Report of an Alcohol Identification and Brief Advice Training Needs Analysis across the North West Region

Regional Report

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Contents

Introduction

The aim of this report is:

- To provide the Public Health Networks of Greater Manchester, Cumbria and Lancashire, and Cheshire and Merseyside with a training needs analysis to assist the planning of systematic alcohol identification and brief advice training in 2009/10 and beyond.

The objectives of this work are to:

- Undertake a Training Needs Analysis
- Develop a Training Tool
- Develop a Training Plan

The training needs analysis is based on a questionnaire which was sent to 21 local authority areas. It should be noted that after discussion it was agreed to treat St Helens and Halton as one partnership, because all their work was joint. The form was completed by a range of different officers within the partnerships (see appendix 1). All areas returned a questionnaire.

The professional groups focused on in this report were chosen partly on the basis of the advice in the Department of Health's *Review of the effectiveness of treatment for alcohol problems*[1] and in part as a result of discussions with the commissioners of the research.

The analysis is being presented in four separate versions:

- A regional overview report
- Greater Manchester report
- Cumbria and Lancashire report
- Cheshire and Merseyside report

Each report is presented in exactly the same way but records and reviews a different dataset.

The commissioners requested that a league table be developed to give some sense of the areas that are performing better or worse in the region. It has to be acknowledged that this is an unscientific undertaking and is only indicative at best.

Each report covers the following themes:

- Overview for the area covered
- A league table
- The data for the area covered
- Barriers
- Comments from other agencies
- Developing a training tool / plan
- Appendix

Methodology

The contents of this research report are based mainly on a series of questions specified and agreed by the lead commissioner. These questions were put to a series of identified local contacts (see appendix 1). The questions could be answered in the form of written responses to a questionnaire (see appendix 2) or answered in a telephone or in a face to face interview. The majority were completed as written returns. This data was then analysed by Alcohol Concern and turned into a draft report. This was sent out for comment to regional leads and the report was adjusted in a number of ways as a result. Desk research was undertaken to produce the latter sections of the report on ideal models for Identification and Brief Advice training.

The data used in this study covers the period 2007-9. It is recognised that while significant efforts have been made to capture all local IBA activity, the information may not be reflective of all activity currently taking place.

Partnerships

It was agreed by the lead commissioner that the basis for this research would be the Drug and Alcohol Action Team (DAAT) partnership boundaries. These are coterminous with the local authority areas. This was chosen in preference to the Primary Care Trust (PCT) boundaries because it was felt that more work related to alcohol would be commissioned on this basis.

However, it is recognised that the DAAT partnership itself may not be the strategic driver for future change. The lead may come from the PCT, the Local Strategic Partnership or the Local Authority. In talking about future action this report still uses the term “partnership” but recognises that other bodies may take the lead.

Acknowledgements

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Section 1

Executive Summary– The Region

Introduction

Alcohol is a major cause of health, social and criminal justice problems in the North West. The region has the highest rates of alcohol specific mortality for both men and women. Seven areas in the region are among the top ten areas for alcohol related harm in the country according to the North West Public Health Observatory. It is recognised at national, regional and local level that action is required to tackle alcohol related harm.

A national indicator (NI39 / Vital Signs 26) to measure change in the rate of hospital admissions for alcohol related conditions has given further impetus to tackling this problem. An essential factor in the achievement of these aims will be the widespread identification of those who are drinking at harmful levels and the delivery of brief advice by a range of professionals in a number of different settings. This is one of seven "High Impact Changes" set out by the Department of Health. [2]

A large body of research evidence supports the effectiveness of Identification and Brief Advice (IBA) in primary care including at least 56 controlled trials. For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels. Patients who received IBA in Accident and Emergency made 0.5 fewer visits to the unit during the following 12 months.[3] However, these changes should not be limited to primary health care and hospitals, the Department of Health also flags up the importance of targeting mental health, criminal justice and social care.[4]

Alcohol Concern was commissioned to provide the Public Health Networks of Greater Manchester, Cumbria and Lancashire, and Cheshire and Merseyside with a training needs analysis to assist the planning of systematic alcohol identification and brief advice training in 2009/10 and beyond. This research has looked at the extent to which IBA training is happening across North West England and made appropriate recommendations.

Recommendations

This report sets out its recommendations in the form of a training plan based on the findings of this research. This plan is generic and sets out the steps that need to be taken by an area which is starting from scratch. It is impossible to develop a single specific training plan for the region or the three areas because each partnership is at a different stage of development. The following sets out 11 stepped recommendations which can be followed to develop a robust approach to Identification and brief advice.

1. Each partnership should identify the provision of identification and brief advice as a strategic priority and that training local Tier 1 staff is a local objective
2. Each partnership should consider whether to establish a LES
3. Each partnership should be encouraging the use of the DES
4. Each partnership should agree which screening tools are to be used
5. Each partnership should consider the priority groups of Tier 1 staff for which IBA training will be provided. These should take into account the priority groups identified by the Department of Health which include primary care, general hospitals, accident and emergency, mental health, criminal justice services and social services.[5] A Training Needs Analysis tool is included in

Appendix 2 and could be developed for use with particular staff groups. Other Training Needs Analysis tools may also be available.

6. Each partnership should identify how training will be provided for each priority group. A range of methods of delivering training should be considered to maximise the staff reached. This should include one day training, half day training and elearning due to issues in releasing /covering staff.
7. Each partnership should identify the resources to provide the training. This should be done in the light of the Department of Health's *Guidelines for the commissioning of Identification and Brief Advice (IBA) training.*[6] Partnerships should also look at the NW focused commissioning guidance, 'Commissioning training for behaviour change interventions: evidence and best practice in delivery, Powell & Thurston 2008'. http://www.nwph.net/champs/Publications/Behaviour%20change/Commissioning%20training%20for%20behaviour%20change%20-%20full%20report%20-%20autumn%202008.pdf
   Interagency collaboration on commissioning and resources will also support this recommendation.
8. Each partnership should identify how training will be provided for each priority group and commission the training.
9. Each partnership should establish monitoring and evaluation systems for the training and ensure that a consistent record of people and professions trained is kept. Measurable outcomes should be developed to ensure that IBA work is undertaken.
10. Each partnership should identify how ongoing support will be provided for those who have received training
11. Each partnership should identify what refresher training will be provided for those who have received training

Summary of the results of the TNA

The vast majority of partnerships (18 out of 21) had a strategic aim to provide IBA training.

A majority of the partnerships have commissioned IBA training. Only 4 of the 21 had not commissioned training. 9 partnerships said they did not have any contracts in place to provide IBA training after 2009/10 and another said the question was not applicable. The other partnerships demonstrated a range of plans for further training.

Over half of the partnerships had a complete record of participants and their roles, however, 7 answered no and 2 others said the question was not applicable. In total the partnerships identified 6823 people who had been trained over the last two and a half years. This included the following professionals in the last two and a half years:

- 1050 GPs and other primary care staff.
- 377 accident and emergency.
- 275 secondary care staff.
- 333 probation staff.
- 288 pharmacy staff but across just 4 partnerships.

- 539 police staff (and 26 magistrates in one partnership), although 12 partnerships had not provided any training to police staff.
- 192 drug workers.
- 503 voluntary sector staff.
- 65 Job Centre staff although very few partnerships had addressed this area.
- 287 social care staff.
- 449 housing staff.

Only one partnership identified any training of prison staff, although three partnerships demonstrated some plans to target this group. 9 partnerships had targeted employers for training: one other said that they were considering such training for next year.

Given the varying size of the areas and the lack of data on the actual number of staff in each group, it is hard to draw specific conclusions about these numbers, however, the numbers of social care staff appears low and the lack of a response for prison and job centre staff is obvious. At the very least these numbers suggest much training is still required.

A variety of trainers were identified by the partnerships, of whom the most commonly used provider was ADS who were providing training for 5 partnerships. HIT were providers for 2 partnerships. 7 partnerships were using a variety of local services and one had a full time trainer. The research asked about the costs of training per one day session, however, the information was too varied to provide an average figure.

Almost no other training was identified by partnerships. Only 2 partnerships identified other pieces of training. In the same way very little other related activity was identified by partnerships.

The majority of partnerships reported having some method of monitoring the impact of the IBA training. However, the methods varied immensely and no standard approach to monitoring exists. The majority of partnerships also identified some kind of ongoing support, although 7 said no or not applicable. However, again no standard approach to follow up was identified. Plans to refresh training were also variable.

13 partnerships either said they did not have a Local Enhanced Scheme (LES) or did not know about a LES. Interestingly these negatives included 2 where the scheme had been suspended and in one case it was stated that this was for financial reasons. 2 said they were developing a scheme. More partnerships provided a positive response about the implementation of the Directed Enhanced Scheme (DES). 13 had DES schemes in operation. All the partnerships that provided information identified AUDIT or one of the shortened versions of AUDIT as the local screening tool.

Efforts were made to compare the response in the three different areas of the region: Cheshire and Merseyside, Greater Manchester and Cumbria and Lancashire. It is impossible to say with certainty that one area's performance is worse than another, however, analysing both numbers trained and the strategic framework suggested that

Cumbria and Lancashire is doing better than the other two areas. Nonetheless, this conceals that two of the four partnerships in that area were performing very well and one very poorly. The same analysis suggests that Greater Manchester was performing slightly better than Cheshire and Merseyside.

Alongside the main review a selection of nine partnerships across the region were asked for their views on the barriers to implementing IBA training. In addition the review itself identified a number of barriers. The message from both these sets of comments was very clear. There are two key problems to implementing IBA training.

- A lack of financial resources for some partnerships, particularly those who were not selected as Early Implementer sites.
- Problems in releasing staff from work to attend training. A&E staff and GPs were both specifically identified.

Section 2

Snapshot of NW Activity Regarding Workforce in Receipt of Brief Advice Training: 2007-2009

Alcohol Concern was asked to develop a "league table" to indicate which were the better and poorer performing partnerships on IBA among the 21 partnerships in the North West. It is impossible to do this in an absolute sense and any table can only be indicative. The key problem is that much of the data is relative. For a large urban partnership to train 100 Tier 1 workers may be a far worse performance than for a small suburban borough which trains the same number. Moreover, boroughs may take different approaches or set different priorities which may be legitimate but which impact on the quantity of training.

Alcohol Concern's approach is to develop two tables and then combine them. The first table focuses on the strategic framework. The second focuses on simple numbers trained but analyses them on a per capita population basis to differentiate between performance in larger and smaller partnerships. The two tables will allow the reader to see the underlying structural performance separated from the potentially confusing factor of numbers trained.

On the strategic side Alcohol Concern has taken six of the indicators where it is possible to say that one partnership is doing better than another, e.g. if you don't have a policy it is poorer performance than if you do have a policy, and scored the performance on each one and then collated the results to provide an indicative league table.

The following indicators have been chosen:

Is there a local policy or strategic aim to provide IBA training?
Yes scores 1 point – No scores 0 points
Do you have a LES operating in your partnership area?
Yes scores 1 point – No scores 0 points
Is the DES being rolled out in your area?
Yes scores 1 point – No scores 0 points
Has the partnership directly commissioned any alcohol IBA training?
Yes scores 1 point – No scores 0 points
Are there arrangements in place for ongoing support / back-up for those trained and undertaking interventions?
Yes scores 1 point – No scores 0 points
Does the area have a complete record of the participants and their profession / role?
Yes scores 1 point – No scores 0 points

Applying these scores to the areas created the following league table.

LEAGUE TABLE		
Position	**Area**	**Score**
1	Blackburn	6
	Bolton	6
2	Blackpool	5
	Lancashire	5
	Manchester	5

	Salford	5
	Stockport	5
	Wigan	5
3	Cheshire	4
	Liverpool	4
	Sefton	4
	Trafford	4
	Bury	4
4	Warrington	3
	Wirral	3
5	Oldham	2
	Rochdale	2
	Tameside	2
6	Cumbria	1
	Halton and St Helens	1
	Knowsley	1

Again, it is important to emphasise that this table is nothing more than indicative.

Alcohol Concern has also looked at the numbers of people trained. Ideally, this would be based on the percentage of each professional group that had been trained in an area. However, the numbers of professionals are not readily available.

Comparing absolute numbers of, for example, probation officers trained is potentially unfair on smaller partnerships. As a proxy indicator, we have compiled a league table based on the absolute numbers of Tier 1 staff trained per thousand of the local population. Again this can only be indicative.

	Rank	Population (,000s)	Number trained	Per/1000
Cumbria & Lancs				
Blackburn with Darwen	4	141.2	333	2.358
Blackpool	2	142.7	866	6.068
Lancashire	8	1,165.7	1400	1.201
Cumbria	17	496.2	0	0
Greater Manchester				
Bolton	12	262.4	85	0.324
Bury	15	182.9	45	0.246
Manchester	5	452.0	893	1.975

Oldham	7	219.6	352	1.602
Rochdale	17	206.5	0	0
Salford	11	218.0	76	0.348
Stockport	9	280.6	261	0.930
Tameside	17	214.4	0	0
Trafford	16	211.8	34	0.160
Wigan	6	305.5	501	1.639
Merseyside & Cheshire				
Knowsley	17	151.3	0	0
Liverpool	14	436.1	120	0.275
Sefton	13	277.4	78	0.281
Wirral	3	311.2	1058	3.399
Halton & St Helens	1	119.5	937	7.841
Warrington	10	194.0	166	0.856
Cheshire	17	686.3	0	0

These two tables can be combined to produce an overall performance table

	Rank Numbers Trained	Rank Strategic Performance	Combined Score	Overall Rank
Cumbria & Lancs				
Blackburn with Darwen	4	1	5	2
Blackpool	2	2	4	1
Lancashire	8	2	10	7
Cumbria	17	6	23	20
Greater Manchester				
Bolton	12	1	13	10
Bury	15	3	18	14
Manchester	5	2	7	3
Oldham	7	5	12	9
Rochdale	17	5	22	18
Salford	11	2	13	10
Stockport	9	2	11	8
Tameside	17	5	22	18
Trafford	16	3	19	15
Wigan	6	2	8	6

Merseyside & Cheshire				
Knowsley	17	6	23	20
Liverpool	14	3	17	13
Sefton	17	3	20	16
Wirral	3	4	7	3
Halton & St Helens	1	6	7	3
Warrington	10	4	14	12
Cheshire	17	3	20	16

A final table compares the performance of the three areas within the North West region.

	Average Rank Numbers Trained	Average Rank Strategic Performance	Combined Score	Overall Rank
Cumbria & Lancs	7.75	2.75	10.5	1
Greater Manchester	11.5	3	14.5	2
Merseyside & Cheshire	11.3	4.14	15.44	3

Two further tables allow an examination of the priority given to different professional groups. The first table simply compares the priority across the region. The numbers trained have been turned into numbers per capita to allow a crude comparison between groups. Clearly what it cannot allow for is the different sizes of these professional groups.

Primary care staff (not GPs)	0.084 trained per 1,000 of the region population
Police	0.078 trained per 1,000 of the region population
Voluntary sector staff	0.073 trained per 1,000 of the region population
GPs	0.068 trained per 1,000 of the region population
Housing staff	0.065 trained per 1,000 of the region population
Probation staff	0.048 trained per 1,000 of the region population

A&E staff	0.043 trained per 1,000 of the region population.
Pharmacy staff	0.042 trained per 1,000 of the region population
Social care staff	0.042 trained per 1,000 of the region population
Secondary healthcare staff	0.040 trained per 1,000 of the region population
Drug service staff	0.028 trained per 1,000 of the region population
Job Centre staff	0.009 trained per 1,000 of the region population
Prison staff	0.003 trained per 1,000 of the region population
Arrest referral staff	0.003 trained per 1,000 of the region population

The second table shows how the three different areas have prioritised the various groups of professionals. It places the different groups in rank order, "1" being the most trained to "14" the least trained. For example, Cumbria and Lancashire have trained more voluntary sector staff than any other group, whereas Greater Manchester have trained more police than any other. Again this data is crude, but it is suggestive of groups which may need to be considered for greater attention e.g. secondary healthcare staff in Greater Manchester or the Police in Cheshire and Merseyside.

	Regional	**Cheshire & Merseyside**	**Cumbria Lancs.**	**Greater Manchester**
Other primary ca staff	1	2	6	3
Police	2	9	4	1
Voluntary sector staf	3	11	1	6
GPs	4	4	7	2
Housing staff	5	1	9	7
Probation staff	6	8	8	3
A&E staff	7	3	12	5
Pharmacy staff	8	6	4	10
Social care staff	8	9	2	8
Secondary healthca staff	10	5	3	11
Drug service staff	11	7	11	8
Job Centre staff	12	13	10	13
Prison staff	13	14	12	12
Arrest referral staff	13	12	12	14

Section 3

The Responses to the Training Needs Analysis

3.1 Is there a local policy or strategic aim to provide IBA training?

The vast majority of partnerships (18) had a strategic aim to provide IBA training. One partnership said that there was no strategic aim[7], another did not answer the question[8] and one other said that this would be part of a future strategy.[9] A number of partnerships identified the location of the strategic aim. In general these were the local alcohol strategy. Those areas which simply reported "Yes" have been excluded from this table:

World Class Commissioning & Alcohol Harm Reduction Strategy[10]
Part of the action plan of the Alcohol Strategy[11]
Alcohol Service Plan agreed with the PCT[12]
Commissioning strategic plan within the alcohol harm reduction strategy[13]
Alcohol Strategy 2008 – 2011[14]
Alcohol Strategy[15]
2008-2011 Alcohol Strategy[16]
Business case for Alcohol Screening and Brief Interventions Service[17]
Draft strategy[18]
Alcohol Strategy.[19]
Local Alcohol Strategy and action plan[20]
Part of our Programme Plan – Mandate Progress Report [21]

Comparing the three areas: Two of the areas without policies or strategic statements were in Cheshire and Merseyside, the other was in Greater Manchester. The four partnerships in Cumbria and Lancashire all had policies.

3.2 Do you have a LES operating in your partnership area?

Partnerships were asked whether they had a Local Enhanced Scheme (LES) operating in their area. Answers were very varied but more negative then positive. 13 either said no or did not know about a LES. These negatives included 2 where the scheme had been suspended. 2 said they were developing a scheme. The table below has removed the simple yes and no answers.

Not to date, piloting pharmacy LES from August 09[22]
Yes – 2008-2009 £25,000. 33 practices. Evaluation of pilot in progress. Quarterly returns and ongoing data collection. Patient survey being conducted. Outcomes not yet available. [23]
Not any more – currently suspended[24]
Not for alcohol as yet[25]
At present, we do not have an Alcohol LES operating in Manchester[26]
Not aware, but probably[27]
LES aimed at primary care and pharmacies was developed but due to the financial freeze is currently on hold[28]
Yes - £200k, 15 practices trained, likely to be redrawn and delivered across Salford by one large practice based on assessment of Practice Plans as nil returns on Plans bar one and scheme is 16 months in [29]
Have DES if a GP practice conduct mini audit they receive a small fee £2.33[30]
Under development[31]
No response[32]
One is currently operating in Western Cheshire PCT and one is in the planning

stage in Eastern Cheshire PCT [33]
Not yet[34]
In 2008/09 the PCT identified the development of alcohol LES as a key priority in its strategic plan. For 2009/10 an investment of £50k has been made available to develop this work. We are currently developing Alcohol LES which will focus on alcohol detox, at the time of writing we are in the process of developing the specification. There is a nominated worker within the substance misuse team who is responsible for developing links and practices with GPs in relation to this area of work[35]
No[36]

Comparing the three areas: Greater Manchester had the highest proportion of partnerships with a LES: 6 out of 10 partnerships. The other two areas had one operational LES each.

3.3 How is the DES being rolled out in your area?

More partnerships provided a positive response about the implementation of the Directed Enhanced Scheme (DES). 11 of the partnerships had in operation. 10 had either no scheme, did not know or did not provide a response. This table has removed the simple yes, no or not known responses.

Yes, 16 practices registered, only 6 claimed to date[37]
DES is being implemented in handful of practices[38]
Done directly with practices through a consortia. Primary care practices over 4 areas PBC's[39]
47 out of 65 practices have signed up for it[40]
Currently within Manchester we have 69 Practices participating in the DES. Monitoring will be undertaken by colleagues in Primary Care Commissioning using the forms and paperwork circulated by the DH[41]
The DES was being developed to run alongside the LES but again due to financial constraints this aspect is now with a different team[42]
49 of 54 practices have signed up. No output data available as yet[43]
56 practices – monitoring done by PCT T&D dept[44]
Rolled out January 2009. No data as yet. Being recorded on a quarterly basis. Built into GP systems population manager [45]
Information was not available from Western Cheshire PCT. Within Eastern Cheshire, 30 out of 52 practices have signed up to the DES and approximately 25 of these have actually screened people. This has not been monitored as of yet as it is in its infancy[46]
All GPs contacted – activity not currently monitored[47]
The current investment for the development of the Alcohol DES is £27k. In Jan 2009 all GP practices were invited to sign up to the Alcohol DES, to date there are 19 practices out of the 29 practices that have signed up. Practices have been asked to provide information on the following: 1.Number of newly registered patients of 16yrs 2. Number of those newly registered patients that have had an AUDIT or FAST completed 3. Numbers of those identified as hazardous drinking

4. Numbers of those identified as harmful drinking 5. Number of those identified in 4 & 5 that received a brief intervention 6. Number of those identified in 5 that received an extended Brief Intervention or referred in for specialist care 7. Number of those screened as dependent drinkers referred on for specialist care[48]

Comparing the three areas: 3 out of 4 partnerships in Cumbria had a DES. The other two areas each had just over half their partnerships with a DES.

3.4 What tool or tools are being used for IBA in this area?

All the partnerships who provided information identified AUDIT or one of the shortened versions of AUDIT as the local screening tool.

AUDIT, Trialling modified SIPS in Primary Care[49]
AUDIT and AUDIT C[50]
N/A[51]
AUDIT[52]
AUDIT used within primary care[53]
FAST and AUDIT[54]
To ensure consistency across the city, any IBA work commissioned by the Public Health team will use AUDIT/AUDIT-C[55]
AUDIT by ADS, Audit C by some GPs, SMAST by Paul Garrett (DAAT) [56]
FAST/AUDIT[57]
AUDIT and FAST at all sites bar A&E where PAT is primary tool[58]
FAST, AUDIT-C, AUDIT and PAT[59]
AUDIT main one AUDIT-C can be used[60]
N/A[61]
N/A[62]
AUDIT-C[63]
AUDIT[64]
FAST and AUDIT[65]
N/A[66]
AUDIT and FAST alcohol screening tools are being used across Blackburn with Darwen which works within an agreed pathway[67]
AUDIT[68]
FAST[69]
AUDIT and AUDIT-C[70]

Comparing the three areas: Two of the partnerships who did not answer were in Greater Manchester compared to one each in the other two areas.

3.5 Has the partnership directly commissioned any alcohol IBA training?

A majority of the partnerships have commissioned IBA training. Only 5 of the 21 had not commissioned training.[71] [72] [73] [74] [75] One of these said that the problem was: *Uncertainty over funding, although external funding is in the process of being sought for a service which will be tendered.*[76] A seventh partnership said that: *"The partnership has started to develop an initiative to ensure that GP's and Pharmacists are trained in IBA, unfortunately due to a freeze on PCT funding this initiative is having to be adapted."*[77]

Some of those who responded identified the trainers.

The Public Health Development Service (PHDS) and Community Alcohol Team (CAT). There are 3 trainers, 2 are based with the PHDS and 1 is based with the CAT. The trainer based with the CAT is responsible for training Primary Care staff and Pharmacists. The two trainers based within the PHDS are responsible for training student nurses, secondary healthcare staff, drug service staff, prison and probation staff. [78]
Commissioned Effective Professional Interactions to develop and deliver training jointly with our own Alcohol Service, which was commissioned to provide IBA training as part of its remit.[79]
Indirectly as part of ADS contract and A&E liaison project[80]
A full time trainer has been employed[81]
We have commissioned a GP to deliver a number of sessions[82]

Comparing the three areas: 2 of the 5 partnerships who did not answer were in Cheshire and Merseyside, 2 in Greater Manchester and 1 in Cumbria and Lancashire.

3.6 Do you have any contracts in place to provide IBA training after 2009/10?

9 partnerships said they did not have any contracts in place to provide IBA training after 2009/10 and another said the question was not applicable. The other partnerships demonstrated a range of plans.

No, currently out to tender[83]
No – St Helens have used tier 4 provider Merseycare NHS Foundation Trust to provide training as when and they don't pay[84]
This function will be part of our modernised treatment service[85]
The SLA with CMFT and UHSMFT ED are in place for 2 years. The MCH contract is renewed on annual basis[86]
Yes ADS commissioned by PCT, plus DAAT Training coordinator throughout year[87]
Yes, currently as part of the SLA with the current provider. There is a 3 year commissioning strategy in place within Rochdale DAAT which has the current provider ADS, scheduled for re tender in 2010. The new service spec will have a requirement for the new provider to deliver IBA to a variety of agencies and professionals… There is also a healthy lifestyle strategy that incorporates IBA within the workplace[88]
Not as yet[89]
Yes, AHA will continue to provide training to meet demand[90]
Yes SATINS (Sefton Alcohol Treatment Intervention Nursing Service) [91]
Post will 18 month post, finishes March 2011[92]

From April 2009, 15 training sessions have been booked[93]
The current contract is with Greater Manchester West NHSFT and the training provision for 09/10 has been added on as a variation to the wider contract (with GMW) for the specialist prescribing substance misuse service (as this was agreed through a separate commissioning process) for 09/10. Consideration will be taken to extend later this year at regular contract meetings[94]
No[95]
No[96]

Comparing the three areas: 5 partnerships in Greater Manchester did not have contracts in place for training after 2009/10. This compared with 4 partnerships in Merseyside and Cheshire and 1 in Cumbria and Lancashire.

3.7 Do you have a complete record of the participants and their profession / role?
Over half of the partnerships had a complete record of participants and their roles, however, 7 answered no [97] [98] [99] [100] [101] [102] [103] and 2 others said not applicable.[104] [105]

Comparing the three areas: 4 partnerships in Merseyside and Cheshire did not have complete records of those trained. This compared with 3 partnerships in Greater Manchester and 1 in Cumbria and Lancashire.

3.8 How many people have received training in each year?
In total the partnerships identified 6823 people who had been trained over the last two and a half years.

2007/8?	**2008/9**	**2009 to date**
262[106]	604[107]	N/A[108]
0[109]	85[110]	0[111]
N/A[112]	N/A[113]	N/A[114]
112[115]	787[116]	38[117]
N/A[118]	400[119]	1000[120]
72 staff were trained from CMFT from June 07 to June 08, doesn't quite fit with the calendar or financial year, but when the project started[121]	506[122]	313 staff trained between July 08 and May 09 by CMFT[123]
Approx 60[124]	Approx 130[125]	Approx 120 plus 42 to come[126]
0[127]	0[128]	TBC[129]
0[130]	46[131]	30[132]
17[133]	231[134]	13[135]
N/A[136] see note 1	78[137]	N/A[138]
0[139]	34[140]	No answer[141]
0[142] see note 1	166[143]	0[144]
April – April 424[145]	April – April 536[146]	April – present 98[147]
Unknown[148] see note 2	Unknown[149]	Unknown[150]
0[151]	0[152]	0[153]
No response[154]	17 from GMW plus	Number –16 staff trained

	additional number through consultancy solutions (unable to clarify number at this time)[155]	so far, the next 12 sessions will bring the total up to approx 175 with a further 5 agencies due to confirm dates (approximately 15 staff each – total 75) and 4 joint session provisionally arranged with the Jarman centre (a further 40-60 staff) (400 planned via contract with GMW)[156]
30[157]	217[158]	154[159] plus five courses to come (100)
0[160]	30[161]	15[162]
40[163]	80[164]	0[165]
0[166]	0[167]	0[168]

Note 1: These two partnerships responded negatively to this question but in later questions identified groups trained. The total identified in the other questions has been attributed to them in order not to disadvantage them in the performance tables.
Note 2: This partnership provided no figures for numbers trained but indicated that training had occurred but had no data. As a result they have received a zero in the quantity of training performance table.

Comparing the three areas:

Cheshire and Merseyside	2339
Greater Manchester	2185
Cumbria and Lancashire	2299

3.9 How many GPs have received IBA training since 2007/8?

In total the partnerships identified 471 GPs and other primary care staff who had been trained over the last two and a half years. This equates to 0.068 trained per 1,000 of the regional population.

9 plus encourage to use e learning course[169]
37[170]
0[171]
16[172]
Not many. Difficult to engage. If you count the guidance for the DES then about 70. Otherwise, it's about 5[173]
63 trained as part of the Alcohol DES and Manchester specific Alcohol Pilot in Primary Care[174]
5 in 09/10[175]
0[176]
15[177]
63[178]
58[179]
11[180]

3 surgeries 18 staff[181]
N/A[182]
Training will be starting in July officially, DAAT training delivered to approximately 40 GP's in Western Cheshire [183]
0[184]
N/A[185]
30[186]
6[187]
30[188]
0[189]

Comparing the three areas (general practice staff):

Cheshire and Merseyside	138 (0.058 per 1,000 pop)
Greater Manchester	254 (0.099 per 1,000 pop)
Cumbria and Lancashire	79 (0.041 per 1,000 pop)

3.10 How many Other Primary Care Staff have received IBA training since 2007/8?

In total the partnerships identified 579 other primary care staff who had been trained over the last two and a half years. This equates to 0.084 trained per 1,000 of the regional population.

95[190]
35 Practice Nurses (approximately 30%) and 13 others[191]
0[192]
187[193]
Again not many. We have a protected learning time event for later on this year. [194]
64 staff including nurses, health care assistants, admin and practice managers trained as part of the Alcohol DES and Manchester specific Alcohol Pilot in Primary Care. We are unable to supply the estimated % total of that staff group as there is no one staff group within this number. [195]
5 in 09/10[196]
N/A[197]
15 - we are considering this group as part of training plans – the issue is that we have focussed on BI Training to Tier 2 GP services – 10 sessions are planned for 2009-2010[198]
44 Est 50%[199]
N/A[200]
22[201]
n/a[202]
39 = 9%[203]
No response[204]
0[205]
N/A[206]
0[207]
30[208]
30[209]
0[210]

Comparing the three areas (primary care staff):

Cheshire and Merseyside	256 (0.108 per 1,000 pop)
Greater Manchester	228 (0.089 per 1,000 pop)
Cumbria and Lancashire	95 (0.048 per 1,000 pop)

3.11 How many Accident and Emergency Staff have received IBA training since 2007/8?

In total the partnerships identified 377 A&E staff who had been trained over the last two and a half years. This equates to 0.055 trained per 1,000 of the regional population.

Not listed, all A&E staff are currently undergoing training[211]
0[212]
0[213]
36[214]
In this year's training plan. Last year saw a freeze on training other than healthcare infections[215]
186 ED staff trained at CMFT, again unable to supply the estimated % total as we do not know the total of ED staff[216]
8 – 7%[217]
This is an area that has been prioritised and a new post has been recruited. This post will be based in the A&E department and will have a remit for training A&E and walk-in centre staff in relation to alcohol IBA[218]
2 specialist Band 6 nurses only trained 1% of total of staff group in the area – but we are considering this group as part of training plans – the issue is that we have focussed on BI Training to Tier 2 GP services – 10 sessions are planned for 2009-2010[219]
30: 20%[220]
0[221]
1[222]
50% difficulty getting access to time off for training some of this has been ad-hoc on the job training this is being reviewed and training policy being worked on by acute trust[223]
34 = 8%[224]
Training has begun but no numbers held in Western Cheshire, similar in Central and Eastern Cheshire [225]
0[226]
N/A[227]
0[228]
80[229]
0 planned for 2009/10[230]
0[231]

Comparing the three areas (A&E staff):

Cheshire and Merseyside	150 (0.064 per 1,000 pop)
Greater Manchester	227 (0.088 per 1,000 pop)
Cumbria and Lancashire	0 (0 per 1,000 pop)

3.12 How many Secondary Healthcare staff have received IBA training since 2007/8?

In total the partnerships identified 275 secondary care staff who had been trained over the last two and a half years. This equates to 0.04 trained per 1,000 of the regional population.

93[232]
Hospital staff trained on alcohol awareness as part of general life style brief intervention programme. [233]
0[234]
93[235]
About 12[236]
N/A[237]
25 – 22%[238]
Ambulance/paramedic staff will be trained by the new A&E post[239]
0% of total of staff group in the area – but we are considering this group as part of training plans – the issue is that we have focussed on BI Training to Tier 2 GP services – 10 sessions are planned for 2009-2010[240]
12[241]
0[242]
0[243]
See above ad hoc training of acute trust staff by alcohol liaison nurse [244]
N/A[245]
Training has begun, but no numbers held[246]
0[247]
N/A[248]
0[249]
40[250]
0[251]
0[252]

Comparing the three areas (secondary healthcare staff):

Cheshire and Merseyside	133 (0.056 per 1,000 pop)
Greater Manchester	37 (0.014 per 1,000 pop)
Cumbria and Lancashire	105 (0.053 per 1,000 pop)

3.13 How many Probation staff have received IBA training since 2007/8?

In total the partnerships identified 333 probation staff who had been trained over the last two and a half years. This equates to 0.048 trained per 1,000 of the regional population.

1[253]
Some trained[254]
0[255]
15[256]
About 50[257]
22 staff, number repeated from above. Do not have total numbers for that staff group so unable to supply the estimated % total. [258]
84 – 73%[259]

N/A[260]
Unconfirmed data - 40 staff - 100% trained FAST / AUDIT (likely to become an Alcohol Court area - existing Alcohol Bail / Alcohol Treatment scheme)[261]
24[262]
Working with probation to NOMS alcohol treatment requirements work in progress numbers probably small 6-8 20 in total in last three years. Trainers are both from the Windsor Clinic, the local Tier 4 provision[263]
0[264]
28 staff 100%[265]
N/A[266]
All probation officers have been trained in IBA but numbers are not available[267]
0[268]
N/A[269]
0[270]
4[271]
58[272]
0[273]

Comparing the three areas (probation staff):

Cheshire and Merseyside	54 (0.022 per 1,000 pop)
Greater Manchester	228 (0.089 per 1,000 pop)
Cumbria and Lancashire	51 (0.026 per 1,000 pop)

3.14 How many Pharmacy staff have received IBA training since 2007/8?

In total the partnerships identified 288 pharmacy staff who had been trained over the last two and a half years. Although over two thirds of these were in just 2 partnerships and the entire number was the result of just 4 partnerships. This equates to 0.042 trained per 1,000 of the regional population.

Training planned to implement LES[274]
0[275]
0[276]
16[277]
Good permeation here. About 100 trained in March 2009[278]
64 Pre Reg Pharmacists. Do not have total number for that staff group, so unable to supply the estimated % total. Training planned for Pharmacists in Sept/Oct 2009[279]
0[280]
N/A[281]
0% of total of staff group in the area – but we are considering this group as part of training plans – the issue is that we have focussed on BI Training to Tier 2 GP services – 10 sessions are planned for 2009-2010[282]
0[283]
No – working with colleagues in pharmacy at the moment to see if this is the appropriate way to go – pharmacists needing payments maybe an issue to take this forward [284]
0[285]

None but will be part of new project [286]
105 = 25% [287]
Not known, possibly 0 [288]
0 [289]
N/A [290]
0 [291]
3 [292]
0 [293]
0 [294]

Comparing the three areas (pharmacy staff):

Cheshire and Merseyside	124 (0.051 per 1,000 pop)
Greater Manchester	64 (0.025 per 1,000 pop)
Cumbria and Lancashire	100 (0.051 per 1,000 pop)

3.15 How many Police staff have received IBA training since 2007/8?

In total the partnerships identified 539 police staff and 26 magistrates who had been trained over the last two and a half years; however, 12 partnerships had not provided any training to police staff. The police data equates to 0.078 trained per 1,000 of the regional population.

79 [295]
1 [296]
0 [297]
51 [298]
About 20 [299]
At present no GMP officers are commissioned to undertake IBA within Manchester, not aware of this approach anywhere else in the country. We work with GMP to use bail conditions to attend alcohol arrest referral clinics [300]
0 [301]
N/A [302]
310 and 0% trained of that staff group in the area – but a staff group of interest as to PCSO, PC, Sergeant rank [303]
0 [304]
N/A [305]
0 [306]
Magistrates 26 PCSOs [307]
N/A [308]
Not known, possibly 0 [309]
0 [310]
N/A [311]
0 [312]
0 [313]
78 [314]
0 [315]

Comparing the three areas (police staff):

Cheshire and Merseyside	51 (0.021 per 1,000 pop)

Greater Manchester	389 (0.152 per 1,000 pop)
Cumbria and Lancashire	99 (0.051 per 1,000 pop)

3.16 How many Drug Service staff have received IBA training since 2007/8?

In total the partnerships identified 192 drug service staff who had been trained over the last two and a half years. This equates to 0.028 trained per 1,000 of the regional population.

14 [316]
Some trained[317]
0[318]
12[319]
0 – alcohol will be treated as part of treatment package[320]
45 staff. Do not have the total number for that staff group so unable to supply the estimated % total[321]
15 – 30%[322]
N/A[323]
10 or 100% of total of that staff group in the area[324]
0[325]
N/A[326]
0[327]
80 people trained in conjunction with the DAAT[328]
N/A[329]
Not known[330]
0[331]
N/A[332]
0[333]
0[334]
26[335]
0[336]

Comparing the three areas (drug service staff):

Cheshire and Merseyside	92 (0.039 per 1,000 pop)
Greater Manchester	86 (0.033 per 1,000 pop)
Cumbria and Lancashire	14 (0.007 per 1,000 pop)

3.17 How many Prison Service staff have received IBA training since 2007/8?

Only 1 partnership identified any training of prison staff. 3 partnerships demonstrated some plans to target this group. 24 prison staff have been trained in total. This equates to 0.003 trained per 1,000 of the regional population.

0[337]
N/A[338]
0[339]
0[340]
No prisons in East Lancs[341]
Work in HMP Manchester planned from August 2009. Work has previously taken place in HMP Styal where 24 member of staff were trained[342]

0[343]
This is an area that is being developed, currently ADS provide a service within the prison, but the new initiative will involve prison staff being trained and all prisoners being screened on reception[344]
0% of unknown total of that staff group in the area in the area information on staff group requested but not returned – but a staff group of interest once IDTS is embedded later in 2009[345]
N/A – no prisons in area[346]
N/A[347]
0[348]
Planned[349]
N/A[350]
Not known[351]
0[352]
N/A[353]
0[354]
0[355]
0[356]
0[357]

Comparing the three areas (prison service staff):

Cheshire and Merseyside	0 (0 per 1,000 pop)
Greater Manchester	24 (0.009 per 1,000 pop)
Cumbria and Lancashire	0 (0 per 1,000 pop)

3.18 How many Arrest Referral Service staff have received IBA training since 2007/8?

Very few partnerships identified specific training for arrest referral workers, but in some cases this is because they either did not have any or they were already trained. 21 workers were trained in total, this equates to 0.003 trained per 1,000 of the regional population.

Team already alcohol trained[358]
N/A[359]
0[360]
0[361]
Alcohol arrest referral workers are trained in IBA[362]
Unclear as to which staff group this questions refers to: if drug arrest referral workers, please see above under Drug Service Staff. If alcohol arrest referral workers, they are specialist workers who would not be targeted to receive IBA training[363]
0[364]
An arrest referral scheme has been piloted from June 1st 2009: this will be evaluated after 3 months[365]
2 staff & 100% of total of staff group in the area - (likely to become an Alcohol Court area and have existing Alcohol Bail and Alcohol Treatment scheme)[366]
4 : 100%[367]

N/A[368]
0[369]
We don't have any[370]
15 = 4%[371]
Not known[372]
0[373]
N/A[374]
0[375]
0[376]
0[377]
0[378]

Comparing the three areas (arrest referral staff):

Cheshire and Merseyside	15 (0.006 per 1,000 pop)
Greater Manchester	6 (0.002 per 1,000 pop)
Cumbria and Lancashire	0 (0 per 1,000 pop)

3.19 How many Voluntary Sector staff have received IBA training since 2007/8?

In total the partnerships identified 503 voluntary sector staff who had been trained over the last two and a half years. This equates to 0.073 trained per 1,000 of the regional population.

66[379]
None[380]
0[381]
32[382]
About 200 (not double counting where the below are also voluntary sector)[383]
In the PHDS recording system voluntary sector staff are registered under a wider grouping of 'Multi Agency'. So we know that 70 staff have been trained but this grouping also includes Housing, Social Care, etc, so we couldn't guarantee that all 70 staff have come from the Voluntary/Third Sector. Impossible to produce an estimated %[384]
18 – 16%[385]
N/A[386]
0% of total of staff group in the area – but we are considering this group as part of training plans – the issue is that we have focussed on BI Training to Tier 2 GP services – 10 sessions are planned for 2009-2010[387]
18 : 5%[388]
N/A[389]
0[390]
Some voluntary services joint trained with the DAAT – more alcohol awareness[391]
8 = 2%[392]
Not known[393]
0[394]
N/A[395]
0[396]
0[397]

91[398]
0[399]

Comparing the three areas (voluntary sector staff):

Cheshire and Merseyside	40 (0.016 per 1,000 pop)
Greater Manchester	197 (0.077 per 1,000 pop)
Cumbria and Lancashire	266 (0.136 per 1,000 pop)

3.20 How many Job Centre staff have received IBA training since 2007/8?

In total the partnerships identified 65 Job Centre staff who had been trained over the last two and a half years. This equates to 0.009 trained per 1,000 of the regional population.

31[400]
None[401]
0[402]
0[403]
About 10[404]
At present Job Centre Staff are not a prioritised group for IBA training within Manchester[405]
0[406]
Identified as an area for development[407]
0% of total of staff group in the area – but we are considering this group as part of training plans – the issue is that we have focussed on BI Training to Tier 2 GP services – 10 sessions are planned for 2009-2010[408]
0[409]
N/A[410]
0[411]
N/A[412]
N/A[413]
Not known[414]
0[415]
N/A[416]
20[417]
0[418]
4[419]
20[420]
0[421]

Comparing the three areas (job centre staff):

Cheshire and Merseyside	4 (0.002 per 1,000 pop)
Greater Manchester	20 (0.007 per 1,000 pop)
Cumbria and Lancashire	41 (0.021 per 1,000 pop)

3.21 How many Social Care staff have received IBA training since 2007/8?

In total the partnerships identified 287 social care staff who had been trained over the last two and a half years. This equates to 0.042 trained per 1,000 of the regional population.

101[422]
N/A[423]

0[424]
36[425]
About 50[426]
At present Social Care Staff are not a prioritised group for IBA training within Manchester[427]
59 – 52%[428]
Identified as an area for development[429]
0% of total of staff group in the area – but we are considering this group as part of training plans – the issue is that we have focussed on BI Training to Tier 2 GP services – 10 sessions are planned for 2009-2010[430]
12: 2%[431]
N/A[432]
0[433]
14 mix of mental health teams more planned[434]
N/A[435]
Not known[436]
0[437]
N/A[438]
0[439]
0[440]
15[441]
0[442]

Comparing the three areas (social care staff):

Cheshire and Merseyside	50 (0.021 per 1,000 pop)
Greater Manchester	86 (0.033 per 1,000 pop)
Cumbria and Lancashire	151 (0.077 per 1,000 pop)

3.22 How many Housing staff have received IBA training since 2007/8?

In total the partnerships identified 449 housing staff who had been trained over the last two and a half years. This equates to 0.065 trained per 1,000 of the regional population.

78[443]
N/A[444]
0[445]
179[446]
About 50[447]
At present Housing Staff are not a prioritised group for IBA training within Manchester[448]
9 – 8%[449]
Housing staff have been identified as a priority group, and will all be trained before the end of 2009. The above groups have been identified for training, times and numbers are yet to be confirmed[450]
0% of total of staff group in the area – but we are considering this group as part of training plans – the issue is that we have focussed on BI Training to Tier 2 GP services – 10 sessions are planned for 2009-2010[451]
0%[452]

N/A[453]
0[454]
Community training some were housing 25 people[455]
58 = 14%[456]
Not known, most probably 0[457]
0[458]
N/A[459]
0[460]
0[461]
50[462]
0[463]

Comparing the three areas (Housing):

Cheshire and Merseyside	262 (0.11 per 1,000 pop)
Greater Manchester	59 (0.023 per 1,000 pop)
Cumbria and Lancashire	128 (0.065 per 1,000 pop)

3.23 Which other groups have been trained not covered by above list?

12 partnerships identified other agencies that had received training. 9 partnerships indicated no other agencies. A great variety of other agencies were identified as having received training. These are simply listed below for information:

Young Peoples Advice[464] [465]
Ambulance Service[466]
Advocacy[467]
Street pastors[468]
Community Engagement Officers[469] [470]
Civil Service[471]
Nursing home staff[472]
Citizen Advice Bureau[473] [474]
Adult Education[475]
Mental Health staff[476]
Fire & Rescue[477] [478] [479] [480] [481]
Licensees[482]
Elected members[483]
Victim Support[484]
Children Centre Staff[485]
Criminal Justice Staff[486]
Students[487]
Territorial Army[488]
Teachers[489]
YWCA[490]
Consumer Protection[491]
Workplace[492]
Student Nurses[493]
Mental Health Practitioners[494] [495]
Youth Workers[496][497]

Sexual Health/GUM staff[498]
Social inclusion services [499]
Those working with children and young people[500]
Health Visitors and District Nurses. Stop Smoking Service staff[501]
Community Wardens[502]
Social Partnership[503]
Arch Initiatives[504]
Brook Advisory Service[505]
Sure Start [506]
Social Partnership [507]
Progress to work [508]
Phoenix Futures [509]
One stop Shop [510]
TNG training group[511]
Elderly Care Agencies[512]
College [513]
Tenancy Support (Younger People) [514]
P66 (Places for People) [515]
Dual diagnosis link workers[516]
PND advocacy[517]
Housing Needs[518]
Early Intervention Service[519]
CPNs[520]
Children's Centres[521]
PCT[522]
Early Years Health Team [523]
Women's Aid [524]
Health Trainers [525]
Crisis Resolution Team[526]

3.24 Have employers been targeted as a group?

9 partnerships had targeted employers for training.[527] [528] [529] [530] [531] [532] [533] [534] [535]

One other said that they were considering such training for next year.[536]

Tier 1 education is provided by two permanent staff who raise awareness amongst staff and managers and encourage managers to complete IBA training[537]
Fire Service, Private Sector employers through Chamber of Commerce[538]
Workplace health events[539]
Oldham Council[540]
Employers have been identified as part of the Healthy Lifestyles strategy and within the new alcohol strategy[541]
Planned for 2nd year of BI training project[542]
Managers are contacted and told about the training and what we are trying to achieve. If the training is relevant then their department team are trained as a group. If they only have a small group of staff then if possible arrangements are made for them to join another group. [543]

Greater Manchester West have liaised with several agencies and information about the training has been cascaded throughout the Borough.[544]

Comparing the three areas:

Cheshire and Merseyside	2 partnerships have targeted employers
Greater Manchester	3 partnerships have targeted employers
Cumbria and Lancashire	4 partnerships have targeted employers

3.25 Which agencies or training providers provided the training?

A variety of trainers were identified by the partnerships, of whom the most commonly used provider was ADS who were providing training for 5 partnerships. HIT were providers for 2 partnerships. 8 partnerships were using a variety of local services and one had a full time trainer.

ADS[545]
Thomas Stott Associates[546]
N/A[547]
Health Improvement Alcohol Team[548]
HIT[549]
NHS Trust, voluntary sector providers, consultancy firms[550]
PHDS and CMFT staff[551]
ADS and Oldham DAAT Training Officer[552]
ADS[553]
DAAT / ADS[554]
Alcohol Health Advice[555]
Lifestyle service Uni Hosp Aintree[556]
NHS Pennine Care Trust[557]
ADS and alcohol community service post currently under recruitment in Health Improvement PCT[558]
Full time trainer[559]
HIT[560]
None[561]
GMW[562]
Consultancy Solutions[563]
Jarman Centre carrying out some joint training with GMW[564]
Alcohol Concern[565]
In-house[566]

The research asked about the costs of training per one day session (excluding accommodation / refreshment costs). The information was too varied to provide an average figure.

£50,000 flat rate per annum to employ part time post and admin support[567]
£500 including administration (course booking, etc) [568]
N/A[569]

N/A[570]
£15k[571]
Per person trained – it can range from £20 to £50 including support materials, support and follow-up. [572]
Difficult to answer at this point as not contracted on this basis? Raises the issue of Unit Costs?
1day Band 6 post? [573]
Internal £60 per day[574]
Will be delivered as part of the contract[575]
£400[576]
Provided as part of commissioned in-house service, and delivered in 1-2 hour sessions rather than full day sessions.[577]
£66K - Number of days not specified, it's a block contact, but they would expect to reach all 56 GP's – over £100 per GP[578]
£800[579]
None – part of service contract[580]
N/A[581]
Unknown[582]
N/A[583]
No response[584]
£600 per day[585]

3.26 Training Materials

Alcohol Concern sought copies of any training materials used in courses. However, only two sets of materials were received: two partnerships felt that this was commercially sensitive information that could not be shared.[586] One of the providers was contacted directly but refused to share details of their course.

3.27 What other IBA training has taken place in your partnership area since 2007/8 but which was not commissioned by you?

Almost no other training was identified by partnerships. Only two partnerships identified other pieces of training.

Some internal training in ADS (Addictions Dependency Solutions)[587]
Probation commissioned our community alcohol service, social services commissioned training for some members of the mental health team[588]
IM staff have undergone Alcohol training sessions[589]

In the same way very little other related activity was identified by partnerships. Only two areas identified other related work.

Alcohol Training which also includes Alcohol Awareness Training. Supporting Behaviour Change Training. Train the Trainer and Responsible Alcohol Retailing courses is just one segment of a comprehensive programme of alcohol related interventions/activities[590]
NHS Manchester is one of the DH Alcohol Early Implementer Sites. In April 2009 Manchester participated in an Alcohol learning event, which was coordinated by Healthy Core Cities group. Within Manchester we are currently running a pilot scheme to use IBA within GP Practices: more information available upon

request. Work is also taking place to undertake IBA within the three EDs across the city. All 3 schemes are in different stages of development: more information available upon request. Within the city there is also an Alcohol IBA Training Group, which meets on a quarterly basis. The purpose of the group is to ensure consistency and quality assure the standard of training delivery and IBA toolkits used across the city. [591]

3.28 What arrangements are in place to monitor the ongoing use and impact of IBA?

The majority of partnerships reported having some method of monitoring the impact of the IBA training. However, the methods varied immensely. No standard approach to monitoring exists.

Follow up sessions for trained staff and random patient satisfaction follow ups[592]
Ongoing collection of data from all participating practices[593]
N/A[594]
Evaluation on the day of training and evaluation three months from date of training[595]
Don't monitor, will monitor DES[596]
Performance monitoring of service contracts and monitoring of participants[597]
In terms of work delivered by the PHDS, for each course delivered participants are asked to complete an evaluation form and telephone follows up are undertaken with the training participants… Within the Primary Care Pilot, the SLA identifies that 10% of patients who are screened need to be contacted within 3 months of the screen to identify changes in behaviour. Work will also take place to evaluate the impact of the training on primary care staff. Participating practices need to submit monthly monitoring reports and a steering group is also overseeing the development of the work… The ED SLA also identifies that 10% of patients who are screened to be contacted within 3 months of the screen to identify changes in behaviour. Each of the EDs participating in the IBA work produce monthly monitoring reports and steering groups which meet on a bi monthly basis, as a minimum. The first ED to participate in the IBA screening project was CMFT and an evaluation report is available… As part of the Early Implementer site, NHS Manchester completes quarterly monitoring reports for DH… There are also internal monitoring systems and lines of accountability including the Alcohol Joint Commissioning Group and internal Board reporting[598]
ADS Statistics, PCT SLA, DAAT SLA[599]
Monitoring is yet to be fully agreed[600]
ADS/DAAT evaluation starting with 3 month follow up[601]
Monitoring of referrals to Alcohol Heath Advice; monitoring numbers screened at A&E, GP read codes will in future be used as a small incentive is being offered to GPs for implementing ABI[602]
Information comes back via PCT[603]
To my knowledge, this has not currently been discussed[604]
Quarterly see above[605]
The trainer role is also to quality assure following the training. This is done by follow up support and quarterly forums for various groups to attend [606]

There is no current data set with Central and Eastern Cheshire[607]
N/A[608]
Within General Practice we have set up templates for both screening tools which will automatically calculate score, from this the necessary action with be determined. • Number of patients that have had a AUDIT or FAST completed • Numbers of those identified as hazardous drinking • Numbers of those identified as harmful drinking • Number of those identified as hazardous or harmful received a brief intervention • Number of those identified as harmful drinkers that received an extended Brief Intervention or who were referred in for specialist care • Number of those screened as dependent drinkers referred on for specialist care[609]
All training participants are asked to report numbers screened and identified to the partnership. A form is provided for this purpose.[610]
Laptus, service database, hospital episode data[611]

Comparing the three areas:

Cheshire and Merseyside	5 partnerships reported having some method of monitoring impact
Greater Manchester	6 partnerships reported having some method of monitoring impact
Cumbria and Lancashire	3 partnerships reported having some method of monitoring impact

3.29 Are there arrangements in place for ongoing support / back-up for those trained and undertaking interventions?

The majority of partnerships identified some kind of ongoing support. 7 said no or not applicable.[612] [613] [614] [615] [616] [617] [618] However, the follow up is of variable quality.

Quarterly follow up workshops to share experiences and further learning. Trained staff may always phone for assistance and advice[619]
Public Health and Alcohol Learning Centre[620]
N/A[621]
Further training needs are identified in the evaluation, top up training is provided together with Train the Trainer Courses for organisations who wish to cascade training to other members of staff[622]
No[623]
Yes – the training involves a follow up at 2 months[624]
Arrangements are in place with each work group allocated a named person to make contact assertively to provide support for any ongoing issues that may arise. This support includes the circulation of any new publicity and materials that might become available locally, regionally and nationally and booster training is also available for staff who have undertaken initial IBA training[625]
Training needs analysis undertaken by ADS on this specific issue, TNA by DAAT on all substance misuse training needs in borough. All agencies targeted by ADS and

DAAT[626]
The training providers will be available for any support required and additional training[627]
Yes, but under review by ADS/DAAT / Primary Care Commissioning as part of review of LES and redrawn commissioning given low level of GP take up post training[628]
Alcohol Health Advice are always available to offer advice and support, and re-fresher training if needed.[629]
This is central to their strategy which is why STATIN is used and therefore are able to find out why GPs are not taking up training if that is the case[630]
No[631]
Not currently but the new post will be involved in this. A&E Nurse undertakes this role in hospital[632]
Yes as above, also refresher training can be provided, and on going support by the training as and when required[633]
Currently this is limited[634]
No[635]
It is made clear within all local training packages that the local specialist treatment services can be contacted if additional advice and support is needed – The Jarman Centre also offer this facility[636]
Ongoing support is available via Alcohol Concern[637]
Yes clinical practice review sessions, regular team meetings and feedback sessions and further training[638]

Comparing the three areas:

Cheshire and Merseyside	4 partnerships reported having some ongoing support
Greater Manchester	7 partnerships reported having some ongoing support
Cumbria and Lancashire	3 partnerships reported having some ongoing support

3.30 What plans are in place to refresh IBA training for those who have received it?

Plans to refresh training were also variable. 5 partnerships either did not answer or gave a negative response. The plans for the other partnerships varied from planned sessions to evaluation and then a response.

Occasional Refresher courses to be provided under new contract[639]
Further training being planned for 2009-2010 including refresher for existing staff. Training planned re web-based interventions (to be launched later in the year) [640]
N/A[641]
As above[642]
N/A[643]
We will evaluate first before rolling out more widely[644]
Please see above[645]
Review of training after the first year, contacts maintained previously trained offering refresh. Ongoing needs analysis by DAAT[646]

N/A[647]
2 sessions banked[648]
As above[649]
Copy of 3 individual programmes will be provided[650]
None that I am aware of, although IBA training is currently being scheduled for the coming year and this is open to anybody who wishes to attend. There is currently no specific refresher course planned[651]
New position will undertake a needs assessment and refresh training including developing training strategy, monitoring and assessment and evaluation of training programme [652]
A new course has recently been designed to ensure all issues highlighted in "evidence and best practice in delivery" are covered.
Refresher train can be provided [653]
No plans as yet[654]
None[655]
Supervision sessions 4-6 weeks following initial training[656]
None at present[657]
Motivational interviewing training Sept 09

Comparing the three areas:

Cheshire and Merseyside	5 partnerships reported having plans to refresh training
Greater Manchester	5 partnerships reported having plans to refresh training
Cumbria and Lancashire	3 partnerships reported having plans to refresh training

Section 4

Other Services

Alcohol Concern contacted representatives of specific professional groups to provide another perspective on IBA training and to determine if other courses or programmes are being undertaken in addition to those already identified from the partnerships. The response to this research was overwhelmingly negative. Little other training was identified.

4.1Supporting People

Alcohol Concern spoke to service managers in various areas. Supporting People staff are not directly responsible for the delivery of front line services: all work with service users is contracted out. No overall strategic plan for the delivery of IBA exists, although it may form the remit of some of the contracted organisations. No records of IBA are kept by Supporting People and each local council has a strategic team that commissions providers who work with vulnerable adults and is more or less autonomous, so no region wide information is available.

4.2 Chambers of Commerce

There is no training directly carried out or commissioned by the Chambers of Commerce. Each area works independently so there is no national or regional policy regarding alcohol. Members have access to a HR company if they have any queries, where they will receive advice on, say, how to support a staff member who has alcohol problems, but this is the extent of their contribution.

4.3 CARAT Workers

No CARAT workers have been trained on a regional basis. Some training may have occurred at individual prisons but it is unlikely as there is no funding for alcohol work of any kind and it is not in the remit of CARAT workers to work with inmates who solely use alcohol. The interviewee was concerned about the lack of funding and feels that IBA may help to cut the re-offending rate in young adult offenders – this has been identified as a major problem.

4.4 Job Centres

No strategic or local initiatives are in place for IBA training. It is possible that the psychologists who work with staff may come across excessive alcohol use among staff or staff may mention clients for whom this is a problem but referral would be made to local alcohol services if deemed necessary as it is outside the remit of Job Centre Plus staff.

4.5 Probation Service

The probation service has a full time trainer who delivers brief interventions training to staff via the North West Training Consortium. However, this is not part of an overall training plan and different probation services have differing training requirements for their staff.

Section 5

Identified Barriers

Alongside the main review a selection of nine partnerships from across the whole region were asked for their views on the barriers to implementing IBA training.

- **Respondent 1** - It is difficult to get staff to attend, as they cannot be released from work. Originally, training was a full day but this has been gradually shortened to just a couple of hours and is often delivered during practice meetings. On occasions it has been possible to provide cover for the time that staff will be out of the workplace but this is not financially viable for all who need the training.[658]
- **Respondent 2** – Same problem as respondent 1. They are now delivering half days. They have found that delivery by a local GP, alongside a DAAT trainer has helped. Often hard to get a response from potential trainees – claim current workload already excessive and could not commit to further involvement. Funding always a problem.[659]
- **Respondent 3** – Same problem as respondents 1 & 2. They have overcome barriers by trying to match IBA to the type of work already carried out. For example the fire service deliver IBA specifically about the fire risks involved when drinking.[660]
- **Respondent 4** - No problem with commissioning training, however, it is difficult for people to commit to a whole day training: they are currently re-commissioning to offer 2 x ½ day sessions instead. They have commissioned research on outcomes of training and found people offering (more) help than they may be qualified to deliver and not referring clients on.[661]
- **Respondent 5** - They have not delivered any due to lack of funding so the barrier is funding and nothing else. They feel that they have won the "hearts and minds battle" already so that is not a real barrier.[662]
- **Respondent 6** – GP attendance was a problem but the provision of a financial incentive via the DES has increased uptake.[663]
- **Respondent 7** – There are no barriers to delivering the IBA training but there is a barrier in staff delivering the brief intervention.[664]

Respondent 8 identified a number of barriers to the roll out of brief interventions.

- Pharmacies will not release staff even for 2-3 hours to attend training
- GPs attend training but do not go on to conduct brief interventions.
- Staff cite the cost of locum cover as the reason for not attending
- Evidence of screening but only a small minority are identified as requiring brief interventions
- There is no funding to provide cover or external training.[665]

Respondent 9 answered at greater length than any other: "Regarding IBA, training has been provided for GPs and primary care staff. In theory, the appropriate services now have the capability to deliver IBA when and where appropriate and should be actively screening to do so. There is no mechanism currently in place to record and monitor whether or not this is happening. More IBA training is planned for any frontline agencies where it might benefit, but as yet this has not taken place. I am currently deeply sceptical (but hoping I am wrong) about the

capability of this model to deliver effective and reliable brief advice that can be monitored as necessary. There seems to be a fairly unproductive relationship between the DAAT and the PCT and I am rarely made aware of what the PCT are up to. There is no effective system in place to record whether or not GPs are delivering IBA and no viable point of access for me to start addressing this. The only sensible way seems to be to contact GPs on a monthly basis for progress updates. There are around 40 practices in the area and this amounts to a considerable work implication. Any ideas or examples of good practice to address this would be incredibly well received as it is fast turning into one of my biggest headaches! I have tried a couple of times to get into this but it has proved very difficult to get anywhere and to find the appropriate people I need to talk with."[666]

The review itself identified a number of barriers:

• Uncertainty over funding, although external funding is in the process of being sought for a service which will be tendered.[667]
• The partnership has started to develop an initiative to ensure that GP's and Pharmacists are trained in IBA, unfortunately due to a freeze on PCT funding this initiative is having to be adapted.[668]
• It is in this year's training plan. Last year saw a freeze on training other than healthcare infections[669]
• A&E service: difficulty getting access to time off for training some of this has been ad-hoc on the job training this is being reviewed and training policy being worked on by acute trust[670]

The message from both these sets of comments is very clear. There are two key problems to implementing IBA training.

- A lack of resources, especially financial, for some partnerships, particularly those who were not selected as Early Implementer sites.
- Problems in releasing staff from work to attend training. A&E staff and GPs were both specifically identified.

Section 6

A Model Training Programme

6.1 Introduction

The term 'identification and brief advice' covers a range of advice giving interactions, generally lasting for 5 – 10 minutes, and containing a number of active ingredients which, when delivered appropriately, may encourage the individual to make changes in drinking behaviour. Opportunistic brief interventions as defined here are not to be confused with specialist brief interventions delivered over several sessions in treatment settings.[671]

Outcome studies show differing levels of change in drinking behaviour after brief interventions and many efficacy studies have found them to be as effective in reducing alcohol consumption as extended interventions.[672] The aim of these interventions is to effect behaviour change in hazardous and harmful, but not necessarily dependent, drinkers. Brief interventions are not a treatment and are most effective in those who are not showing signs of dependence. However, if during the course of conversations between practitioner and patient, it becomes apparent that a patient is drinking problematically, motivational techniques can be used to encourage referral to specialist agencies.

6.2 Course Structure

The content of any IBA course will be dictated by the structure and content of the intervention being promoted. Thus the first question in designing a course is to clarify what outcomes are expected.

A number of frameworks exist to structure these outcomes. For example the US Substance Abuse and Mental Health Service Administration states that interventions typically use three components:

"a. Information or feedback about screening results, BAC upon admission, the link between drinking and injury, guidelines for low-risk alcohol consumption, methods for reducing or stopping drinking, etc.

b. Understanding the patient's view of drinking and enhancing motivation.

c. Clear and respectful professional advice about the need to reduce risk by cutting down or quitting drinking and to avoid high-risk alcohol-related situations."[673]

Therefore any course would have to focus on enabling people to undertake these three elements.

The literature identifies a number of active ingredients for practitioner training. To effect change in practitioner attitudes and practices, the training needs to focus on:

- the evidence for the effectiveness of brief interventions and the benefits of skilful implementation;
- content and brevity of interventions;
- skills development and skills practice in delivery and increasing motivation and self-efficacy.[674] [675]

Although GPs are not the only professional group a training tool would need to be developed for, there is more research evidence about their perceptions around talking about alcohol issues. This is likely to be similar for other professional groups. Research suggests that if GPs are unconvinced of the potential benefits of tackling alcohol issues, or at least if a cost benefit analysis suggests that time could be better spent on other patient problems, there is little incentive to commit to

a programme of brief interventions (Rollnick *et al*, 1997). This, therefore, has to be a key component of any course.

Research also suggests that GPs may differ about what is considered to be an appropriate consumption level at which to instigate a brief intervention.[676] Therefore, staff need to be clear about what constitutes hazardous and harmful levels of alcohol use.

Research by the Department of Health suggested that GPs do not routinely discuss alcohol with patients as they perceive a lack of specialist services to refer patients on to.[677] Therefore, available services need to be part of the training.

6.3 Brief Intervention Course Models

Since 2000, a variety of materials have been produced such as the World Health Organisation manual for delivery of brief interventions in primary care.[678] These provide comprehensive guidelines and materials for effective evidence based brief interventions to guide the practitioner through interventions without any specialist prior knowledge. They suggest session content and give practical examples of delivery.

The World Health Organisation outlines a framework for delivery of brief interventions, based on a study by Bien *et al*, (1993).[679] This uses the FRAMES model to guide the content of an intervention. FRAMES is the acronym for six elements of an intervention, which, ideally, should be structured and tailored to the patient's current position in the cycle of change. This is a client centred, non-confrontational approach, using a mixture of motivational and educational statements to bring about change in drinking behaviour. It may be supplemented by literature or worksheets for the patient to study at home. A key feature of brief interventions is that they can be delivered by non-alcohol specialists, such as GPs.

The Drug and Alcohol National Occupational Standards have developed a unit: AH10 - Carry out brief interventions with alcohol users. To perform competently in this unit a worker needs to have:

1. a working knowledge of how alcohol, as a drug, affects the body and mind, how this can affect behaviour
2. a working knowledge of the characteristics of dependence
3. a working knowledge of legal implications of alcohol use in specific circumstances, including road traffic legislation and issues around consent while intoxicated
4. a working knowledge of the risks alcohol can present to an individual's health and wellbeing, including:
a) the immediate risks that can arise from being drunk
b) the potential health and social risks associated with longer term risky drinking
5. a working knowledge of the unit system of measuring alcohol content and what constitutes safe, hazardous, harmful and dependent drinking as defined by the World Health Organisation
6. a working knowledge of the changes which can be made to drinking behaviour to improve health, wellbeing and personal safety
9. a working knowledge of how to administer and interpret results from an

appropriate screening tool (AUDIT or AUDIT derivative)
10. a working knowledge of the principles of active listening, and how to apply them
11. a working knowledge of how to present and explore options with different individuals
12. a working knowledge of how to present information and advice fully, accurately, concisely and in ways appropriate to people's needs
13. a working knowledge of how the cultural background of the individual can affect the working relationship
14. a working knowledge of the cycle of change model and how to help individuals make and review decisions and establish priorities
15. a working knowledge of how to identify how alcohol might contribute to current risk situations
16. a working knowledge of the importance of brief interventions to enable individuals who do not need specialised treatment to change their drinking behaviour
17. a working knowledge of the services available to treat individuals with alcohol problems

This project sought details on the courses used within the region. Very few were received, in some cases because of concerns about confidentiality. [680] [681]

The Cheshire and Wirral Partnership NHS Foundation Trust's course material was provided by their commissioners. Its objectives are to:

- Identify the difference between hazardous, harmful and dependent drinking levels
- Recognise the reasons why people drink
- Undertake the delivery of brief interventions
- Identify situations when they will be able to conduct alcohol screening (AUDIT)
- Calculate units of alcohol
- Use the correct pathways to refer individuals to the harm reduction team and the dependant team.

It covers:

• The impact of alcohol
• Information on alcohol, e.g. units, physical effects
• AUDIT
• The types of drinker
• Targeting interventions at the different types of drinker
• Brief interventions

Alcohol Concern's own course aims to enable participants to:
1. Apply knowledge of the alcohol unit system in the calculation of overall individual consumption.
2. Use and interpret the AUDIT alcohol screening tool in order to assess hazardous, harmful and dependent drinking.

3. Communicate effectively and confidently with service users about their alcohol use based on a respectful and non-judgmental approach.
4. Impart alcohol related knowledge such as long-term health implications and short-term biological/psychological/behavioural effects of alcohol in an effective and non-judgmental way that supports change.
5. Provide information about the various treatment and support options available for alcohol users.
6. Identify and make appropriate referrals to local support mechanisms for those experiencing problems with alcohol.

The training covers:

• Units and limits
• Drink-driving
• Harms related to alcohol
• National drinking trends, types of problem drinking and the importance of brief interventions.
• Screening with AUDIT tools.
• Referral and support options.
• Brief Intervention procedures and tools.
• The language of intervention for alcohol misuse.
• Structured dialogue practice.
• Extended Brief Interventions
• Referral pathways

The Department of Health has developed an elearning tool which is available on the Alcohol Learning Centre website.[682] This provides a two hour interactive course aimed at GPs and primary care staff, albeit the course is also relevant to other frontline staff. This covers a number of elements:

• Session Introduction
• Alcohol Facts
Covering units, Recommended limits, Modern drinking habits including home drinking, the risks, clarifying terminology, alcohol dependence
• Alcohol as a Drug
Covering alcohol's effects, alcohol and physical and mental health and social well-being, drink-driving, antisocial behaviour.
• Looking at Brief Advice
Covering simple identification, attitudes, cost to NHS, evidence for brief intervention, characteristics of brief advice, the IBA pathway
• Using Identification Tools
Covering AUDIT-C, FAST, SASQ, AUDIT-PC
• Full AUDIT Tool
Covering Introduction, scoring, analysing results and practice
• Brief Advice in Practice
Covering attitudes among the professional and the patient, the stages of change, benefits of alcohol reduction
• Structuring Brief Advice
Covering information for lower risk drinkers, brief advice using information leaflets, providing encouragement.

• Conducting Brief Advice
Covering practitioner attitude and approach and clinical approach, video examples
• After Brief Advice
Covering the principles of extended intervention, knowing when to refer patients and treatment pathways

6.4 A Model Course

All of the courses outlined above appear to offer an adequate framework for providing identification and brief advice training. Drawing on these models and research evidence it is possible to develop a synthesised model for a one day course.

Aim: To enable Tier 1 workers to identify, offer brief advice and appropriately refer people with alcohol-related problems.

Learning outcomes: By the end of the course participants will:

- Understand the unit system for measuring alcohol consumption
- Understand the safe/sensible drinking limits
- Understand the law around drink driving
- Understand the physical, psychological and social effects of alcohol
- Understand the definitions / characteristics of hazardous (increasing risk), harmful (high risk) and dependent drinkers.
- Be able to use screening tools including AUDIT
- Be aware of the evidence on the effectiveness of brief interventions
- Be able to offer brief advice to hazardous and harmful drinkers
- Be aware of extended brief interventions
- Be able to make appropriate referrals into treatment services.

Associated Drug and Alcohol National Occupational Standards Competencies

The course will provide participants with knowledge and understanding specified in the following DANOS units:

- AH10 - Carry out brief interventions with alcohol users.
- AA1 - Recognize indications of substance misuse and refer individuals to specialists.
- AA3 - Enable individuals to find out about and use services and facilities.
- AD1 - Raise awareness about substances, their use and effects.

Sample Programme

9.15am **Arrival / coffee**

9.30am **Session 1.1 - Welcome**
Introductions
Practical issues e.g. fire exits, toilets, lunch.
Warm Up Exercise

9.45am **Session 1.2 – Alcohol: the facts**
Knowledge about alcohol: units, limits, drink driving, physical, social and psychological effects

11.15 am **Coffee**

11.30am **Session 1.3 – Identifying Hazardous, Harmful and Dependent Drinkers**
The categories of drinkers
Using the AUDIT tool and other screening tools
12.30pm **Lunch**
1.30pm **Session 1.4 – Making An Appropriate Simple Intervention**
How to talk to hazardous, harmful and dependent drinkers about change
Understanding and applying the stages of change
Using the FRAMES model
Video examples of brief interventions in practice
Information on extended interventions
3.15pm **Tea**
3.30pm **Session 1.5 - Understanding Substance Misuse Services**
Understanding substance misuse services
Making appropriate referrals to substance misuse services
4.15pm **Session 1.6 – Summary, Final Questions and Evaluation**
4.30pm **Close**

6.5 Adjusting the Course for Different Requirements

This report cannot provide a tailored course for every eventuality. It is likely that the model course will need to be adjusted to meet the myriad variations that real circumstances will require. For example some groups will require a briefer training course to accommodate time pressures, GPs may be an example of this. Police or Accident and Emergency staff may require a course which is split over a number of shorter sessions to accommodate shift patterns. A half-day course programme is attached below as a model of a shorter session.

9.15am **Arrival / coffee**
9.30am **Session 1.1 - Welcome**
Introductions
Practical issues e.g. fire exits, toilets, lunch.
Warm Up Exercise
9.40am **Session 1.2 - Identifying Increasing Risk, High Risk and Dependent Drinkers**
Knowledge about alcohol: units, limits, drink driving
Knowledge about the physical, psychological and social effects
Knowledge about Increasing Risk, High Risk and Dependent Drinkers
Group work and Feedback
11.00 am **Coffee**
11.15am **Session 1.3 – Screening Tools to Identify Increasing Risk, High Risk and Dependent Drinkers**
Using the AUDIT Tool; presenting the FAST and AUDIT-C tools
Group work and Feedback
11.45am **Session 1.4 – Providing Appropriate Brief Advice**
Brief Advice: How to talk to Increasing Risk, High Risk and Dependent Drinkers about change
Making Appropriate Referrals to Substance Misuse Services
Group work and Feedback
12.50pm **Session 1.5 – Summary, Final Questions and Evaluation**

1.00pm **Close**

Section 7

Strategic Steps to Planning / Recommendations

This report sets out its recommendations in the form of a training plan based on the findings of this research. This plan is generic and sets out the steps that need to be taken by an area which is starting from scratch. It is impossible to develop a single specific training plan for the region or the three areas because each partnership is at a different stage of development. The following table sets out an 11 step process which can be followed to develop a robust approach to Identification and brief advice. At each step it identifies broad actions at the regional level and highlights some specific activity at the three area levels.

It is recognised that the DAAT partnership itself may not be the strategic driver for future change. The lead may come from the PCT, the Local Strategic Partnership or the Local Authority. Individual agencies, such as the Probation Service, may also choose to take action themselves.

Step 1
Ensure that each partnership has identified the provision of identification and brief advice as a strategic priority and that training local Tier 1 staff is a local objective
Regional Action: *The three areas identified that did not have policies or strategic statements should be supported to develop such policies.*
Cheshire & Merseyside: *The two areas identified that did not have policies or strategic statements should be supported to develop such policies.*
Cumbria & Lancashire: *No specific action required.*
Greater Manchester: *The area identified as not having a policy or strategic statement should be supported to develop such a policy.*
Step 2
Each partnership will have considered whether to establish a LES
Regional Action: *Consideration should be given to whether the 13 areas which did not identify a LES should be encouraged to have one.*
Cheshire & Merseyside: *Consideration should be given to whether the 6 areas which did not identify a LES should be encouraged to have one and how to respond to the scheme which has been suspended.*
Cumbria & Lancashire: *Consideration should be given to whether the 3 areas which did not identify a LES should be encouraged to have one.*
Greater Manchester: *Consideration should be given to whether the 3 areas which did not identify a LES should be encouraged to have one. Work should be done to address the financial constraints affecting one partnership.*
Step 3
Each partnership will be encouraging the use of the DES
Regional Action: *The 8 partnerships which did not identify a scheme should develop schemes.*
Cheshire & Merseyside: *The 3 partnerships which did not identify a scheme should develop schemes.*
Cumbria & Lancashire: *The 1 partnership which did not identify a scheme should develop a scheme.*
Greater Manchester: *The 4 partnerships which did not identify a scheme should develop schemes.*
Step 4
Each partnership has agreed which screening tools are to be used
Regional Action: *All partnerships should identify which screening tool is being used*

and ideally this should be AUDIT or one of the shortened versions. Four partnerships failed to identify which tool is used.
Cheshire & Merseyside: *One of the partnerships needs to identify which screening tool is being used and ideally this should be AUDIT or one of the shortened versions.*
Cumbria & Lancashire: *One of the partnerships needs to identify which screening tool is being used and ideally this should be AUDIT or one of the shortened versions.*
Greater Manchester: *Two of the partnerships needs to identify which screening tool is being used and ideally this should be AUDIT or one of the shortened versions.*
Step 5
Each partnership will consider the priority groups of Tier 1 staff for which IBA training will be provided. These should take into account the priority groups identified by the Department of Health which include primary care, general hospitals, accident and emergency, mental health, criminal justice services and social services.[683]
Each partnership will consider the priority groups of Tier 1 staff for which IBA training will be provided
Regional Action: *Prison, voluntary sector, police and job centre*
Cheshire & Merseyside: *Prison, social care, secondary health care and job centre*
Cumbria & Lancashire: *Prison, housing, accident & emergency and job centre*
Greater Manchester: *Prison, pharmacy, secondary health care and job centre*
Step 6
Each partnership will identify how training will be provided for each priority group
Regional Action: *Despite the number of partnerships working on this issue, very little joint commissioning has occurred. It could be considered whether regional or area consortia could be put together to commission IBA training and possibly reap the benefit of economies of scale.*
Step 7
Each partnership should identify the resources to provide the training. This should be done in the light of the Department of Health's *Guidelines for the commissioning of Identification and Brief Advice (IBA) training.*[684] Partnerships should also look at the NW focused commissioning guidance, 'Commissioning training for behaviour change interventions: evidence and best practice in delivery, Powell & Thurston 2008'. http://www.nwph.net/champs/Publications/Behaviour%20change/Commissioning%20training%20for%20behaviour%20change%20-%20full%20report%20-%20autumn%202008.pdf Interagency collaboration on commissioning and resources will also support this recommendation.
Regional Action: *Funding is clearly an issue of concern for a number of partnerships, particularly those which did not receive Early Implementer Status. Regional action could be taken to support partnerships securing funding, e.g. highlighting that this is a regional priority to PCTs.*
Step 8
Each partnership will identify how training will be provided for each priority group and commission the training.
Regional Action: *Different groups may benefit from different training styles, e.g. GPs may require half day courses to accommodate tight timeframes, A&E or police*

staff may need two shorter courses timed to fit in with shift work patterns. It would be useful to provide regional guidance on which groups need which style of training.
Step 9
Each partnership will establish monitoring and evaluation systems for the training and ensure that a consistent record of people and professions trained is kept. Measurable outcomes should be developed to ensure that IBA work is undertaken.
Each partnership will establish monitoring and evaluation systems for the training and ensure that a consistent record of people and professions trained is kept
Regional Action: *Regional guidance on monitoring and evaluation should be developed.*
Cheshire & Merseyside: *3 partnerships need to develop monitoring and evaluation systems*
Cumbria & Lancashire: *1 partnership needs to develop monitoring and evaluation systems*
Greater Manchester: *4 partnerships need to develop monitoring and evaluation systems*
Step 10
Each partnership will identify how ongoing support will be provided for those who have received training
Regional Action: *Regional guidance on ongoing support should be developed.*
Cheshire & Merseyside: *4 partnerships need to develop an ongoing support system*
Cumbria & Lancashire: *1 partnership needs to develop an ongoing support system*
Greater Manchester: *3 partnerships need to develop an ongoing support system*
Step 11
Each partnership will identify what refresher training will be provided for those who have received training
Regional Action: *Regional guidance on refresher training should be developed.*
Cheshire & Merseyside: *2 partnerships need to develop plans to refresh training*
Cumbria & Lancashire: *1 partnership needs to develop plans to refresh training*
Greater Manchester: *5 partnerships need to develop plans to refresh training*

Appendix 1 – People Completing the Form

Partnership	Contact	Position
Salford	Andrew MacDonald	DAAT Coordinator
Stockport	Simon Armour	Senior Public Health Advisor
Cumbria	Paul Musgrave	Joint Commissioning Manager
Blackpool	Steve Morton	Alcohol Harm Reduction Policy Officer
Wirral	Theresa Whittingham	Trainer
Sefton	Ian Canning	Health Promotion Specialist
Rochdale	Jenny Lovett	DAAT Coordinator
Warrington	Jane Knight	Alcohol Coordinator
Halton and St Helens	John Holden	Commissioning Manager, Substance Misuse
Bolton	Joanne Higham	Alcohol Joint Commissioning Manager
Bolton	Phil Ramsell	Senior Health Promotion Specialist
Safer Trafford	Andrew Clark	Data Analyst
Oldham	Perry Gunn	DAAT Joint Commissioning Manager
Manchester	Janet Mantle	Consultant in Public Health
East Lancashire	Ian Treasure	Alcohol Harm and Reduction Commissioning Manager
Cheshire	Jane Stairmand	Alcohol Commissioning Manager
Tameside	Sabrina Fuller	Public Health Consultant
Blackburn & Darwen	Karen Cassidy	DAAT Coordinator
Liverpool	Phil Sadler	Alcohol Coordinator
Wigan	Paul Keeling	Alcohol Coordinator
Bury	Elma Ikin	DAAT Manager
Knowsley	Stuart Dodd	Alcohol Coordinator

Appendix 2 – The Training Needs Analysis Tool

North West Alcohol Identification and Brief Advice Training Needs Analysis

Please note that this questionnaire uses the term "Identification and Brief Advice" to cover what was formerly called screening and brief interventions training.

Name of partnership:
e.g. Wigan
Contact name:
Partnership lead
Contact details:
Email, phones, address
Is there a local policy or strategic aim to provide IBA training?
(Secure a copy)
Has the partnership directly commissioned any alcohol IBA training?:
How many days / sessions in 2007/8? *Number*
How many days / sessions in 2008/9? *Number*
How many days / sessions are planned in 2009/10? *Number*
Do you have any contracts in place to provide IBA training after 2009/10?
Yes/no plus details
Do you have a complete record of the participants and their profession / role?
Yes/no
How many people have received training in each year:
2007/8? *Number*
2008/9? *Number*
2009 to date? *Number*
How many people in each of the following groups have received IBA training since 2007/8
GPs
Other Primary Care Staff *Number and estimated % of total of that staff group in the area.*
Accident and Emergency Staff *Number and estimated % of total of that staff group in the area.*
Other Secondary healthcare staff *Number and estimated % of total of that staff group in the area.*
Probation staff *Number and estimated % of total of that staff group in the area.*
Pharmacists *Number and estimated % of total of that staff group in the area.*
Police officers *Number and estimated % of total of that staff group in the area.*
Drug service staff *Number and estimated % of total of that staff group in the area.*
Prison service staff *Number and estimated % of total of that staff group in the*

area.
Arrest referral workers *Number and estimated % of total of that staff group in the area.*
Voluntary sector staff *Number and estimated % of total of that staff group in the area.*
Job centre staff *Number and estimated % of total of that staff group in the area.*
Social care *Number and estimated % of total of that staff group in the area.*
Housing *Number and estimated % of total of that staff group in the area.*
Which other groups have been trained not covered by above list?
List other agencies
Have employers been targeted as a group? Yes / No
If yes please describe:
Which agencies or training providers provided the training?
Names and contact details for each provider
How much have you paid on average for trainers per one day session (excluding accommodation / refreshment costs)?
£xxx
What other IBA training has taken place in your partnership area since 2007/8 but which was not commissioned by you?
Training – *details*
Target groups – *details*
Training Providers – *details*
Number and professions/roles if known? – *details*
Contact details for agencies commissioning training
Details
Details
Details
Other activity.
List any other relevant activity
Could you provide us with a lead contact for your:
PCT – regarding primary care
Name, agency, email, phones, address
Trust providing A&E /secondary care services
Name, agency, email, phones, address
Probation service
Name, agency, email, phones, address
Police
Name, agency, email, phones, address

Do you have a LES operating in your partnership area?
Please provide details of investment, number of practices, monitoring arrangements and outputs / outcomes identified to date.
How is the DES being rolled out in your area?
Please provide details of investment, number of practices, monitoring arrangements and outputs / outcomes identified to date.
What tool or tools are being used for IBA in this area?
e.g. AUDIT / FAST / Audit C and if more than one who is using which?
What arrangements are in place to monitor the ongoing use and impact of IBA?
Please describe
Are there arrangements in place for ongoing support / back-up for those trained and undertaking interventions?
Please describe
What plans are in place to refresh IBA training for those who have received it?
Please describe
Could you please send us a copy of training materials used and a copy of your local alcohol strategy and any other strategic statement relevant to IBA training.
Note what and when secured

Appendix 3 – Glossary of Terms

AUDIT - Alcohol Use Disorders Identification Test, a World Health Organisation alcohol screening tool
AUDIT-C – A briefer version of the AUDIT tool
BAC – Blood alcohol count
CARAT workers – Prison drug workers
DAAT – Drug and Alcohol Action Team
DANOS – Drug and Alcohol National Occupational Standards
DES – Directed Enhanced Service, a national health service scheme which can pay primary care to screen for problem drinkers
FAST– A briefer version of the AUDIT tool
IBA – Identification and Brief Advice, the term used to cover what was formerly called screening and brief interventions.
LES – Local Enhanced Service, a local health service scheme which can pay primary care to screen and offer other help to problem drinkers
PAT – Paddington Alcohol Test, a screening tool for A&E units
Supporting People – Commissioner of housing services

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