Public Health England

Protecting and improving the nation's health

CLeaR thinking

CLeaR system improvement model: achieving excellence in local alcohol harm reduction

Peer Assessment Report
Durham
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Prepared by Improving Performance in Practice (iPiP)

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Executive summary

Durham completed the alcohol CLeaR self-assessment and subsequently requested and received a peer assessment to validate the findings of the self-assessment. Details of the learning coming out of the peer assessment process are set out in the body of this report.

1.1 Headline messages from the alcohol CLeaR

- Durham has a robust partnership with political and senior officer buy-in. Those engaged, at both the strategic and operational level, demonstrated an understanding of the benefits for the wider partnership of reducing alcohol-related harm.
- Durham's public health team is very active across the alcohol misuse agenda, and has strong support from the police and colleagues with a criminal justice remit as reducing alcohol harm is seen as an essential pre-requisite for the Safer Durham Partnership in the achievement of their ambition for reducing crime, disorder and vulnerability in the locality.
- However key health partners, did not contribute to the CLeaR process and are not actively engaged strategically. Even where there is evidence that health are delivering interventions that reduce alcohol harm it appears that this activity is not necessarily perceived as being part of the bigger picture nor joined up operationally in a way that benefits partners and the population as a whole.
- The existing alcohol strategy is still in date, however the action plans supporting the strategy's implementation were described as either complete or static. The findings from the CLeaR process will inform the development of a new partnership action plan.
- Governance for this agenda sits with the Community Safety Partnership. You advised that there are established structures to ensure leaders are kept informed of progress. Notwithstanding clarity about lines of accountability we heard that in practice, examination of improvement against agreed priorities has not been rigorous recently. The re-fresh of the local alcohol action plan presents an opportunity to review the metrics agreed to monitor progress against key objectives and consider how best to ensure there is continuous and thorough scrutiny of the agenda.
- The last few years have been difficult for the community-based treatment services following problems with the provider initially awarded the service contract. The subsequent temporary contract re-let, re-tender process and award were described as a "bumpy road" for service users, local services, commissioners and partners. Performance was adversely affected as a result of this disruption, and although progress towards a recovery has been made, especially in the growth of successful completions, numbers in treatment

continue to fall and the rate of unmet need among the dependent population remains a concern.
- There have been significant changes to the Alcohol Harm Reduction Unit over the past 12 months that have impacted on information sharing and joint working around the alcohol agenda.
- Work with the community neighbourhood teams and the Drug and Alcohol Recovery Service has worked to address visible homeless in Durham City, but this needs to be maintained and reviewed.

1.2 CLeaR opportunities – recommendations for strategic leaders

Senior leaders in the local alcohol partnership are encouraged to consider the following in local planning for improvement:

- An updated action/improvement plan should be produced to support your alcohol strategy and the good ongoing work to reduce alcohol-related harm. Refreshing the local plan presents an opportunity to reinvigorate wider partner interest in the agenda, re-establish a shared local vision and to rationalise local planning and commissioning processes at a senior level to ensure resources are identified and efficiently allocated across the partnership. This plan should seek to align individual agency and partner priorities at strategic and operational levels.
- Political leaders and senior decision makers within the council are encouraged to use contact with their counterparts in health to increase engagement and ensure appropriate representation at relevant strategic boards and commitment to the development and subsequent implementation of the refreshed action plan.
- Strong partnership relationships will be required to jointly manage the impact of anticipated but enforced changes to resources. Promotion of a well-integrated approach to planning, commissioning and operational activity may encourage economies of scale and assist the partnership to make best use of available resource and capacity.
- Supporting the delivery of the Preventing Ill-Health CQUIN provides an opportunity for senior leaders to encourage health practitioners in secondary care settings to embed the identification of, and provision of brief advice addressing alcohol risk into local practice and to promote a review of the effectiveness of local pathways between secondary care and the community alcohol treatment system when alcohol dependence is identified.
- Public Health expressed ambition for more meaningful involvement in the local licensing process. Investigating how this is managed successfully in other areas of the country and ensuring health consideration is actively embedded into the local Statement of Licensing Policy may provide useful insight and help shape future plans.
- A strategically agreed benchmark for co-ordinated communications will help ensure consistency in messages linked to alcohol-related harm.

- Public Health should engage with any partner who has direct involvement in the delivery of a recordable treatment episode to understand how such activity can best be recorded and uploaded to NDTMS.
- Engaging clinical champions to promote work to reduce alcohol harm across the NHS, particularly within secondary and primary care settings, could support this agenda being seen as a health priority. This approach could be taken forward by key strategic leaders on the Health and Wellbeing Board.

CLeaR context

2.1 Introduction to the model and purpose of the report

CLeaR is a system improvement model which provides local government, the NHS, the police and other partners with a structured, evidence-based approach to achieving excellence in preventing and reducing harm from alcohol at the local level.

The model comprises a self-assessment questionnaire allowing review of local arrangements and activity to reduce alcohol harm against NICE guidelines, backed by an optional challenge process from a team of external peer assessors. The purpose of the peer assessment is to examine the scores awarded and evidence selected by the locality when completing their self-assessment and to provide objective feedback on local performance against the model.

The report offers a number of recommendations (CLeaR messages) and provides the assessment team`s revised scores, accompanied by detailed feedback on specific areas of the model (CLeaR detail). In addition we suggest some resources you may find useful in further developing your work to prevent and reduce alcohol harm (CLeaR resources).

This CLeaR peer assessment presents an opportunity to validate the findings coming out of your self-assessment; offering both challenge and assurance to the partnership to support you prioritise the actions identified for inclusion in your improvement plan.

2.2 CLeaR in Durham

Durham invited the CLeaR peer assessment team to validate your self-assessment process as a benchmarking exercise for the local alcohol strategic partnership. It is anticipated that learning from the CLeaR process will help shape your local action plan for improvement.

This report summarises the conclusions of the CLeaR peer assessment team following our visit on October 9th 2018. The report sets Durham's challenge in context, providing information on the impact of alcohol misuse across the locality.

In carrying out the peer assessment we built on the local alcohol partnership's insights into areas of strength as well as opportunities for further development and improvement, as recognised through your self-assessment. The peer assessment team endorse many aspects of the learning coming out of your internal CLeaR discussions and the most significant of these findings have been detailed in this report, but we also focus on the

areas where our rating of your local evidence diverges with your scoring, and offer some explanation for this variation.

This difference in how the local evidence of achievement is rated probably reflects our different perspectives. Local partners will have used the CLeaR to identify potential priorities for further action based on an indepth understanding of local partnership working, current resources and the needs of your local population, whilst the observations of our peer assessment team have the benefit of detachment and are framed by an awareness of how similar issues have been dealt with in other localities.

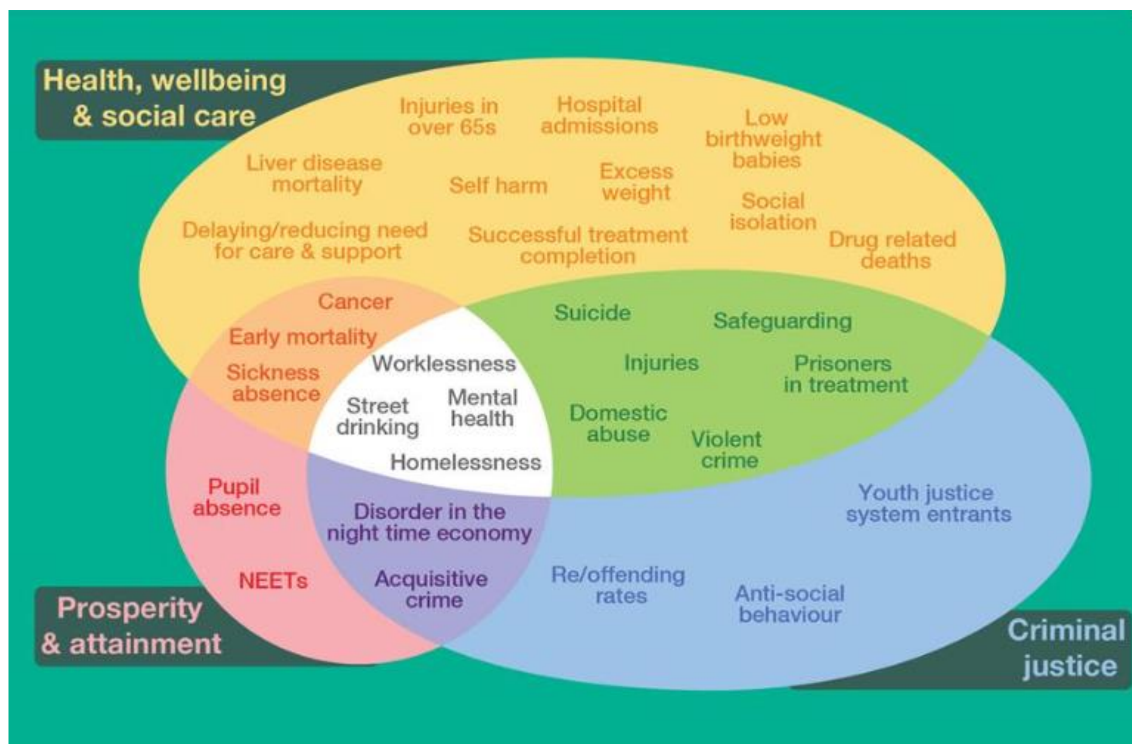
Senior leaders, commissioners and operational managers based in the local agencies represented on your alcohol partnership are encouraged to consider all the findings from the alcohol CLeaR system improvement approach, building on identified strengths and creating opportunities to address local structures and delivery arrangements that have been identified as potential areas for development, in the production of a local action plan for improvement. To this end, as well as reporting on the opportunities for development you identified through the self-assessment we also include a few recommendations for future action from the perspective of the visiting peer assessment team which the local partnership may wish to consider in your improvement planning.

Special thanks go to Sean Barry for his assistance in organising the visit and his time and energy when we were in Durham. Thanks also go to all the other local partners who gave their time as participants in the peer assessment visit for their enthusiasm and willingness to engage with the process. This was greatly appreciated.

CLeaR opportunities

3.1 Making the case for continued investment in reducing alcohol harm

The public health burden of alcohol is wide ranging, relating to health, social or economic harms. These can be tangible, direct costs (including costs to the health, criminal justice and welfare systems), or indirect costs (including the costs of lost productivity due to absenteeism, unemployment, decreased output or lost working years due to premature pension or death). The consequences of alcohol misuse are borne by individuals, their families, and the wider community. The figure below sets out the range of Public Health Outcomes Framework indicators that alcohol impacts upon. By taking action to reduce alcohol-related harm at the local level, it is possible to improve the positive outcomes achieved across systems.



Mechanisms for reducing consumption, such as the delivery of identification and brief advice (IBA), can produce net savings particularly to the NHS where it is estimated to save £27 per patient per year. Similarly, alcohol care teams in hospital settings can reduce the demand for hospital services. Optimally resourced teams can return £3.85 for every £1 invested by reducing length of stay and re-admission. Alcohol treatment is also a cost effective intervention, with every £1 invested in alcohol treatment generating a social return of £26 over 10 years. Furthermore, investment in treatment for alcohol-only clients can generate significant savings at the local level in terms of preventing crime and its average social and economic cost.

Your commissioner will have access to the alcohol and drug Social Return on Investment and Value for Money tools and resources published by PHE. These will help you demonstrate that local activity to reduce alcohol harm is generating savings over time.

3.2 The extent of alcohol harm in County Durham

At a glance	
Consumption of pure alcohol per capita per year (based on off-trade sales)	7 litres
Proportion of the adult population estimated to be abstainers	10.5%
Proportion of the adult population drinking above low risk guideline	33.8%
Rate of alcohol-related hospital admission episodes (narrow measure)	754 per 100,000
Estimated number of alcohol dependent adults	7,174
Estimated number of children living with an alcohol dependent adult	2,489
Proportion of Children in Need assessments that record alcohol as a contributory factor	13.2%

Alcohol-related health risk is determined by the volume of alcohol consumed and the frequency of drinking occasions. Broadly, the more someone drinks, the greater the risk. As such, understanding levels and patterns of alcohol consumption in your local area can help you plan the activity needed to reduce alcohol-related harm. Dependent drinkers have a particularly high impact on NHS, police, criminal justice, and social care service costs per head.

In Durham it is estimated that alcohol consumption is currently at 7 litres per capita[1], representing an annual average expenditure on alcohol of £361.44 per person.[2]

Available data about drinking behaviour[3] in the locality indicates that the 10.5% of the adult population in Durham reporting abstinence from alcohol is lower than the national and regional average. The proportion of dependent drinkers in Durham, at 1.7%, is higher than the national but slightly lower than the north east regional average rate of dependence. The data also indicates that a higher than national and regional average proportion of the population, 33.8% of adults, report drinking more than the Chief Medical Officers' low risk guideline of 14 units of alcohol per week, putting them at increased risk of harm. Similarly the proportion of those who report binge drinking in Durham, at 23.9%, is higher than the proportion identified nationally and regionally.

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[1] This is based on the volume of pure alcohol purchased in off-trade settings and the number of adults living in the area.
[2] If this per capita consumption level is adjusted to take into account the proportion of the local adult population known to abstain from drinking alcohol (10.5%), per capita consumption rises to 7.8 litres per drinking adult with an annual expenditure per head of £403.84.
[3] Public Health Profiles: Local Alcohol Profiles for England: consumption and availability indicators

Some binge drinkers are alcohol dependent, and there is good evidence for specialist alcohol treatment addressing dependence. However, most binge drinkers are not dependent, so wouldn't necessarily benefit from specialist treatment but may benefit from an alcohol brief intervention. The pattern of consumption in your locality, and the lower than national and regional average proportion of individuals reporting abstinence from alcohol suggests there may be an opportunity for health to work in partnership with the other responsible authorities to review how licensing can be used locally to influence the availability of alcohol to the general population.

Hospital admission episodes in Durham for both alcohol-specific and alcohol-related conditions remain above the national, but below the regional, average. Although the former is currently on a downward trajectory, the trend is upward for the alcohol-related admission rate. In 2016/17 the rate of alcohol-related hospital admission episodes against the narrow measure (where the main cause for the admission to hospital was attributable to alcohol) was 754 per 100,000. In analysing hospital admission episodes by condition it is apparent from the incidence rates (which are all above the national but, in the main, below the regional average) that alcohol is having a harmful impact on population health in the geographical area. We heard that public health has ambitions to work with NHS partners to support an increase in capacity to identify alcohol-related ill-health earlier and to deliver evidence-based interventions for those at risk in healthcare settings. This could support a reduction in the rate of hospital admissions due to alcohol in those drinking regularly at above low risk levels.

The harmful consequences of alcohol dependence are not only experienced by the individual, but by their families and the wider community. Nationally alcohol misuse has been identified as a contributory risk factor in 18.4% of all the children in need assessments undertaken in 2017/18. In Durham alcohol was recorded as a risk factor in 610 of the 4,637 children in need assessments undertaken during this period. This equates to 13.2% of all the assessments undertaken in year. More details on this cohort, the harms to children and potential responses can be found in the parental alcohol and drug use toolkit produced by PHE.

Across the locality it is estimated there are around 1,390 alcohol dependent parents with approximately 2,500 children living with them. 77% of these parents are not engaged in specialist treatment. This is slightly above the national average rate of dependent parents not engaged in treatment (79%). There is an opportunity for public health and their commissioned providers to work more closely with Durham children's services to agree an approach which supports the early identification of families affected by parental alcohol misuse and both encourages dependent adults to take action to address their drinking and supports affected children to achieve their full potential.

7,174 adults (1.7% of the local population), are estimated to be dependent on alcohol in Durham. The proportion of dependent drinkers in Durham is higher than the national,

but marginally lower than the regional, average. Unmet need among this population, based on 2017/18 treatment figures, remains at 79%.

The number of new alcohol-only clients presenting to treatment in Durham year on year continues to decline. Alcohol-only presentations have reduced by 19% since 2013/14, contrasting with new presentations for all other substances which have grown by approximately 15% in the same period. Durham participated in the inquiry conducted by PHE to better understand what was behind the national fall in numbers in alcohol treatment. Details of the findings with recommendations can be found in the report of this inquiry.

The rate of successful completion of alcohol treatment with no representation within 6 months, at 34% continues to improve and Durham performance is now above the regional rate, although it remains below the national average.

High levels of unmet need can contribute to crime, welfare and social care costs, as well as health burden and may also affect productivity. Effective and accessible evidence-based treatment for alcohol dependent adults is a cost-effective response to high levels of need and an essential element of a local integrated alcohol harm reduction strategy. The partnership is therefore encouraged to continue to work towards lowering the rate of unmet need and improving the outcomes achieved by those who access specialist alcohol treatment.

Research shows that alcohol-related harm falls disproportionately on the poorest in society. The most deprived fifth of the population suffer:

- two to three times greater loss of life attributable to alcohol
- three to five times greater mortality due to alcohol-specific causes
- two to five times more admissions to hospital because of alcohol.

This is evident in Durham specific data contained in the Local Alcohol Profiles for England (LAPE), in particular in respect of death from chronic liver disease, alcohol-specific mortality and the incidence rate of a range of alcohol-related health conditions. Continued investment in activity to prevent or reduce alcohol harm in the area will therefore support local ambition to reduce health inequalities.

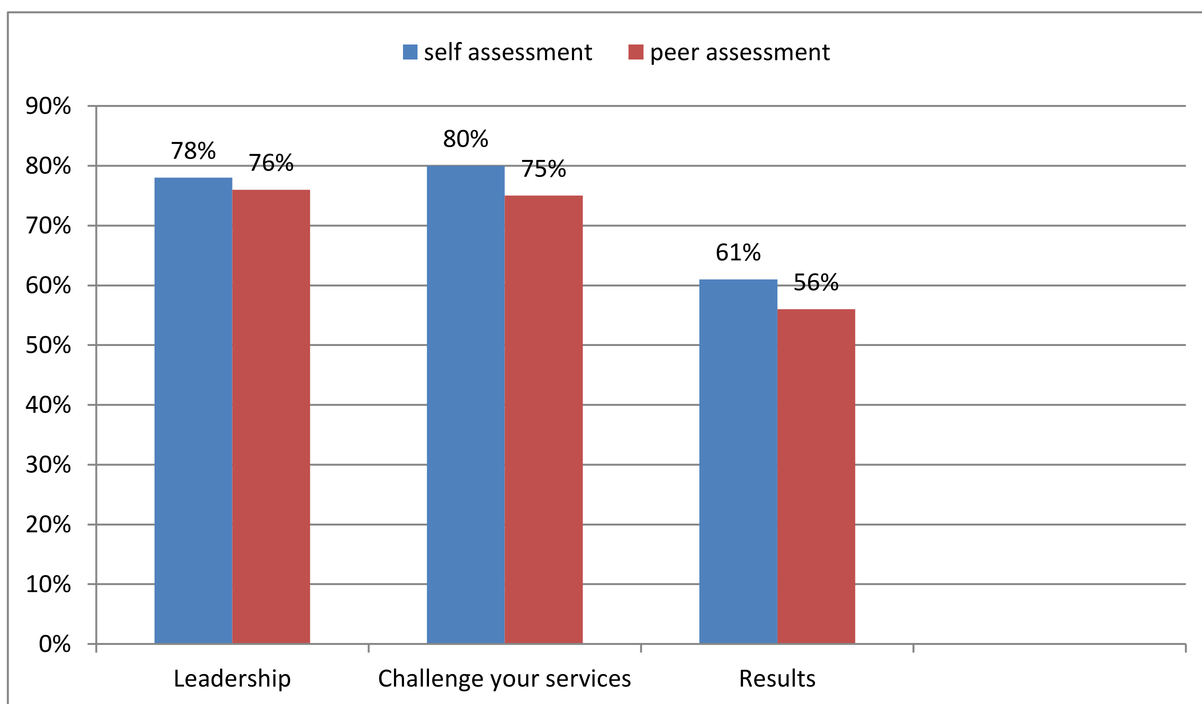
CLeaR messages

This chapter sets out your insights, summarises the strengths and good practices demonstrated by your alcohol partnership and also reflects the opportunities for further action that were identified both during the internal discussions informing the completion of the CLeaR self-assessment and at the subsequent peer assessment visit.

4.1 CLeaR evidence

There were many areas of agreement between the rating of the evidence for the CLeaR criteria as scored within the self-assessment and the ratings awarded by the visiting peer assessment team. Any differences between overall domain scores are shown in the bar chart and table below and the reasons for variation are set out within the narrative of this chapter with more detail in chapter 5.

Bar chart comparing Durham self-assessment and peer assessment domain scores



CLeaR domain	Self-assessment rating of evidence	Peer assessment rating of evidence	Maximum score
Leadership	36	35	46
Challenge services	35	33	44
Results	11	10	18

4.2 Leadership domain

Summary of findings

You rated your evidence of achievement against the leadership criteria at 78% in the self-assessment. The peer assessment team largely agreed with your assessment and commend your integrity in scoring your evidence of achievement so honestly.

What you told us - partnership insights

- You told us that the alcohol agenda has the support of senior elected members, with the portfolio holder passionate about the agenda and helping communities overcome alcohol issues.
- You described how local criminal justice partners address alcohol harm at the strategic level. For example, reducing the harm caused by drugs and alcohol is one of the priorities of the local Police, Crime and Victims Commissioner and the local Criminal Justice Partnership plan has a focus on alcohol as a key pathway to assist with reducing reoffending.
- We heard that the Safe Durham Partnership has reducing the harm from alcohol misuse as a priority and Durham Constabulary operates a Harm Reduction Unit that tackles a range of alcohol-related harms including licensing matters.
- You feel that senior managers across the partnership in Durham understand the need to reduce alcohol-related risk and harm and engage well. Commitment among those involved in the agenda is strong, but there are gaps in engagement, with crucial partners such as health not fully engaged.
- You told us that activity delivered by your commissioned providers is routinely monitored and understood. Those around the table acknowledged that there will be other areas where work is being done that is not necessarily joined up, performance managed or reported on, either at the strategic or operational level.

- We heard that there is a current alcohol harm reduction strategy in Durham, with no refresh due until 2020. The partnership wish to use the CLeaR assessment process as an opportunity to refresh the focus and direction of local action – to demonstrate to Durham as a whole that reducing alcohol harm is still an important area of work.
- You told us that Durham's strategy has been taken forward by means of an action plan. The key priorities for action in the current plan have already been achieved. The timing of the self-assessment was described as ideal, as itsfindings will inform the development of a new action/improvement plan.
- You believe partners understand that to further advance the agenda, senior representation from additional external organisations is required. This will benefit improve pathways and add visible engagement to partner organisations, service users and the wider population as a whole.
- You suggested that from a strategic level, data sharing could be improved with certain partners such as Fire & Rescue, Ambulance Service, acute wards and emergency departments.
- You told us that the new Childrens Services case management system (Liquid Logic) was launched in September 2018. This should provide opportunities to identify, record and share information about hidden harm in a more systematic way.
- We heard the co-location of associated teams has proved positive. Trading Standards, Licensing, the Police Alcohol Harm Reduction Team (Inspector, 2xSergeants, SPCSOs), Special Ops, Business Regulation, Early Help, Licence Processing, and Licence Enforcement are all based on the same floor, resulting in better information sharing and joint working.
- You told us that there was comprehensive consultation to inform the re-letting for the Drug and Alcohol Recovery Service contract both before and after the services new contract was awarded).
- Attendees were passionate about their role and how it impacts on partner agencies, service users and the wider population of Durham.
- As not all key agencies were represented at the review, the level to which their staff understand their personal and organisational role in the wider partnership is unknown.

What we found – peer assessor reflections

- We heard that there is a positive and supportive alcohol partnership in Durham. Elected officials, Public Health, Community Safety and other partners all contribute significantly to the overall agenda and were engaged with the CLeaR process.
- We understand that gaps exist between the undoubtedly strong strategic ambition and leadership of the alcohol agenda in Durham and the translation of the leaders vision into operational activity.

- We understand that the Safer Durham Partnership Board monitors the progress of each local action plan, however this has been with minimal challenge to date.
- We saw strong engagement with criminal justice partners at both the strategic and operational level, with reducing alcohol-related harm and its links to re-offending identified as priorities for the Police, Crime and Victims Commissioner and the local Criminal Justice Partnership. The partnership priority of reducing the harm from alcohol misuse and Durham Constabulary's Harm Reduction Unit reinforces Durham's commitment to this agenda.
- We recognise that the lack of co-ordinated engagement from key health partners means that there will be gaps in provision and missed opportunities to engage with those at risk of alcohol-related harm. This will affect the ability of the partnership to achieve all its priorities.
- We feel that there is good understanding locally of the role and remit of commissioned services from partners and amongst providers and that treatment pathways are understood.
- We heard you acknowledge that resources are limited and this means that there will be times when efforts are not as co-ordinated or seamless as everyone would like. However, when issues arise, there is a willingness to work collectively to resolve them in ways that benefit services users and promote partnership ambition.
- We understand that Durham sees reducing the harm caused by alcohol as an important issue. It is evidently the intention to use the CLeaR assessment process as a prompt for partners to demonstrate the breadth of work that currently goes on, and to highlight the importance of engagement in the agenda from all relevant organisations. The CLeaR process will also be used as a springboard from which a revised action/improvement plan will be launched.
- We heard that additional engagement from partners who are currently not fully invested in the agenda will greatly enhance the overall ability of the partnership to make positive steps forward, both at individual organisation and partnership level.
- We believe that, in respect of under-engaged health partners, the preventing ill-health CQUIN could provide an opportunity for re-engagement.
- We heard that data sharing is good in many areas, but could be improved in respect of some partners. Some health data is traditionally difficult to obtain and can be inconsistent, however other partners such as Fire & Rescue may have data that is easier to access.
- We also heard that the quality of data from Children's Services may improve following the launch of the new case management system (Liquid Logic) in September 2018.
- We understand that the co-location of teams such as Trading Standards, Licensing, Police Alcohol Harm Reduction Team, Special Operations, Business Regulation, Early Help, Licence Processing and Licence Enforcement offers every opportunity for more positive, joined up work.

- We heard that the consultation for the Drug and Alcohol Recovery Service was comprehensive with pre and post award sessions. However, the refusal of Durham's procurement department to allow service user representation on the assessment panel is a concern.

Recommendations - opportunities for development

- Whilst Durham has an up-to-date alcohol strategy, you are encouraged to produce an updated action/improvement plan to support ongoing work in reducing alcohol-related harm. Particularly, this should look at formalising the relationship with less engaged partners in ways that complement both individual agency, as well as partnershipwide, agendas, at both strategic and operational levels.
- The preventing ill health CQUIN may be an opportunity to engage with the foundation trust. Senior officers are encouraged to establish whether the trust has implemented this as a first step to aligning activity in secondary care with wider partnership ambition.
- All relevant organisations should be involved in the development of the updated action/improvement plan and understand how it contributes to wider agendas. If this is unachievable, it might be useful for the senior leadership to use their contacts and influence to improve engagement with health partners, with officers working to improve operational arrangements once senior level buy-in has been achieved.
- Formalised agreements about data sharing between health and criminal justice agencies are needed to support your ambition to reduce alcohol-related crime and disorder. Visible senior partner commitment to the development of inter-agency information sharing protocols may help prioritise this work.
- Changes to partnership resources, such as the Alcohol Harm Reduction Unit, will impact across Durham. Strong partner relationships increase the opportunities for consultation and planning to enable successful management of enforced change.

4.3 Challenge your services domain

Summary of findings

You rated your evidence of achievement in relation to operational delivery at 80%.

Whilst the peer assessors endorsed your self-assessment scores against most criteria, there were reservations about the rating of evidence of achievement offered for aspects of secondary and tertiary prevention. As a result the overall peer assessment rating for the Challenge Services domain was slightly lower than your scoring in the self-assessment.

What you told us - partnership insights

- You told us that Durham has actively engaged Area Action Partnerships (AAP), Neighbourhood Watch and Health Networks. There are opportunities to use these more than they are at present through the Public Health Healthy Communities strand.
- You reflected that Public Health does not feel able to have meaningful input into licensing decisions. However, you believe that there should be more involvement following the restructure and there are good working relationships between Durham Constabulary Licensing and DCC Licensing who are co-located.
- You also reflected that there is little input from other responsible authorities such as Fire & Rescue and immigration enforcement in the licensing process.
- You told us that the number of operations targeting test purchases and proxy sales of alcohol to those under-age have reduced. This is reflected in the low numbers of fixed penalty notices issued by police.
- You recognised that there have been instances in the past where the Local Authority has been reluctant to communicate 'sensitive' agendas. More could be done to challenge this and a more co-ordinated approach to communications with partners may help.
- You do not believe that the pathways between acute hospitals and community treatment services are robust. The new treatment provider is working to make these more formal.
- You described a lack of meaningful data (Cardiff model) from local emergency departments.
- You described close working with Balance and support the campaigns they lead regionally but you advised us that local information regarding alcohol is inconsistent and there is no agreed strategic approach to ensure a consistent message. You are keen to avoid any collaboration with the alcohol industry in any information development, so need to investigate other ways of achieving this.
- You described how the Harm Reduction Unit has made attempts to use Snapchat as part of its communications work. A future project will attempt to identify a group of media students to deliver peer led messages.
- You described innovative approaches to local work with children and young people.
- You explained that the young people’s service is outreach focussed. It also provides flexible transition arrangements and will work with vulnerable clients who are over age.
- You described how there is a single front door to access a variety of services for vulnerable young people. Agencies are able to cross-reference referrals against existing information so that professionals are well-informed about the young person.

- You told us that some schools bypass local governance and support structures by using external and un-linked people/organisations to deliver interventions to pupils. Ultimately this is outside of public health control, although they advise against it.
- You said that a significant proportion of the budget (approx. 20%) has been removed from the system making service re-configuration necessary. However, a large number of staff TUPEd across from the previous provider, ensuring a high degree of consistency for service users.
- You described how hospital in-reach provision could be extended onto other wards such as fracture clinics, as well as more obvious ED and gastro wards.
- You told us about good links and in-reach programmes with the local prison.
- You reflected that although numbers in treatment have reduced, there are indications that alcohol caseloads now comprise more complex cases that will be in treatment for longer.
- You feel that strong attempts are being made to try to work with CCGs and GPs to help overall health management.
- You indicated that there is a pharmacy lead in Public Health and a clinical inspector who are well placed to approach and speak appropriately to pharmacists and GPs should there be any concerns in respect of their prescribing practices for alcohol clients.
- You understand that there needs to be a focus on priority areas such as the NHS capacity to identify risk and intervene appropriately, with the Preventing ill health CQUIN representing an obvious engagement tool in the first instance.

What we found – peer assessor reflections

- Use of AUDIT C is incentivised to embed routine screening to identify alcohol-related risk across GP surgeries.
- The Clinical Commissioning Group and NHS acute/mental health trusts could be more actively engaged in the routine identification of alcohol-related harm and delivery of information and advice or onward referral as required.
- We were pleased to hear Public Health's commitment to licensing and understand the frustration that health is not a current licensing objective, even though Public Health are a responsible authority. Working closely with the co-located Durham Constabulary Licensing and DCC Licensing may help.
- We heard that licensing in Durham is made more difficult due to the lack of input from other responsible authorities.
- We acknowledge that financial restrictions have meant a reduced number of test purchase and proxy sale operations.
- We appreciate that local authority communications don't always reflect the challenging nature of the topics being tackled.
- We heard that acute hospitals and community services do not appear to have strategically and operationally linked pathways and that data from departments

such as A&E is inconsistent. The community service may require senior level support to formalise these pathways with relevant organisations, although the planned in-reach activity will help develop then raise awareness of these.
- Durham is very active in communications and social marketing. They are the lead commissioning body for the North East regional contract with Balance, an agency focussing on health campaigns. This gives Durham opportunities to engage at regional level and provide prevention and early intervention work at scale.
- We heard that other alcohol communications are inconsistent, with messages coming from different sources. A single source or strategically agreed approach to ensure a consistent message would be helpful, but this should avoid collaboration with the alcohol industry.
- You explained how partners have attempted to use social media as part of their communications offer. Peer led messaging via social media platforms is an interesting future project.
- Your outreach focussed young people's service is positive, as are the flexible transition arrangements we were told about.
- The single front door access to services for vulnerable young people and the ability to accept referrals from both public and professional sources is welcome, as is the ability to cross-reference referral information with existing cases to avoid duplication of assessment and respond to need in a more timely way.
- The use of external and locally un-supported agencies to provide input to schools is a concern, although we acknowledge that schools have the right to follow such a course of action.
- We heard that potential disruption to service users and referring agencies as a consequence of ongoing issues with the treatment contract has been tempered slightly by the fact that a significant number of staff transferred over from the previous provider, giving at least some level of consistency in service delivery.
- Your peer led prison in-reach and through the gate support is very positive, although the fact that this may be dependent on individual governor readiness to engage is a concern for the future.
- We can see that there has been a fall in the number of alcohol misusers accessing treatment and understand that remaining caseloads are dominated by more complex cases that will require engagement in treatment for longer periods. Linking in with CCGs and GPs to contribute towards overall health management would be useful.
- We understand that the Public Health pharmacy lead and clinical inspector could yield positive results when dealing with health partners.

CLeaR recommendations - opportunities for development

- The preventing ill-health CQUIN provides an opportunity for local partners to encourage health practitioners in hospital settings to embed the routine

identification of alcohol risk and the delivery of brief advice or onward referral as required into local practice.

- You told us about your resolve to actively involve service users in the development of services, including the co-production of resources. This could help improve engagement with the commissioned service and the outcomes achieved.
- Opportunities to use the already engaged Area Action Partnerships (AAP), Neighbourhood Watch and Health Networks should be sought, potentially via the Public Health Healthy Communities strand.
- Public Health's willingness to do more to influence licensing is noted. An exercise investigating how this has been achieved in other areas would be beneficial. The possibility of negotiating the inclusion of health considerations into the next Statement of Licensing Policy could be explored to ensure health need and impact are routinely addressed in the licensing process.
- Innovative ways to communicate difficult messages should be sought. Co-ordinated response through partners may be one possibility.
- Partnership wide communications standards or criteria would be useful if partners have concerns regarding the consistency of alcohol messages.
- Those with the responsibility for hospital in-reach should consider contacting wards/clinics that may deal with alcohol attributable injuries, such as fracture clinics, as well as gastro and emergency departments, in a bid to expand the breadth of pathways into treatment.
- Arrangements with the local prison should be formalised at a senior level to ensure that the peer led work can continue regardless of personnel change.
- An audit of the complex alcohol caseload may flag similarities that could benefit from targeted work.
- Public Health should use its position to try and engage with the CCG and GPs in order to build responses to alcohol use into overall health management.
- Co-ordinated partnership responses to issues that could be considered contentious may be a solution to help a single agency address difficult subjects, especially when this is unpalatable for senior stakeholders.
- Direct communication with schools from someone senior such as the DPH may help raise the profile of local free services and avoid unnecessary spending on external provision that is not linked to local support networks.
- Commissioners and the provider will wish to consider ways in which user involvement for young people can be improved and offer training for staff to ensure service users are listened to.
- Commissioners may wish to consider ways in which locally run campaigns can be evaluated to ensure they add value. There may be learning from the Balance approach to evaluation that the partnership can adapt for this purpose.
- Now that the new treatment service is established there is an opportunity to work with the commissioned provider to review how the current system is working to meet the needs and improve the outcomes achieved by alcohol misusers. This

will enable partners to better understand the treatment delivery model and its suitability for Durham.

4.4 Results

Summary of findings

There was a degree of evidence to support the impact of local activity in reducing alcohol-related harm reflected in conversations throughout the day. The self-assessment score of 61% was slightly reduced, but, in the main, there was a high level of agreement from the peer assessment team.

What you told us - partnership insights

- You told us that Durham's data shows mixed results against its priorities. You advised that alcohol-related mortality, although improved against the national picture, still lags behind the rest of the North East.
- You described that the number of interventions being undertaken by GPs and pharmacies is good, and partners should be encouraged by the rate of young people engaging with, and leaving services in a planned way (albeit with the latter falling slightly). Adult alcohol successful completions and representations are improving, however you indicated these require further work to make the partnership feel comfortable about the progress being made.
- You suggested that local unmet need still lags behind the national average. Public Health are hoping that participation in the recent national inquiry investigating the reason for the reduction in alcohol treatment numbers will provide insight.
- You reflected that local data regarding alcohol-related incidents and violent crime show a falling trend that reflects the activities undertaken to reduce alcohol-related crime and disorder.
- You recognised that there are a number of under-utilised local data sources such as primary and secondary care data, access to, and analysis of which, could increase understanding of need and the outcomes achieved locally.

What we found – peer assessor reflections

- On the whole, Durham's data shows mixed results against local priorities.
- We heard that GP and pharmacy intervention numbers are strong. The numbers engaged with YP services and successfully completing treatment are encouraging, as is the year on year improvement in the rate of adult successful completion with no representation within 6 months for alcohol cases.

- Whilst the estimated rate of unmet need in Durham at 79% indicates that currently only around one in five dependent drinkers is accessing treatment in this locality, the estimated rate of met need is marginally stronger than the national average rate. Participation in the PHE inquiry into the reasons for the fall in numbers in alcohol treatment nationally may provide additional understanding and identify ways to address this. There could also be an opportunity to engage with partners, the local population and data/intelligence providers to help you better understand the needs of your population.
- We observed that the falling trend in violent crime and alcohol-related incidents reflect well on the activities undertaken to reduce alcohol-related crime and disorder in Durham.

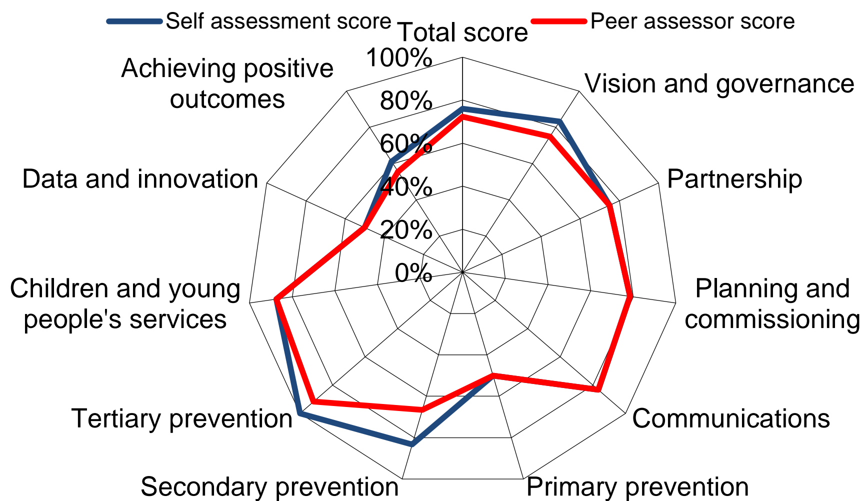
CLeaR recommendations - opportunities for development

- Despite recent improvements, adult alcohol successful completions with no representation will require further work to match the national rate.
- Opportunities to engage with partners to better understand unmet need, in particular to gauge where those with an alcohol dependence may be presenting and how to improve the pathways into structured treatment when dependence is identified should be sought.
- As well as agreeing priorities for action to support onward referral into structured treatment there may also be opportunities to consider how the treatment service model is supporting improved engagement with dependent drinkers. The report outlining key findings of the PHE national inquiry with recommendations has been published. The partnership is encouraged to reflect on this learning in shaping its local plan of action.
- The partnership need for an action/improvement plan rather than a strategy refresh is understood at this time. Partners and stakeholders will need to keep this regularly reviewed and adapt as and when changes to the strategy or other national and local issues emerge.
- Helping less engaged partners understand how tackling alcohol-related harm can have a positive impact on their own agency, as well as the individuals in their care, for example by reducing occupied bed days or representations, can help demonstrate the cost effectiveness of engaging with the agenda and partnership work, as well as addressing unmet need.
- Routine analysis of primary care and preventing ill-health CQUIN data may enhance local understanding of where unmet need is presenting and help inform the development of effective pathways between health care settings and the community treatment system.
- Formalised inter-agency agreements about data sharing are needed to support your ambition to develop a clearer understanding of local need and monitor progress against local priorities.

CLeaR results in detail

5.1 Durham CLeaR profile

The spider graph below shows (in blue) Durham's original self-assessment scoring, as a proportion of the available marks in each section and (in red) the peer assessment results. The results of the peer assessment were lower in some areas and higher in others, than the ratings of the evidence within the self-assessment. The detailed comments below show where the assessments differ. Both assessments highlight areas where improvement can be made.



5.2 Detailed comments on learning from your peer assessment

CLeaR Theme	Local score	Peer score	Max score	Comments
Leadership				
Vision and governance	7	6	12	• The assessment team agreed with the majority of the self-assessed scores in this area and found Durham to have strong partnership commitment and accountability. • The assessment team did reduce the score by 1 mark in this section as they felt that although Durham clearly has senior level support from Public Health, Community Safety and some other partners, the evidence did not indicate high level understanding of the strategic vision across the partnership in its entirety. • With there being no need for an alcohol strategy refresh at this time, it is important that the partnership focus on an action plan that will influence the key priorities around alcohol and maintain forward momentum. • The 2018 report from the Director of Public Health, "A New Vision for the Taylors" has alcohol as a theme and acknowledges the role Public Health plays in reducing alcohol-related harms across the wider population. • Elected members that support the alcohol agenda are represented on both the Health & Wellbeing Board and Community Safety Partnership. Both groups are chaired by the leader of the Council.
Partnership	13	14	20	• Durham's CLeaR assessment was co-ordinated by Public Health but input was received from a number of individual partner agency representatives indicating strong and supportive partnership relationships. • Ideally Durham would have preferred to have undertaken the assessment with face-to-face conversations, but the realities of limited availability meant that the majority of meetings were virtual. • The Alcohol & Drug Reduction Strategy Group has a wide range of stakeholders engaged, but to date there has been limited CCG and Acute Trust participation. • Council Substance Misuse Team has a reporting mechanism to senior

				CCG colleagues, but this was described as sometimes challenging. • The absence of senior health partner input into the process highlighted a gap within the partnership.There were clear gaps between the obvious operational activities undertaken in acute settings or emergency departments and the strategic oversight that should embed such activity as part of a connected and overarching strategic response to reducing alcohol-related harm. • A potential tool for engagement exists via the "Preventing Ill Health" CQUIN and should be explored as a first option. However it may be that the local acute trust has decided not to undertake this piece of work and other avenues for engagement should also be considered in the event that this is the case. • The action plan that supports the strategy should be clear in terms of what individual partner roles and responsibilities are. Raising awareness of benefits at an organisational level may also help engage partners, for example, reducing frequent A&E attendance may be of interest to disengaged health agencies. Inter-linking partnership priorities can sometimes be helpful to ensure that individual agencies understand how their activity supports the overall agenda. • The work with criminal justice partners, especially prisons, is very positive, however it is a concern that this seems to be based on personalities, rather than as an embedded systemic action. Agreement to formalise this work would be advantageous. • There is a dedicated partnership team in place to link the Safer Durham Partnership with the City Safety group. This provides an opportunity to coordinate campaigns to ensure a consistent message across the partnership.
Planning and commissioning	7	7	14	• As previously highlighted, since the alcohol strategy is current, an alcohol action plan to drive forward the aims of the strategy may help reinvigorate the role of partners. • There are challenges for commissioners to provide effective

				and appropriate services in a difficult financial climate. It is therefore important to engage with as many partners as possible in order to forge strategic and operational links and lever potential resources and help with addressing unmet need. This underlines the importance of up to date strategic level plans that can be used to reinvigorate disengaged partners where necessary, especially those from health. • The governance structures in Durham indicate that genuine joint commissioning is undertaken. • Durham's treatment services underwent a comprehensive tendering process in 2015, followed by the failure of the treatment provider, subsequent temporary provision and further tender. Commissioners and services users have therefore had to deal with 3 different providers in 3 years. • There are signs of improvement, for example in successful completions. With an integrated drugs and alcohol service, partners will need to remain vigilant to ensure services are equally appropriate for alcohol clients as they are for those who use drugs. • A period of consolidation will help commissioners understand which issues have been due to the changes and which are actual gaps in treatment provision.
Challenging your services				
Communications and social marketing	4	2	6	• Balance have produced successful campaigns on the links between alcohol and cancer, as well as the wider risks of drinking. Target groups are the key health inequality and socio- economic groups such as C2-D,E. • The evaluation process for Balance campaigns is strong, with baseline taken and sense checked at wave 1 and 2. Additionally they test the creative material, measure post campaign effectiveness and produce an annual report on acceptability. Campaigns are rolled out via the quarterly Champions Network • Campaigns undertaken locally that are not run by BALANCE do not receive the same level of evaluation. Ways to overcome this to ensure

				local campaigns add value and support objectives should be pursued. • Durham has also been involved in the Dead Drunk and 1-Punch and it is acknowledged that there will be difficulties in quantifying the impact of these. • Public Health can explore more opportunities to engage with social media, for example, by following up national news items with how this relates to people locally, ensuring that any messages and campaigns are aligned to the overarching priorities around reducing alcohol-related harm. • It is encouraging to hear that communications from partners such as the police concerning young people and alcohol have shifted their focus from being about nuisance and ASB to being about vulnerability and safeguarding.
Primary prevention (reducing demand and availability)	4	1	6	• Durham support the creation of a 5th licensing objective and are actively engaged in supporting/lobbying. As things stand it is difficult to relate any health impacts to single premises. Durham could explore the use of a zonal system to help them better understand the health impacts of alcohol use linked to licensed premises. Data from partners about incidents of violence or injury would greatly enhance this. • Due to the geographical make-up of Durham, setting up a zone system for the entire county could be complicated and costly. Durham should therefore focus on known areas of high harm, perhaps starting with a pilot. • Durham's ideas regarding a late night levy to supplement support and enforcement should be explored further, as should the provision of health information to licensed premises that is displayed at point of sale. • The availability of tap water and cheaper pricing of healthier options also has merit. Such initiatives on their own may have limited effect, but as part of a raft of measures there could be some impact. • Public Health needs to be visible in licensing committee meetings and be seen by the committee to be part of the process to begin to gain

				momentum for health to be an influencing factor in licensing issues. • The consultation on a new responsible licensing policy is in process. This recommends that licensees and retailers are contacted to see if they are willing to engage with public health and display CMO approved alcohol guidance. • Joint working, colocation and shared access across multiple teams to different organisations systems is a significant strength in this county. • It was noted that although the Acute Trust now has a record system that should allow data to be shared with partners, Public Health still lacks sufficient data to be able to strengthen their position on licensing, leaving the police as the main objective voice in respect of action. • Partnership intelligence is used to address health risks and harms. Examples such as student deaths linked to alcohol and the river and the preventative action taken are positive and can be highlighted to partners as evidence of what can be achieved when people work together.
Secondary prevention (targeting those at risk)	3	3	6	• Hospital admissions data concerning inequalities would be incredibly helpful for local alcohol area plans. • GPs and pharmacies are paid to undertake IBA and extended IBA. Areas of low or poor activity need to be followed up. • There is dedicated training/coaching around IBA. 2,126 BIs have been undertaken in pharmacies. However it is uncertain how quality is measured although audits are carried out and poor performing pharmacies are visited and re-trained. • The nurse consultant follows up AUDIT C and IBA episodes to see if further action is necessary. • Data is available concerning IBA delivery, but such data is not always accessible or reliable. • Community practices, wellbeing groups and AA & peer mentoring groups are linked. • CDF Trust are commissioned to do wider health interventions (MECC style), that include alcohol. • CYP services have a mandatory alcohol assessment tool for families and undertake IBA and/or refer.

				• Checkpoint undertake IBA, along with maternity and early help services, family 1st and vulnerable intervention practitioners. • Fire and Rescue services use AUDIT and MECC to check vulnerabilities during fire safety checks. These are being evaluated by Teesside University. • Links between alcohol, suicide prevention and mental health services exist, although more could be done to align these, especially in relation to men. • Annual alcohol training is available for sexual health and maternity workers, including FASD awareness and CSE/alcohol links. • The street liaison service also works with people with alcohol problems. • Better investigation of alcohol-related mental health is leading to greater numbers of engagements, rather than a rise in alcohol-related mental health issues. • There is a suicide prevention co-ordinator employed by Public Health and funded by the CCGs. They attend the preventable death group that includes a focus on alcohol. • There is an audit of coroner data to identify alcohol-related deaths and alcohol is included in the suicide prevention action plan. • The majority of mental health deaths are related to long-term alcohol and/or drug use, along with associated physical health issues. Information such as this is used to locate gaps in provision and help improve services.
Tertiary prevention (alcohol care teams and community based treatment provision for adults)	11	9	12	• The last few years were described as difficult, with the loss of the specialist hospital provision, the collapse of the main community treatment provider and two re-tenders creating a great deal of uncertainty. • Numbers engaged in alcohol treatment have been low and continue to fall, successful completions had fallen although are now gradually increasing and retention has been poor. • Comprehensive consultation was undertaken prior to the last tender to help identify issues and rectify these. Pathways for CJ, acute, MH, complex needs and CYPF have improved as a result.

				• Approx. 20% of budget (£1.3M) has been removed from the system making re-configuration necessary. Provision has reduced from 6 centres to 3 plus outreach model to engage alcohol clients, including input to GPs and pharmacies. • A high proportion of drug staff TUPEd over from the previous service. As a result a great deal of re-training for former drug staff to assure their awareness of alcohol interventions was required. • Early indications for the new service are that the alcohol caseloads comprise more complex need that will be in treatment for longer. • A distinct 4-8 week programme has been developed (dependent on demand) to boost successful completions. • Good relationships with Durham & Low Newton prisons • A post prison housing initiative was planned but local opposition to it was strong, so it had to be dropped. • Work is being done with GPs and CCGs to address wider health conditions and help with overall health management of alcohol users. • There is currently no alcohol care team in the hospital, although there is a pathway to help people finish unplanned detox in the community. However people are being lost between hospital discharge and community. • Community based approaches to detox are making substantial savings when compared to previous residential rehabilitation methods. • There is a well-supported independent recovery forum made up of people in and out of treatment. Those with lived experience were fully consulted on specification development, however the procurement department refused to allow SU involvement on the actual panel for the tender. • Recovery Academy Durham (RAD) has an ambassador scheme where people work with workers and nurses to support clients and complement staff input, enabling more visible recovery. • The academy offers structured day support from Humankind and Spectrum, along with mutual aid from

				Basement Recovery.
Children and young people	3	2	8	• Peer assessors endorsed Durham's single front door approach, the systems which ensure information is shared appropriately amongst key agencies, the decision making process and the escalation protocols. There are also safeguards in place to protect against malicious referrals. • Telephone and formal referrals are accepted from professionals and the public and are triaged by social workers. Identification of alcohol triggers a cross reference with other services to see if the person is already known to services. • The response demonstrates a positive understanding of need and a strong partnership ethos, with those present describing close working relationships with key agencies and ease of information sharing. • Some schools bypass local governance and support structures by using external and un-linked people/organisations to input in school settings. Ultimately this is outside of PH control, although they advise against it. Regular reiteration to such schools of the free services that PH can offer may assist. • There is a resilience programme in some schools that follows a Swedish model of YP mental health, which is also a train the trainer programme. Durham university are evaluating the programme to establish its efficacy. • Drop-ins are run in schools, with multi-agency partners such as Police/F&R/ASB and treatment services offering a range of advice and information. Some sessions are general in nature, whilst others are targeted based on police intelligence regarding seizures. • There are joint group interventions around risky behaviours of 10-15 yr olds. This includes a group of YP, a group of parents, followed by a joint group to facilitate understanding. • There is a whole range of endorsed materials used, available to the public on the CC website. • Local groups of professionals such as school staff, school nurses (0-19 services), early help (children's services) and appropriate others

				meet regularly around children, young people and families that they may be worried about to plan interventions to stop concerns escalating. • The 0-19 service also employs AUDIT as a routine tool for its service users in order to explore their potential levels of harm from alcohol and risks from other issues. • The network of resilience nurses that support young people with their emotional health, their parents and staff who care for them is a positive input from the mental health trust. • Durham Agency Against Crime provide diversionary activities for people at risk of criminality, such as those from criminal families. • Although there have been a number of challenges for treatment provision, with 3 providers in as many years. • Specific user involvement for young people will help make the voice of the child stronger. • The message from the police to the young person was described as sometimes inconsistent, dependent upon the officer involved. Training around the delivery of a consistent message would be useful. • The use of body cam footage is now being attached to written police reports so professionals can visually assess people as per the time of any incident. • Information and referrals between emergency and inpatient departments could be improved. • Attempts are being made to change the tone of the conversation around alcohol including messages around an Alcohol Free Childhood. • The group described the close working relationships and said that they felt really lucky in Durham as all the key agencies work very closely with each other. Information sharing is not a problem or a barrier to delivery.
Data, innovation and learning	0	0	6	• Data sharing is good with certain partners, but less so with others. Fire & Rescue, Ambulance Service, acute wards and emergency departments will all have information that relates to alcohol that could be routinely shared and used to benefit Durham.

				• JSNA/Durham Insights is on one platform and easy to navigate, with GIS mapping. The inclusion of an alcohol landing page, fact sheet, infographics, along with an asset based approach have been very helpful. • Consistent Cardiff model data, or models from areas such as Cornwall, could help improve Durham's understanding and aid responses to violence and licensing issues. • Data regarding alcohol-related incidents and violent crime show a falling trend that reflects the activities. However, partners need to avoid becoming complacent in the light of positive results and continue with initiatives that will continue to tackle Durham's issues with alcohol. • Durham may find it useful to have their local data as aligned as possible to NDTMS methodology. This will help with accurate forecasting and alleviate national data lag issues. • Including alcohol wherever possible in any appropriate deep-dive exercises may help raise understanding of the issues in Durham. • There may be opportunities to access the IBA data extract from the CCG. However it has been unavailable since 2013. The three honorary contracts with the local commissioning support unit may be able to support this gap in data. • Data is used to measure progress in an appropriate way, by sharing through established governance structures such as the Alcohol Strategy Group and Safer Durham Partnership. • It is important that there is an appropriate level of understanding of data within governance groups to ensure information is challenged when necessary. With the right partners in attendance there should be greater possibility of creating partnership solutions to situations that the data reflects, such as the high level of YP hospital admissions. • Interrogation of additional data sources such as Liquid Logic can greatly enhance your understanding and targeting. Using the TOP for alcohol clients may also provide

				more outcome focused insight. • It is positive to see that the impact gap is closing in relation to hospital admissions and to learn your nearest neighbours data categories were recently amended through close work with PHE locally, to better reflect the partnership context.
Results				
Achieving positive outcomes	4	4	12	• Assessors felt that the agenda would benefit from more challenge at board level. • The rural nature of Durham is noted. Targeted approaches based on local intelligence may help. • There seems to be a reliance on participation in the PHE audit to uncover reasons behind falling numbers in treatment locally. Widening the risk base, to encompass hazardous drinkers, may provide more understanding.
Local priorities	3	3	6	• Assessors agreed with the assessment provided in the CLeaR that some steps have been taken towards achieving local goals, but there is still much to be done. In particular, the reduction referred to in the 2nd objective around alcohol-related hospital admission episodes is more precisely a reduction in the rate of increase, rather than an actual reduction.

5.3 Challenges facing Durham as identified by the peer assessment team at the visit

- Making sure that all key stakeholders understand the role that their organisation plays at a strategic and operational level, in reducing alcohol-related harm.
- Engaging with all key stakeholders, including those who have previously been less actively involved, in the production of an updated action/improvement plan.
- Managing the impact of changes to partnership resources.
- Ensuring a period of consolidation and stability for treatment services and service users following several years of turmoil.
- Ensuring that public health input in to the primary prevention field is constructive.
- Creating a co-ordinated partnership wide communications standard and calendar of events.
- Guaranteeing that all recordable activity delivered across the partnership that meets the criteria for structured treatment is logged on NDTMS.

- Formalising peer led activity at local prisons to make sure that such work is accepted as standard, rather than being dependent upon any one particular member of staff.
- Improving treatment outcomes for those presenting with an alcohol dependence: reducing unmet need by promoting access and increasing numbers coming into the system, increasing retention as appropriate in line with presenting need and demonstrating visible recovery as evidenced by increasing the rate of successful completions with no representation.

CLeaR resources

Based on discussion at the peer assessment visit we suggest that Durham may find the following resources useful as you progress local work to prevent and reduce alcohol harm:

The evidence base and a range of guidance and tools setting out the case for investment in alcohol harm reduction can be found on www.gov.uk/alcohol-and-drug-misuse-prevention-and-treatment-guidance. Partnerships can use these guidance documents, information and resources to help them understand the case for investment and to assist in the provision and improvement of alcohol and drug misuse prevention and treatment services.

- Evidence base
  This review looks at the impact of alcohol on the public health and the effectiveness and cost-effectiveness of alcohol control policies.
  www.gov.uk/government/publications/the public health burden of alcohol evidence review

- Local data
  Local alcohol profiles for England (LAPE):
  fingertips.phe.org.uk/profile/local-alcohol-profiles
  Public health dashboard – alcohol treatment indicators
  fingertips.phe.org.uk/public-health-dashboard-ft
  Public health outcomes framework (PHOF):
  fingertips.phe.org.uk/profile/public-health-outcomes-framework

- Commissioning support pack for alcohol prevention, treatment and recovery
  This comprises two discrete documents which encourage best practice in local planning and commissioning arrangements:
    1. A series of good practice evidence-based prompts to help local areas assess need, plan and commission effective services and interventions.
    2. Key data for each local area to help them commission effective prevention, treatment and recovery services and interventions.

  www.gov.uk/alcohol commissioning support pack

- NICE guidance:
  www.nice.org.uk/guidance/qs83
  This quality standard covers a range of approaches at a population level to prevent harmful alcohol use in the community by children, young people and adults.
  www.nice.org.uk/guidance/qs11

This quality standard covers the care of children (aged 10 to 15-years), young people (aged 16 to 17-years) and adults (aged 18-years and over) drinking in a harmful way and those with alcohol dependence in all NHS-funded settings.
www.nice.org.uk/guidance/ph24
This guidance is for government, industry and commerce, the NHS and all those whose actions affect the population's attitude to, and use of, alcohol.
www.nice.org.uk/guidance/cg100
The advice in this guideline covers the care of adults and young people (aged 10-years and older) who have any of the following physical health problems that are completely or partly caused by alcohol use.
www.nice.org.uk/guidance/cg115
This clinical guideline offers evidence-based advice on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10 to 17-years.
www.nice.org.uk/guidance/ng50
This guideline covers assessing and managing suspected or confirmed cirrhosis in people who are 16 years or older. It aims to improve how cirrhosis is identified and diagnosed.
www.nice.org.uk/guidance/ph49
This guidance makes recommendations on individual-level interventions aimed at changing health-damaging behaviours among people aged 16 or over.

- Addressing inequalities
  WHO: Alcohol and Inequities.pdf

- Improving joined up approaches and partnership working:
  Guidance on commissioning and providing better care for people with co-occurring mental health, and alcohol and drug use conditions.
  www.gov.uk/people with co-occurring conditions

  A resource from the Prevention Concordat for Better Mental Health Programme to help local areas with prevention planning arrangements.
  www.gov.uk/prevention concordat for better mental health

  The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.
  www.crisiscareconcordat.org.uk

  Guidance offering support to ongoing work to assist in the implementation of the government's suicide prevention strategy.
  www.gov.uk/suicide prevention developing a local action plan

- Local planning and commissioning arrangements:
  Guidance for local areas to identify problematic parental substance use to help commission services to reduce and prevent harm to children and families.
  www.gov.uk/parental alcohol and drug use understanding the problem

- Tools for assessing value for money in alcohol and drug treatment:
  www.ndtms.net/Value for Money.aspx
  Why invest slide pack
  why invest slidepack 2018

- Primary prevention: The focus is on creating environments that support lower risk drinking. Effective population-level approaches reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol-related harm.

  Licensing and compliance:
  Public Health and the licensing act 2003 – guidance note on effective participation by public health teams has now been published:
  www.gov.uk/revised guidance issued under section 182 of the Licensing Act 2003 updated April 2018.pdf

  The Analytical Support Package (ASP), brings together nationally available data and materials with local information to support local authorities in accessing and using a range of databases and tools. Local teams are able to input their own data and create interactive maps and reports to help them in their existing role as a responsible authority.
  www.gov.uk/guidance/alcohol licensing: a guide for public health teams

- Secondary prevention: The focus is on lowering consumption in those drinking at risk. Large-scale delivery of targeted brief advice and early interventions aimed at individuals in at-risk groups can help make people aware of the harm they may be doing and can prevent extensive damage to health and wellbeing.

  Alcohol identification and brief advice (IBA):
  An online learning resource for health and social care professionals working to reduce alcohol-related harm.
  www.e-lfh.org.uk/alcohol

  The Alcohol Identification and Brief Advice (IBA) Commissioning Toolkit, developed by the Health Innovation Network, South London brings together the evidence base, best practice and most up-to-date knowledge about IBA and commissioning of IBA into one easy-to-use online resource. It includes step-by-step guidance on all the key aspects of commissioning and some exploration of how to commission strategically and on commissioning to improve quality of IBA delivery.

healthinnovationnetwork.com/HIN AIBA Toolkit FINAL.pdf

This document outlines the need for the NHS to take action to address risky behaviours, with a focus on alcohol consumption and smoking to prevent ill-health – alcohol and tobacco (prevention) CQUIN.
www.england.nhs.uk/preventing ill-health cquin supplementary guidance

This document outlines public health interventions that can improve the health of the population and reduce health and care service demand.
www.gov.uk/local health and care planning menu of preventative interventions

- Tertiary prevention: The focus is on reducing dependency and improving recovery. Prompt access to effective alcohol treatment including packages of psychosocial, pharmacotherapeutic and recovery interventions that are accessed by the target populations can deliver sustained recovery from alcohol dependency.

  This guidance can be used to create or review quality governance structures which:
  - drive quality up and improve service effectiveness
  - ensure the safety of service users
  - make services cost-effective.

  www.gov.uk/alcohol and drug treatment quality governance

  This report sets out the findings of the rapid inquiry undertaken by Public Health England in 2018 to better understand what is behind the fall in numbers of people in treatment for alcohol dependence in England. It also makes recommendations about next steps.
  www.gov.uk/alcohol treatment inquiry summary of findings

  This is a guide for local authorities and substance misuse services to help them work together to safeguard and promote the welfare of children.
  www.gov.uk/safeguarding children affected by parental alcohol and drug use

  This guidance sets out the benefits of involving service users in planning and improving substance misuse treatment and includes good examples of service user involvement from across the country.
  www.gov.uk/service user involvement in alcohol and drug misuse treatment

  The *Blue Light project* is an approach to tackling the needs of one of the most challenging groups in the community through the development of alternative methods and care pathways for treatment resistant drinkers who place considerable burden on public services.
  www.alcoholconcern.org.uk/blue light project

CLeaR next steps

7.1 What happens next

Thank you for using the alcohol CLeaR approach to sytem improvement.

Having completed your self-assessment and CLeaR peer assessment, you will now be awarded CLeaR accreditation until March 2020. This gives you the right to use the CLeaR logo.

In the meantime we invite you to:

- share this report with partners and stakeholders, and develop actions based on the recommendations
- contact the regional PHE alcohol lead if you'd like to discuss further support for alcohol prevention and harm reduction in your locality
- allow the members of staff trained as CLeaR peer assessors to participate in, and learn from, other assessments by acting as peer assessors
- repeat your self-assessment in 18 months time to track how your local evidence of achievement have changed
- consider commissioning a further CLeaR peer assessment in 2020.

7.2 CLeaR contacts

Will Johnston	giguk1@gmail.com
Iain Armstrong	Iain.armstrong@phe.gov.uk
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7.3 Durham participants at the peer assessment visit

1. Amanda Hale, Sexual Health, County Durham and Darlington NHS Foundation Trust
2. Amanda Healy, Director of Public Health
3. Andrea Petty, Strategic Manager, Partnerships
4. Ann Bell, Service Manager, County Durham Drug & Alcohol Recovery Services (HumanKind)
5. Belinda Boam, Nurse Consultant, Tees, Esk and Wear Valley NHS Foundation Trust
6. Chief Superintendent Jane Spraggon, Durham Constabulary
7. Colin Shevills, Director, Balance
8. Councillor Lucy Hovvels, Portfolio Holder for Health and Wellbeing

9. DC Dean Haythornthwaite, Durham Constabulary
10. Denis Bryan, Recovery Ambassdor
11. Gemma Wilkinson, Performance and Improvement Team Leader
12. Gina Daley, County Durham Drug and Alcohol Recovery Service, Children, Young People and Family Team Manager
13. Helen Riddell, PH Advance Practitioner, Vulnerable Children, Young People and Families
14. Jan Fulford, 0-19 Service, Harrogate and District NHS Foundation Trust
15. Jane Sunter, Public Health Strategic Manager, Living and Ageing Well
16. Joanne Waller, Head of Environment, Health & Consumer Protection
17. Karen Davison, Head of Early Help, Inclusion, Vulnerable Children
18. Michael Fleming, Strategic Manager, Research and Public Health Intelligence
19. Michael Lamb, Commissioning Policy & Planning Officer
20. Owen Cleugh, Consumer Protection Manager
21. PC Claire McNaney, Durham Constabulary
22. Samantha Level, Analyst, Durham Constabulary (skype or phone facility required)
23. Sean Barry, Public Health Practitioner
24. Stella Hindson, Marketing and Communication Manager, Durham County Council
25. Stephanie Kilili, Policy Officer, Office of the Durham Police, Crime and Victims' Commissioner
26. Sue Taylor, Partnership Manager, Balance
27. Tammy Edwards, Checkpoint Navigator.