

The Poor Relation - has the emphasis on 'localism'
really improved alcohol commissioning



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Alcohol Concern
Making Sense of Alcohol

Table of Contents

Summary	3
A guide to policies shaping alcohol services provision	7
Survey Results: Investigating the effect of local guidance on alcohol commissioning	11
Conclusions and recommendations	14
Appendix 1 Preliminary results from the Freedom of Information survey broken down by government office region	16

Summary

Most if not all of the decisions on 'whether', 'how much' and 'how' to spend on alcohol treatment are now made at the local level. The public health white paper, *Choosing Health*, published in 2004, set out a commitment to reduce health inequalities and better tailor health and care services to meet individual needs. It outlined action that individuals and organisations could take to make this a reality. Reducing harm, early identification and encouraging sensible drinking was one of six *Choosing Health* priority areas. However, the impetus for delivery at the local level would be decided by local commissioners, based on assessment of local need.

In order to deliver this agenda for alcohol treatment, starting in 2004 the Department of Health (DH) and the National Treatment Agency (NTA) released guidance to help local commissioners develop more integrated and effective alcohol treatment systems. The main toolkit within this set, *Models of Care for Alcohol Misusers* (MoCAM), establishes Primary Care Trusts (PCTs) as the primary commissioner and purchaser of alcohol services. Without central Public Service Agreement targets to reduce alcohol harm until 2007, further guidance such as *Local Programme for Improvements* from DH attempted to persuade PCTs that it could meet other national targets on reducing stroke, cancer and heart disease via alcohol treatment. However, DH has been powerless to insist that local alcohol treatment is either considered or provided, even where the need has been most transparent. This lack of strategic focus has meant that alcohol treatment provision at the local level has been left largely unplanned, under-funded and undervalued.

In the last 12 months, with the introduction of PSA targets 14 and 25, the new LAA indicator set and the NHS Performance Framework, DH have attempted to tighten the focus for commissioners, ensuring that alcohol related hospital admissions reduce by 1%. However, the central push to achieve this stems from an over-focus on Screening and Brief Interventions (SBI) for hazardous and harmful drinkers, with little mention of the value of alcohol treatment for dependent drinkers as part of an integrated system, in spite of the call for this in MoCAM.

In the absence of counter signals from DH and targets for dependency treatment, there is a risk that decentralisation, the SBI agenda and the NHS reform ideology may render MoCAM's call for integrated care obsolete before it has had a chance to have a positive impact.

This report, drawn from the results of a freedom of information survey carried out by Alcohol Concern between November 2007 and February 2008, examines the state of health of alcohol treatment commissioning among PCTs in each Government region. In particular, we were keen to investigate how DH guidance had impacted on alcohol commissioning over the past 2-3 years.

A detailed questionnaire was distributed to each of the 152 merged PCTs soliciting information on local needs assessment, planning, spending and waiting times. Despite the statutory requirement to release information, there was a response rate of 60%. It should also be pointed in many cases PCTs provided the information many weeks after the legal deadline because of difficulties in extrapolating the

requested data. Since almost 40% of trusts weren't able to return the questionnaire, it would not be unreasonable to claim that the figures presented in this report represent the *best case* scenario, and in reality the national figures on needs assessment, waiting times and identifiable spending may well be lower. It is a disappointing indictment of alcohol commissioning policy, that four years after the Alcohol Harm Reduction Strategy for England was published, 40% of PCTs are unable to either provide figures for prevalence levels of problem drinkers or levels of treatment expenditure.

Drawing on the available data we developed four key metrics that could be used to compare trusts' performance with specific reference to the agenda for improvement contained within MoCAM and related documents. The results indicate that MoCAM and other DH related guidance have not improved alcohol commissioning or treatment provision at the local level.

Many trusts did not have a clear understanding of how much they were actually spending on alcohol interventions or how many individuals required alcohol treatment making service commissioning and planning in the long term extremely difficult.

The results also showed a substantial range in the amount of time moderately and severely dependent drinkers had to wait to access treatment. Two regions-the East of England and the South West show a particularly marked need for improvement in this area. We also observed within, and between regions marked differences in the proportion of dependent drinkers accessing structured treatment.

Principal Findings:

Needs assessment

- Just over half (51%) of all the areas covered have not carried out a needs assessment to establish the number of hazardous, harmful and dependent drinkers in their area

Waiting Times

- Dependent drinkers in England face waits of up to a year to access any form of structured treatment.
- In 45% of areas covered in the survey, waiting times for alcohol treatment were longer than they were for drug rehabilitation services

Access to treatment

- In 41% of the areas covered, access to treatment was less than ten percent.

Spending on alcohol misuse

- There are wide variations in how much local areas spend on bring down alcohol-related harm, from an average of £7 in Bassetlaw, to £373 in Harrow.

The findings of this survey highlight a number of shortcomings in alcohol treatment commissioning, falling well short of recommended guidance and MOCAM's original vision of a well planned, thought out commissioning strategy for alcohol service provision. Instead, a postcode lottery exists, services provision often does not meet demand and waiting times are unacceptable.

The findings also suggest that PCTs are yet to be convinced that narrowing the service gap will yield cost savings to its primary and secondary care operations. Until they are, structured alcohol treatment is likely to remain at the periphery of many trusts' social care strategies despite the cross cutting implications of severe misuse on the public services.

Alcohol Concern contends that recent guidance on alcohol treatment commissioning has not had sufficient impact to ensure adequate, equitable and responsive provision of tiered alcohol support across all PCTs. To ensure PCTs improve commissioning standards for alcohol misuse more stringent standards and targets are required, with current funding restrictions for substance misuse relaxed, to include alcohol treatment.

Recommendations

- 1) We recommend that at a local level the pooled substance misuse treatment budget should include the funding of alcohol treatment where required, in addition to current PCT or Local Authority alcohol treatment expenditure. This would allow commissioners to prioritise alcohol treatment where demand existed. The Pooled Treatment Budget should be increased as necessary to meet the needs of drug and alcohol dependent users. Local commissioning decisions can then be made to meet the needs of all substance misusers.
- 2) DH should establish an optimal level of access for alcohol treatment for England and Wales. The current access level of 1 in 18 should be reduced to around 1 in 7 (15%) – this would chime with moderate treatment access targets in the USA, as described in ANARP. While access is poor in many areas, more than a few trusts are able to offer 'high' numbers of treatment places. Establishing a national consensus on a realistic target would help trusts measure their performance against a credible baseline in the medium term.
- 3) Now that service providers must report alcohol treatment and waiting time data to the National Drug Treatment Monitoring System (NTDMS), DH should consider demanding of local commissioners that waiting times for alcohol treatment match targets for drug treatment in the next NHS operating framework. This simple step would do much to drive improvements in needs mapping and accurate service planning, an area that the survey shows needs improvement in many areas.

- 4) In the long term, PCTs will need a stronger case for treatment's benefits before committing to the radical levels of investment that many in the sector believe it merits. Currently the evidence in favour alcohol treatment is weakened by the difficulties in expressing the benefits of different interventions in terms of generic health care measures such as quality adjusted life years gained (QALYS). Finding a robust way to express value in a way that lends itself to easy comparison with alternative treatments is critical for developing this agenda locally, especially now that DH appears no longer to be championing it nationally.
- 5) MoCAM appears to be having a limited effect when it comes to helping alcohol services conform to the developmental goals contained in *Standards for better health*. Strategic Health Authorities in areas with particularly low levels of access need to strongly encourage their respective PCTs to ensure that *Standards* is mainstreamed within the commissioning and delivery of alcohol treatment services.

A guide to the policies shaping alcohol service provision locally

Introduction

The Department of Health's (DH) commitment to 'local innovation and incentive-led' systems means that only the most health-critical or politicised issues are likely to experience centrally driven programmes of improvement at present.¹ Having made what it considers a sizeable policy investment in alcohol treatment provision through the Models of Care guidance documents (2004 onwards); it has had to depend solely on local commissioners to drive forward alcohol harm reduction measures and future policy is likely to continue in this vein.²

With that in mind, this section lays out the various national forces shaping alcohol strategy at the local level and describes the opportunities and threats they pose for the tiered treatment agenda. In the absence of strong signals from DH, the risk is that that new strategies, priorities and NHS reform ideologies will render MoCAM obsolete before it has had a chance to have a positive impact.

The Commissioning Framework for Health and Well-being (2007)

Health and Well-being seeks to bring about in NHS trusts a 'strategic reorientation towards promoting health and wellbeing; investing now to reduce future ill health costs.'³ It forms part of the wider reform agenda that sees the NHS moving away from being a provider to commissioner and its ethos is expected to fundamentally shape local thinking around the delivery of Local Area Agreement (LAA) targets (see below).

Our main concern is that the emphasis on 'promoting health and wellbeing' will, in the case of alcohol, encourage PCTs to prioritise pre-emptive 'awareness raising' at the expense of interventions aimed at challenging harmful behaviour. The King's Fund makes the point that it may be unwise to encourage PCTs to begin commissioning 'public health interventions' that are difficult to evaluate and the payback from which in terms of health gain and saved costs is uncertain.

This is particularly true in the case of social marketing, where it has been established that to be effective, health promotion programmes need to work at both national and

¹ Department of Health (2007). *The NHS in England: The operating framework for 2008/9*. London: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

² Department of Health/NTA (2006) *Models of Care for Alcohol Misusers (MoCAM)*: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136806; Department of Health/NTA (2004) *The Alcohol Needs Assessment Research Project*: <http://www.nwph.net/alcohol/anarp.aspx>; Department of Health/NTA (2005) *Alcohol Misuse: Guidance on developing a local programme of improvements*: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123297; Department of Health/NTA (2007) *Review of the effectiveness of treatment for alcohol problems*: http://www.nta.nhs.uk/publications/documents/nta_review_of_the_effectiveness_of_treatment_for_alcohol_problems_fullreport_2006_alcohol2.pdf

³ Department of Health (2007) *Commissioning Framework for Health and Well being*. London: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

local levels. Isolated, 'tick box' local-level interventions may be ineffective, and a poor use of limited resources. ⁴

Local Area Agreements (LAA)

These are three year compacts between a local area and central government. From April 2008 a new National Indicator Set (NI) of 198 indicators replaces all existing local authority indicators⁵. LAAs can include a maximum of 35 improvement targets drawn from this indicator set. Crucially, the NI set offers the choice of three specific indicators for alcohol-related harm for the first time:

- Perceptions of drunk or rowdy behaviour as a problem (NI 41)
- Alcohol-related hospital admission rates (NI 39)
- Substance misuse by young people (NI 115)

As part of the process of agreeing health-related targets to include within their respective LAA, PCTs and local authorities are now required to produce a Joint Strategic Needs Assessment (JSNA) on the health and well-being of their respective communities. JSNAs are expected to identify groups whose needs are not being met and may be experiencing poor outcomes.⁶ In a certain sense therefore JSNAs and the LAA negotiation process represent something of an opportunity to spotlight the service gaps in areas with high levels of harmful drinking.

However, initial indications appear to show that although LAA and PSA targets for alcohol have resulted in a welcome spurt of screening and brief intervention work at mainstream level, alcohol treatment commissioning for mild or severely dependent drinkers remains underdeveloped. Meaning that Tier 1 and 2 works is possibly expanding at the expense of Tier 3 and 4.

The Department of Health's Standards for better health

Standards was published by the DH in 2004 to ensure that health services of an acceptable quality were provided through the meeting of core standards. It also sets out a framework for continuous improvement in the overall quality of care that people receive through the pursuit of 'developmental standards'. ⁷ MoCAM names the developmental standards local alcohol commissioners should aspire to as part of their work (p38):

(Second Domain) Clinical cost effectiveness. Patients were expected eventually to receive care which:

- Conforms to nationally agreed best practice, particularly defined in the National Service Frameworks, NICE Guidance, national plans and agreed national guidance on service delivery.

Cont'd below

⁴ King's Fund (2007) *Response to the Department of Health consultation on the Commissioning Framework for Health and Well-being*. London: http://www.kingsfund.org.uk/publications/consultation_responses/index.html

⁵ Department for Communities and Local Government (2007) *The New Performance Framework for Local Authorities and Local Authority Partnerships: Single Set of National Indicators*. London:

<http://www.communities.gov.uk/publications/localgovernment/nationalindicator>

⁶ Department of Health (2007) *Guidance on Joint Strategic Needs Assessment*. London:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

⁷ Department of Health (2004) *Standards for better health*. London:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665

- Takes into account their individual requirements and their physical, cultural, spiritual and psychological needs.
- Is well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations.
- Is delivered by healthcare professionals who make clinical decisions based on evidence-based practice.

(Fifth domain) Accessible and responsive care. Healthcare organisations were expected to plan and deliver services that:

- Reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice.
- Maximises patient choice
- Ensures access (including equality of access) to services through a range of providers and routes of access
- Uses locally agreed guidance, guidelines or protocols for admission and discharge that accord with the latest national expectations on access to services

(Seventh Domain) Public Health: Healthcare organisations:

- Identify and act upon significant public health problems and health inequality issues, with primary care trusts taking the lead role
- Implement effective programmes to improve health and reduce health inequalities
- Protect their populations from identified current and new hazards to health
- Take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion, and prevention services for the public, and the general commissioning and provision of services.

Unfortunately *Standards* has proved something of a missed opportunity for the alcohol treatment sector. The absence of specific targets around alcohol treatment means that during the first three year cycle in which *Standards* applied there were no measurements through which to encourage accountability and quality improvement.

To a *very* limited degree, this historical oversight has now been redressed with the inclusion of an alcohol indicator in the new *NHS Operating Framework for 2008/2009* (demanding a reduction in alcohol-related hospital admissions).⁸ However, this target is unlikely to drive provision of tiered treatments for chronic and dependent drinkers. ‘Alcohol-related admissions’ cover those episodes where *hazardous* drinking and other risk factors combine to lead to acute injury. To prevent repeat episodes and meet their target one can easily imagine that PCTs will lean heavily on screening and brief interventions delivered in primary care, including GP and A&E settings.

Safe. Sensible. Social.

In June 2007 the government published *Safe. Sensible. Social* (SSS) – the revised national alcohol strategy.⁹ SSS sets out a ten year strategy for government and other key bodies with a role to play in reducing alcohol harm. The strategy is largely focused on ‘culture change’. It aims to make public drunkenness and its related consequences socially unacceptable. To that end guidance is planned to help parents take more responsibility for their children’s drinking habits, and there is an expectation that the irresponsible elements within drinks industry will be curtailed.

⁸ Department of Health (2007) *The NHS in England: The operating framework for 2008/9*. London: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

⁹ Department of Health (2007). *Safe. Sensible. Social*. London: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075218

The new strategy is a marked improvement from its predecessor not least by more openly acknowledging the scale of misuse. Noticeably though, it devotes little discussion to the question of how to improve integrated treatment across the country. Instead, it strongly implies that the delivery of screening and brief interventions, and new 'DIY' websites aimed at heavy drinkers form the mainstay of plans to support problem drinkers. This represents a significant departure from the central precept of MoCAM-namely that PCTs *should* seek to provide comprehensive, tiered treatment systems.¹⁰.

¹⁰ Don Shenker (2007) *Safe. Sensible. Social. The next steps in the National Alcohol Strategy: A response from Alcohol Concern*. London:
http://www.alcoholconcern.org.uk/files/20070621_155009_AC%20Briefing%20FINAL%20Jun07.pdf

Survey Results: Investigating the effect of local guidance on alcohol commissioning

Introduction

Most if not all of the decisions on 'whether', 'how much' and 'how' to spend on alcohol treatment are now made at the local level. The public health white paper, *Choosing Health*, published in 2004, set out a commitment to reduce health inequalities and better tailor health and care services to meet individual needs. It outlined action that individuals and organisations could take to make this a reality. Reducing harm, early identification and encouraging sensible drinking was one of six Choosing Health priority areas.

In order to deliver this agenda, starting in 2004 DH and the National Treatment Agency (NTA) began to release guidance to help local commissioners develop more integrated and effective alcohol treatment systems. The main toolkit within this set- *Models of Care for Alcohol Misusers (MoCAM)*, establishes Primary Care Trusts (PCTs) as the primary commissioner and purchaser of alcohol services.

This section draws on the results of a freedom of information survey carried out by Alcohol Concern between November 2007 and February 2008. It argues that MoCAM and its related guidance have not improved treatment commissioning and provision at the local level.

National Results

A detailed questionnaire was distributed to each of the 152 merged PCTs soliciting information on local needs assessment, planning, spending and waiting times. Despite the statutory requirement to release information, there was a response rate of 60%. It should also be pointed in many cases PCTs provided the information many weeks after the legal deadline because of difficulties in extrapolating the requested data.

Since almost 40% of trusts weren't able to return the questionnaire, it would not be unreasonable to claim that the figures presented in this report represent the *best case scenario*, and in reality the national figures on needs assessment, waiting times and identifiable spending may well be lower. It is a disappointing indictment of alcohol commissioning policy, that four years after the Alcohol Harm Reduction Strategy for England was published, 40% of PCTs are unable to either provide figures for prevalence levels of problem drinkers or levels of treatment expenditure.

Drawing on the available data we developed four key metrics that could be used to compare trusts' performance with specific reference to the agenda for improvement contained within MoCAM and related documents. These were:

- *Choosing Health Monies spend;*
- *Spend per harmful and dependent drinker on reducing harms*
- *The Gap Between Need and Access (Prevalence Service User Ratio)*
- *Maximum average waiting time for those accessing tier 3 and 4 treatment*

Choosing Health monies

Rationale: MoCAM brought no new extra money to support its programme of improvements. DH did however notionally identify an annual sum of £15million (from Choosing Health beginning in April 2007) to help PCTs to improve their commissioning and delivery of alcohol treatment. The money is part of the general allocation however, meaning that PCTs are free to ignore the government's advice on what it should be spent on. At the time of this announcement there were concerns that some trusts facing considerable pressure to turn around their deficits might ignore the guidance all together. This question was aimed at discovering whether this was the case among trusts.

1) 37% of Primary Care Trusts ignored government advice and did not spend *Choosing Health* money on alcohol interventions

Average per capita spend on harmful and dependent drinking population

Rationale: There were two reasons for condensing the data we had on spending into this one metric. Firstly, it provides a useful, if slightly rough snapshot of how much different trusts are spending on alcohol interventions. Secondly, calculating this figure requires two very specific pieces of data (clearly identified funding of alcohol interventions and an assessment of harmful, hazardous and dependent drinkers in any one area). This allows for a judgement to be made as to which PCTs are working towards the developmental standards within 'Accessible and Responsive Care' and 'Public Health' (see previous chapter)

The preliminary results suggest that relatively few areas have identified alcohol interventions as a formal priority and laid aside specific money to pay for them; many PCTs could not accurately identify how much they were spending; for example, in some cases alcohol was nominally part a 'generic substance misuse budget' that one would expect to privilege drug treatment.

The extent to which PCTs had some sort of needs analysis data also provided us with a clearer sense of which were working towards services that reflected the needs of the local population (Accessible and Responsive Care standards).

1) Just over half (51%) of all the areas covered have not carried out a needs assessment to establish the number of hazardous, harmful and dependent drinkers in their area

2) Average spending varies widely, from £7 in Bassetlaw, to £373 in Harrow

3) In 15% the areas covered by the survey, it was impossible for authorities to specify how much they were spending on alcohol

The gap between need and access

Rationale: This is calculated as a percentage of the dependent population. In North America, an access level of 10% of alcohol dependent individuals entering treatment each year is considered 'low', 15% is considered 'medium' and 20% considered high

1) In 41% of the areas with useable data, access to treatment was less than ten percent (low).

2) 15% of local areas have not kept records of how many people were in alcohol treatment

Maximum average waiting time for those accessing tier 3 and 4 treatments

Rationale: The NTA has specific targets in place for illicit drug users entering treatment: that 83% will access their first intervention in any new treatment journey within three weeks of referral (15 working days).¹¹ This does not apply to alcohol service clients. However, from April 2008 all providers of specialist alcohol treatment services will need to report on their clients' treatment journeys to the National Drug Treatment Monitoring System (NTDMS). This data will allow for more accurate needs analysis and commissioning. Our survey reveals that up till now there have been big differences in the voluntary collection of this data, and performance (based on rough parity with the drugs target) has been mixed.

1) In 45% of areas covered in the survey, waiting times for alcohol treatment were longer than they were for drug rehabilitation services

¹¹ NTA (2008) *NTDMS Core Data Set: Guidance for Adult alcohol Treatment Providers*. London: http://www.nta.nhs.uk/areas/ndtms/docs/core%20data%20set/ndtms_core_data_set_guidance_adult_alcohol_treatment_providers_ver_5.0.pdf

Conclusions

The preliminary results of our survey reveal the need in many local areas for a stronger, clearer and more accountable performance framework to improve local residents' access to alcohol interventions. The majority of the areas covered have not carried out a local needs assessment, did not know how many problem drinkers existed in their area and a surprisingly high proportion did not have a clear understanding of how much they were actually spending on alcohol interventions. This makes service commissioning and planning in the long term needlessly difficult.

The results found that within, and between regions there were marked differences in the proportion of dependent drinkers accessing structured treatment and the quality of needs assessment varies widely. The results also showed a substantial range in the amount of time moderately and severely dependent drinkers had to wait to access treatment. Two regions-the East of England and the South West show a particularly marked need for improvement in this area.

The findings also suggest that PCTs are yet to be convinced that narrowing the gap between needs and service provision will yield cost savings to its primary and secondary care operations. There is a risk that with the emergence of the new LAA, structured alcohol treatment may become even more marginalised within local health economies as authorities strive to meet their target to cut the number of binge related hospital admissions.

Overall, the findings of this survey highlight a number of shortcomings in alcohol treatment commissioning, falling well short of recommended guidance and MOCAM's original vision of a well planned, thought out commissioning strategy for alcohol service provision. Instead, a postcode lottery exists, services provision often does not meet demand and waiting times are unacceptable.

Alcohol Concern contends that recent guidance on alcohol treatment commissioning has not had sufficient impact to ensure adequate, equitable and responsive provision of tiered alcohol support across all PCTs. To ensure PCTs improve commissioning standards for alcohol misuse more stringent standards and targets are required with current funding restrictions for substance misuse relaxed, to include alcohol treatment.

Recommendations

- 1) Alcohol Concern recommends that at a local level the pooled substance misuse treatment budget should include the funding of alcohol treatment where required, in addition to current PCT or Local Authority alcohol treatment expenditure. This would allow commissioners to prioritise alcohol treatment where demand existed. The Pooled Treatment Budget should be increased as necessary to meet the needs of drug and alcohol dependent users. Local commissioning decisions can then be made to meet the needs of all substance misusers.

- 2) DH should establish an optimal level of access for alcohol treatment for England and Wales. The current access level of 1 in 18 should be reduced to around 1 in 7 (15%) – this would chime with moderate treatment access targets in the USA as described in ANARP. While access is poor in many areas, more than a few trusts are able to offer ‘high’ numbers of treatment places. Establishing a national consensus on a realistic target would help trusts measure their performance against a credible baseline in the medium term.
- 3) Now that service providers must report alcohol treatment and waiting time data to the National Drug Treatment Monitoring System (NTDMS), DH should consider demanding of local commissioners that waiting times for alcohol treatment match targets for drug treatment in the next NHS operating framework. This simple step would do much to drive improvements in needs mapping and accurate service planning, an area that the survey shows needs improvement in many areas.
- 4) In the long term, PCTs will need a stronger case for treatment’s benefits before committing to the radical levels of investment that many in the sector believe it merits. Currently the evidence in favour alcohol treatment is weakened by the difficulties in expressing the benefits of different interventions in terms of generic health care measures such as quality adjusted life years gained (QALYS). Finding a robust way to express value in a way that lends itself to easy comparison with alternative treatments is critical for developing this agenda locally, especially now that the DoH appears no longer to be championing it nationally.
- 5) MoCAM appears to be having a limited effect when it comes to helping alcohol services conform to the developmental goals contained in *Standards for better health*. Strategic Health Authorities in areas with particularly low levels of access need to strongly encourage their respective PCTs to ensure that *Standards* is mainstreamed within the commissioning and delivery of alcohol treatment services.

Appendix 1 Preliminary results from the Freedom of Information Survey broken down by government office region

East Midlands

PCT	Choosing Health Monies 07/08	% of dependent drinkers in treatment	Maximum average time for those entering alcohol treatment (Tiers 3-4)	Time spent waiting for alcohol treatment as compared with drug treatment	Average per capita spend on harmful and dependent drinking population	Does the trust carry data on the numbers of hazardous, harmful and dependent drinkers?
Bassetlaw	Yes	n/a	10 days	X 1	£7	Yes
Leicester	Yes	27.3%	30 days	X 2.00	£44	Yes
Leicestershire and Rutland	No	n/a	n/a	n/a	n/a	Yes
Northamptonshire	Yes	n/a	n/a	n/a	n/a	Yes
Nottingham City	-----	n/a	20 days	X 1.33	£45	Yes
Nottinghamshire Teaching	Yes	30%	30 days	X 2.00	£56	Yes

East of England

PCT	Choosing Health Monies 07/08	% of dependent drinkers in treatment	Maximum average time for those entering alcohol treatment (Tiers 3-4)	Time spent waiting for alcohol treatment as compared with drug treatment	Average per capita spend on harmful and dependent drinking population	Does the trust carry data on the numbers of hazardous, harmful and dependent drinkers?
Bedfordshire	n/a	n/a	n/a	n/a	n/a	No
Hertfordshire	Yes	10.49%	n/a	n/a	£7	Yes
Norfolk	No	6.2%	n/a	n/a	n/a	Yes
Suffolk	Yes	n/a	n/a	n/a	n/a	Yes
West and East Hertfordshire	No	n/a	n/a	n/a	n/a	No

London

PCT	Choosing Health Monies 07/08	% of dependent drinkers in treatment	Maximum average time for those entering alcohol treatment (Tiers 3-4)	Time spent waiting for alcohol treatment as compared with drug treatment	Average Per capita spend on harmful and dependent drinking population	Does the trust carry data on the numbers of hazardous, harmful and dependent drinkers?
Barking and Dagenham	Yes	n/a	15	X 1.5	n/a	No

Bromley	Yes	37%	30	X 2.00	£56	Yes
Camden	-----	13.37%	n/a	n/a	£64	Yes
City and Hackney	Yes	n/a	60	X 1	n/a	Yes
Croydon	No	n/a	44	n/a	n/a	No
Ealing	No	n/a	n/a	n/a	n/a	No
Haringey Teaching	Yes	30.8%	25	n/a	£119	Yes
Harrow	Yes	79%	40	X 4.00	£473	Yes
Hillingdon	No	n/a	5	n/a	n/a	No
Islington	Yes	89%	100	X 6.66	£193	Yes
Kensington and Chelsea	Yes	n/a	15	X 1	n/a	No
Lambeth	Yes	6.88%	20	X 1.33	£39	Yes
Lewisham	Yes	4.9%	n/a	n/a	n/a	Yes
Richmond and Twickenham	Yes	n/a	n/a	n/a	£48	Yes
Southwark	Yes	n/a	15	X 1	£270	Yes
Sutton and Merton	No	n/a	15	X 1	n/a	Yes
Wandsworth	Yes	13%	30	X 8.21	n/a	Yes

North East

PCT	Choosing Health Monies 07/08	% of dependent drinkers in treatment	Maximum average time for those entering alcohol treatment (Tiers 3-4)	Max time spent waiting for alcohol treatment as compared with drug treatment waiting times	Average Per capita spend on harmful and dependent drinking population	Does the trust carry data on the numbers of hazardous, harmful and dependent drinkers?
County Durham	Yes	N/A	n/a	n/a	n/a	Yes
Hartlepool	Yes	65.93	n/a	n/a	£20	Yes
Middlesborough	Yes	N/A	5	X 1.25	£75	No
Newcastle	Yes	N/A	n/a	n/a	n/a	No
North Tees	Yes	N/A	n/a	n/a	n/a	No

North Tyneside	Yes	N/A	35.5	X 4.9	n/a	No
Northumberland	Yes	N/A	Closed waiting list	n/a	n/a	No
Redcar and Cleveland	Yes	N/A	10	X 0.66	n/a	No

North West

PCT	Choosing Health Monies 07/08	% of dependent drinkers in treatment	Maximum average time for those entering alcohol treatment (Tiers 3-4)	Max time spent waiting for alcohol treatment as compared with drug treatment	Average Per capita spend on harmful and dependent drinking population	Does the trust carry data on the numbers of hazardous, harmful and dependent drinkers?
Bolton	Yes	n/a	15	n/a	£32	Yes
Blackburn and Darwin	Yes	n/a	20	X 1.33	n/a	No
Blackpool	Yes	17.74	40	X 1.60	£22	Yes
Central and Eastern Cheshire	No	131.98	50	X 5.00	n/a	Yes
Cumbria	No	9	20	X 1.33	n/a	Yes
Halton and St. Helens	Yes	n/a	80	X 5.33	n/a	No
Heywood, Middleton and Rochdale PCT	Yes	153.3	30	X 2.00	n/a	No
Liverpool	Yes	n/a	25	X 1.66	n/a	No
Manchester	Yes	18.7	10	X 0.66	n/a	No
Oldham	n/a	n/a	n/a	n/a	n/a	No
Salford	Yes	35	n/a	n/a	£52	Yes
Tameside and Glossop	Yes	9	15	X 1.00	£13	Yes
Trafford	Yes	36	11	X 0.73	£47	Yes
Western Cheshire	No	4.6	n/a	n/a	n/a	No
Wigan	Yes	n/a	n/a	n/a	n/a	No
Wirral	Yes	86	n/a	n/a	£83	Yes

South East

PCT	Choosing Health Monies 07/08	% of dependent drinkers in treatment	Maximum average time for those entering alcohol treatment (Tiers 3-4)	Time spent waiting for alcohol treatment as compared with drug treatment	Average Per capita spend on harmful and dependent drinking population	Does the trust carry data on the numbers of hazardous, harmful and dependent drinkers?
Berkshire East	Yes	1.87	25	X 1.66	n/a	No
Berkshire West	No	8.6	30	n/a	n/a	No
East Sussex Downs and Weald	No	n/a	n/a	n/a	£31	Yes
Hastings	No	n/a	n/a	n/a	£31	Yes
Kent	Yes	n/a	30	X 2.00	n/a	No
Medway	-----	n/a	15	X 1.00	n/a	No
Milton Keynes	Yes	n/a	15	X 3.00	n/a	No
Oxfordshire	Yes	n/a	50	X 3.33	n/a	No
Portsmouth	Yes	n/a	15	X 1.00	n/a	No
Southampton	Yes	n/a	80	X 8.00	n/a	No
West Kent and Eastern Coastal	Yes	n/a	17	X 1.13	n/a	No
West Sussex	Yes	6.34	n/a	n/a	n/a	No

South West

PCT	Choosing Health Monies 07/08	% of dependent drinkers in treatment	Maximum average waiting time for those entering alcohol treatment (Tiers 3-4)	Time spent waiting for alcohol treatment as compared with drug treatment	Average Per capita spend on harmful and dependent drinking population	Does the trust carry data on the numbers of hazardous, harmful and dependent drinkers?
Bath and North East	Yes	71.42	20	X 0.66	n/a	Yes
Bristol	Yes	22.2	25	X 1.66	£56	Yes
Cornwall	Yes	3.8	30	X 2	n/a	No

Devon	Yes	n/a	n/a	n/a	n/a	No
Dorset	Yes	n/a	n/a	n/a	n/a	No
Gloucestershire	Yes	7.5	45	X 4.1	£25	Yes
Plymouth	No	8	253	X 25	n/a	Yes
Swindon	-----	n/a	n/a	n/a	n/a	No
Torbay	Yes	n/a	50	X 1.61	n/a	No

West Midlands

PCT	Choosing Health Monies 07/08	% of dependent drinkers in treatment	Maximum average time for those entering alcohol treatment (Tiers 3-4)	Time spent waiting for alcohol treatment as compared with drug treatment	Average Per capita spend on harmful and dependent drinking population	Does the trust carry data on the numbers of hazardous, harmful and dependent drinkers?
Birmingham East and North PCT	No	21.04	n/a	n/a	£54	Yes
Coventry Teaching PCT	No	189.24	10	X 0.66	n/a	Yes
Dudley PCT	No	n/a	20	X 1	n/a	No
Heart of Birmingham Teaching PCT	Yes	21.04	20	X 1.33	£54	Yes
North Staffordshire PCT	No	8.43	42	X 1.05	£27	Yes
Sandwell PCT	Yes	n/a	20	X 1.33	n/a	No
Shropshire PCT	No	n/a	29.5	X 3.4	n/a	No
South Birmingham PCT	No	21.04	n/a	n/a	£54	Yes
Warwickshire PCT	No	n/a	n/a	n/a	n/a	n/a

Yorkshire and the Humber

PCT	Choosing Health Monies 07/08	PSUR	Maximum average time for those entering alcohol treatment (Tiers 3-4)	Time spent waiting for alcohol treatment as compared with drug treatment	Average Per capita spend on harmful and dependent drinking population	Does the trust carry data on the numbers of hazardous, harmful and dependent drinkers?
Bradford PCT	Yes	1.2	10	X 0.66	n/a	No
Doncaster PCT	Yes	28.7	65	X 4.59	£43	Yes
East Riding of Yorkshire PCT	No	3.3	22	X 1.04	£26	Yes
Kirklees PCT	Yes	n/a	n/a	n/a	£54	Yes
North Lincolnshire PCT	No	5.5	15	X 1	n/a	No
Sheffield PCT	No	3.4	n/a	n/a	n/a	No

Alcohol Concern Is

- The national agency on alcohol misuse
- Working to reduce the level of alcohol misuse, and to develop the range and quality of helping services available to problem drinkers and their families
- England's primary source of information and comment on a wide range of alcohol related matters

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Alcohol Concern
Making Sense of Alcohol