Evaluation of the Alcohol Learning Centre

ALCOHOL
LEARNING CENTRE

Feedback Report From
Early Implementer Primary Care Trusts
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Michelle Cornes & Jill Manthorpe
Social Care Workforce Research Unit
King's College London,
Melbourne House (5th Floor)
Strand
London WC2R 2LS

☎ +44 (0)1931 713123
📠 (Mobile) 0797 989 7234
✉ michellecornes@aol.com

1: **Introduction**

This short feedback report[1] presents the findings of a small scale evaluation of the support provided to twenty specially targeted Primary Care Trusts (PCTs) as part of the Department of Health's 'Alcohol Improvement Programme.' The 'Alcohol Improvement Programme' aims to reduce the rate of alcohol-related admissions to hospital and provides a range of support through the 'Alcohol Learning Centre' (www.alcohollearningcentre.org.uk).

The study was carried out between July and October 2009 and was commissioned by the Department of Health's Policy Research Programme as part of the evaluation[2] of the 'Care Services Improvement Partnership'.[3] The 'Care Services Improvement Partnership' (which has since been abolished) was responsible for the initial development of the 'Alcohol Leaning Centre.' Although CSIP was abolished, it was felt that this evaluation should still go forward to provide some practical feedback to the 'Alcohol Improvement Programme Working Group' on how the support provided to PCTs could be improved.

2: **Background to the Alcohol Improvement Programme**
According to the Department of Health[4] alcohol-related illness or injury currently accounts for nearly a million hospital admissions per year and this figure is increasing. Previously, published 'Hospital Episodes Statistics' (HES) data showed that the top three reasons for alcohol related hospital admissions were alcoholic liver disease, alcohol poisoning and mental and behavioural disorders. There were 207,000 admissions for these reasons in 2006/7, rising at around 20,000 admissions a year. The total annual healthcare cost related to alcohol misuse adds up to £2.7 billion per year.

Concern about the rising number of alcohol-related hospital admissions led the Department of Health to put in place a new national Vital Signs Indicator (VSC 26) for the NHS. From April 2008 this is measuring the change in the rate of alcohol-related hospital admissions. Reducing alcohol-related hospital admissions is also included in the National Indicator Set for Local Authorities and Local Authority Partnerships (NIS 39). In addition, a Public Service Agreement (PSA 25) seeks to reduce the harm caused by alcohol.

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[1] A researcher from King's College London (MC) joined the 'Alcohol Improvement Programme Working Group' for the duration of the evaluation. The evaluation of the improvement supports provided through the Programme commenced in July 2009. Prior to this the researcher was engaged on a different project brief linked to the co-ordination of evaluation activities across the 20 PCTs involved in the Programme.

[2] Ethical approval was secured from COREC.

[3] CSIP was initially sponsored by the Department of Health in April 2004, becoming operational in England in April 2005, as a work-stream within the Department of Health, employing staff outside the civil service structure but separate from local service delivery. CSIP's core purpose was to be service improvement and its primary objectives were to promote better performance and higher quality care. It was abolished in 2009. For full details of the evaluation of CSIP see Cornes et al. (2007, 2008).

[4] Unless otherwise stated, information presented in this report on alcohol related harms and on the aims and objectives of the Alcohol Improvement Programme are extracted from a working paper produced by the DH Alcohol Policy Team (2008) entitled 'Background and Selection Process to Become an Early Implementation Site within the Alcohol Improvement Programme'.

The 'Alcohol Improvement Programme' was launched in April 2008[5] by the Department of Health to provide a wide range of resources and support to PCTs and other local stakeholders to support them in reducing the rate of alcohol-related admissions to hospital. As part of the Programme, extra support is being targeted at twenty PCTs identified as having the greatest level of alcohol-related hospital admissions.

> '[The Alcohol Improvement Programme] will establish a group of 'Early Implementers' who will go that little bit faster in defining and implementing solutions for tackling alcohol-related harm. These PCTs will have priority access to [resources] and their experiences will contribute to the bank of good practice which will be disseminated via [a] learning centre to the rest of the NHS'
>
> http://www.integratedcarenetwork.gov.uk/laiip/index.cfm?pid=1035
> [Accessed 14.8.09]

The objectives of the 'Alcohol Improvement Programme' are to:

- Provide priority support to twenty 'Early Implementer' PCTs who have high rates of alcohol-related hospital admissions;
- Support capacity and capability building in local sectors to ensure sustainability and growth for change;
- Collate and disseminate evidence and learning to support PCTs in delivering against Vital Signs Indicator VSC26 to reduce the rate of increase in alcohol-related hospital admissions as measured by HES data;
- Produce guidance on the key enablers and activities for change;
- Ensure that advice and guidance which have the most impact on reducing alcohol-related hospital admissions are developed with regional input to support regional implementation.

www.alcohollearningcentre.org.uk [Accessed 3.2.09]

'Early Implementer' PCTs were eligible to apply for up to £150,000 funding for 2008/9 and up to £200,000 funding in 2009/10 to support a programme of local improvement. It was expected that local programmes would 'lead the way' in implementing 'High Impact Changes'. According to the Department of Health (2009) these are 'calculated' to be the most effective actions for those local areas that have prioritised the reduction in alcohol-related harm. The 'High Impact Changes' are:

1. Work in partnership

2. Develop activities to control the impact of alcohol misuse in the community

3. Influence change through advocacy

4. Improve the effectiveness and capacity of specialist treatment

5. Appoint an Alcohol Health Worker

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[5] See Appendix 1 for the first year's costs incurred in setting up the AIP.

6. Information and Brief Advice (IBA) - provide more help to encourage people to drink less

7. Amplify national social marketing priorities

To support 'Early Implementers' and other stakeholders to implement the 'High Impact Changes' and to reduce alcohol-related admissions to hospital the 'Alcohol Improvement Programme' offers a wide range of improvement support. This is delivered principally through the 'Alcohol Learning Centre' (www.alcohollearningcentre.org.uk).[6] The 'Alcohol Learning Centre' was launched in November 2008. Its stated purpose is to allow experts in alcohol intervention to relay information from and to policymakers to enable better service improvement and co-ordination amongst providers:

> 'The Alcohol Learning Centre is an on-line one-stop-shop which collates, co-ordinates and disseminates learning and promising practice from across the NHS and the Third Sector. It contains alcohol specific policy documents, guidance and tools and provides training resources to support front line practitioners in delivering 'Identification and Brief Advice' (IBA) and the 'High Impact Changes for Alcohol'

> www.alcohollearningcentre.org.uk [Accessed 15.10.09]

Other resources co-ordinated through the 'Alcohol Learning Centre' include: a programme of national events and workshops (with an online booking system); video film podcasts; online discussion forums; eLearning; news bulletins and email alerting; guidance on setting-up collaboratives and learning sets; and a peer visit and mentoring scheme:

> 'Local project groups [collaboratives] will be formed to analyse local need, and plan and implement changes. The groups should ideally be cross sector and work across organisations, and team boundaries and should include a senior clinician. Improvement methods such as PDSA (Plan Do Study Act) or Rapid Cycle Reviews are used by the group to rapidly deliver local sustained improvement. The collaborative develops local staff for future innovation and improvement work'

> www.alcohollearningcentre.org.uk [Accessed 2.3.09]

In addition, the 'Alcohol Improvement Programme' works with a number of other organisations that also provide a range of improvement support to PCTs and other stakeholders. It should be noted that these supports are beyond the scope of this small scale evaluation. These supports include:

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[6] See Appendix 2 for details of the information to be found on the web site (the web site map).

Regional Alcohol Managers/Offices: New arrangements were put in place to establish Regional Alcohol Managers and Offices (RAOs). These provide linkage between different agencies to assure local delivery and performance monitoring, and provide regional and local advocacy and championing. Most recently, the Department of Health has launched the 'Alcohol Interventions Improvement Centre' which forms an umbrella organisation for the 'Alcohol Learning Centre' and the improvement support which is provided through the Regional Alcohol Offices (DH, 2009).

National Support Team[7]: From September 2008, a National Support Team has supported PCTs and their partner organisations in areas with the highest rates of alcohol-related admissions to review their commissioning and delivery systems for alcohol harm reduction, identifying what improvements could be made.

3: Methodology

The evaluation of the improvement support co-ordinated through the 'Alcohol Learning Centre' involved in-depth face to face interviews with designated lead managers in each PCT who were responsible for managing work carried out under the banner of the 'Early Implementer Programme' (see Appendix 3 for topic guide). Managers leading the 'Early Implementer' work were either commissioners of alcohol (usually drug and alcohol) services or public health consultants. Although there were twenty PCTs involved in the Programme, two of the managers held responsibility for 'Early Implementer' work in more than one PCT (usually because they were geographically adjacent). This meant that there was total of eighteen potential participants. Interviews were subsequently carried out with thirteen participants. In two of the sites, staff turnover meant that at the time of the evaluation no one was available to be interviewed. A further three potential participants did not respond to the invitation to participate (which was followed-up with two reminder emails one sent through the university and then one sent via the Department of Health). The interviews were digitally recorded (where it was feasible to do so) and transcribed. Two further (albeit brief[8]) focus group style discussions were held in two sites when the researcher was invited to attend part of the meeting of the full 'Early Implementer' project steering group. These meetings were attended by six and nine people respectively. The interviews were carried out at the beginning of year two of a three programme (between July and September 2009).

The qualitative data were analysed by hand, using structured feedback headings (as detailed in the next section of the report). An approach to triangulation, to compare data from different sources, was achieved by comparison of the qualitative findings against the quantitative findings of an online survey of the 984 registered users of the 'Alcohol Learning Centre' which was carried out in July/August 2009 (Young,

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[8] The discussions were brief because the evaluation was one item on a full meeting agenda.

2009).[9] This was commissioned separately from this evaluation and achieved a response rate of 5% meaning that this comparison of data is limited.

The findings were also checked and agreed by means of a brief feedback session held with representatives from six of the 'Early Implementer' sites (this included representation and in-put from three of the 'Early Implementers' who had not previously been involved at the earlier interview stage). All participants were sent a draft of the report for comment.

4: Findings

Overview

Reflecting back over the first year and half of the Programme, participants spoke very positively about the 'Alcohol Learning Centre' and of the various benefits and opportunities that went along with 'Early Implementer' status. Most participants had not been involved in a service improvement programme previously and the concept of 'funding with support' was greatly appreciated:

> 'A fabulous opportunity isn't it - with the additional money and support' [13][10]

> 'Very engaging, makes you feel that you in the forefront - leading the way' [7]

> 'Glad we did it, glad we applied for it and that we were selected. It's a privilege to be awarded the ['Early Implementer'] status' [11]

Some of the supports provided through the 'Alcohol Improvement Programme' are working more effectively than others and there are clear messages to emerge from the study about the kind of support 'Early Implementers' would like to see across the remainder of the Programme. These issues are discussed in the sections below which explore: how the Programme aims and objectives were communicated; how the money is being used; views on the different improvement supports delivered through the 'Alcohol Learning Centre' (the web site, tools and resources, podcasts,

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[9] The survey method is described as follows: 'A short anonymous online survey, using Zoomerang surveys, which was placed on key pages (the most visited) of the Alcohol Learning Centre website, including the homepage and elearning page, for a two month period from the 1st June 2009 to 31st July 2009. The survey was also advertised via the site's June and July 09 ebulletins and discussion forums, and via regional alcohol officers and managers as well as at the National AIP conference at the beginning of June and at other regional and national AIP meetings. The decision was made not to use an automatic pop up window for the survey as it was felt by the website designers, Cubicstate, that this was off-putting to many users. The results to the questionnaire were generated automatically via spreadsheet on the 1st August and this data is captured in the charts and figures in the report' (Young 2009)

[10] Participants were given assurances that they would remain anonymous in this report. The number in brackets denotes the transcript reference number.

conferences and events, learning sets and the mentoring scheme); arrangements for monitoring review of the Programme; and the perceived outcomes of participating in the Programme.

Communication of programme aims and objectives

Participants felt that the aims and objectives of the 'Alcohol Improvement Programme' could have been better communicated:

> 'Right at the beginning, I don't think [the Programme] was particularly well communicated. We got an invitation if you will. We were told there was a maximum amount of money [you could bid for]... The letter went to the Chief Exec and then got cascaded down to me. I analysed what we had done already for the 'High Impact Changes' and identified where the gaps were... [Researcher: And was the money to be spent on the 'High Impact Changes'?] It was but the 'High Impact Changes' document didn't come out until the second year, so at the beginning the only focus was that there should be something in addition to what you already doing - not just putting the money into mainstream funding... but to move forward in certain areas particularly around the vital sign indicator and NI39' [12]

Participants commented that they were already implementing many of the 'High Impact Changes' prior to the launch of the 'Alcohol Improvement Programme' and that the Programme was not therefore as timely as it might have been.[11] As noted, the fact that the 'High Impact Changes' were not finalised until mid-way through the Programme was problematic for some:

> 'What has been messed up is that they have changed [the High Impact Changes] – I had my nice list and the some things were changed... Things like the alcohol health worker suddenly crept in and I didn't even know what one was... The communication around the 'High Impact Changes' wasn't so good' [10]

The process of *project bidding*

Of the range of support provided to the Early Implementers, the financial support (up to £150k in Year 1 and £200K in Year 2) was perceived to be the most important:

> 'The main focus really is that [the Programme] has given us the additional money which has given us the ability to do stuff that we kind of talked about but maybe couldn't do [in the current climate]. The implementer money has meant that we can just crack on really' [2]

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[11] While the perception of the 'Early Implementers' was that they were already implementing many of the 'High Impact Changes' prior to the launch of the Programme, this view was not supported by the Programme Leads based at the Department of Health who felt that this assertion was not always clearly evidenced through the documentation that had been submitted to the DH by some of the Early Implementer PCTs.

'The funding gives the opportunity to do those new things you want to do but no one else would be brave enough to invest in previously' [8]

The fact that the money is non-recurrent and has restrictions placed upon it (such as having to spend it quickly before the end of the financial year) made it somewhat of a 'double edged sword'. For example, there were concerns about the sustainability of some the initiatives that had been introduced using 'Early Implementer' funding. Some sites for example used the money principally for evaluation and research purposes (pilot studies) or to purchase training, avoiding making staff appointments which were perceived to be unsustainable; while other sites had used the money on substantive posts:

'We have got the mainstream funding allocated to posts and we are using [the 'Early Implementer' money] to fast track some of the things like training, and research, evaluation – and also, we are going to look at somebody coming in for six months to fast track some of the pathway development work' [9]

Indeed, there was some uncertainty as to what exactly the money could be spent on:

'Well there is a woman in charge of the 'Early Implementer' funding and she decides whether what you want to do is within the criteria... I have never seen the criteria but she is having to have a really good hard think about [our latest proposal] and it has taken three weeks... that's a bit frustrating' [1]

Furthermore, many of the 'Early Implementers' felt hampered by the fact that there was no certainty as to how much money would be provided and even if it would be provided at all in Years 2 and 3 of the Programme:

'At the moment we are in a bit of gap with the funding and some of the work has had to be suspended – Had I known I would probably have thought about it differently but I quite naively thought, get some more funding, stock this up and then it will run for three years and it will make a difference... [Participation in the Programme] will make a positive difference - but it has been a bit stop and start' [11]

Use of the 'Alcohol Learning Centre' website

Participants who had used the 'Alcohol Learning Centre' website described it as an excellent resource and all felt that it delivered on its objective of becoming a 'one stop shop' for alcohol related resources. These findings are supported by those of the survey in which all respondents stated that their overall impression of the site was good or excellent, with 88% of defining the site as useful:[12]

> 'It puts everything at your finger tips' [4]

> 'I think the 'Alcohol Learning Centre' website is really good resource… Particularly for areas not in the 'Alcohol Improvement Programme' it will save so much time from going here there and everywhere trying to pull everything together' [13]

> 'I spend my time sign posting people [to the 'Alcohol Learning Centre' website], because it is a wonderful service… If you are doing something and you haven't got the information… the resources are all there… The design is quite good and it is very good in terms of promoting good practice' [3]

The website was generally felt to be accessible and easy to navigate (though one participant thought it had started to become more complex as more material was added). It was said to be well maintained and up to date (with the exception of some contact details on HubCAPP[13]). A few technical glitches were reported such as difficulties in downloading some documents but these were not considered to be a major problem.

The extent to which participants were using the 'Alcohol Learning Centre' website varied considerably. A few participants were using it two to three times a week, while

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[12] According to the report of the survey, 'Despite the fact that the overall response rate to the online evaluation questionnaire was disappointingly low, the 52 responses that were received demonstrate that the vast majority of site visitors are satisfied with the site overall, and with the usefulness, presentation and accuracy of content. Given that the website is still relatively new and content development in its infancy these results are extremely positive and indicate that organisation and delivery of content is working on the right lines. The feedback received on where information gaps exist is also encouraging as many of these areas, for example, evidence, cross departmental partnership working and strategic sharing of information are in development. The first evidence section on IBA and Hospitals will be published on the website in the coming month. There are other areas namely service user input, greater information about costs, linkage of indicators and local impact that require further action and this is something that the Alcohol Improvement Programme via the process regional engagement can move forward with' (Young, 2009).

[13] HubCAPP (http://www.hubcapp.org.uk/) stands for the Hub of Commissioned Alcohol Projects and Policies. It was commissioned by the Department of Health and is run in partnership through Alcohol Concern with a link on the 'Alcohol Learning Centre'. The Hub highlights not only what projects exist but how they link to local and national strategies and meet government targets and indicators. The Hub also outlines how initiatives were commissioned, received funding, why alcohol was prioritised as an issue in the area and what the outcomes have been.

most tended to use it much less often, about once or twice a month. One participant had not looked at the web site at all:

> 'It's a great resource but it's just having the time to just to look at it. I wouldn't normally look at it unless I was specifically looking for something... I wouldn't sort of check it even on a monthly basis to be honest' [12]

More frequent email alerting was thought to particularly important in terms of reminding people to use the website:

> 'I was using it this morning to find out about the pen profiles for the social marketing so I usually go there for something specific or I have to remind myself to go there to see if anything new has sort of come up, actually that might be one thing which would help me to use it more, because I don't think it happens at the moment, was if we got e-mail alerts' [1]

Some 'Early Implementer' leads played a role in encouraging colleagues and other local stakeholders to use the web site. One participant commented that promoting the website was 'a way of ensuring everyone is singing from the same hymn sheet' [4]:

> 'As individual queries have come in from GPs I have been directing them to the online IBA training [on the website]... One GP that I have been working with has created a user friendly short cut...because it was tricky to find otherwise' [1]

> 'The IBA trainers in the public health department would access [the website]. My colleagues in the Community Alcohol Team would access it and also the colleagues over in the Drug and Alcohol Team' [2]

Participants tended to use the web site in many different ways and often tended to have a preference for one format over another:

> 'I mainly download the PowerPoint presentations' [7]

Few participants reported that they used the website to find journal articles or more depth information on the evidence base. The importance of producing information in formats which were easy to use was frequently emphasised:

> 'What would be useful is for us to have a newsletter, because lets face it, as modern managers, we get absolutely bombarded with information... and you don't have a lot of time to fit everything in research and stuff, so what would be helpful is almost like a spoon-fed newsletter' [11]

One of the most frequent reasons for using the website was to book places at events and workshops. The other most common reason for using the website was to search for what was perceived as 'practical information' (e.g. local alcohol strategies, service specifications, job descriptions, training briefs, treatment pathways, terms of reference for strategy groups, and so on):

'I have been asked to help out with drawing the action plan for the Alcohol Strategy and I thought someone must have done an action plan and so I went [to the website] and looked at other people's ideas' [3]

'Would be good if the site could be developed as a melting pot for job descriptions and service specifications' [7]

In terms of contributing information to appear on the website, including case studies for HubCAPP, a common complaint was that the information was not being handled efficiently:

'I have sent off three business cases, I can't find them anywhere on the 'Alcohol Learning Centre' web site. I got an email back saying these are really interesting but we need a bit more information... I e-mailed back saying I am not clear what it is you are asking for and I have heard nothing since. So we have submitted stuff and it feels as though it has gone into a void' [2]

Across the Programme more generally, administrative backup to support the full range of development activities was often perceived to be lacking:

'Many a time you know I have been told such a body is doing that and I have said great can you send me some information, and I have never got it' [13]

'Going back to [the event], just something basic was that we were asked to give our email addresses and we have not had the [contact list] back yet. You know the longer it goes you lose the impetus' [12]

'I haven't got anywhere a list of what is happening in all of the sites' [8]

'I had a query over data, an email went around the Department of Health and there was no response' [6]

'I get the impression, I could be wrong, that the Programme itself is being squeezed, I get the impression that [the Regional Alcohol Manager] is being increasingly asked to do a lot of other things [in addition to supporting the 'Early Implementers'] [13]

Tools and resources

A number of tools and e-learning resources have been commissioned by the 'Alcohol Learning Centre' and can be accessed through the website (see Appendix 2). Though the general perception was that most were useful (notably the IBA training for GPs), there were specific criticisms about some of the tools. One participant, for example, pointed to the need for more consistency and the need to double check some of the information for accuracy:

'Information on the 'Alcohol Learning Centre' isn't consistent. If you look at two different bits of the Audit C, in two different files, the scores are different' [2]

In the IBA training for GPs, in one interactive exercise the units had been 'rounded up' with the consequence that, not knowing this, participants were getting the answers wrong and, rather frustratingly, could not then work out why.

There was one query as to what extent the resources to be found on the website, such as IBA training for GPs, could be adapted to reflect the models/care pathways that were being implemented locally (rather than taking GPs through the entire range of options). Getting answers from Programme staff at the Department of Health around specific queries such as these was perceived to be difficult.

Another tool, the 'Ready Reckoner' which calculates the potential cost savings linked to the implementation of the 'High Impact Changes' was eagerly anticipated by the 'Early Implementers' but when it finally arrived it was perceived to be disappointing:

> 'It's hugely flawed... I am not particularly IT literate but if you put in the percentages and you increase the number of admissions you divert... your community based dependent drinkers doesn't change, well that's bonkers... so in the end I binned it and I have not used it since' [13]

Video podcasts

None of the participants had watched any of the video film podcasts:

> 'I don't think I would sit down and watch a podcast really [Researcher: why not?] I use the website but I can't imagine going on to listen to a podcast... It makes a noise and in an open office environment it would be noisy and disruptive for other people... And when have you ever got time to [watch one]?' [8]

Events, Workshops, Regional Meetings and Opportunities for Networking

Because the 'Early Implementers' felt that they were already implementing the 'High Impact Changes', the first national event which outlined these was thought to have been disappointing:

> '[Discussing the first national event] I can't say I got a lot out of it to be honest. I have to say that I was disappointed with some of the presentations being delivered... I was thinking, we have done more than that, why are we listening to that when we are a year ahead of that. They really weren't very well thought out and it was frustrating to have gone all the way to London' [12]

> 'The [first] conference that I went to I didn't learn anything and I think that could be because I had worked on the agenda for quite a few years and it could be because we did so much work last year before we even heard about the Early Implementer stuff' [11]

> 'The opening meeting in Leeds was 2/10, it was too wishy-washy. It was mundane. There was nothing – no substance – They should have co-opted more local operational people within the alcohol field' [6]

> 'I haven't learned anything new, from most of the big events I have been to, if I am honest' [10]

In contrast, regional meetings and events were perceived to be more useful because they afforded more scope for discussion and networking with fellow 'Early Implementers':

> 'What I really enjoyed was the treatment pathway event a couple of weeks ago, because we had a lot of time in very small groups to share what we were doing. [The Regional Alcohol Manager] put people into groups where she said they were at a similar sort of level in terms of what they were doing… This gives you a sort of way in… I mean knowing that [one Early Implementer] had done something similar and had got a couple of lessons learned [meant] that we could try to avoid those pitfalls' [12]

> '[Discussing informal networking at Programme events] I always find you get more value outside the classroom environment so to speak than in the structured sessions' [8]

The amount of support provided to the 'Early Implementers' varied from region to region depending on the in-put and style of the Regional Alcohol Managers. In the North West, North East and East Midlands regular network meetings were organised. In the other regions, where there were fewer 'Early Implementers' there were fewer opportunities for networking. Some 'Early Implementers' were working very much in isolation:

> 'We haven't formed any particular relationships with any of the other Early Implementers' [1]

Use of 'learning sets' and the mentoring scheme

As part of the support offered through the 'Alcohol Learning Centre' the 'Early Implementers' were encouraged to set up 'learning sets' and to participate in a peer visit and mentoring scheme. Detailed guidance about these initiatives appears on the alcohol learning centre website (http://www.alcohollearningcentre.org.uk/Topics/Browse/mentoring/ [Accessed 3.11.09]). However, very little use appears to have been made of these supports mainly because of capacity issues and uncertainty around the potential value of such activities:

> 'Particularly in the beginning there was a lot of pressure to set up these mentoring, or peer mentoring sets. Talking to other 'Early Implementer' leads we were all confused as to what they were and what they were being set up for, what would we get out of it? [12]

'We're a small team and we're involved already with such a lot that we haven't grabbed the mentoring and peer visits... I think the learning set and the collaborating and stuff were good ideas but whether they are absolutely necessary or not I don't know because, for instance, in the region we have a very high powered regional alcohol advisory group... which has kind of taken on the role of pulling things together' [3]

In one site there was a conscious decision not to use 'learning sets' as they were perceived not to be the most appropriate improvement tool:

'We haven't chosen to bring GPs together... My experience is it can be quite combative, we found it easier to work on a practice to practice basis. Certainly there has not been a wish or a desire from the practices to come together so we haven't facilitated that' [2]

It was suggested that Programme staff should take more of lead in organising these kinds of activities rather than expecting 'Early Implementers' to organise events or buy-in facilitation:

'The mentoring bit hasn't really happened and I don't know whose responsibility that is, I am sure if we really pushed it we could organise it, it is time really stopped us doing that... It almost needs somebody to push it and make it happen and I suppose that is part of the role of the regional manager but she has just started in post, maybe she can start making something happen' [8]

'We now need some facilitation to move this forward... I am not senior enough to do it, and similarly you need somebody from outside to come and do that because it is not just a health agenda... and that hasn't happened. It shouldn't be down to us, that facilitation should come from the Programme shouldn't it?' [13]

Although the eventual visits did not always live up to expectations, the kind of 'hands on' improvement support offered through the National Support Team (NST) was highly sought after by the 'Early Implementers':

'I think the NST visit is probably [going to be the] most useful [form of support] because the process allows people to self assess themselves and then the visits involve people as senior as possible in the PCT. So it brings everybody together to identify what the key issues are... It's kind of diagnostic - it looks at what you are doing and suggests where you can do better and where you can share resources... I don't think the peer visit and mentoring would achieve that' [12]

Monitoring and reporting

Arrangements for monitoring and reporting of 'Early Implementer' activity do not appear to have been clearly communicated to the 'Early Implementers'. Some 'Early Implementers' were more aware than others of the expectation to produce a quarterly monitoring report to an agreed template. As yet, none of the sites had been given information about what will happen in the final year of the programme. Will they be expected to produce a final report of their activity and will this feed into a final Programme report?:

> 'We have to fill in templates, it is just that one template, but other than that there has been no other monitoring of balances other than the fact that we haven't spent the money' [12]

> '[Researcher: So what reporting do you have to do?] It has been very – I have to say for the DH - very light touch' [1]

> 'Occasionally you might get a phone call saying where are you up   to?' [13]

One drawback of having light touch arrangements for monitoring and reporting of activity is that the Programme will not be in a position to generate much in the way of activity and performance related data that will lend itself easily to informing future intelligent commissioning:

> [Researcher: Are you keeping track of the numbers people who have received IBA?] 'We haven't and as we are rolling it out that is what I actually want to develop' [1]

The 'Early Implementers' were most concerned about any monitoring against the indicators or targets for reducing the rate of increase in alcohol-related admissions:

> 'We can't actually report on the actual indicator because the data is rubbish – but that will improve' [1]

> 'I think we are making good progress, but we don't know how reliable the numbers are' [3]

> '[Researcher: What is your target for reducing the rate of alcohol related admissions?] 2% sticks in the mind but [we are] having all sorts of trouble [with the data]. We need some more support and that hasn't been available... The more you get people to start unpicking [the data] the answers get more complicated which just adds to the confusion rather than gives me a solution' [5]

> 'What I have struggled most with it is the indicator. We have this NI39 indicator and I have lots of questions whether that is a suitable indicator[14] to measure performance' [10]

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[14] Some 'Early Implementers' wanted to see the so called 'attributable fractions' revised, whereby a percentage of hospital admissions linked to certain conditions such as hypertension were attributed to alcohol (whether or not anything was known about the role

Indeed, many of the Early Implementers were keen to know how they were doing in comparison to the other sites and if they were ahead or behind 'the game'. However, the Programme was perceived to provide little in the way of constructive feedback:

'You send your report and get nothing back, good, bad or indifferent' [13]

The general feeling was that the Programme now needed to be far more pro-active in growing the 'evidence base' by capturing the learning of the 'Early Implementers':

'They are always bringing us together to tell us what they are doing, but maybe they could ask about what we are doing' [3]

Perceived outcomes of participating in the 'Alcohol Improvement Programme'

Participants felt that the main outcome of participating in the 'Alcohol Improvement Programme' was that it had helped them to raise the profile of alcohol-related harm locally:

'I think you will find we have used [the Programme] to get a higher probability of better outcomes around the target… The alcohol investment is still so much less than the drugs investment… but now I know that alcohol will be on the agenda at every meeting… It really helps… I am all for it' [5]

'The most helpful thing about [becoming an 'Early Implementer'] is that it has helped to get alcohol higher up on the agenda politically and operationally locally. That has definitely been the most helpful thing…. It has helped us to build the case for saying we need a lot of new investment in alcohol services' [1]

'It made our borough sit up – I don't think they believed the figures beforehand' [7]

In some sites, the 'Alcohol Improvement Programme' was perceived to be promoting improved partnership working; often by providing 'Early Implementer' leads with 'moral support and back up in the face of much resistance to change' [7]:

'[The Programme] has helped us to work with the acute trust to look at alcohol across all the departments… What [the Programme] is doing is giving us that extra lever or mandate to go to our partners and say we have a problem, the Government is organising nationally' [3]

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of alcohol in those attributed cases). This method of counting the rate of admission was felt to make hitting the target difficult in terms of how could managers concerned principally with alcohol issues start to address issues around diabetes and hypertension in the broader sense.

However, some sites were concerned that the Programme was not doing enough to sustain interest at the most senior levels within organisations with the consequence that this was likely to threaten the success of the Programme:

> 'I think this is where the frustration comes in because you have the money there to do some potentially fantastic pilot work, but unless you have got the [support] you are stuffed… I would like to see our Chief Exec challenged as to why he isn't getting involved because the invitation [to become an Early Implementer] was sent to him… It feels a little bit like the spotlight is coming down to people like myself who are much further down the food chain' [12]

> 'I would really like to see more support [from the Programme] around influencing change at a partnership level… particularly now that PCTs are financially in the red' [13]

As regards reducing the rate of alcohol-related admissions to hospital, confidence levels were generally low among the 'Early Implementers' that significant progress would be made during the lifetime of the Programme:

> 'I think that the top line measurement of the [target] will be hit because there will be a focus on a bit more efficiency in terms of measuring, a bit tighter criteria, so you will cut your 10%. But you can cut 10% off any target with a little bit of thought. It's the next level of improvements to reduce the demand in acute services and that's where you need significant investment in community services and maybe a five or six year programme… it's a long term, really grinding issue and you need long term investment plans to deliver' [6]

In the one site which did report positive progress, this achievement was felt to predate the support of the Programme:

> '[Researcher: Do you think you will meet the targets as regard reducing the rate of alcohol-related hospital admissions?] Yes, we have got [a reduction already] but none of that is as a result of this Programme it is just the result of the work which took place in 2006 and that has then been continued and ongoing work with our providers' [11]

There were a number of reasons as to why the 'Early Implementers' were guarded about the likelihood of success against the Programme targets. As noted above there was general concern about the data underpinning the targets, how they should be used and understood, and the extent to which they were reliable. Each site had set itself a different target[15] and in some sites there was concern that these were overambitious. There were also concerns that the 'High Impact Changes' were not targeted enough to impact directly on alcohol-related hospital admissions:

> 'I think if your wider [alcohol] strategy doesn't address most of [the 'High Impact Changes'] or all of them, then you are already on your back foot…

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[15] Targets set ranged from reducing the rate on increase of alcohol related admissions by 1% to reducing the number of admissions by 10%.

but actually the partnership type work in terms of the criminal justice system, for example, is so detached from this in NI39 work' [5]

Indeed, there was a general lack of confidence or belief in the evidence base underpinning the 'High Impact Changes'. There was a strong desire to 'see the results for oneself' and a reluctance to take at face-value the results shown in the academic literature:[16]

'It's is all around IBA... but we need to look at that in a few years to see the true impact' [12] [17]

'The difficulty is that Department of Health's policy documents tend to be over simplistic and easy to read but often lack substance. I have slight concerns over the 'High Impact Changes' and whether or not they are really realistic in terms of being able to deliver – there is a real sense that it is not a rigorous academic piece of research, that it is underpinned by some very simple quick reviews and I would question it... [The 'High Impact Changes'] always go back to Brief Interventions and I think this has been oversold – I am not convinced it will deliver long term goals' [6]

'[Discussing plans in some sites to extend IBA into pharmacies] I don't think that's been well evaluated and I just wonder who is evaluating the whole. I should probably know if it is independently evaluated, but it seems to me too quick does that, too quick for it to actually be put down as good practice' [12]

Indeed, rather than seeing themselves as early implementers of evidence based practice, most participants saw themselves as 'trail blazers':

'[Discussing the 'High Impact Changes'] they are not very specific are they but I think they represent where everybody is at the moment with the state of play and the state of knowledge as it stands. We are learning as we go... One of the 'High Impact Changes' is to appoint an alcohol health worker, and it is particularly unspecific but I think that is a good thing because I think if it had said the Liverpool model is the way to go, then I would have found that quite difficult to deal with because we don't really agree with the Liverpool model here... Sometimes you get very specific guidance and you think yes right, okay that is what I need to do, just go off and do it. But here we are feeling our way' [1]

At the time of the evaluation, frustration was growing among the 'Early Implementers' as some seemingly insurmountable implementation challenges had begun to surface. The greatest challenge was perceived to be how to address the lack of investment and capacity in services for 'dependent drinkers' in order to pave the way for the implementation of IBA. Without this investment it was perceived that there was a 'risk of generating a whole lot more referrals that the system can't cope with' [1]:

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[16] See, for example, the Cochrane review produced by Kaner et al. (2007)

> 'I think there is too much focus on IBA... You can identify all the people in the world with alcohol problems, but if you don't have services to support them what's the point?'[3]

Other key implementation challenges included how to promote interprofessional working, for example, how to get other groups of workers (e.g. those in criminal justice) to deliver IBA post training if it was not written into their job descriptions, and how to promote interagency working more generally (e.g. how to get the full range of agencies involved in supporting dependent drinkers).

For some participants the Programme was felt be disappointing because it was not forthcoming with targeted support to address these specific challenges:

> 'I haven't found an expert within the alcohol field. I haven't come across someone who can give you an answer... There doesn't seem to be a central body of knowledge... Ideally you would want a central core with some real operational experience, someone with some research experience and someone with knowledge in terms of the strategic and making it happen. And I am not sure that that exists within the 'Alcohol Improvement Programme'' [6]

Furthermore, while there was thought to be increasing pressure from Programme staff to 'report on good and innovative practices at every meeting' there was an underlying concern that this did not necessarily flow from the kind of work the 'Early Implementers' were engaged with:

> 'We have the national event in November and they want each of the twenty areas to run a workshop. I phoned them up and said what would you like me to present on? I would depress people if I started to use my workshop to tell them how far we have <u>not</u> got' [13]

> 'I think what [Programme staff] are doing now is to pull together what the learning outcomes have been for the implementers so that they can then disseminate that to other PCTs... but I am not sure that there is much that is going to come out of the programme ... I don't there is going to be a wow factor...' [3]

5: Conclusion

> 'Pulling all these people together nationally, then regionally is wonderful. Some events haven't been particularly useful, but the opportunity to just meet and chat, compare notes and sort of lean on each other a little bit has been fantastic. But it is disappointing really that there is so much more that could have been done' [13]

Reflecting back on the first year and half of the Programme, participants spoke very positively about the 'Alcohol Learning Centre' and of the benefits and opportunities that came with 'Early Implementer' status. Most participants had not been involved

in a service improvement programme previously and the concept of 'funding with support' was greatly appreciated.

Most participants agreed that the 'Alcohol Learning Centre' had delivered on its objective of becoming a 'one stop shop' for alcohol related resources. In terms of future development it was recognised that more regular email alerting would promote greater use of the web site. Most participants would also like to see the website evolve as a repository for very practical information such as service specifications, job descriptions, local alcohol strategies, and so on.

National events were, on the whole, thought to have been disappointing providing only limited opportunities for learning and networking. Regional events were thought to have been better though the amount and style of support varied between regions. The general feeling was that the Programme now needed to become more pro-active in terms of drawing in the experiences of the 'Early Implementers'. To a certain extent this point has already been taken on board with more interactive workshops planned as part of the next national conference in December.

Participants felt the main outcome of participating in the 'Alcohol Improvement Programme' was in helping them to raise the profile of alcohol-related harm locally. However, there was a lack of confidence amongst 'Early Implementers' that significant progress would be made against targets to reduce the rate of alcohol-related admissions to hospital. This highlighted a number of key concerns:

- There were concerns about the data underpinning the targets, how they should be used and understood, and the extent to which they were reliable.
- In some sites there was concern that the targets were overambitious.
- There were concerns the 'High Impact Changes' were not targeted enough to impact directly on alcohol -related hospital admissions.
- There was a lack of belief in the evidence base underpinning the 'High Impact Changes' and a sense that IBA may have been oversold.
- Significant implementation challenges had begun to surface, for example how to address the lack of investment and capacity in services for 'dependent drinkers' in order to enable sites to move forward with the implementation of IBA without *generating a whole lot more referrals that the system can't cope with* [1]. How to promote interprofessional and interagency working were also perceived to throw-up many issues.

The overall conclusion to be drawn from the feedback is that the Programme does not seem to be providing enough of the right kind of support and that unless there is (1) a longer time for delivery against the targets; (2) more resources; and (3) more 'hands on' improvement support (to sit alongside the 'virtual support' provided through the 'Alcohol Learning Centre') then the Programme will not deliver its objective of supporting the 'Early Implementers' to go that 'little bit faster' in defining and implementing solutions for tackling alcohol-related harm.

Indeed, participants reported feeling pressured to identify 'good or innovative practice' and were concerned that this did not necessarily flow from the work they were undertaking as 'Early Implementers'. However, in seeking to 'bank' only good

practice it might be argued that the 'Learning Centre' is in danger of missing out on what people really need to know about the implementation of the 'High Impact Changes': What are the challenges? What are pitfalls? What works? What doesn't work? There is good evidence from realistic evaluation (Pawson and Tilley, 1997) that it is only by capturing the totality of the implementer's experience ('warts and all') that we can begin to grow the evidence base:

> 'Even so called 'evidence based' innovations go through a lengthy period of negotiation among potential adopters, in which their meaning is discussed; contested and reframed; such discourse can either increase or decrease the perceived relative advantage of the innovation' (Greenhalgh et al, 2004).

Recommendations

- More 'hands on' improvement support (external facilitation) needs to be provided to the 'Early Implementers' alongside the virtual support provided through the 'Alcohol Learning Centre'. This support needs to be linked directly to the specific implementation challenges identified by the 'Early Implementers'. It should not be assumed that the 'Early Implementers' will have the 'know how' or time to work with 'learning sets' and other improvement methodologies without this additional support.

- There is a need to grow 'expertise' and to reassess how best this can be shared (for example, engaging some 'Early Implementers' as paid consultants or 'change agents' rather than expecting them to share their expertise for free in the context of a mentoring scheme).

- There is a need to explore ways of promoting confidence and trust in research evidence, thus avoiding the perceived need to '*see for oneself*'.

- To grow the evidence base around the 'High Impact Changes' the Programme needs to capture the totality of the implementation experience ('warts and all') not just 'good and innovative practice'.

- The Programme architecture needs to be developed and better communicated, especially around arrangements for data collection, monitoring and review.

- Clarification is needed about the plans for Year 3 of the Programme and how the Programme will be bought to a close - will there be a final report or conference and how will the 'Early Implementers' be expected to contribute to this?

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Appendix 1: Alcohol Learning Centre Costs, First Year Aug 2008-March 2009

Web Hosting, site build and management (inc admin and technical training and support)	£40,000
Design Costs -Branding including ALC Logo and Marketing Materials	£10,279
Production of Launch Publicity Materials including Conference stands, mugs, bags, pens, post its and postcards +4 leaflet types	
Podcast Filming Production Editing and Rendering	£6,758
Conference and Events (stands)	£16,718
Total	**£73,755**
Staff Costs- ALC Manager (AIP funded covered everything else including content research and uploading)	£30,000
Total	**£103,755**

Appendix 2: Alcohol Learning Centre Site Map

About Us
Alcohol Learning Centre
Alcohol Improvement
Programme
High Impact Changes
PSA 25
National Indicators and NI 39
Supporting the PCTs
National Support Teams
Regional Offices
Data
Topics
Browse
Social Marketing
Social Marketing Guidance
Introduction
Alcohol social marketing
Alcohol social marketing in-depth
Case study
How to carry out your own social
marketing activity
The DH alcohol social marketing
strategy
Future activity
Social Marketing Artwork
Units Campaign
Direct Marketing
Identification and Brief Advice
SIPS
About and Contact SIPS
SIPS Research
Identification Tools
Brief Advice Training and Tools
Local Initiatives
About HubCAPP
Contact HubCAPP
Alcohol Harm
Alcohol Harm Data
Alcohol Policy and Guidance
Links
Resources for Commissioners
Primary Care
Alcohol Resources
Early Implementers
GP Templates
Mentoring and Peers
Collaboratives and Learning Sets
Children and Young People
Evaluation
Commissioning

Data Tools
Housing
Evidence
Research
Emergency Medicine
Databases
Athens
Offender Health
IBA Pilot
Contact
Patient Information
Conferences
Past Events
Hospitals
Emergency Medicine
EM Articles
Workforce Development
Training Providers
Training Courses
High Impact Changes
Work in partnership
Develop activities to control the
impact of alcohol misuse in the
community
Influence change through
advocacy
Improve the effectiveness and
capacity of specialist treatment
Appoint an Alcohol Health
Worker
IBA - Provide more help to
encourage people to drink less
Amplify national social marketing
priorities
Latest Resources
Browse by Tag
Podcasts
e-Learning
IBA e-Learning
IBA Technical Checker
IBA User Guide
Feedback
News
Events
Archived Events
Discuss & Debate
Forum Conditions of Use
Regions
Contact Us

Appendix 3: Alcohol Learning Centre Evaluation - Topic Guide

Can you tell me about your role in the PCT? What does your job entail?

A: How is the Alcohol Learning Centre used in everyday practice?

- How familiar are you with the Alcohol Learning Centre? How often do you use it?
- How user friendly is it?
- Which resources and linked services do you use most often (news letters, resource links, events, podcasts, collaboratives, peer visits, mentoring)?
- Which, if any, don't you use? Why?

B: Usefulness of the resources

- How well does it convey information about the evidence base in the area in which you are working?

C: Scope for interactivity

- Have you contributed anything to the Learning Centre in terms of local good practice or other kinds of learning?

D: Comparative quality assessment

- Do you use any other service improvement tools and websites? If yes, how does the Learning Centre compare?
- What other kinds of training and support do you receive to enable you to develop in your job role?

E: Outcomes

- What impact, if any, has the Learning Centre had in helping you to achieve the outcomes you have specified?
- How could the Learning Centre be improved?
- What is your overall assessment of being involved in a Programme of this kind?