Executive Summary

Tri-borough Substance Misuse and Offender Health Needs Assessment 2012-13

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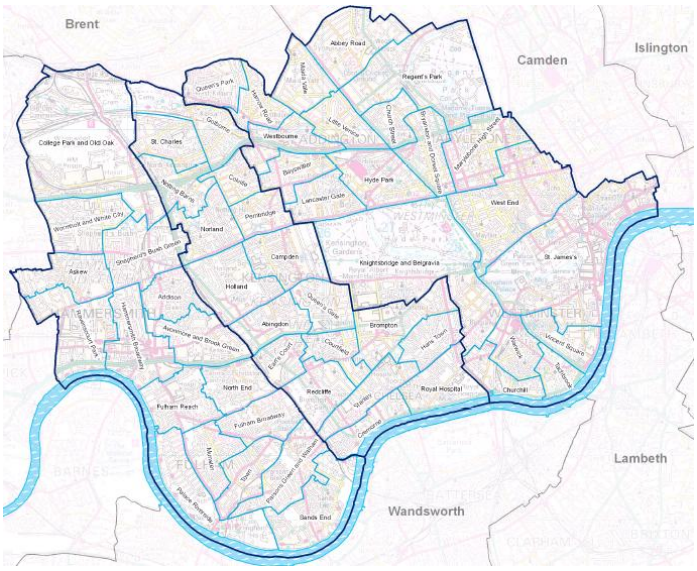

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City of Westminster

h&f hammersmith & fulham

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Content

Introduction

This is the first needs assessment undertaken by the tri-borough Substance Misuse and Offender Health Commissioning Team, formed in April 2012.

The aim of the partnership is to reduce the harm that substance misuse has on the individual, their family and society as a whole. In 2013-14, the delivery of this objective will be assessed through two high level partnership ambitions:

- To deliver treatment outcomes which position each of the tri-borough local authorities in the top quartile.
- To reduce or maintain the rate of alcohol related hospital admissions for each of the tri-borough local authorities.

These overarching aspirations are complemented by a performance monitoring framework which focuses on minimum standards and service specific ambitions.

The needs assessment provides an overview of need, provision and satisfaction. Monitoring and evaluation are routinely undertaken by the Commissioning Team and therefore the needs assessment provides an annual opportunity to assess and review current provision with the intention of informing future strategic plans and areas for development.

Analysis has been provided for each of the individual boroughs and recommendations are made for either the partnership as a whole or for a specific local authority.

In this assessment particular focus was made to new club trends, alcohol related hospital admissions and blood borne viruses. There are other areas which have been touched on but require greater exploration and development in the coming year. In particular 2013-14 will see a more in-depth review of mental health and substance misuse and links with Family and Children's Social Services.

Demographics

The population of the UK and London is growing although this trend isn't mirrored across the tri-borough partnership. While the 2011 Census evidenced a 21% growth in Westminster's population and a 10.4% increase in Hammersmith + Fulham's resident population from the 2001 Census, Kensington + Chelsea's population remained static.

Westminster's struggle to ensure that the census reflects the true resident population, due to both physical and social factors, is well documented. However, for consistency, the 2011 Census estimates have been used throughout this document to draw comparisons between the resident and treatment population. Caution therefore needs to be applied when interpreting this information and prevalence estimates in this local authority may be underestimated.

Prevalence of Substance Misuse

Substance misuse can be defined as using substances not consistent with legal or medical guidelines. Dependence focuses not so much on the quantity of use but on the consequences (physical, emotional and social).

Accurately being able to identify the prevalence of misuse dependence is complex. Those who misuse can often remain hidden within the population, until the use escalates to a level where the consequences result in the misuse becoming exposed. For this reason, the majority of prevalence estimates are based on national surveys applied to the local socio-demographics of a borough. These self reported surveys are likely to underestimate the true extent of use, as a consequence of excluding those most chaotic who are unlikely to be in a position to participate, and because of a social desirability bias.

Prevalence estimates however provide a useful means of allowing commissioners to ensure services have capacity to meet local need and ensure pockets of treatment naive populations continue to be explored and targeted into services. Using the wealth of prevalence information available, the borough based prevalence of misuse and dependence can be summarised as followed:

Estimate of Substance Use	Hammersmith and Fulham	Kensington and Chelsea	Westminster
Individuals who have taken a drug in the last year [1]	16,212	14,238	19,782
Individuals who have taken a Class A Drug in the last year [1]	6,639	5,831	8,101
Opiate and Crack Cocaine Users[2]	1,548	1,563	2,255
Dependent Drug Users[3]	4,239	3,667	6,225
Binge Drinkers [4]	34,894	29,968	41,071
Higher Risk Drinkers [4]	9,027	8,048	10,419
Dependent drinkers [3]	7,520	6,471	11,024

[1] Home. Office. Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales (2nd Edition) July 2012.
[2] The University of Manchester. Glasgow Prevalence Estimation. Estimates of the prevalence of opiate use and/or crack cocaine use (2010/11) January 2013
[3] National Centre for Social Research and the Department of Health Sciences, University of Leicester. Adult psychiatric morbidity in England, 2007: Results of a household survey
[4] Local Alcohol Profile for England

In the coming year the tri-borough partnership will be working in partnership with the Drugs and Drink Meter to be able to gather information about our resident population. This will enable us to supplement national surveys with borough based intelligence and have a more informed approach to local pockets of problematic use.

Availability and Accessibility of Substance Misuse Services

The structure of substance misuse treatment systems across the tri-borough differs. Kensington + Chelsea and Westminster both provide integrated substance misuse treatment hubs which enable individuals to have their needs accommodated by one service. Hammersmith + Fulham by contrast still operates a more traditional system where services specialise in different interventions for the needs of drug and or alcohol users.

The treatment population in Hammersmith + Fulham and Kensington + Chelsea has reduced, mainly as a result of the reduction in opiate, crack and alcohol misusers engaging with services. While Westminster has also seen a reduction in opiate and crack cocaine misusers in treatment, the increase in alcohol and other drug users has seen the overall population remain stable.

In order to accommodate local need the tri-borough treatment system needs to increase and re-balance treatment capacity, particularly for alcohol misusers. While not all of the estimated alcohol dependent population will need the input of specialist services, the tri-borough treatment system is not currently meeting the Department of Health's recommended guideline to provide treatment for 15% of the estimated dependant cohort.

Historically drug treatment systems have evolved to meet the needs of opiate and or crack cocaine users, and this is a declining treatment cohort, although local estimates would suggest the potential for growth. In order to ensure that the system as a whole is responsive to local need, there needs to be a greater understanding about the treatment needs of a broader range of substance misusers. A separate section of the needs assessment has been devoted to this subject.

By examining the demographics of the treatment population we can identify that services need to undertake more targeted work to engage female drug users and younger drinkers into services. From national estimates we know that the highest levels of alcohol dependence are in men aged 25 to 34, and women aged 16 to 24, yet both cohorts are under-represented within services.

Westminster has nearly twice the proportion of residents in treatment who are homeless or have a housing instability than the other boroughs. With specialist services continuing to develop good working relationships with the hostels and day centres, ensuring the Westminster treatment system is accessible and appealing to the housed population is also a priority.

From the proportion of the treatment population who are parents, it is difficult to identify how adequately the treatment system responds to their needs. This will be better understood through greater joint working with

Family and Children's Social Services and this need will be prioritised in 2013-14. Another area where joint working is essential to effectively meeting the needs of substance misusing residents is Mental Health Services.

GP Shared Care is integral to the efficiency and effectiveness of the provision of drug treatment. A substantial amount of the opiate and crack cocaine using treatment population is seen within Shared Care. This activity has not always been sufficiently resourced and patients have not routinely had access to the required 'wraparound' support and recovery opportunities. Therefore it is imperative that the tri-borough continues to demonstrate improvements in Shared Care and these supportive elements.

The provision of substance misuse treatment is cost effective and delivers a range of benefits for the individual and wider society. This has been demonstrated by several national studies. Depending on the source, the return on investment of drug treatment ranges from £2.50 to £13 for every £1 invested[5]. Less detailed analysis is available on the cost benefits of alcohol treatment although most estimates give a £5 return for every £1 spent[6].

Recommendations

1. Increase the capacity to accommodate alcohol misusers in treatment.
2. Undertake focus groups to understand the treatment barriers for female drug misusers.
3. Review alcohol support available, and pathways into treatment, for our younger residents.
4. Undertake a tri-borough audit of the prevalence of misuse within the hostel dwelling population, and the proportion of those who are engaged in treatment.
5. Define, promote and ensure pathways are utilised between Family and Children's Services and substance misuse treatment and mental health services and substance misuse services.
6. Repeat the 2012 Shared Care audit to identify areas of improvement and those requiring further development.

[5] University of York was commissioned by the Home Office to look into value for money and concluded that for every £1 spent on treatment, £9.50 worth of benefits were accrued to the community. *National Treatment Agency for Substance Misuse* Business plan 2008/09. The Drug Treatment Outcomes Research Study estimated the benefit-cost ratio of treatment as approximately 2.5:1. The Drug Treatment Outcomes Research study (DTORS): Cost-effectiveness analysis 2nd Edition *Linda Davies, Andrew Jones, Georgios Vamvakas, Richard Dubourg and Michael Donmall.* World Health Organisation acknowledged that as a minimum there is a 3:1 saving but if you include all the broader costs this rose to 13.1. 'Principles of Drug Dependence Treatment. WHO March 2008.

[6] National Audit Office. Department of Health Reducing Alcohol Harm: health services in England for alcohol misuse. 29th October 2008.

Club Drugs and New Drug Trends

Accurately identifying the prevalence of misuse and dependence is complex. This is particularly true for those who misuse substances not traditionally targeted by treatment services. Surveys, although likely to under-estimate the true extent of use, remain one of the best indications of prevalence of use. From the 2011-12 Crime Survey for England and Wales we know the use of cocaine and GBL/GHB has increased. Supplementing this with information gathered by the "Global Mixmag Survey" we can understand more about levels of use and problematic use of a broader range of substances.

However there remains a gap in national and local intelligence. Overcoming this gap is integral to providing interventions which adequately address local need. In 2013 the tri-borough will therefore be working with the Global Drug Survey to promote a web based tool which provides residents with comparative information about their levels of use and health messages, while directing those who request help into local services. Commissioners will also be able to utilise this tool to gather data on levels of use.

Due to high social functioning often associated with use of these substances, problematic use can be harder to identify. Traditional routes of engaging residents in to substance misuse treatment, such as criminal justice and employment services, do not identify this group. It is therefore often the physical ailments which lead to the identification of this cohort and not necessarily social triggers. For example, psychosis from the use of ecstasy, bladder problems associated with ketamine use or sexual infections/ unplanned pregnancy associated with methamphetamine.

Treatment services have traditionally been established to meet the needs of opiate, crack cocaine and alcohol misusers and therefore the local and national proportion of individuals seeking treatment for use of 'other' substances is low.

While users of club drugs would not be excluded from treatment within the tri-borough substance misuse treatment system, promotional activity would not seek to attract these individuals into core services which prioritised the use of crack cocaine, opiates and alcohol. An alternative treatment option for these residents would be the Club Drug Clinic, run by Central and North West London Foundation Trust in partnership with Antidote.

The Club Drug Clinic sees two broad categories of users, those from the Lesbian, Gay, Bi-Sexual and Transgender (LGBT) community and heterosexual clubbers. The substances used by these two cohorts, and the socio-demographics differ.

Across the tri-borough partnership the proportion of residents who engage in substance misuse treatment, for problematic use of substances which exclude opiates, crack cocaine and alcohol is low. By examining the primary substance, we can identify that the majority of these non-traditional users seek help for cannabis and cocaine, and in Westminster steroids, not these newer substances.

It is clear that more needs to be done to make services accessible and flexible to the needs of users of a broader range of substances. In addition to enhancing services for the club drugs, given the high prevalence of use, more needs to be done to provide suitable interventions to residents who misuse powder cocaine and cannabis.

Recommendations

7. Utilise the intelligence from the drugs and drink meter to scope the potential need for specialist services.
8. Up-skill staff working in the treatment system, to ensure that all staff are trained in the identification and management of the club drug cohort.
9. Formalise commissioning arrangements with the Club Drug Clinic.
10. Provide tailored interventions specifically for residents who develop problematic cannabis and powder cocaine use.

Blood Borne Viruses

Blood Borne Viruses (BBV) impacts on an individual's health and cost society. These viruses can be treatable and are preventable.

While there is a wealth of national prevalence estimates, including the prevalence among the drug injecting cohort, there isn't a lot of local data to supplement these estimates.

Nationally the prevalence of Hepatitis B and HIV among injecting drug users is low. In comparison injecting drug use continues to be the most important factor in Hepatitis C infection with an estimated 45% of injecting drug users believed to be infected.

As part of the comprehensive assessment tool, a wealth of BBV screening, prevalence and treatment information is gathered in addition to associated risk taking behaviours. However this information is not easily extractable from case management systems and therefore the quality of tri-borough information is variable. In Westminster the North and South treatment hubs are able to report on this information for new presentations since the service opened its doors in November 2010, but this excludes the longer term treatment cohort as well as the 700 individuals engaged in GP Shared Care. The other boroughs have not previously been asked to report this information and information systems have therefore not been developed.

The guiding principle for the tri borough is to ensure that all health considerations are supported during the assessment process in accordance with the National Institute for Health and Care Excellence (NICE) Guidance. This would include all drug users being offered vaccinations against Hepatitis A and B and all drug users offered testing and, if required, treatment for Hepatitis C and HIV. This does not reflect local practice. Therefore screening, vaccination and treatment for BBVs remains a tri borough priority amongst those who use drugs and alcohol.

Across the tri-borough treatment system there are a number of initiatives to reduce the risk of infection and to maximise the update of identification and subsequent treatment of those who are identified as living with a BBV. Developing and adopting best practice is key. The Commissioning Team are in a position to promote

education, prevention, screening and treatment for BBV, and as the Club Drug Clinic has demonstrated, this shouldn't be limited to just individuals who inject, but should also include those that are participating in risky sexual activity, and those who have liver disease and long term conditions.

Recommendations

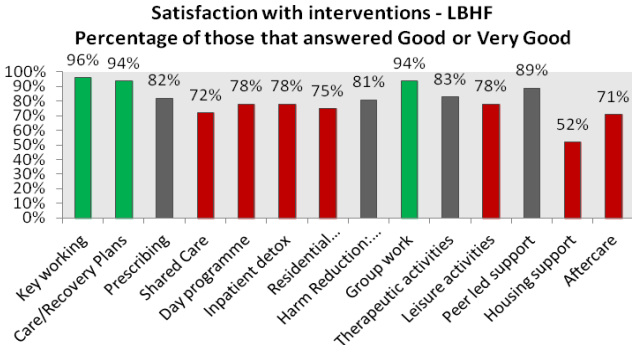
11. Implement minimum standards of service delivery (including Shared Care) and roll out a tri-borough best practice model of identification and treatment of BBVs.
12. Improve local data capture on the take up of BBV screening, interventions and treatment.
13. Improve links with other health services (HIV treatment and sexual health services).
14. Implement a one stop approach to addressing the health needs of our treatment population.
15. Improve the knowledge of risk of infection amongst service users.

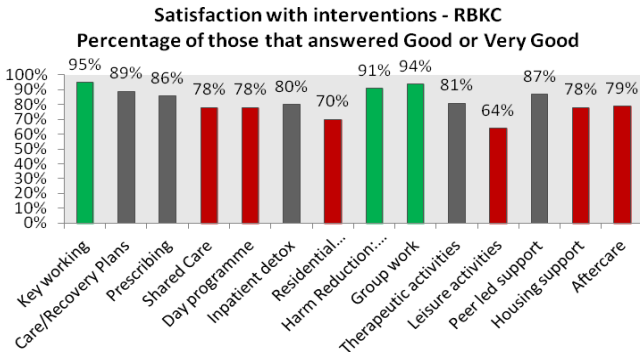
Service User Satisfaction

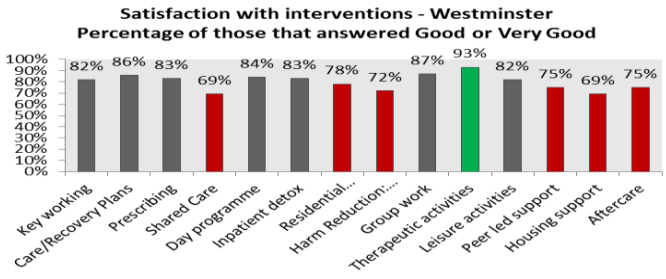
To ensure our treatment system meets the needs of those who require them, and deliver the best possible outcomes, it is imperative we use service users' feedback to shape our services. While this should be done routinely through regular ad hoc service user comments and borough wide service user groups, satisfaction surveys provide an opportunity to gather a broad range of service users' views and allow commissioners to request their input on specific areas requiring development.

The annual service user satisfaction survey is therefore integral to the tri-borough performance management of our services. This is the first time it has been utilised as a tri-borough tool. Through standardising the format across all services, comparisons can be made and best practice can be identified.

A total of 255 questionnaires were completed as part of the annual survey. The findings showed that overall satisfaction was high.







2012 Service User Satisfaction Survey

Feedback around the quality of the group work and 1:1 support was particularly high with Shared Care, Aftercare and Housing support being areas that our service users were least satisfied with.

Service users were particularly complementary of the staff and felt the locations were convenient. Areas requiring improvement related to other service users treating each other with respect, services taking the views of the service users into account and wanting additional key working.

With Class A service users stating they wanted to stop using, and one in five of respondents stating their substance use has not decreased since they started treatment, maximising recovery opportunities for these residents is key.

In addition to this questionnaire, a service development survey around residential treatment was also rolled in 2012. This development survey was created to ensure this treatment pathway was seamless and accessible. The survey also provided the opportunity to bridge a current gap around service user feedback feeding into the use of different providers.

The survey identified that the majority of service users had their key worker/ care manager suggest residential treatment and most felt that the community based service adequately prepared them for their residential stay.

A broad range of residential treatment providers continue to be used which makes accessing satisfaction, particularly as a snapshot problematic. One of the main recommendations is therefore to employ more routine means of capturing this information.

Residential treatment remains an important intervention which, given the current levels of usage, could be more accessible to our services users. The appropriateness of the placement, as well as post treatment support, is vital to ensuring the individuals' needs are addressed and longer term sobriety is maintained.

Recommendations

16. In the 2013 survey adjust the roll out of the annual questionnaire to ensure those who respond are more representative of the treatment population as a whole.
17. Adopt common assessment and care planning tools to ensure they reflect the means in which service users want to be contacted and recovery opportunities are more rigorously explored.
18. Ensure the findings of the survey translate into service improvement, through the implementation of service level improvement plans and system wide promotion.
19. Maximise the availability of abstinent based groups and promote aftercare support services.
20. Ensure employment and training opportunities are visible and service users are aware of local housing support available.
21. Ensure service user satisfaction with their residential placements is made available to potential service users and feeds in to the frequently used provider lists.
22. Review the continuity of care provided by community based treatment services while an individual is engaged in residential treatment.

Treatment Outcomes

The testament to the effectiveness of a substance misuse treatment system is to identify the number of individuals who successfully complete treatment and go on to lead lives free from the burdens of dependency. This remains a strategic priority across the tri-borough partnership. Delivering a high proportion of outcomes is reflective of a system which engages and responds to need. However while maximising treatment outcomes and recovery opportunities remain a clear priority, this needs to be tempered with the need to reduce the harm caused to those who are unwilling or unable to currently embrace abstinence.

With a shift away from national targets focusing on numbers in treatment, the Public Health Outcomes Framework is the first time the treatment system has been assessed on our ability to deliver treatment outcomes. In its current structure it is limited to primary drug users only and published figures do not take into account the differing complexities. This means that the tri-borough the partnership delivers less favourably when compared to some outer London Boroughs. In addition the definition requires an individual to not re-present within 6 months of successfully completing treatment which makes in year monitoring complex. To enable commissioners and services to be more responsive to local trends, latest numbers completing continue to be used as indicative of this performance and outcomes for primary alcohol misusers are included in local performance frameworks.

In April 2012 Westminster was identified by the National Treatment Agency (NTA) as a partnership requiring improvement around the delivery of outcomes to opiate misusers. This led to the development and an implementation of a tri-borough improvement plan. Improvements in Westminster and Kensington + Chelsea have been demonstrated however in Hammersmith + Fulham additional local agency improvement plans have been implemented to support further growth.

In order to deliver further improvements it is important to understand who is most and least likely to complete treatment. The characteristic and treatment experience of our substance misuse residents provides a valuable insight into treatment outcomes. Across the tri-borough partnership there is a need to re-energise the recovery opportunities for those residents whose continuous treatment journey has spanned many years. In addition treatment interventions for non opiate misusers, and those with a very low complexity need to be revisited to ensure the intensity matches the individual's level of need.

So far analysis has centred on the use of national systems and tools however these are often limited to outcomes measured at the point an individual leaves treatment and not the longer term outcomes which the treatment system support. The need to identify the effectiveness of our treatment system, through understanding the longer term benefits and outcomes it delivers, is integral to needs led commissioning and remains a priority. It is therefore imperative that capture of information post treatment is mainstreamed and adopted across the tri-borough partnership. In addition local service user feedback has requested that the service does not simply cease upon exit and that some limited support or contact is still available for those experiencing 'difficult moments' in their recovery post-treatment.

Recommendations

23. Revisit the recovery opportunities for residents whose continuous treatment journey has lasted in excess of two years.
24. Review the current support provided to those residents with low complexity to ensure they are provided with suitably matched treatment interventions.
25. Implement a standardised tri-borough approach which integrates collection of data about post treatment outcomes with a post-treatment 'check-in' intervention
26. Review the care plan to ensure it has a recovery focus.
27. Explore current best practice around the treatment interventions which deliver the best outcomes to crack cocaine users. (Hammersmith and Fulham)
28. Investigate the injecting behaviour among non opiate misusers to ensure harm reduction messages are promoted to this cohort (Kensington and Chelsea)
29. Examine the links between levels of use and changes in reported health and well-being (Kensington and Chelsea)
30. Review the post treatment care packages for residents to ensure that this addresses re-presentations levels. (Westminster)
31. Explore the treatment interventions delivered to crack and powder cocaine users (Westminster)
32. Revisit women focused treatment elements.

Substance Misuse and Offending

The relationship between substance misuse and offending is well established. National estimates suggest that between a third and half of all acquisitive crime is drug related and that annually nearly 1 million violent offences are alcohol related. Diverting these individuals into substance misuse treatment presents an effective means of managing substance misuse related offending.

Historically the Drug Intervention Programme (DIP) has acted as the main conduit into identifying these individuals and making attendance at a treatment service for an assessment compulsory. Given the transient nature of the offending population, these initiatives have not always reaped borough based benefits. The rigors of the processes required to support implementation have also limited the ability to demonstrate the full benefits from this front end function.

As the strategic and commissioning landscape for substance misuse commissioning changes, the tri-borough has been exploring ways to restructure criminal justice front end services. The tri-borough has been successful in becoming one of four national pilots to work in collaboration with central government to develop a whole place community budget. The justice strand of this pilot will establish a reducing reoffending service that will work with short term sentenced prisoners who do not fall under statutory supervision. The service, which will begin in September 2013, will provide end to end support from police custody, through court and prison and back out into the community.

Identification and diversion remains a key priority however, and with the introduction of community budgets, there is the opportunity to evaluate existing processes to ensure learning and best practice shape future engagement strategies.

Not all individuals who misuse substances will offend and not all offences committed by the offending cohort will be linked to their substance misuse. National data on drug misusers engaged in treatment would suggest that roughly half do not. The local use of the Treatment Outcomes Profile (TOP) to gather information from service users about their offending levels throughout their treatment journey is not effective. Without being able to measure the changes in these offending levels, we cannot ensure treatment packages are effective in addressing the needs of the individual and wider society. Local improvement is therefore required.

While not necessarily causal, the impact of substance misuse on domestic violence situations have been well documented. Ensuring identification within specialist substance misuse services and clear pathways into local domestic violence support is therefore a priority. In 2012-13 implementing training packages has been a focus to facilitate in the identification of domestic violence among substance misusing residents. Monitoring to identify whether there have been improvements in identification and joint working will be a focus for 2013-14.

For some of our substance misusing residents, being detained in prison can comprise an element of their treatment journey. While treatment services are available within prisons, these episodes do not always reflect a continuation of an individual's community based treatment. Similarly post release continuity of care could be enhanced. In order to improve the continuation of these individuals' care it is therefore important that we revisit and evaluate initiatives currently used and ensure that improving this pathway forms part of the reducing reoffending service.

Community orders (Drug Rehabilitation Requirements and Alcohol Treatment Requirements) provide a means of allowing an individual to address their substance misuse as part of their rehabilitation. Joint work with Probation is integral to ensuring these orders are used appropriately and the treatment provision is tailored to deliver the best possible outcomes.

Substance misuse impacts on society, both financially and their perception of their community. In order to reduce these harms, and maximise the effectiveness of the treatment system, it is important that there are clear links from criminal justice agencies into support services. In addition it is paramount that services are responsive to the needs of this cohort and that treatment packages are responsive to changes in offending behaviour.

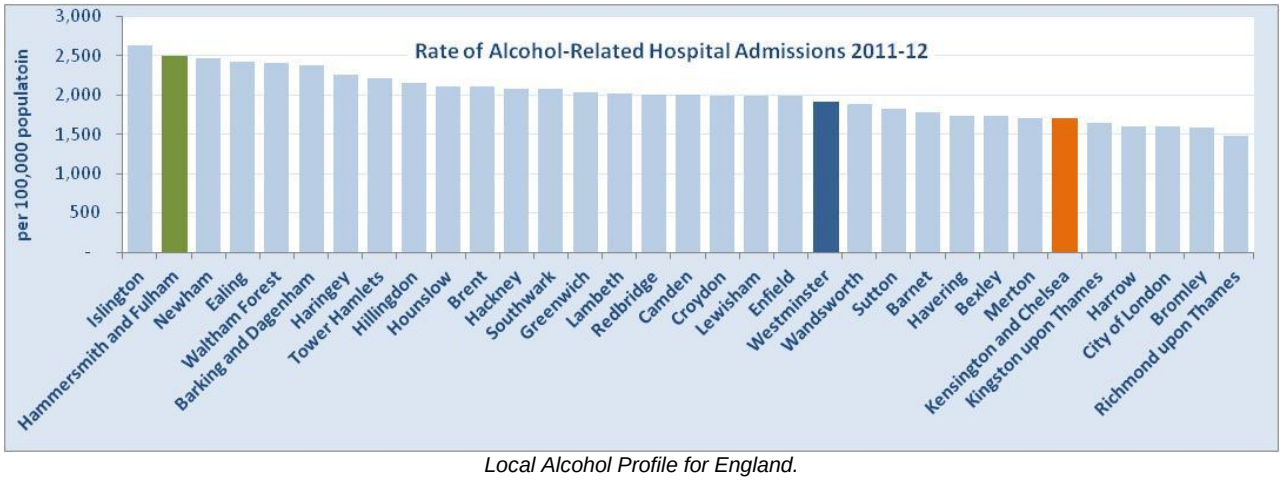
Recommendations

33. Reconfigure criminal justice front end engagement in line with the reducing reoffending community budget pilot to maximise referrals into specialist substance misuse services for residents.
34. Develop proposals to widen out drug testing to include other drugs such as cannabis, amphetamines, mephedrone and ketamine.
35. Ensure front end criminal justice engagement across the tri-borough focuses on alcohol misusers in addition to those who misuse illicit substances.
36. Ensure treatment services more accurately record offending levels and that Treatment Outcomes Profile accurately reflect offending behaviour.
37. Ensure treatment packages address and challenge offending behaviour.
38. Monitoring the local identification of domestic violence within substance misuse services and to ensure pathways into additional support are utilised.
39. Improve continuity of the treatment journey for residents whose treatment journey has included a prison stay in Wormwood Scrubs, Wandsworth, Holloway and Bronzefield prisons.
40. Develop further links with probation to ensure the community orders are utilised and effective throughout the tri-borough.
41. Develop further work with probation to support offender managers to identify substance misusing offenders who have not come through the traditional drug rehabilitation or alcohol treatment requirement.
42. Develop relationships with the new reducing reoffending service provider in order to share data on reconviction and reoffending levels of substance users engaged with the service.
43. Ensure front end criminal justice services are working with local providers of mental health and learning disability services in order to ensure substance misusing offenders with these needs are diverted into treatment and away from the criminal justice system, where appropriate.

Alcohol Related Hospital Admissions

The Government's alcohol strategy estimates that alcohol-related harm costs society £21 billion per year[7]. A substantial amount of this cost is incurred by the NHS in the management of alcohol related illness and injury. Across the tri-borough partnership, in 2011-12 alcohol related hospital admissions cost at least £18.3 million.

Although comparatively low, Westminster and Kensington + Chelsea have seen year on year increases in the number of residents who were admitted to hospital for an alcohol related condition. Hammersmith + Fulham have the 2nd highest rate of alcohol related admissions, although the rate was stable between 2010-11 and 2012.



Local Alcohol Profile for England.

Given the large amount of admissions which are partially attributable to alcohol, it is important that the partnership focuses on a broad range of interventions, from the promotion of healthier lifestyles and brief advice, to robustly targeting those dependent drinkers in to specialist services**.**

In winter 2012 Hammersmith and Fulham was selected by the National Treatment Agency to be one of eight pilot areas to introduce local improvements that focus on implementing the Government's Alcohol Strategy. The partnership has therefore commenced a stock take and identified areas for delivery. The findings of this pilot will be utilised across the tri-borough to inform future service development.

Recommendations

44. Promoting public health campaigns which encourage a sensible approach to drinking.
45. Strengthen referral pathways from hospital into specialist alcohol services for those with multiple alcohol related hospital admissions.
46. Develop/ improve partnership working with St Thomas's hospital.
47. Standardise alcohol interventions targeted at older drinkers.
48. Undertake targeted work in GP practices which contribute the highest number of patients to alcohol related hospital admissions.
49. Review support to GP Practices which contribute a higher proportion of alcohol specific hospital admissions.
50. Implement the findings of the Hammersmith and Fulham Alcohol Pilot.

[7] Home Office. The Government's Alcohol Strategy. March 2012

Next Steps

This needs assessment is adopted as a working document used to inform future commissioning priorities. To do this the following actions will be progressed:

- Recommendations will be brought together to form key activities into a business plan. Within the context of specified local, regional and national priority areas they will be grouped.
- Recommendations not requiring significant interventions will become part of core business improvements negotiated with providers and can be dealt with during the process of producing the needs assessment report.
- Complex and new areas of work will be progressed through project management processes. This will ensure the issues raised and gaps identified through the process of carrying out this needs assessment are addressed in a transparent way.
- Information gathered from all stakeholders including service users will be shared and contributions recognised
- Clear feedback systems are developed to ensure ongoing involvement of stakeholders in developing the needs assessment process to deliver the information we need to improve the commissioned treatment and recovery system.
- Commissioning priorities for 2013/14 will be based on the outcomes of the needs assessments of the previous 2 years. This is to ensure that in the reorganisation into a Tri-borough structure that previous recommendations have been implemented or included in strategic planning.