to reflect different ways of working and the Medium Term Financial Plan would support new and enhanced levels of service provision.

3.4.5 Sensitivity analysis - scenarios

Activity estimates are based on a number of assumptions. These will be further tested at FBC:

- The estimated amount of need is based on the JASS 2010 survey, which included a range of questions about alcohol consumption. This allowed an island wide prevalence to be estimated. However, the survey relies on self-reporting their consumption; this often underestimates actual consumption
- Estimates of hospital activity are based on UK consumption levels. These are lower than in Jersey, and therefore the hospital activity calculations are probably underestimated
- Coding for therapeutic Hospital Detox is rare as at present the need for Detox is identified as a result of the patient being admitted for another condition, often alcohol specific e.g. mental or behavioural issue related to alcohol.

3.4.6 Assessment of affordability and value for money

A wide range of savings are quoted in Quality Improvement Prevention Programme literature. It could be reasonable to expect the unique Jersey health and social care economy to exceed some of the average savings for the following reasons:

[28] British Society of Gastroenterology and the Royal Bolton Hospital NHS Foundation Trust: 2009: Alcohol Care Teams to reduce acute hospital admissions and improve quality of care.
[29] North West Public Health Observatory: 2008-9: The Economic and Social Costs of Alcohol –Related harm in Leeds 2008/9

- A robust, well-resourced pathway in a small definable health system, where constituent parts are known and able to be influenced, may perform better then a similar pathway as part of the larger NHS footprint
- Many of the regions where alcohol harm is highest have a socio-economic context of deprivation with marked health inequalities. The social context in Jersey is not one of overall deprivation, although some pockets exist. Therefore, returns on investment may be larger than in Beacon sites such as Liverpool
- An Alcohol Strategy, with evidenced-based population approaches to reduce consumption will further increase benefit and impact

3.4.7 Verification procedures and assumptions

Quality Improvement Prevention Programmes[30] [31] in the UK suggest that an average of 5% reduction in hospital admissions for alcohol related activity can be expected.

Assumptions have been informed by the specialist stakeholders in the OBC Working Group, a range of supporting publications and relevant local and national health intelligence.

All staff grading used in this OBC have been verified by appropriate line managers and Human Resources Department, and are comparable to existing employees in existing roles.

The development of the OBC also benefited from Dr Julia Sinclair Consultant, Psychiatrist from Southampton Medical School. Dr Sinclair is a Researcher / Academic and specialist in this area; she provided a 'critical friend' role, providing challenge, support and guidance. Dr Sinclair is familiar with Jersey's health and social care system, having led on our recent Suicide Audits.

[30] British Society of Gastroenterology and the Royal Bolton Hospital NHS Foundation Trust: 2009: Alcohol Care Teams to reduce acute hospital admissions and improve quality of care.
[31] North West Public Health Observatory: 2008-9: The Economic and Social Costs of Alcohol –Related harm in Leeds 2008/9

3.5 Implementation Actions and Timescales

	2012				2013				2014				2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Agree Alcohol Strategy																
Agree QIF																
Commissioning priorities																
Citizen's Portal																
Create leadership team																
Roll out pathway in Hospital																
Alcohol Liaison Nurse recruitment																
Workforce development																
Pilot Brief Intervention in Primary Care																
Begin Brief Intervention in Primary Care																
Recruit to Community Alcohol Detox																
Strengthening Families Programme																
Alcohol Specific School Prevention Programme																

4 Stakeholders

4.1 Stakeholder involvement in service model development

The preferred model for service development was identified over the course of three workshops in October and November 2011.

Follow-up discussions with key stakeholders outside the workshops allowed the model to be developed, reviewed and refined during the two month period.

Independent expert advice was received throughout the process from Southampton University Medical School.

Name	Organisation	Responsible	Accountable	Consulted	Informed
Michael Gaffoor	Alcohol & Drug Service	✓			
David Bailey	General Practitioner			✓	
Susan Turnbull	Medical Officer of Health		✓		
Marie Leeming	Adult Mental Health Services		✓		
Dr Miguel Garcia	Consultant Psychiatrist	✓			
Jill Birbeck	Public Health Department	✓			
Andrew Heaven	Public Health Department		✓		
Jason Wyse	Silkworth Lodge	✓			

A full outline of stakeholder involvement is presented at Appendix 6.5

4.2 Communications to Internal Stakeholders

Monitoring and reporting the performance of the alcohol pathway and enhanced service will be achieved through HSSD Corporate Directors.

Monitoring and reporting on metrics associated with General Practice will be completed by the Primary Care Unit and the Public Health Intelligence Unit.

4.3 Communications to External Stakeholders

A similar group of stakeholders would need to be engaged and be engaged and updated of progress during the initial FBC development. In the longer term a managed network approach, which included statutory and non-statutory services, would be developed to ensuring key external stakeholders were kept informed of key developments across the alcohol pathway. This will include summary activity for key parts of the pathway as well as opportunities for CPD and pathway revision and development.

5 Conclusion and Next Steps

5.1 Conclusion

Jersey consumes more alcohol than comparator jurisdictions. This leads to issues with crime, disorder and domestic violence and, longer term health issues such as liver cirrhosis. We are currently experiencing very high rates of alcohol related hospital admissions and our rate of alcohol specific deaths is almost twice that of the national average.

Services are currently not integrated; there is no agreed pathway for alcohol services.

There is also limited choice, with the majority of individuals accessing services in hospital. This puts pressure on acute services, both within the Emergency Department and on wards.

Some services are provided in Primary Care and by the Third Sector, however, data on activity and outcomes are not provided consistently.

The alcohol pathway will support consistent quality of care in the most appropriate setting. It comprises awareness and information, screening and brief advice, and detox in non-hospital settings.

The services need to be robustly commissioned, and delivered in partnership. Clinical leadership, clarity of roles and support to staff is also required.

5.2 Capacity and project management requirements

At present capacity to develop the FBC does not exist. Careful consideration needs to be given as to who should lead this stage of the process - to date the OBC has been developed by the Public Health Department, who are not specialists in alcohol services.

Capacity will also be required to implement the new pathway; this is intended to be secured by backfilling a medical role and employing a Nurse lead.

5.3 Next Steps

Continued stakeholder engagement is required in order to ensure the alcohol pathway is robust, deliverable and co-owned. This includes Primary Care and Third Sector organisations.

Existing Service Level Agreements need to be reviewed, with a view to ensuring consistency with future direction of services operating within the alcohol pathway.

QIF is being considered and developed as part of the Primary Care cross cutting workstream.

During 2012, the FBC needs to be developed. Detailed service specifications, outcome measures and metrics will need to be co-produced, working closely with stakeholders. These will then form part of the FBC, which will:

- Verify the continuing need for investment in the project

- Demonstrate that the preferred solution represents value for money
- Establish that the HSSD is capable of delivering the project
- Confirm that the planned investment is affordable
- Demonstrate that HSSD is capable of managing a successful implementation and subsequently sustaining success
- Provide an essential audit trail for decisions taken
- Identify how benefits will be realised and monitored
- Confirm the investment decision

The FBC will need to be approved and provide sufficient assurance to senior management that the service change can proceed and resources can be committed. The FBC is used as a reference point in the event of any business changes during the project lifecycle and in the event of a post project review or equivalent major review following implementation of the project.

Sign off by Minister
.....……

6 Appendices

6.1 Appendix 1 - Benefits Log

What is the benefit	Type	'One-off' or ongoing benefit?	How will the benefit be measured	What is the baseline (in 2010)	Target
Earlier identification of at risk drinking	Patient	Ongoing	Clinical Audit	215 individuals screened in hospital using validated tool in 2010	2,000 brief interventions across the pathway per year by 2015
Increase in number of referrals to Alcohol and Drugs Service that lead to Community Detox	Patient	Ongoing	• Number of referrals from General Hospital	135 in 2010 No baseline on bed days	Reduction in beds days p.a by 2015 2,000 people screened in hospital setting by 2015
Reduction in repeat admissions and pressure on hospital beds	Patient	Ongoing	Service activity monitoring	95 individual clients admitted into JGH in 2010	Reduction in individuals with more then five repeat admissions in one year
Reduction in Emergency Department presentations	Patient	Ongoing	Clinical Audit	Total of 252 alcohol related admission (2008)	No target set
Reduction in the number of patients with a length of stay > 10 days	Patient	Ongoing	Clinical Audit	11% admissions in 2008 stayed longer then 10 days (2008)	No target set
Reduction in the proportion of hospital detox compared with community detox	Patient	Ongoing	• Number of detox in hospital • Number of detox in community	200 hospital detox 50 community detox	No target set
Improved access to a wider range of services, particularly in	Patient	Ongoing	SLA activity monitoring	No baseline	No target set

community settings and in Primary Care			GP prescribing		
Clinical leadership, focus and support	Staff Client Service	Ongoing	• Integration of care across pathway • Improved clinical governance, communication and coordination • Reduction in clinical risk across the pathway • Nurses feel more supported, able to contribute to the pathway • Increased skills and increased motivation	Estimate 22 nurses completed substance misuse module in last two years	Increase capacity of workforce in hospital setting to assess and refer patients with alcohol problems
More consistent prescribing	Patient	Ongoing	Endorsed hospital and Primary Care prescribing guidance for alcohol detox	Monitoring of alcohol detox prescribing within hospital and General Practice	No data
More informed lifestyle changes	Patient	Ongoing	Number of unique visits to Citizens Portal	None	4,000 hits a year by 2015
Consistency of care, in accordance with local protocols	Staff Clients	Ongoing	Audit of compliance against pathway protocols agreed by Integrated	No baseline	No target set

			Governance Group		
Reductions in alcohol consumption in young adults, particularly women	Young People	Ongoing	Repeat health related behaviour Survey 2014	11% of 14-15 year olds drink alcohol regularly	Reduce percentage of children aged 14-15 drinking alcohol regularly to below 5% by 2015
Reduce sickness absence and long term incapacity due to alcohol	Clients Society Taxpayer	Ongoing	Social Security benefit payments Sickness payments	No baseline	No target set
Broadening of skillset across professions	Teams (both specialists and generalists) Other public sector teams e.g. police Clients Community	Ongoing	JASS Staff survey	No baseline	No target set
Reduction in alcohol related dementia (long term care)	Clients	Ongoing	Audit of care settings/hospitals Audit	No baseline	No target set

6.2 Appendix 2 - Stakeholder log

Name	Organisation	Responsible	Accountable	Consulted	Informed
Dr Tracy Wade	Psychology Assessment Department		✓		
Dr Carolyn Coverly	Children's Adolescent Mental Health Service		✓		
Dr Neera Watts	Community Contraceptive Service	✓		✓	
Jackie Boath	Brook Advisory Service			✓	
John Hodge	Shelter Trust		✓		
Hostel Manager	Roseneath		✓		
AXA Manager	States of Jersey Occupational Health (AXA)		✓		
Practice Managers	Individual General Practice			✓	
Jason Wyse	Silkworth Lodge			✓	
Mark Capern	Youth Enquiry Service			✓	
Jill Rattle	Occupational Therapy Department		✓		
Team Leader	Workwise / Jobscope			✓	
Manager	Women's Refuge			✓	

Manager	Samaritans			✓	
Dr Peter Bates	Diabetic Centre			✓	
	Alcoholic Anonymous				
Mike Cutland	Prison & Probation Service			✓	
Director MIND	MIND (Jersey)			✓	
Pam Massey	FNHC			✓	
Andre Bonjour	Police Service			✓	
Chief Ambulance Officer	Ambulance Service			✓	
Manager	Citizens Advice Bureau			✓	

6.3 Appendix 3 - Risk Log

No	Risk	Consequence	Probability L/M/H	Impact L/M/H	Risk timing	Risk owner	Action	Timing of action	Risk status
1. Scope of the change									
1.0	Limited alternatives to hospital out of hours (particularly on Friday and Saturday nights)	Lost opportunity to intervene	H	M	2013	SRO	Leadership team to review as part of pathway development	2013	H
1.1	Specialist service fails to work across Primary, secondary and Third Sector	Inconsistency of care	H	H	2014 Q1	SRO	Plan a staged roll out of service so that challenges can be identified early and resolved as service builds up its capacity Roll out hospital based pathway first and then progress to Primary and community settings	2014 Q1	M
1.2	Lack of support of multi-disciplinary teams for Strengthening Families Project	Limited preventive intervention	H	H	2013 Q1	SRO	Engage key stakeholders Set up a coordination group	2013 Q1	H
2. Plan and Timescale									
2.0	Failure to change referral pathways enough to make a difference between 2013 - 2015	Reductions in Emergency Department activity and length of stay fall below targets	H	H	2013 Q1	SRO	Ensure leadership team is able to champion and support key parts of the pathway development.	2013 Q1	H
3. Resources									
3.1	Underestimation of	Inadequate capacity	H	H	2014 Q1	SRO	Ensure assumptions behind estimates	2012	M

No	Risk	Consequence	Probability L/M/H	Impact L/M/H	Risk timing	Risk owner	Action	Timing of action	Risk status
	demand due to poor data	leading to increased waiting times, high DNA rates and poor treatment completion rates					for capacity are checked independently for errors		
4. Leadership									
4.1	Leadership team fails to offer a credible clinical force for change	Inconsistent and/or low use of pathway for screening and subsequent interventions	H	H	2014 Q4	SRO	Ensure most appropriate lead identified	2014 Q3	H
5. Commitment of staff									
5.1	Staff are reticent to change the service model, pathway or approach	Limited commitment to new way of working	H	H	2013	SRO	Leadership team to address as part of pathway development	2013	H
5.2	Generalist staff are reticent to provide screening and brief intervention	Limited commitment to new way of working	H	H	2013	SRO	Leadership team to address as part of pathway development	2013	H
5.3	Staff lack of confidence and / or knowledge, skills and experience	Limited commitment to new way of working	H	H	2013	SRO	Leadership team to address as part of pathway development	2013	H
5.4	Failure to engage key staff across	Low uptake of screening and brief	H	H	2014 Q1	SRO	Ensure key stakeholders are engaged in	2012 Q1	H

No	Risk	Consequence	Probability L/M/H	Impact L/M/H	Risk timing	Risk owner	Action	Timing of action	Risk status
	Primary, Secondary and Third Sector	interventions					full business case work up and roll out of workforce development training and broader communication planning		
6. Data and Information Availability									
6.1	Hospital activity remains poorly coded	Unable to measure impact on length of stay and/or reductions in Emergency Department activity	H	H	2014 Q1	SRO	Agree metrics, develop data collection systems	2013 Q1	M
6.2	Health intelligence capacity is not resourced	Key metrics and outcomes remain unidentified and unmeasured	H	H	2013 Q3	SRO	Ensure analyst capacity is increased	2013 Q3	M
6.3	Poor quality Primary Care data	Unable to profile alcohol misuse across practices and monitor alcohol screening activity	H	H	2013	SRO	Ensure GP Central Server is operational before 2014 with time for baseline alcohol misuse practice profiles to be established	2013	M
7. Implementation									
7.1	Insufficient project management capacity to lead implementation	Implementation and benefits delayed.	H	H	2012 Q1	SRO	Identify time specific project management lead	2012 Q1	H
7.2	Lack of agreement on QIF	Low take up of screening in Primary Care	H	H	2012	SRO	Include alcohol screening and brief intervention in QIF	2012	H
7.3	Lack of agreement from Third Sector	Unable to demonstrate good	H	H	2013	SRO	Need to develop clear metrics for success that will form basis for	2013	H

No	Risk	Consequence	Probability L/M/H	Impact L/M/H	Risk timing	Risk owner	Action	Timing of action	Risk status
	providers regarding commissioning and provision – including outcome measure and metrics	value to tax payer					commissioning		
8. Financial									
8.0	Smaller number of hospital detox are able to be managed in the community	Cost containment estimates fall below forecast	M	M	2014 Q1	SRO	Review and test current assumptions Ensure robust application of alcohol pathway	2013 Q4	M

6.4 Appendix 4 - Issue Log

No	Issue	Consequence	Issue owner	Action	Timing of action
1.0	No obvious access point for public information	Opportunity to self assess and self care lost	SRO	OBC includes investment for public information that allows independent and guided self help	2014 Q4
1.1	Services not connected and siloed in thinking and action	High risk of patients receiving inconsistent and suboptimal care	SRO	Develop a resourced pathway	Q1 2014
2.2	No capacity within Public Health to develop FBC	Slow progression towards developing FBC	SRO	Use of secondments and/or reshape resources	Q2 2012
2.1	Hospital activity difficult to access and poorly coded	Slow progression towards FBC with risk of inaccurate estimates relating to impact on service activity	SRO	Develop more sustainable approach to collection and analysis of hospital data Triangulate local estimates with near neighbours wherever possible	Q1 2013
3.1	Limited alcohol specific training exists for key parts of the workforce	Low level of skills and knowledge lead to reluctance to engage on alcohol issue perceiving it as a specialist area requiring other to intervene	SRO	Review workforce development needs as integral part of developing pathway Provide additional training, targeted to areas of highest need	2013 Q3
5.0	Historical reluctance by hospital clinical staff	Low number of referrals from hospital wards and	SRO	Recruit credible clinical lead	2013 Q1

No	Issue	Consequence	Issue owner	Action	Timing of action
	to address alcohol issues	no consistent screening attempted			
5.1	Historical reluctance by some General Practice to address alcohol issues	Low levels of referral to Alcohol and Drugs Services and variations in prescribing	SRO	Recruit credible clinical lead	2013 Q1
6.0	Poor data collection	Difficult to accurately assess baseline and future activity	SRO	Estimates using existing activity based on most reliable information we have, triangulated against UK data and activity where possible. Independent expert asked advice on assumptions behind key parts of service planning and activity estimates	2012 Q2
9.0	True cost of alcohol activity across health system difficult to identify	Baseline costs difficult to identify and judge saving/efficiencies from	SRO	Finance team need to use examples from other areas to check estimates of costs and efficiencies	2012 Q2

6.5 Appendix 5 - Enablers and dependencies log

Description of Dependency *(Is this linked to another OBC, Strategy or scheme?)*	**Dependency lead**	**Dependency 'Strength'**	**Comments**
IAPT Service - extended interventions delivered by IAPT practitioners	Chris Dunne	H	• IAPT is a new service and workforce will need to be trained in order to take on extended interventions,
Existing Third Sector service providers: • Shelter Trust • Silkworth Lodge • Silkworth Lodge plans for a community detox unit	John Hodge Jason Wyse	H	• No obvious previous strategy to commissioning in this area
GP Quality Improvement Framework	Susan Turnbull (MOH) Rachel Williams (Service Redesign)	H	• Incentivisation Primary Care • Develop Social Policy • Prioritise on MOH agenda
Pathway and protocols for alcohol related problems being developed and agreed	Dr Andrew Luska Medial Directors	H	• Needs to be undertaken jointly with all providers • Develop detailed service specification, outcome measure and metrics for commissioning • Monitor and report
Robust community service provision to cope with increased demand from increased screening	OBC	H	• Invest in workforce • Correct skill mix • Effective referral route • Based on evidenced models from UK
Alcohol awareness training for all - HSS, Primary Care, Third Sector	OBC	H	• Clinicians' variability in judgment of screening and intervention requirements • Increased training and awareness will increase

			consistency
Public awareness of service provision and how to access service, education – including citizen's portal	Policy campaigns Education/schools OBC	M/L	• Public expectation re: screening / questions from GP • Good opportunity to involve Third Sector in information provision
Accurate coding within Primary Care (EMIS), Hospital (TrakCare), Mental Health (FACE) to provide data for commissioning and contract monitoring	Madeline Simpson (Trackcare) Ronan Mulhern (FACE)	H	• Need accurate activity collection and coding • Health Intelligence Team to analyse data effectively
States Alcohol Strategy and policies required to increase accessibility, availability and affordability	Paul Bradbury	H	• Fundamental • Required for cultural and societal change
The Jersey Licensing law (1973) is scheduled to be reviewed and updated	Nathan Fox	H	• Progress is slow

6.6. Appendix 6 – Financial Analysis

Note: the costs shown in the table below, and throughout the document, have been inflated to reflect the relevant prices for each year.

Initiative title & resource requirements	Additional FTE required	Implementation date	Implementation costs £ (000)	2013 revenue £ (000)	2014 revenue £ (000)	2015 revenue £ (000)
Citizen's portal. Design and maintain website / portal to enable public to access self help materials and service information. Part of cross-cutting workstreams.	Included in IT cross cutting workstream					
Social Marketing. Integrated campaign to help 'at risk' drinkers.	Existing workforce	Jan 2013	11	5	5	6
Dedicated Leadership Team. To act as alcohol champions, to ensure alcohol policy is co-ordinated across H&SS and provide care co-ordination and case management to staff and users of the service.	1.2	Jan 2013 (begin recruitment); Jul 2013 (estimated start date)	10	102	178	182
Alcohol Liaison Service (Hospital). To provide support to A&E and hospital staff working towards prescribing.	1.0	Jan 2013		54	56	57
Alcohol detox and Re-lapse Prevention Team. To increase numbers of individuals treated for alcohol-related problems within the community. Benefits include a reduction in hospital admissions, a reduced length of stay and a reduction in emergency admissions.	4.1	Jan 2014 (begin recruitment); Jul 2014 (estimated start date), with 1 HCA starting in Jan 13	13	39	99	162
Screening in Primary Care. Extended 'Brief interventions' via GP's and in-house clinics - net cost of GP screening to be covered by Health Insurance Fund (HIF).	Existing workforce	Jul to Dec 2013 (50%); Jan 2014 onwards (100%)				

Initiative title & resource requirements	Additional FTE required	Implementation date	Implementation costs £ (000)	2013 revenue	2014 revenue	2015 revenue
Workforce Development. Ensure staff receive alcohol awareness training that promotes respect and non-judgemental care of people who misuse alcohol.	Existing workforce	Jun 2013	-	16	11	6
Education of Young People Delay the start of the consumption of alcohol for children aged between 11 and 15.	0.5	Jul 2015 (estimated start date)	2	-	-	29
Strengthen Families Project. This will be achieved through improved skills in nurturing and children by parents and improved interpersonal and personal competencies amongst young people, thereby increasing parenting skills, building life skills in adolescence and strengthening family bonds. This will reduce alcohol and substance misuse and other behaviour problems during adolescence.	Existing workforce	Jan 2014	16	-	-	-
Accommodation. Rental of GP rooms	N/A	Jan 2013	**-**	84	86	88
Total	**6.8**		**52**	**300**	**435**	**530**