Improving support to service improvers: an evaluation of alcohol service changes

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Abstract

The extent and cost in human lives and public expenditure on alcohol-related illness or injury are high. In England the Government has set performance targets to address this problem and has provided local managers with a range of support and information to help them make service changes. This article reports findings from an evaluation of the Alcohol Learning Centre (ALC). This afforded opportunities for web-based learning and provided incentives to a group of selected Primary Care Trusts (PCTs) that were Early Implementers of the Department of Health's Alcohol Improvement Programme (AIP). The evaluation took the form of interviews with 13 lead managers to explore their views and experiences of using the ALC information resource and its other forms of support under the AIP. Participants were positive about the ALC and appreciated the benefits and opportunities that came with Early Implementer status. Most had not previously been involved in a service improvement programme and the concept of 'funding with support' was greatly appreciated. The findings of this small study suggest the value of a combination of online information and in person support for managers charged with service improvements.

Keywords: alcohol related admissions, service improvement, virtual learning, online resource

Introduction

There are many theories about how information can be used to maximise the impact of change (Marshall & McLoughlin, 2010). A common understanding is that people rationally use information, detached from local context, to make decisions. Alternatively, decisions may be influenced by many subjective factors – personal experience, fears, advice from trusted others, local contexts and so on. In many areas, such as public sector management, there are conscious but also unconscious linkages between 'hard' data and other trusted sources of intelligence or 'ways of knowing' (see Bate, 2004, on the power of storytelling). Grol and Grimshaw (2003) have observed that service managers often combine their own professional experiences with their managerial experiences and learning, as confirmed more recently:

Professionals within such organisations interact and regulate themselves largely through direct democracy, peer pressure and the use of technical knowledge as described above, but in larger partnerships a distinct stratum of manager-professionals may emerge. (Sheaff *et al.*, 2012, p.15)

Increasingly, electronic information resources are widely available but reviews of them suggest they are variable in quality. Whitehead *et al.* (2012), for example, found that websites offering falls-related advice to older people contained accessible material but their 'information was generally inadequate and lacking in credibility, and information was frequently out of date' (p.58).

It is not always clear how far these are trusted by service managers and commissioners in health and social care.

Within this context of different kinds of information and reliance upon it, there are expectations among policymakers that United Kingdom (UK) National Health Service (NHS) managers and others need to demonstrate that:

... the organisation makes full use of the external resources available to support local quality improvement. (Powell *et al.*, 2008, p.ii)

However, local leaders may not have such resources at their disposal. In current contexts, policymakers in health and social care may consider commissioning a range of support materials to meet requirements for different types of information. This article reports on the use and value of a dedicated web resource and other related support provided to English NHS Primary Care Trust (PCT) managers holding responsibilities to commission and provide primary health care (PCTs have since been succeeded by Clinical Commissioning Groups). Their PCTs had been charged by policymakers to implement one specific improvement - the reduction of alcohol-related hospital admissions.

As Checkland *et al.* (2011) observed, nominating early adopters or implementers is one way of stimulating change within a multi-faceted organisation. Wider, if more diffuse, initiatives include enlisting local enthusiastic leaders to act as 'champions' (Manthorpe, 2012). Without overplaying the relevance/significance of this approach, the subject of the evaluation – an information website with interactive support – is an approach to policy implementation and information resources which social care information providers and policymakers might find of interest.

Background to the Alcohol Improvement Programme

The extent and cost in human lives and public expenditure on alcohol-related illness or injury are high. Alcohol-attributable reasons show a continued upwards trend in hospital in-patient admissions annually in England, especially for liver disease, alcohol poisoning, and mental and behavioural disorders. By 2011-12 these had reached 304,206 admissions (Health and Social Care Information Centre, 2012, p.30).

Concern about rising numbers of alcohol-related hospital admissions prompted Department of Health (DH) policymakers to develop a national Vital Signs Indicator (VSC 26) for the NHS. From April 2008 this has measured changes in the local and national rates of alcohol-related hospital admissions. A specific goal of reducing alcohol-related hospital admissions was included in the National Indicator Set (NIS) for Local Authorities and Partnerships (NIS 39). In addition, a Public Service Agreement (PSA 25) aimed more broadly to reduce alcohol-related harm.

To provide resources and support to PCTs and other local stakeholders, such as local authorities who were seeking a reduction in alcohol-related hospital admissions, the DH launched the Alcohol Improvement Programme (AIP) in 2008 (see DH, 2009). Under the AIP, support was targeted at the 20 PCTs with the highest levels of alcohol-related hospital admissions. These Early Implementer PCTs could apply for up to £350,000 funding in 2008/10 to support local improvement activities. DH hoped that these local projects would 'lead the way' in implementing 'High Impact Changes' – which were calculated to be the most effective local actions to reduce alcohol-related harm. The seven 'High Impact Changes' comprised:

1. Working in partnership

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

3. Influencing change through advocacy

4. Improving the effectiveness and capacity of specialist treatment

5. Appointing an Alcohol Health Worker

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

7. Amplifying national social marketing priorities (Alcohol Learning Centre, 2012)

The AIP's purpose was to enable alcohol intervention experts to relay information from and to policymakers to improve services and coordination.

From 2008-11 the AIP commissioned an online Alcohol Learning Centre (ALC) to facilitate this. Its role was to exchange, coordinate and disseminate evidence (http://www.alcohollearningcentre.org.uk). It received further funding in 2011 and is now managed by Public Health England. While it was a constituent part of the AIP, in practice most of the project leads interviewed in this study referred to the AIP and ALC interchangeably.

Other resources coordinated through the ALC included: national events and workshops (with online booking); video podcasts; online discussion forums; eLearning; news bulletins and email alerting; guidance on setting up collaboratives and learning sets; and a peer visit and mentoring scheme.

The study

An evaluation of the ALC was commissioned by the Department of Health's (DH) Policy Research Programme as part of a wider evaluation of the Care Services Improvement Partnership (CSIP) because members of CSIP staff were responsible for the ALC's initial development. Although CSIP was abolished shortly thereafter, the evaluation informed the DH's Alcohol Improvement Programme (AIP) Working Group on how the ALC was meeting its objectives from the viewpoint of the PCTs and whether the chosen model of its multi-faceted support was considered effective.

Methods

This evaluation undertook in-depth face-to-face interviews with the designated local leads who were responsible for managing the local Early Implementer Project (**Box 1** details the interviews' semi-structured topic guide). Managers leading this work were either local commissioners of alcohol services (usually combined drug & alcohol) or public health consultants (then working in the NHS, now (2014) in local authorities). Although 20 PCTs were involved in the AIP, two managers held responsibility for Early Implementer work across adjacent PCTs. There were thus 18 potential participants of whom 13 agreed to be interviewed. Staff vacancies in two sites meant that no-one was available for interview at the time of the evaluation. A further three potential participants did not respond to the invitation to participate (followed up by reminder emails from the researchers and the DH). Interviews were digitally recorded and transcribed. The research was approved by the relevant National Research Ethics Service and data were anonymised. Details of participants and locations are not provided as this would risk their identification; however, all were experienced managers or clinicians working in PCTs.

The qualitative data were analysed thematically. We had hoped to explore the qualitative interview material with the quantitative findings of an online survey that had been circulated to the 984 registered users of the Alcohol Learning Centre in July/August 2009 (Young, 2009). This survey was commissioned separately from this present evaluation but its response rate of five percent meant that this comparison could not take place.

Our findings were presented at a meeting of representatives from six of the Early Implementer sites (including managers from the three sites where managers' interviews had not been possible). All participants were sent a draft of the evaluation report for comment.

Box 1. Alcohol Learning Centre Evaluation – Summary of Topic Guide

General – Details of participant's role? What does the job entail?

A. Use of the Alcohol Learning Centre in everyday practice

- Familiarity with the Alcohol Learning Centre? Fequency of use?
- Perceptions of 'user friendliness'.
- Extent and frequency of consultation of ALC resources and linked services (newsletters, resource links, events, podcasts, collaboratives, peer visits, mentoring).
- Reasons for not using ALC resources.

B. Usefulness of the resources

- Views of ALC in effectively conveying information.

C. Scope for interactivity

- Nature and extent of contributions to the ALC, e.g. examples of local good practice or other kinds of learning.

D. Comparative quality assessment

- Use of any other service improvement tools and websites? If yes, views of relative quality of the ALC.
- Use and uptake of other training and support facilitating job and improvement efforts.

E. Outcomes

- Impact, if any, of ALC in helping to achieve the outcomes?
- Ideas for improvement or change.
- Overall assessment of being involved in a programme of this kind.

Findings

The findings reported here start with participants' reflections on being 'Early Implementers'. Most spoke positively about the Alcohol Learning Centre (ALC) and of the various benefits and opportunities accompanying Early Implementer status under the AIP. They had generally not taken part in a service improvement programme previously and 'funding with support' was greatly appreciated:

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

Very engaging, makes you feel that you are at the forefront - leading the way [7].

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

Communication of programme aims and objectives
However, despite their enthusiasm, some participants felt that the overall aims and objectives of the AIP could have been better explained, as one observed:

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

Participants commented that they were already implementing many of the High Impact Changes and that the AIP was not therefore sufficiently timely.

Support
Of the support provided to the Early Implementers, all agreed that the financial grant was the most important:

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

As this money was non-recurrent with some restrictions (such as having to spend it before the end of the financial year), these factors rendered it somewhat of a 'double edged sword'. For example, concerns were voiced about the sustainability of some initiatives that were funded. Some PCTs, for example, had used the money principally for evaluation and research or to purchase training, avoiding staff appointments which they perceived unsustainable; while others had spent the grant on substantive posts. Indeed, there was uncertainty as to what the grant could be spent on:

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

Furthermore, many Early Implementer sites felt hampered by uncertainty about whether and if so how much money would be provided for Years 2 and 3 of the Programme.

Use of the Alcohol Learning Centre (ALC) website
Participants who had used the ALC website described it as an excellent resource and all considered that it met its objective of becoming a 'one-stop shop' for alcohol-related resources:

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

The website was deemed accessible, easy to navigate, well maintained and up to date. A few technical 'glitches' were reported, such as difficulties downloading some documents, but these were not considered major problems. However, participants' use of the ALC website varied considerably, with a minority accessing it twice a week, but most far less, about once or twice a month. One participant had never accessed it - reporting that they did not have the time to do so.

More frequent email alerting from the ALC was considered to be a way of usefully reminding managers to consult the website:

I was using it this morning to find out about the pen profiles for the social marketing so I usually go there for something specific or I have to remind myself to go there to see if anything new

has sort of come up, actually that might be one thing which would help me to use it more, because I don't think it happens at the moment, was if we got email alerts [1].

Some participants had encouraged colleagues and other local stakeholders to use the website. One commented that this was 'a way of ensuring everyone is singing from the same hymn sheet' [4].

Once accessing the ALC website participants tended to use it differently and often expressed a personal preference for one format over another. One reported: 'I mainly download the PowerPoint presentations' [7].

Interestingly, few reported using the website to find journal articles or detailed evidence. The importance of producing information in formats which were easy to use and pertinent was frequently emphasised:

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

The most frequent reasons for using the website were to book places at events and to search for 'practical information' (e.g. local alcohol strategies, service specifications, job descriptions, training briefs, treatment pathways, terms of reference for strategy groups, and so on). Where such information had been produced by their peers or fellow managers this seemed to make it particularly valued.

In terms of contributing information that could appear on the website, including case studies, a common complaint was that such information was not handled efficiently:

I have sent off three business cases, I can't find them anywhere on the ALC web site. I got an email back saying these are really

interesting but we need a bit more information… I emailed back saying I am not clear what it is you are asking for and I have heard nothing since. So we have submitted stuff and it feels as though it has gone into a void [2].

Across the AIP more administrative support for the full range of development activities was recommended to ensure the ALC was used to its potential:

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

Tools and resources
The ALC had commissioned several tools and eLearning resources which it published on its website. Though the general perception was that most were useful (notably the Identification and Brief Advice training http://www.alcohollearningcentre.org.uk/eLe arning/IBA/), there were specific criticisms of some. One participant pointed to the need for better consistency and accuracy.

Another tool, the 'Ready Reckoner', which calculated the potential cost savings linked to the implementation of the 'High Impact Changes', was eagerly anticipated by the Early Implementers. When it finally arrived it was perceived disappointing overall:

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

Despite their doubts about using traditional research publications, only one of the participants had watched any video podcast, with the views of one participant (8) typically explaining why:

I don't think I would sit down and watch a podcast really'. [Researcher: why not?] 'I

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

Events, Workshops, Regional Meetings and Networking Opportunities

Perhaps because many Early Implementer managers felt that they were already implementing the 'High Impact Changes', the first national event outlining these was generally regarded as disappointing:

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

In contrast, regional meetings and ALC events were perceived to be more useful because they enabled discussion and networking with fellow Early Implementer managers:

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

The amount of support provided to the Early Implementers from the AIP varied regionally, seemingly depending on the input and style of the Regional Alcohol Managers. Some Early Implementers seemed to regret working in isolation:

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

Use of 'learning sets' and the mentoring scheme

As part of the support offered through the ALC the managers had been encouraged to establish 'learning sets' and to participate in a peer visit and mentoring scheme. However, little use appeared to have been made of these opportunities, mainly because of limited time or capacity but also some uncertainty around the potential value of such activities. For example, some had decided not to use 'learning sets' as they perceived them as an ineffective improvement tool among disparate practitioners. Some participants suggested that the AIP staff should take more lead in organising such activities rather than expecting them to organise them or to pay for facilitation.

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

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

Monitoring and reporting

Arrangements for monitoring and reporting of activity did not appear to have been clearly communicated to the Early Implementers on the ALC site or elsewhere. Not all were aware of the expectation to produce a quarterly monitoring report to an agreed template. Indeed, many of the managers were keen to know how they were doing in

comparison to the other sites and if they were ahead or behind 'the game'. However, the AIP overall was perceived to provide little constructive feedback:

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

A general feeling was that the AIP needed to be more pro-active in capturing the learning of the Early Implementers and using the ALC to hold such material:

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

Perceived outcomes of AIP participation
Participants judged that the main outcome of participating in the AIP was that it helped them to raise the profile of alcohol-related harm locally:

> *It made our local authority sit up – I don't think they believed the figures beforehand [7].*

In some sites, the AIP was perceived to have improved partnership working between different agencies; often by providing Early Implementer leads with 'moral support and back up in the face of much resistance to change' [7]:

> *[The Programme] has helped us to work with the Acute (hospital) Trust to look at alcohol across all the departments… What [the Programme] is doing is giving us that extra lever or mandate to go to our partners and say we have a problem, the Government is organising nationally [3].*

However, some participants were concerned that the Programme was not doing enough to sustain interest at the most senior levels within organisations, potentially jeopardising the success of the Programme. Others reported feeling pressured to identify only 'good or innovative practice' to submit to the ALC website and were concerned that this did not necessarily flow from the work they

were undertaking as Early Implementers or reflect the challenges of the AIP approach.

There appeared to be several reasons why the Early Implementer managers were guarded about the likelihood of success in meeting the AIP targets. As noted above, general concern was expressed about the data underpinning the targets, how they should be used and understood, and the extent to which they were reliable. Each site had set itself a different target (ranging from reducing alcohol related hospital admissions by 1%-10%) and in some sites viewed these as overambitious. There were also concerns that the 'High Impact Changes' were not targeted enough to impact directly on alcohol-related hospital admissions:

> *I think if your wider [alcohol] strategy doesn't address most of [the 'High Impact Changes'] or all of them, then you are already on your back foot… but actually the partnership type work in terms of the criminal justice system, for example, is so detached from this in NI39 work [5].*

Indeed, there was a general lack of confidence or belief in the evidence base underpinning the 'High Impact Changes'. Some participants expressed a strong desire to 'see the results for oneself' and a reluctance to take at face-value the evidence from the academic literature (e.g. Kaner *et al*., 2007) which was included on the ALC site:

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

Despite the ambitions of the ALC, other participants felt the Programme was disappointing because it was not forthcoming with trusted and targeted support to address specific challenges:

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

Discussion

Reflecting on the Programme's first 18 months, the evaluation found very positive views about the Alcohol Learning Centre (ALC) and of the benefits and opportunities that came with Early Implementer status. Most participants had not previously been involved in a service improvement programme and the concept of 'funding with support' was greatly appreciated. This evidence may encourage policymakers who often hear about the problems of pilots or demonstrator sites (Salisbury *et al.*, 2011).

Most participants agreed that the ALC had met its objective of becoming a 'one stop shop' for alcohol-related resources but more regular email alerting might have promoted greater use of the website. Participants envisaged it evolving as a helpful and cost-effective repository for practical information, such as service specifications, job descriptions, local strategies, and so on. For the strata of '*manager-professionals*' identified by Sheaff *et al.* (2012, p.15), online resources provide rapid information about unfamiliar subjects. Moreover, the '*animateur*' role of NHS managers and others seeking to make local NHS changes, as identified by Checkland *et al.* (2012a; 2012b), is aimed '*not simply at changing perceptions but also at bringing about specific action in a specific time frame*' (2012a, p.14). Such requirements fit neatly with the pressures experienced by the participants in this study who needed specific information rapidly at times and wanted an online site to be well administered.

Participants had identified the main benefit from their participation in the AIP and their use of the ALC as helping them to raise the profile of alcohol-related harm locally. National events were judged, on the whole, as disappointing in extending only limited opportunities for learning and networking. Regional events were better appreciated, although the amount and style of support varied between regions. This theme of information needing to be locally relevant is a challenge for national systems. Nonetheless the ALC had contributed to local skills and resources by providing ideas, evidence and momentum for these '*animateurs*' (Checkland *et al.*, 2012a). Participants envisaged that such online resources could usefully be accompanied by other localised support, especially more 'hands on' assistance through tailored information and advice, visits and inter-agency linkages.

Conclusion

This small evaluation indicates that 'virtual' support (internet resources), when accompanied by 'hands on' support improvement with meeting targets or implementing policy, may be valued and generally trusted by managers. Such support seemed most authentic and relevant when linked directly to specific rather than general implementation challenges or changes. It needs to be well and consistently administered. Those commissioning support services to help local leaders with local implementation should not assume that managers will have the skills or time to work with 'learning sets' or other improvement methodologies.

There are some key findings from this small study. Use of and confidence in accessing online information resources is growing but

commissioners and developers need to ensure that these are accurate, responsive and 'user friendly'. Holding information that is deemed 'practical' in nature seems to be a convincing way of demonstrating that a web resource is trustworthy, potentially worth consulting, and this may entice novice users. Despite the widespread use of online communications and information, some managers do not turn to these as a matter of course.

This study is limited in the number of participants responding to the invitation to be interviewed. Other evaluations of such an initiative and its constituent parts might usefully identify accurate usage and consultation of different sources of support or evidence, together with comparisons of web usage with other activities. This study has exposed a need to explore ways of promoting confidence and trust in information placed on websites thus avoiding the perceived need to '*see for oneself*'. More work is needed to investigate how web-based information can capture the attention of busy practitioners and managers, and those who lack confidence that consulting them is time efficient. Like evaluators, service improvement professionals may wish to ensure that the totality of an implementation experience is communicated and is able to convey to local leaders that the 'messiness' and complexity of their world are understood. Policymakers may wish to consider our observations when making decisions about the best way to support the implementation of their policy goals.

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