the mackinnon partnership

**Reducing Harm from Alcohol -
National Resources for Local
Workforce and Skills Development**

A Report to Skills for Health

April 2010

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1. Executive summary

1.1   This work was commissioned by Skills for Health with support from the Department of Health. It was undertaken by The Mackinnon Partnership and is endorsed by the Federation of Drug and Alcohol Professionals and the Alcohol Academy.

1.2   Three nationally transferrable roles (NTRs) have emerged in our research for the alcohol workforce: Alcohol Co-ordinator, Alcohol Specialist Practitioner, and Provider of IBA[1]. Towards the end of this research project it became apparent that there was the potential for a fourth NTR within the alcohol workforce – the 'Alcohol Health Worker'. This occurred too late for a NTR to be developed as part of this research project. It is Skills for Health and their partners' intention to develop an Alcohol Health Worker NTR at the next foreseeable opportunity.

1.3   We have created templates for using the three NTRs locally, using Skills for Health Templates for Nationally Transferrable Roles created in September 2009. Following a three-week feedback process involving a wide range of stakeholders, we have revised these templates and incorporated suggestions wherever possible. These templates accompany this report as a stand-alone document. Skills for Health will consult further with stakeholders to seek agreement and finalise the templates.

1.4   The majority of job descriptions used when identifying these NTRs, could be aligned to Drugs and Alcohol National Occupational Standards (DANOS). However, there was significant variety in job titles and pay scales across all the job descriptions used. We do not intend to address these variations as part of this work and the templates are all based on the Career Framework for Health descriptors.

1.5   There currently exists a wide variety of formal and informal learning and development opportunities for the alcohol workforce. Many of these are based on DANOS; others can be easily aligned.

1.6   Most of the specific competences in each NTR are covered by the learning and development opportunities explored in this project. We have highlighted those specific competences that are not covered. When exploring the wide range of learning opportunities available it is also important to bear in mind the wide range of skills and experiences that alcohol workforce staff already possess, and therefore the different development needs of staff. A 'one size fits all' approach would not cater for these differing needs; therefore there is an opportunity to provide a tailored approach by blending different kinds of formal and informal learning to enhance skills and demonstrate competence. The National Occupational Standards (NOS) that exist in the NTRs and learning packages would facilitate this process.

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[1] Identification and Brief Advice.

1.7   Many alcohol service providers use bespoke training packages that are tailored to their workforce needs.   Whilst this may lead to a diverse range of learning opportunities across England, with little commonality between them, and little transferability across organisations, it is positive in that learning can be catered to specific organisations' and teams' needs.   Our interviews also revealed a number of gaps in both skills and learning development opportunities, especially in view of trends and future needs.   We present these in more detail in Chapter 6, with conclusions and recommendations in the final chapter.

2. Introduction

2.1   Skills for Health has commissioned The Mackinnon Partnership to research the alcohol workforce in England, with the aim of identifying nationally transferable roles (NTRs), aligning them with National Occupational Standards (NOS), exploring relevant learning and development, and drawing-out the implications for further developments which might be required.

2.2   This is our report with our findings and recommendations. It is accompanied by a stand-alone document with the nationally transferrable roles we have identified and revised following feedback from relevant stakeholders.

Project specification

2.3   The focus of this project was to:

1. identify existing nationally transferable roles for the alcohol workforce engaged in reducing hospital admissions through delivery of brief interventions and specialist services;

2. identify emerging nationally transferable roles for the alcohol workforce engaged in reducing hospital admissions through the delivery of brief interventions and specialist services;

3. advise on future workforce trends where possible to inform workforce planning and the development of learning and development packages;

4. review the use of DANOS[2] and other NOS in both role and learning package developments;

5. review the existing learning opportunities, formal and informal, based on DANOS and make recommendations regarding any further developments required;

6. identify learning and development packages required to underpin existing and emerging roles;

7. identify and make recommendations regarding what can be done centrally to address skills gaps.

2.4   In our Conclusions chapter we make recommendations based on our findings according to the above areas.

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[2] Drug and Alcohol National Occupational Standards

Background - reducing alcohol related harm

2.5   Reducing the harms inflicted on both individuals and wider society by the consumption of alcohol has been a longstanding aim of Government. The aim was articulated in the development of Public Service Agreement (PSA) 25.2 that expressed the need to reduce the number of alcohol-related hospital admissions and within the Alcohol harm reduction strategy for England.

2.6   The intention is that PSA 25 Indicator 2 (which is defined in terms of the number of alcohol-related hospital admissions) will:

> *Drive the reduction of the harms caused to health and well-being by frequent consumption of harmful levels of alcohol. But it will also measure the impact of prevention interventions: when they are improved, hospital admission for specific chronic and acute conditions are expected to slow in the short, medium and long term.*   PSA Delivery Agreement 25, Oct 2007

2.7   Best practice guidance to help local organisations and their partners commission and deliver a planned and integrated local system of alcohol interventions, is outlined in Models of Care for Alcohol Misusers (MoCAM). This uses a four-tier model of interventions related to alcohol misuse, and it recommends associated competences required for effective delivery of services in each of these tiers. [3]

2.8   The Alcohol Improvement Programme (AIP) was established in April 2008 by the Department of Health to help reduce Alcohol-related Hospital Admissions across the NHS. The AIP provides support to Primary Care Trusts and to the wider NHS.   As part of the Alcohol Improvement Programme, in July 2009 the Department of Health also published *Signs for Improvement – Commissioning Interventions to Reduce Alcohol Related Harm*. This guidance directs commissioners to resources and good practice guidance to help them to commission interventions to reduce alcohol related harm in their local communities.

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[3] See Models of Care for Alcohol Misusers (MoCAM), developed by the National Treatment Agency for Substance Misuse, with guidance from the Department of Health.

Nationally transferrable roles

2.9   Skills for Health defines nationally transferable roles (NTRs) as follows:

> *A nationally transferable role is a named cluster of competences and related activities levelled to the career framework that is applicable, relevant and replicable across different geographic locations in the UK. An NTR may be either a subset of a job at more than one level of the career framework, eg supplementary prescribing, or a whole job at one level of the career framework eg physiotherapy orthopaedic practitioner.*   Skills for Health, 2009

2.10   Skills for Health intends nationally transferable roles to:

- provide patients with comparable service provision of consistent quality across the UK, delivered by staff working to transparent, nationally-agreed, standards;

- ensure that employers can expect consistent skills, knowledge and competences when selecting staff, which will in turn enable them to source learning and development packages to meet those needs, and inform commissioning; and

- provide staff with portable and transferable learning and development, skills, competences and qualifications, and improved opportunities across the career framework without having to repeat education and training.

2.11   Skills for Health's focus is on the skills and related attributes of the alcohol workforce, rather than the range of different services provided to patients.

2.12   In commissioning this project, the intention of Skills for Health and the Department of Health is to align and build on these two streams of work – the programme supporting PSA 25.2, and nationally transferrable roles – in order to develop the alcohol workforce so that it can make more difference to alcohol misusers.

Our methodology

2.13   Our project consisted of three phases. We outline our approach to each, below.

Phase 1: Exploring the nature of the alcohol workforce

2.14   The first phase involved exploring the alcohol workforce in terms of the various kinds of role involved, how they can be categorised, and gaining an understanding of how members of the alcohol workforce themselves view the nature of the workforce.

2.15   For this phase we:

- undertook desk (principally internet-based) research to identify relevant literature and job descriptions;

- interviewed eight of the nine[4] Regional Alcohol Managers (RAMs), to gain their perspective on the alcohol workforce, and to tap their knowledge of which employers within their regions are most active in pursuing PSA 25.2;

- e-mailed 102 of these active employers and interviewed eight of them[5] to get their perspective on the alcohol workforce and to get copies of job descriptions for posts within the alcohol workforce. During this phase we received 36 job descriptions from 27 employers; and

- began the process of mapping the job descriptions against NOS, particularly DANOS.

2.16   We then produced an interim report where we explored the varying definitions of the alcohol workforce, the roles within it, and the implications for the rest of the project. We also offered a first example of roles mapped against NOS. Please see Chapter 3 for a summary of the findings in our interim report.

Phase 2: Identifying nationally transferrable roles

2.17   In the second phase, we:

- mapped 50 job descriptions against NOS, specifically DANOS, to identify commonalities in roles, tasks, and the use of DANOS;

- identified three nationally transferrable roles in the alcohol workforce and using Skills for Health's template, sought feedback from a wide range of stakeholders on their views on the competences and tasks related to each; and

- started our research into learning and development opportunities in the alcohol workforce, including preliminary recommendations for indicative learning and development for the three nationally transferrable roles in the templates.

2.18   Further detail about the process and outcomes of identifying the three nationally transferrable roles and the feedback process, is given in Chapters 4 and 5. Revised nationally transferrable role templates accompany this report as a standalone document.

Phase 3: Learning and development in the alcohol workforce

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[4] We made several attempts to contact the ninth, without success.
[5] The question prompts we used are in Appendix A.

2.19   This phase involved a combination of desk research and telephone interviews to explore the learning and development opportunities that are available for the alcohol workforce.

2.20   More specifically, we:

- conducted desk research to explore the range of learning and development packages available for the alcohol workforce, if learning and development opportunities for the alcohol workforce are or can be mapped against DANOS, and how closely they align with the three NTRs we have identified;

- related our findings to the nationally transferrable roles identified in Phase 2;

- spoke to learning providers to discuss the packages they supply to the alcohol workforce; and

- spoke to alcohol workforce representatives to discuss their views on the learning and development opportunities that are available for their alcohol workforce and any gaps.

2.21   We provide more detail about the process and outcomes of this phase in Chapter 6.

Final outputs

2.22   This report presents our findings from all areas of the project as outlined in the project specification and provides recommendations based on our analysis.   In tandem with the report we have produced a template for the three nationally transferrable roles we have identified, following feedback from relevant stakeholders.

3. The Alcohol Workforce

3.1 This chapter presents a summary of our findings in Phase 1 of the project, exploring the nature of the alcohol workforce.

Official definitions

3.2 We understand there is no official definition of 'the alcohol workforce', and that in normal usage it covers both specialist interventions roles and Identification and Brief Advice (IBA).

3.3 The Alcohol Improvement Programme Position Paper describes specialist alcohol treatment services as those delivering greatest short-term impact on admissions and mortality, because they target the patients at greatest risk of death or serious disease.

3.4 It refers to IBA services as those delivering medium and longer-term reductions in the kind of 'everyday' drinking which leads to coronary heart disease, liver disease and other problems. IBA roles are also defined by the Alcohol Learning Centre as a "5-10 minute intervention" that is:

> *a structured tool used by healthcare professionals to assist individuals whose alcohol consumption may now or in the future cause short or long term health problems.*

3.5 The emphasis on "structured tool" is important, as is the reasonably substantial time involved. We found another example which defines IBA as a 'three minute intervention', which suggests something rather less substantial. RAMs were clear that practice relating to IBA varies a good deal.

Interviewees' views

Regional Alcohol Managers (RAMs)

3.6 A common theme emerging from our interviews with the RAMs is that the alcohol workforce should be defined very broadly. Though not all would necessarily go this far, one suggested this:

> *The alcohol workforce is anybody who contributes to reducing alcohol-related harm.*

3.7 "Anybody who contributes" is a very broad definition indeed, potentially embracing the whole health workforce, and many others beyond. We explore this idea later in this chapter.

3.8 RAMs commonly mentioned commissioners, GPs, nurses, A&E receptionists, criminal justice workers, youth workers, specialist alcohol treatment workers, and pharmacists.

3.9 RAMs suggested various ways of categorising the alcohol workforce:

- most commonly between specialist and IBA roles;

- between health and non-health roles;

- between clinical and non-clinical roles;

- between strategic and operational roles;

- and according to MoCAM's four-tier delivery model.

3.10 One made a further point about the importance of not seeing the alcohol workforce as a specialised set of roles requiring specialised skills, arguing that there are common competences for most alcohol related roles:

> *Treating alcohol issues requires common competencies around how to alter behaviour: this is not unique.*

Employer interviewees

3.11 The eight employers we spoke to held very similar views in terms of the broad range of roles in the alcohol workforce. A local authority drugs and alcohol education advisor, for example, argued that it includes everyone from school nurses to A&E staff.

3.12 A number of employers commented on the similarity between the work of drug and alcohol workers who are delivering IBA services.

3.13 During our interviews we spoke to employers about their views on the tasks in job descriptions, and how well aligned they are to NOS and particularly DANOS. Chapter 4 discusses in more detail, the types of job descriptions we used to identify nationally transferrable roles for the alcohol workforce.

4. Identifying Nationally Transferrable Roles

4.1   In this chapter we present how we identified nationally transferrable roles using job descriptions provided by employers. We also discuss the use of DANOS in the job descriptions.

4.2   As one of the purposes of using nationally transferrable roles is to ensure consistency of skills between employers, the starting point needs to be finding commonalities between roles that currently exist in the workforce. We contacted 102 employers to ask for job descriptions of various roles involved in their alcohol workforce. We received 36 job descriptions from 27 of these employers, and we supplemented these with others we identified through internet research.

Background to the job descriptions used

4.3   The following table shows the breakdown of the job descriptions we found across the public, private and charity sectors.

Table 4.1: Breakdown of job description across sectors:

Sector	Number of job descriptions
Public	33
Private	10
Charity	7
TOTAL	50

4.4   In the table over the page we list the many job titles used: 43 for 50 job descriptions. It is worth noting that for NHS roles, jobs with the same or similar titles were not necessarily allocated to the same pay band.

4.5   This is not an exhaustive list, but the range of job titles points to the difficulty in identifying core commonalities between roles in the workforce simply based on titles, which in turn would make it difficult to gauge similarities, competences and related skills and knowledge between these roles. This diversity illustrates how it can be difficult for workers to move from organisation to organisation, from geography to geography, or indeed from one sub-sector of the health service to another.

4.6   It would also make it difficult for workforce planning leads to cater for staff recruitment and learning and development.

Table 4.2: Job titles in job descriptions received	
Addictions Counsellor	Health Promotions Worker
Alcohol Brief Interventions Worker	Nurse Consultant
Alcohol and Drug Liaison Nurse	Nurse Practitioner
Alcohol Harm Reduction Co-ordinator	Project Worker
Alcohol Interventions Practitioner	Public Health Lead
Alcohol Liaison Support Worker	Public Health Strategist
Alcohol Nurse	Regional Alcohol Programme Manager
Alcohol Nurse Specialist	Screening and Training Worker
Alcohol Peer Support and Aftercare Lead	Senior Alcohol Worker
Alcohol Specialist Nurse	Senior Project Worker
Alcohol Strategy Co-ordinator	Senior Counsellor
Alcohol Strategy Development Officer	Service Manager
Care Manager – Maturing Practitioner	Shared Care Substance Misuse Worker
Care Manager – Newly Qualified Practitioner	Speciality Doctor
Community Alcohol Nurse	Substance Misuse Nurse
Community Alcohol Treatment Worker	Substance Misuse Practitioner
Counsellor	Substance Misuse Specialist
DAAT Alcohol Co-ordinator	Substance Misuse Worker
Drug and Alcohol Education Advisor	Support Worker
Enhanced Case Management Senior Worker	Targeted Care Manager
GP Liaison Nurse	Treatment Manager
Head of Partnerships	

4.7   The use of DANOS intends to streamline recruitment and learning and development processes, and facilitate finding commonalities in competences of roles and the learning required.

Finding commonalities

4.8   Our approach was to map these 50 job descriptions against the entire suite of DANOS. Some of the job descriptions were already based on DANOS. We mapped the remainder against DANOS task by task in order to assess the commonalities between the competences required for each job description.

4.9   We then clustered the job descriptions into different groups, according to the similarity of DANOS-linked tasks in each.

4.10   The table below provides an example of how this mapping exercise worked. In it we have taken three roles from three geographical areas from one of the groups of job descriptions, and compared them against DANOS. Two of these jobs have the same title, Community Alcohol Nurse, and the other is a Substance Misuse Nurse. All are at level 5.

Table 4.3: Example of our mapping exercise:

Organisation		A	B	C
Job Title		Community Alcohol Nurse	Substance Misuse Nurse	Community Alcohol Nurse
Band		5	5	5
DANOS – Competence Title	**DANOS - Code**			
Recognise indications of substance misuse and refer individuals to specialists	AA1	Y	Y	Y
Relate to and interact with individuals	HSC233 (AA2)	Y	Y	Y
Support individuals to access and use services and facilities	HSC330 (AA3)	Y	Y	
Promote the equality, diversity, rights and responsibilities of individuals	HSC3111 (AA4)			

- the 'Y' in yellow indicates that this job description has a task that relates specifically to the corresponding DANOS competence in the table;

- a blank cell indicates that this job description does not have a task that relates to the corresponding DANOS competence.

4.11   This approach enables users to tell at a glance what correlation there is between job description tasks and DANOS and whether there are any DANOS that are not used in any of the job descriptions. This enables us to identify gaps in the coverage of NOS.[6]

4.12   With the caveat that DANOS also serve the drugs field, not just alcohol, this approach enables us to test the relevance of DANOS against the reality demonstrated by employers of the alcohol workforce.

4.13   A further caveat is that job descriptions serve a number of purposes, and are not always created with an eye on precise delineation of a job. They may not be wholly accurate guides to what job holders actually do.

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[6] Appendix B lists the DANOS which did not apply to any of the job descriptions we used.

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Three Nationally Transferrable Roles for the alcohol workforce

4.14 In order to identify nationally transferrable roles emerging from each group of similar job descriptions, our approach was to look at the job descriptions in each group in more detail to identify common tasks between them. We then ensured that at least two thirds of the DANOS-linked tasks in each group, applied to each job description in that group. Those common tasks and associated competences formed the basis of the three NTRs that emerged.

4.15 We used Skills for Health's Health Functional Map to find correlating reference functions and underpinning principles for each competence that formed individual NTRs. The Health Functional Map is an online tool that orders National Workforce Competences and NOS into logical functional groupings.[7]

4.16 We used one job description from the fifty to underpin each NTR. To select which job description to use we analysed which job description out of the 50 best correlates to the range of tasks and competences in each NTR. We then gave each NTR a name that we felt relates well to the tasks and competences in each NTR:

- Alcohol Co-ordinator;

- Specialist Nurse - which we changed to Alcohol Specialist Practitioner after consultation with the Department of Health Workforce Training Group;

- Provider of IBA.

4.17 Skills for Health used its career levelling tool to find the associated Career Framework levels[8] for each of these roles:

Alcohol NTRs	Career framework level
Alcohol Co-ordinator	Advanced Practitioner: Level 7-8
Specialist Practitioner	Practitioner: Level 6
Provider of IBA	As a cross cutting role, it does not correspond to any specific career framework level

4.18 We used Skills for Health's current templates for nationally transferrable roles as a base to develop the nationally transferrable roles for the alcohol workforce.

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[7] See http://www.skillsforhealth.org.uk/competences/health-functional-map.aspx.
[8] The Career Framework provides a common standard to assist competence-based workforce planning and career development. The levels in the framework differ from the Agenda for Change pay scales. For more information see: http://www.skillsforhealth.org.uk/workforce-design-development/workforce-design-and-planning/tools-and-methodologies/career-frameworks.aspx

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4.19 Skills for Health had previously developed core competence profiles for roles at these career framework levels (ie Advanced Practitioner, Practitioner and Cross-cutting roles), and we supplemented these with the specific competences that came from the job descriptions we reviewed, which relate specifically to the alcohol NTRs that emerged. Sections for locality-specific competences are intentionally blank in the templates for local organisations to complete according to their needs.[9]

4.20 In line with Skills for Health's original templates for nationally transferrable roles, we suggested indicative learning and development for each alcohol NTR based on the job descriptions we used and our research on learning and development opportunities in the alcohol workforce.

Links with MoCAM

4.21 There are clear links between the MoCAM 4-tier model and two of these roles.

4.22 MoCAM Tier 1 interventions include the provision of identification of hazardous, harmful and dependent drinkers, information on sensible drinking, simple brief interventions to reduce alcohol-related harm, and referral of those with alcohol dependence or harm for more intensive interventions. This provision depends on at least minimal skills in alcohol misuse identification, assessment and interventions, including the DANOS competence AH10 'Carry out brief interventions with alcohol users'.

4.23 Tier 2 interventions include provision of open access facilities and outreach that provide alcohol-specific advice, information and support, extended brief interventions to help alcohol misusers reduce alcohol-related harm, and assessment and referral of those with more serious alcohol-related problems for care-planned treatment. Tier 2 interventions require competent alcohol workers who should have basic competences in line with DANOS including those required for Tier 1.

4.24 The competences identified in the Provider of IBA NTR correlates well to Tier 1, and to an extent Tier 2 (please see standalone NTR Templates document).

4.25 Tier 3 interventions include provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned. Tier 3 services require competent drug and alcohol specialised practitioners whose range of competences required will depend on job specifications, remits and the type of alcohol treatment provided.

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[9] See the standalone document with the completed templates, which accompanies this report.

4.26   Tier 4 interventions include provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare. Inpatient and residential interventions providing medically assisted alcohol withdrawal and specialist assessment would normally require medical staff with specialist competence in substance misuse. The level of specialised medical staff competence required will depend on the types of service provided and the severity of the service users' problems.

4.27   It could be argued that the Specialist Practitioner NTR could work across MoCAM Tiers 3 and 4.

4.28   The Alcohol Co-ordinator NTR has no specific link to the competences in the MoCAM 4-tier model. However, being a predominantly leadership-oriented role, it could be argued that such a role could be relevant across all the settings described within MoCAM.

Feedback process

4.29   We consulted with the steering group to decide on a group of relevant stakeholders to send the templates to, seeking their feedback, particularly on the competences associated with each role, and associated indicative learning development.

4.30   This group consisted of:

- The Department of Health Workforce Training Group;

- Royal Colleges of Nursing, GPs, Physicians and Psychiatrists;

- 10 Strategic Health Authorities;

- 20 Primary Care Trusts (PCTs);

- The Federation of Drug and Alcohol Professionals;

- Alcohol Concern;

- Alcohol Academy; and

- other training providers and alcohol workforce representatives from the third sector and private sector, who we spoke to during the course of our research.

4.31   The feedback process lasted three weeks, and the results have been incorporated wherever possible as suggestions in the revised templates, included as a standalone document with this report. In the next chapter we discuss the range of feedback we received during the feedback process.

5. NTR templates: analysis of feedback

5.1   This chapter presents a summary of the feedback we received from the NTR process on the three roles and the indicative learning and development suggested for each. We first present the feedback in general terms, and then focus on the specific comments on each of the roles and indicative learning and development.

5.2   We received feedback from 16 individuals from an email sent to 110 organisations.

Views on the NTR feedback process

5.3   Overall most of the respondents were positive about the aim of establishing NTRs for the alcohol workforce, and welcomed the opportunity to contribute to the development of the NTRs:

> *I welcome the aim of trying to get some standardisation of competence.*

> *Overall the templates are to be welcomed as a common starting point for establishing the language of the alcohol workforce.*

> *We welcome the opportunity to contribute to the development of creating nationally transferrable roles.*

5.4   Two respondents commented that more time to respond would have been beneficial.

Overall impressions on the NTR templates

5.5   Respondents made a number of specific suggestions about different parts of the templates; we detail these later in this chapter.

5.6   On the whole however most of the respondents felt the NTRs, competences, and indicative learning and development were comprehensive and in line with their understanding of the requirements of those roles:

> *Lots of detail here and look to be pretty comprehensive.*

> *The key competences seem to fit the identified roles.*

> *In general the competences and learning and development sections look about right.*

> *The work you have carried out aligns very well to the guidelines and outcomes of the roles. In particular the opportunity to add locality specific competences – as this is an aspect we found most useful in previous work to achieve transferability but also transparency.*

> *I have found the documents very reassuring; the competences do fit well with the roles outlined.*

5.7   One respondent commented that providing feedback in a useful way on the competences associated with each role requires a sound knowledge of a wide range competences and their subsets, in order to extrapolate meaning and relevance from the terminology to each role.   The respondent felt they did not have enough knowledge and although they were keen to find out more in order to comment, they felt it was a time consuming task.

5.8   This view was echoed by another respondent who felt the competences and learning and development in the NTRs were in line with requirements, but remarked on how difficult it can be to ensure all roles in a service are aligned with a manageable amount of competences, saying it may be:

> *… unrealistic to expect all roles to go through this intensity of development due to the sheer number of competences that need to be reviewed and the capacity in the work environment to undertake this activity.*

5.9   One could argue however, that having agreed nationally transferrable roles developed at different levels of the career framework would aid this process as individual employers would only need to develop the locality-specific competences.

Comments on the use of language

5.10   There were a number of comments about the use of language in the NTR templates, within the reference functions and associated competences. (These were adopted verbatim from the Skills for Health Functional Map.)

5.11   Two of the comments were about the use of the word 'research' in the Co-ordinator and Specialist Practitioner templates. One respondent felt that academic research is a time-consuming task and wondered whether undertaking such a task should fall within the remit of the Co-ordinator role. The second was that its meaning in the templates for the Co-ordinator and Specialist Practitioner roles is ambivalent.

5.12   One respondent felt the use of the word 'support' is not clearly defined enough in the Specialist Practitioner template;

> *If we believe that the contribution here is distinctive and deserving of a requirement to be a registered nurse then the term support requires further depth.*[10]

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[10] See Reference Function B2.9.5 'Support individuals in their daily living,' and Competence AB2 "Support individuals who are substance misusers.'

5.13   One respondent commented on the use of the term 'encourage behavioural change' as a reference function in the Provider of IBA template.[11] They felt that brief advice is not the same as motivational interviewing, and suggested therefore that the reference function could be 'support behavioural change.'

Changes to the NTR templates

5.14   Upon consultation with the Project Steering and Executive Groups, we have incorporated suggestions wherever possible and directly relevant, on the standalone NTR Templates document that accompanies this report.

5.15   It was agreed that suggested changes for language used in the Health Functional Map or in the NOS used within, can not be changed at this stage, but all suggestions will be considered by Skills for Health during future review processes for NOS and the Health Functional Map.

5.16   In order to make suggested changes to the NTR templates:

- we used Skills for Health's online Functional Map toolkit, to identify underpinning principles, reference functions and competences that we feel relate to specific suggestions from respondents around the inclusion of new areas of responsibility;

- in relation to the above: some respondents added specific suggestions on the NTR templates themselves and sent them back to us. Where respondents have inserted a specific competence, we have used the Health Functional Map to find a corresponding reference function and underpinning principle and included them in the appropriate columns;

- we have included recommendations for changes in indicative learning and development.

5.17   Skills for Health will consult further with relevant stakeholders, and final agreements on these NTR templates will be sought in the summer of 2010.

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[11] See Reference Function C2.1.2 'Encourage behavioural change in people and agencies to promote health and wellbeing.'

Feedback on individual roles and indicative learning and development

5.18   In the table below we report respondents' views on each of the NTR templates and the indicative learning and development they suggested for each.

5.19   Table 5.1: Feedback on NTR templates:

Role / Topic	Feedback
Alcohol Co-ordinator	• This is a very broad role, sometimes relating to strategic responsibilities and sometimes relating to commissioning responsibilities. It is not a practitioner role, therefore the word 'Co-ordinator' in the title can be misleading. An alternative could be to use the word 'Implementation' in the title. For example the title could be **Alcohol Service Implementation Lead**. • Consider scope for skills relating to interpreting and acting on data analysis of hospital admissions.[12] • A competence based on supporting spiritual well-being would be quite relevant for this role.[13] • Agreed that this role has authority and power to act but line of accountability needs to be clarified. • Suggest that this role's caseload and work area responsibilities are made explicit at the start, eg with a primary focus on health promotion or harm reduction. • Under the underpinning principle 'Communication,' consider including competences around communicating at group level with wider audiences. This would tie in with the underpinning principles C and F. • Consider including more strategic responsibilities around the development of policy and programmes, as at present the focus is more on local impact. • Some specific changes in wording on the diagram at start of template and suggestions for specific competences and reference functions. • Safeguard and protect individuals – this underpinning principle should be changed to something to do with health and well-being, and include more emphasis on competences around behaviour change, perhaps through motivational interviewing. The current HCS24 and HSC35 only partially address this.[14]
Specialist	• Include an option to become a non-medical prescriber.[15]

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[12] We searched relevant competences on the Health Functional Map, and added the competence ITTP9: Data analysis, on the Alcohol Co-ordinator NTR.

[13] The respondent referred to HSC350 'Recognise, respect, and support the spiritual well-being of individuals' (now an option in the NVQ Level 3 framework). We have included this in the templates.

[14] We searched the Health Functional Map and did not find an Underpinning Principle specifically around health and well being. Under the Underpinning Principle: C Promotion and protection of the health of the public, we have therefore included: AD1 as a Specific Competence. We have also included CHD HA3 Provide support for individuals who express a wish to reduce their alcohol consumption, and PE8 Enable individuals to manage their defined health condition, under the Reference Function H4.6.

[15] We searched relevant competences on the Health Functional Map, and found no specific competence for this, so added the competence AH1: Prescribe controlled drugs for substance users.

Role / Topic	Feedback
Practitioner	• A competence based on supporting spiritual well-being would be particularly relevant for this role.[16] • Safeguard and protect individuals – this underpinning principle should be changed to something to do with health and well-being, and include more emphasis on competences around behaviour change, perhaps through motivational interviewing. The current HCS24 and HSC35 only partially address this. • Specific changes recommended: AF1 to AF3; inclusion of competences around detoxification AH7 and medication AH2; changing AG2 to AG1; include AL1; consider including AH10 and AB7.
Provider of IBA	• The reference function 'Encourage behavioural change' should perhaps be changed to 'Support behavioural learning.' • More emphasis should be given to behaviour change as well as the current AD1 competence[17], which should be brought into the core competences of the role, not remain as a specific competence. • Consider including a higher level of assessment for some workers with Af2.
All three roles	• All three roles could have more responsibilities around leadership as a particular area of competences, not just at the start of the templates as currently stands in the Co-ordinator and Specialist Practitioner templates.[18] • More emphasis should be given to responsibilities around predicting and preventing harm through early intervention, and not just tackling harm caused. • All three roles should be supported with training to predict and prevent early intervention, balanced with tackling the harm caused by alcohol misuse. The lack of this aspect weakens all three roles. • All three roles should be responsible for, and be supported with minimum training, to recognise health inequalities and social determinants of health both as a risk factor and as a result of alcohol harm, in order to understand that individuals can have many competing influences in the community.[19] • Consider including a section in all three templates for case studies on how using these NTRs could add value to services and how they would contribute to delivery of quality care for patients.

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[16] See point [12] above.

[17] We searched relevant competences on the Health Functional Map, and added the competence HSC3112 Support individuals to identify and promote their own health and social well being.

[18] We searched the Health Functional Map and did not find any competences related to leadership per se. In all three templates, we have therefore included a somewhat generic competence that suggests leadership in promoting a population's healthcare, through encouraging people and communities: C2.1.2 Encourage behavioural change in people and agencies to promote health and wellbeing.

[19] We searched the Health Functional Map for a competence related to this area and did not find one closely linked to it. We have however included hfm_A1.2 Screen populations for specific health characteristics, as a suggestion where relevant, along with the relevant Reference Function and Underpinning Principle. Our research on learning and development has not revealed a course specifically related to the suggested area, however we have included this suggestion in the indicative learning and development sections of each NTR.

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Role / Topic	Feedback
Learning & Development	• A wide range of training opportunities would be deemed appropriate for these roles, many of which are already aligned with DANOS. • Bearing in mind many people in the alcohol workforce have come from disparate routes and backgrounds, it is important to ensure that specifying previous learning and development does not lead to restrictive person specifications that do not allow for those whose competency only comes from experience. • The inclusion of prior learning and informal learning is very positive, especially as the latter assists with individual morale and places a value on their contribution to their own development and service delivery to date. • Coaching, shadowing and peer mentoring could be used within the learning methodologies. • Link could be made to skills passports which are under development so that even if formal qualification is not an outcome of learning, there is still a recognition that this is accumulative.[20]

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[20] The Learning and Skills Council defines a Skills Passport as: "... a portable way of recording the skills and competencies that an individual learns in different jobs over time. Skills passports allow learners to gather evidence of their training and skills, both formal and informal." See http://www.skillspassport.org/

6. Learning and Development

6.1   In this chapter we explore learning and development opportunities available to the alcohol workforce.

6.2   Our approach was to:

- conduct desk research to gain an overview of the range of learning and development packages currently available;

- explore whether these courses align with DANOS and how closely they align with the DANOS used in the three NTRs we have identified; and

- interview a selection of training providers and alcohol workforce representatives to discuss their views on the learning and development packages they currently deliver and use.

Courses related to alcohol service delivery

6.3   When exploring alcohol-related learning and development packages, we used the Alcohol Learning Centre website, the National Database of Accredited Qualifications and search engines. We identified around 90 courses delivered by higher education institutions, further education colleges, private and voluntary providers.

6.4   Our research showed a wide range of formal and informal learning opportunities available for the alcohol workforce, ranging from academic higher education qualifications, shorter competence-based modular courses, online modules, distance learning programmes, workshops and bespoke learning offered by providers according to specific needs identified by an organisation.

6.5   We selected ten accredited courses and ten non-accredited courses to gain an understanding of what some of these alcohol-related courses entail. The table overleaf provides a brief description of the ten accredited courses we found. This is not an exhaustive list and there are many others, however this provides a snapshot.

Table 6.1: Accredited qualifications:

Qualification title	Provider/Awarding Organisation	Course overview (adapted from website)
Level 3 Certificate in Understanding Substance Misuse	Ascentis	This qualification is aimed at staff, volunteers, and youth workers who are involved in working with people who are at risk of substance misuse.
Managing Drug and Alcohol Misuse (FD)	Blackpool and The Fylde College - An Associate College of Lancaster University	Drugs and Alcohol National Occupational Standards (DANOS) form the bedrock of the Foundation Degree Managing Drug and Alcohol Misuse and, as such, are the key benchmark against which the course is set.
Progression Award in Community Justice Drug and Alcohol Service	City of Wolverhampton College	This course provides underpinning knowledge for DANOS: - - A vocationally related qualification to NVQ in Community Justice: Working with offending behaviour' - NVQ in Health & Social Care; - Academic Level 3 modular award; - Accredited by City and Guilds and approved by the Qualification Curriculum Authority; - Provides underpinning knowledge for Drug and Alcohol National Occupation Standards(DANOS) - Suitable for workers in criminal justice and health related fields; - Supported by the Home Office, Drug Action Teams/Community Safety Partnerships in the region and the National Treatment Agency.
Addiction Studies BHSc Honours Degree	Leeds Addiction Unit (accredited by Leeds University)	This course is designed for those who are currently practising in the field of health, social welfare and addiction and would like specialist knowledge and practitioner skills in the treatment of addiction field.
Diploma of higher education in addiction studies	Leeds Addiction Unit (accredited by Leeds University)	A distance learning programme of study designed for students who: - are seeking specialist knowledge about the addiction field - would like to study in their own time and in their own home - would like to focus on theory, research, policy and the underpinnings of current practice - may live a long way from an educational institution
Management of Substance Misusing Offenders CertHE	University of Kent	The Certificate in Management of Substance Misusing Offenders, is aimed at all those working with substance users within the criminal justice system, including probation officers, criminal justice workers and prison officers. Within this programme participants can choose to follow either a practitioner or a management pathway.
Level 2 Award in Understanding Substance Misuse	CPCAB (Counselling & Psychotherapy Central Awarding Body)	No previous training or experience is required. It is a stand-alone qualification. However, progression is available to Level 2 or Level 3 National Vocational Qualifications (NVQs) in Health & Social Care (H&SC), and/or level 2 counselling skills qualifications and/or level 3 substance misuse qualifications.

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Qualification title	Provider/Awarding Organisation	Course overview (adapted from website)
Level 2 Award Recognising and Responding to Substance Misuse	City & Guilds	This qualification is aimed at people who may already be professionally qualified (e.g. youth workers, police officers, teachers and nurses) and who occasionally identify or deal with problematic substance misuse. It is relevant for people new to their role as well as those already working with people who substance misuse.
Level 4 NVQ Health and Social Care	City & Guilds	The level 4 qualification is aimed at people in supervisory or management roles. It includes a pathway for adults and one for children and young people. The adults pathway is appropriate for senior care workers, healthcare workers, home care organisers and community support workers. The children and young people pathway is appropriate for residential child care workers and fosters carers as well as individuals in health, youth justice and educational settings.
Level 1 Certificate in Drug and Substance Awareness	EDI	This programme is designed to give learners an awareness of the implications of using drugs and substances. It will provide underpinning knowledge to identify the signs and symptoms of substance misuse and the steps that can be taken to overcome this. It gives learners an introduction to the implications of misusing a range of common drugs and substances, both legal and illegal, and deals with the many myths surrounding their use. It raises awareness of the risk of performance being affected due to the effects of drugs or alcohol.

6.6   The table overleaf presents the ten non-accredited qualifications, with a brief description about each; this again is not an exhaustive list.

Table 6.2: Non-accredited qualifications:

Course title	Provider	Course overview (adapted from website)
An introduction to identifying and addressing alcohol harms	AERC Alcohol Academy	This course is designed for practitioners or staff who directly work with people who may be at increasing or higher risk levels and could benefit from support, advice or onwards referral. The course introduces the concepts of alcohol related harm and how to deliver simple evidence based interventions thorough a number of structured and interactive learning sessions. The course will explore the learnings, practical application and challenges that are key for identifying and responding to harmful alcohol use amongst those accessing generic or primary care services.
Identification and Brief Advice for mainstream staff in any Tier One or Two setting	Alcohol Concern	This IBA training is delivered using the Department of Health recognised 'SIPS' models, and it has been delivered to primary healthcare staff, social workers, housing and mental health professionals. Offered in full days or half days bespoke to needs.
Abuse, addiction and disclosure-anchoring trauma	The Training Exchange	A two day course for practitioners to raise awareness and develop the skills to respond to disclosure. These skills enable practitioners to retain clients in treatment until they are ready to explore their experience of trauma.
Addiction, dependency & change	The Training Exchange	Develop understanding of addiction and treatment by exploring the role of drugs within society, the factors that contribute to the drug using experience and how people change. Learn what tolerance, withdrawal, addiction and dependency mean. Gain more confidence to work with drug & alcohol users.
Alcohol - brief interventions	The Training Exchange	A one day course designed to develop techniques to help individuals to adopt sensible drinking behaviour.
Alcohol & poly drug use - what you need to know	The Training Exchange	A course based on the premise that it is rare for someone to present to a drug project using only one substance. The course explores interactions of drugs on the body and explore the issues that relate to working with people who use many different substances. Aims: - to give participants a greater knowledge and understanding of the current poly-drug using culture - to explore best practice in working with people with complex substance use.
Assessment skills	The Training Exchange	This one day course discusses the skills needed to be effective in engaging with some of society's most marginalised people. Examines a range of different assessment techniques and brief interventions to enable practitioners to enhance practice. Plans a process that is useful for both the person approaching the service and the worker providing it.
At risk young people - the essentials	The Training Exchange	This two day course equips those who work with at risk young people with a solid foundation from which they can develop their practice. It links relevant theory to a

Course title	Provider	Course overview (adapted from website)
		range of practical skills that support young people's personal and social development.
Dual diagnosis	The Training Exchange	Two day course for practitioners who work with people who experience both mental health and substance misuse problems. Two days of learning and reflection enable practitioners to explore dual diagnosis as a treatment issue, discuss clinical guidance, find out more about methods to assess need and develop skills in working with this client group.
Evidence Based Approaches to Counselling Substance Users	The Training Exchange	The course is divided into 4 units; students need to attend 13 days of formal training (78 hours) that take place over 8 months. Students who want to accredit their learning submit course work for the previous unit before attending the next. Additional time commitments vary according to the level at which students submit evidence of learning. For OCN Level 2, students complete learning packs on the training days and need to complete additional comprehension tests based on course learning. This requires a minimum of 6 extra hours work per unit. For OCN Level 3, students complete learning packs on the training days, additional comprehension tests based on course learning, and one assignment (1500 words) per unit. Students also need to collect evidence to demonstrate that they can apply what they have learnt in the workplace. Requires minimum of 12 extra hours work per unit.

6.7   It is evident that there are a wide range of learning and development opportunities available to the alcohol workforce, at different levels and for different kinds of alcohol-related service delivery.

6.8   It is important to explore how closely these opportunities align with NOS/DANOS, if they are to link closely with alcohol workforce roles that are based on DANOS, and especially if they are to relate closely to the NTRs that have emerged in the alcohol workforce.

The use of DANOS in learning and development packages

6.9   We located training specifications for 60 of the 90 courses we identified through internet searches and from providers. We explored how many of them were already based on DANOS, and how many were not but could easily be aligned with DANOS.

6.10   Encouragingly two thirds of these courses were already based on DANOS, and we mapped the remainder against the DANOS suite of competences, using a similar mapping process that we used to identify commonalities between job descriptions to develop the NTRs.

6.11   The aim of this was to see how closely they covered the same competences used in the three NTRs we have identified for the alcohol workforce. Hence we compared the DANOS used in the courses, with the DANOS used in each of the NTRs.

6.12   The table overleaf illustrates this process, mapping the DANOS used in learning and development packages against the DANOS that formed the Provider of IBA NTR.

Table 6.3: Example of our mapping exercise for learning packages:

Provider		A	B	C	D
Course		Addiction, dependency & change	Alcohol - brief interventions	Alcohol & poly drug use - what you need to know	Assessment skills
Uses DANOS?		Y	Y	Y	Y
DANOS - Competence Title	**DANOS Code**				
Recognise indications of substance misuse and refer individuals to specialists	AA1	Y		Y	Y
Relate to and interact with individuals	HSC233 (AA2)				
Support individuals to access and use services and facilities	HSC330 (AA3)				
Reflect on and develop your practice	HSC33 (AC1)				
Make use of supervision	GEN36 (AC2)				
Raise awareness about substances, their use and effects	AD1				
Carry out screening and referral assessment	AF1				Y
Contribute to care planning and review	AG2 (also HSC328)				
Carry out brief interventions with alcohol users	AH10		Y		
Supplying information for management control	BE4				
Develop productive working relationships with colleagues	M&L D1 (BI1)				
Promote effective communication for and about individuals	HSC31 (BI5)				

6.13   Our mapping process revealed that most of the specific competences that made up the three alcohol NTRs, are covered by at least one of the learning and development packages that we mapped[21].   It also revealed that none of the learning and development packages covered every one of these specific competences.   The Alcohol Learning Centre offers an online module for IBA staff and this is most closely aligned with the IBA role as it emerged through our mapping process.   For the Co-ordinator and Specialist Practitioner roles, we found that there is a wide range of learning opportunities that address various aspects of their roles.

6.14   In view of the wide range of learning opportunities available, it is important to note that there is also a wide range of backgrounds and skills amongst alcohol workforce staff.   This is something a number of our interviewees mentioned, and consideration needs to be given to a tailored approach to address individual needs.   For example not every specialist practitioner will come from the same employment background with the same skills; therefore they will not all require the same learning and development opportunities.

6.15   A blended approach, mixing both formal and informal learning, would enable individuals in the alcohol workforce to address and develop specific aspects of their roles.   Having alcohol NTRs should make this process simpler as they would provide specific competences to focus on, when embarking on learning opportunities.   The fact that most learning opportunities for the alcohol workforce are aligned with NOS, also provides a positive foundation to for employers to decide which courses are relevant for the skills their staff need to develop.

6.16   Our desk research and our interviews suggest that although there is a wide range of learning opportunities available, not all of them are easily accessible or available. Our interviews with the alcohol workforce and learning providers, provided us with further understanding of some of these opportunities and issues related to learning opportunities for the alcohol workforce.

Interviews with providers

6.17   We spoke to ten learning providers that deliver courses related to alcohol and substance misuse. Overleaf is a summary of our discussions with them.[22]

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[21] Appendix C shows those Specific competences which were not covered by the learning opportunities we mapped.
[22] See Appendix D for the discussion guide used during these interviews.

<u>Formal learning alignment with DANOS</u>

6.18   Our respondents informed us that many small organisations do bespoke courses that are developed at a client's request – ie they have a pre-existing relationship with the commissioning organisation and they get commissioned to develop and run specific courses.

6.19   Formal learning designed for the specialist alcohol workforce is nearly always mapped to DANOS. Courses such as those addressing 'alcohol and young people' designed for youth workers and other courses like it, are not necessarily based on DANOS, and courses addressing IBA are almost always mapped to DANOS. Our interviewees were in agreement that of all the courses available to the alcohol workforce the one most likely to be mapped to DANOS is IBA.

6.20   A few providers emphasised that although a course may be mapped to DANOS what really matters are the learning outcomes from the various training courses:

> *The starting point is deciding what you want the person to deliver after their training. Only then do you align the course.*

6.21   One interviewee suggested that as one progresses up the career ladder the odds of the course being mapped to DANOS diminish considerably.

6.22   There was little conformity between training providers regarding how they deliver a particular course. It appears that a course designed for those who will deliver IBA may well be significantly different in different locations. This means that no two courses are likely to be identical.

6.23   This would suggest that it can be difficult for organisations to compare different learning and development options for their alcohol workforce.

6.24   The providers who provide bespoke packages, informed us that the target audience for each course differs from course to course, based on the needs of the client they deliver to.

6.25   There are some providers however which deliver 'off the shelf' courses for employers. The Open University, for example, delivers three courses that are not NVQs, but use a combination of units from the Health and Social Care NVQ Level 3, and DANOS. It offers a 10-unit award for practitioners, a 5-unit award for managers supervising staff, and a 3-unit award for employees involved in assessment and care planning, such as people who are called out by the police service to do an initial screening for alcohol misuse.

Accreditation

6.26   Our interviewers suggested that accreditation of alcohol training is not widespread.

6.27   We were told that some courses for those working with young people are accredited – for example a Wirral Metropolitan College course accredited by the Open College Network – but our interviewee suggested that this is probably the exception rather than the rule.

6.28   The Open University courses mentioned above are accredited by the Federation of Drug and Alcohol Professionals.

6.29   Of the providers we spoke to none were accrediting their IBA course, but some of the slightly larger ones were thinking of exploring it in the future.

6.30   A barrier to the increased use of accreditation is that more informal learning opportunities are generally short and providers are unsure whether the cost of accreditation is worth the added benefit, when learners do not necessarily see the value and the provider has a relatively small market.

Changes in the future

6.31   There was a difference of opinion among the providers as regards learning and development in the future, with some thinking that the sector is relatively static and others thinking it is changing all the time and will look nothing like what it currently does.

6.32   One of the interviewees said there has not been much change in what they deliver in the past, but that they are delivering four new courses this year: alcohol treatment for adults, IBA, young people and alcohol, and supporting parents to supervise and support their children.

6.33   Another interviewer argued that the rate of change in the alcohol workforce over the last five years has been significant with the birth of IBA, and that there are two things that could make a large impact:

- Night time economy – in Australia anyone who serves alcohol (eg in a bar or off-licence) has to receive training similar to that of IBA, it is possible the UK will implement similar requirements;

- Domestic violence – there is now a statutory obligation to identify those who are likely to be at risk from domestic violence. Our interviewee suggested that since domestic violence is closely linked to alcohol problems, it is likely that domestic violence workers will have to do more alcohol IBA training than is currently the case.

6.34   Another interviewee emphasised that there is significant crossover between smoking, drugs and alcohol in terms of both how to tackle them and their effects on the human body. Therefore a more joined-up approach to screening is likely to be implemented that draws together the current different screening and assessment tools (ie those for smoking cessation, alcohol, eating health) into a single one. He argued that there will be a more holistic approach to legal and illegal substance misuse.

6.35   One of the larger training providers informed us that they are looking to move into new job areas. Key targets for future training are those working with; young people, offenders including young offenders, workers in the criminal justice system (eg care planners such as probation officers and prison staff).

Interviews with alcohol workforce representatives

6.36   Below is a summary of our interviews with workforce representatives. We spoke to seven interviewees from across Drug and Alcohol Teams (DAATs) and PCTs, and the Joint Commissioning Team from NHS Bradford and Airedale[23].

Overview of the learning and development

6.37   Overall, there was consensus that there are many learning and development opportunities for the alcohol workforce, but the opportunities available do not necessarily meet their needs.

6.38   Reasons for this were varied. Two interviewees told us that finding the right courses in their geographical areas can be difficult, and sending staff further afield has resource implications. It is common therefore for organisations to commission local training providers who deliver courses in-house, tailored to the need of the specific workforce. This is in line with what we found in our interviews with learning providers.

6.39   One interviewer argued that among 'off-the-shelf' courses available to the alcohol workforce, many are based on both drugs and alcohol. He feels that combining the two can complicate the needs of alcohol workforce staff, and these courses are not reflective enough of their specific needs. Views such as this need to be carefully considered if, as one of the providers we interviewed suggested, learning and development in the future is likely to combine alcohol, drugs and smoking.

6.40   Another interviewer simply said:

> *Learning and development in the field does not meet the needs of the alcohol workforce.*

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[23] See Appendix E for our discussion guide for these interviews.

6.41   When expanding on her views, she emphasised the difficulty of getting a level playing field when looking at the needs of an alcohol workforce. People in the alcohol workforce come from varied backgrounds: they can be former substance misusers, can come from a medical or social work route, be physiotherapists, counsellors, former prison officers, counsellors or come from various other backgrounds. They will all have different skills and knowledge, and catering for everyone's needs can be complicated, if done through a 'one size fits all' approach.

<u>Formal accredited and in-house courses</u>

6.42   A number of formal qualifications were mentioned by our interviewees, some receiving better reviews than others.

6.43   An interviewee from the Nottingham Alcohol and Drug Liaison team mentioned that he had qualified with a substance misuse qualification from Nottingham University, which, although broader than alcohol, he did find very useful.

6.44   Another informed us that some of his staff have undertaken the Diploma in Substance Misuse at the University of Brighton, but he feels this focuses too much on drugs and not alcohol (he added the university is responding to feedback to put more emphasis on alcohol issues). He argues that workforce growth has been more concentrated in the drugs field than in the alcohol field, and that is where the money is: providers offer more courses around drugs than alcohol. This has obvious implications for the needs of workers who specialise in alcohol work.

6.45   Our representative from the Joint Commissioning Team in Bradford and Airedale informed us that a Diploma in Addiction Studies and a Health and Social Care NVQ are delivered locally which many alcohol staff undertake, but again neither of these focuses specifically on alcohol.

6.46   All organisations we spoke to deliver in house training to their staff, with the aim to focus on specific skills needs of their teams.

6.47   Thurrock Council for example, hires a local training provider to deliver a one day DANOS-based course to any staff who may come in contact with alcohol misusers, and the staff fill in a workbook that tests their knowledge. Our interviewee added though, that this training can be difficult to tailor specifically enough to meet everyone's needs, eg a receptionist who could refer an alcohol misuser may need different knowledge and skills from a counsellor.

6.48   The Southend DAAT ensures that every job description is aligned to DANOS, and they commission local training providers to deliver courses based on these competences. He informed us that some of these providers deliver courses that are already aligned to DANOS, and for any courses that are not closely aligned enough to DANOS, the DAAT works with providers to align them. Although this addresses staff needs more closely, it does have resource implications. However, this could be considered to be best practice.

6.49   Torbay Care Trust told us that there is not much scope for staff to take formal qualifications locally and there are funding issues associated with sending them further away. Therefore staff access in-house training delivered by local providers.

6.50   One of our interviewees said that to her knowledge there is no one nationally-recognised qualification for alcohol workers based on DANOS, and that different providers deliver different courses based on different DANOS.

6.51   Although delivering courses in-house by commissioning local providers is positive in that it may address more closely the needs of specific alcohol workforce teams, it would be important to explore in more detail the commonalities between these bespoke courses, and any implications a lack of conformity may have on developing an alcohol workforce with standardised, transferrable skills.

Gaps and shortages

6.52   We asked our interviewees their views on both gaps in learning and development opportunities for specific roles, and skills gaps and shortages. The answers were varied and provide a useful backdrop for education commissioners to base future decisions on.

6.53   Three of our interviewees suggested that there are not enough opportunities for developing staff who require a combination of psycho-social and medical skills. For example, an interviewee from West Suffolk Hospital NHS Trust told us that most of their nurses will need to work with very distressed clients with complex needs and it is imperative to have the right interpersonal and management skills that address a patient who may be suffering from, for example, delusions and a high state of agitation. Although the nurses will have a medical background often they will not have the right skills to deal with the more personal, psychological complexities in this situation.

6.54   This view was echoed by our interviewee from Torbay Care Trust who has recently employed two Alcohol Liaison Workers. He explained that this is a new role that is developing in the alcohol workforce, whose responsibility is to travel around different wards and identify alcohol misusers, screen them and refer them to appropriate specialists. Some of these patients can be very difficult to manage and more attention needs to be given to providing learning and development opportunities for these workers, to be able provide more effective support to these clients. He explained that it is rare to find staff with the right mixture of a medical background and training in motivating skills required in difficult psychological settings.

6.55   One of our interviewees mentioned a Level 3 award available in Thurrock that consists of generic substance misuse risk management modules, but does not look in enough depth at the medical consequences of alcohol misuse on the body.

6.56   On the other hand our interviewee from Nottingham informed us that many courses provide medical information but do not link this well enough with alcohol misuse and management. He gave an example of attending a training course on liver disease thinking it would address the effect of alcohol on the liver, but only 20% of the 8 day course actually explored working with alcohol misusers who suffer from liver disease.

6.57   The representative from Bradford and Airedale Joint Commissioning Team emphasised the importance of more standardised IBA training across the country for anyone who may come into contact with alcohol misusers, including doctors and nurses. There are increasing demands on hospital staff with the high numbers of alcohol related hospital admissions, and increasing demands due to a decrease in public funding. Training clinical staff with better IBA skills is essential, especially as IBA is crucial in engaging someone at a 'teachable moment.' She described this as the moment when an appropriately trained clinical staff can help stop someone from continuing on to more harmful levels of alcohol consumption, eg talking to someone who has come in to A&E with a head injury from falling when drunk, asking questions such as, "Have you thought about cutting down your alcohol consumption..?"

6.58   The above interviewee is aware of the online IBA training course provided by the Alcohol Learning Centre and finds it a useful tool. She feels more online courses would address resource implications for any organisations who may find it too costly to send staff to training courses for a number of days.

6.59   Better training for staff who meet clients at this initial contact point, was also highlighted by our interviewee from West Suffolk Hospital NHS Trust, who emphasised that junior staff especially, are often cautious and nervous about asking patients about their alcohol consumption as they find the nature of the questions personal and intrusive.

6.60   One of our interviewees feels that managers in the alcohol field need more effective training, as he feels managers in health in general do not have the right skills to motivate and manage staff.

6.61   In terms of difficulties in recruiting particular alcohol staff, two of our interviewees mentioned that they have found it difficult to recruit alcohol nurses. Our interviewee from East Sussex feels substance misuse in general is an unpopular career option in the NHS, although he is unsure why this is other than perhaps it involves working with people who often have complex needs, and this is not something that everyone wants to do.

Future trends

6.62   One of our interviewees feels there will be more of a push for roles such as Alcohol Health Workers, and that this is a positive development as it will allow for particular staff to take on the role of advising people across hospital wards on alcohol and referring them to relevant organisations, which is something other staff like nurses are currently doing in their roles but find it is an added pressure on an already busy workload.

6.63   The interviewee from Suffolk Hospital NHS Trust feels it is important to develop the skills of nurses and doctors who can engage alcohol misusers through early intervention, a view that correlates across most interviewees.

6.64   The Southend DAAT will soon hire a local provider to deliver IBA training to night time economy staff in the locality, eg taxi drivers, pub staff, clubs, Connexions workers, youth offending team managers and those particularly working with the 18-25 year old population. This view correlates to the training provider mentioned earlier in this chapter, who felt that the UK will soon place more importance on staff in the night time economy as Australia has.

6.65   One of our interviewees expressed concern that he feels education commissioners:

> … just don't think ahead.

6.66   This view was echoed by another interviewee who feels the UK needs a change in mindset when addressing the needs of the alcohol workforce, as currently it is short-sighted with respect to alcohol when compared to drugs. He suggested that the UK suffers from a culture of pop psychology:

> … wanting to get the easy things done quickly, but then we wonder why our approach is not as efficacious as we would like it to be, when we view the results.

6.67   He said that in future the UK needs to develop an alcohol workforce that has an appetite for learning. He emphasised that the research economy in the USA is much more buoyant than in the UK, where the alcohol workforce engages in much more work around Social Behaviour Network Therapy and Manual Based Motivational Enhanced Therapy[24], whereas the UK does not pay enough attention to them. He added that learning and development in the UK also needs to focus more on specialist alcohol skills and not only on generic skills which he feels is the current area of focus.

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[24] See http://www.ncbi.nlm.nih.gov/pubmed/16024177 and
http://www.addictioninfo.org/articles/736/1/Motivational-Enhancement-Therapy-with-Drug-Abusers/Page1.html

7. Conclusions

7.1   This chapter outlines our conclusions from our findings, based on the areas outlined in the project specification.

7.2   Our research shows that roles in the alcohol workforce are varied, and most of them are or can be aligned with DANOS. Using a range of job descriptions for alcohol roles, three nationally transferrable roles have emerged, which we present in the standalone document with this report, with suggestions from the feedback process with a wide range of stakeholders. These will be finalised by following further consultation.

7.3   The case for providing a common core to both roles and learning and development opportunities, along with sufficient room for local interpretation, is clear. This could be done by encouraging the use of the alcohol NTRs and the suggested indicative learning and development for each role. Careful consideration needs to be given when doing this however, as some of our respondents from the feedback process emphasised the importance of allowing indicative learning and development opportunities for the NTRs to remain flexible and non-prescriptive in requirements.

7.4   There is a wide range of learning and development opportunities for the alcohol workforce, and many of these are based on DANOS. These include modular competence-assessed units available in short chunks of time, longer academic courses, distance learning options, online modules, interactive workshops, and bespoke packages delivered in house by private and voluntary providers according to specific needs.

7.5   Our research shows that within the wide range of learning opportunities available for the alcohol workforce, most of them cover most of the specific competences that have formed our alcohol NTRs, although not all specific competences in the current NTRs were covered by any one learning package. In tandem with this, it is clear that alcohol workforce staff come to their roles with differences in their pre-existing skills and experiences.

7.6   In order to meet the differing development needs of individual staff, the wide range of learning packages available provides an opportunity to blend the types of learning required to meet individual needs, providing flexible, accessible learning opportunities. Bite-size learning with a strong mix of both formal and informal learning approaches should be sourced wherever possible, focussing the learning on the competences in each of the role profiles. The fact that the majority of learning is based on NOS would facilitate this process.

7.7   Locally identified learning solutions may have resource implications for the education provider in terms of sustainability. However E-learning or distance learning packages may resolve this as learning will be open to a wider audience, can be designed to fulfil the requirements of small clusters of NOS and therefore promotes transferability across organisations and geographies.

7.8   Publication by Skills for Health and the Department of Health of the results of the final NTR templates should encourage education providers to build learning opportunities based on NOS, in small easily accessible parcels of learning. It should also help them reflect on how well what they offer aligns with the thinking behind nationally transferable roles. If there is an appetite to push this further (and the resources to do so), Skills for Health might consider convening a conference for education and training providers, to alert them to the work on NTRs and encourage greater alignment at course level. There is currently an ongoing programme of work between Skills for Health and education providers, linked to NTRs, and this programme should include addressing the needs of the alcohol workforce.

7.9   There is always a degree of ambivalence in the health service about 'standardisation'. The benefits of identifying and adopting nationally transferable roles are clear, but there is a good deal of variety in the sector, and that variety encourages innovation. Nationally transferable roles do not seek to standardise roles but to harmonise both the role and the underpinning learning and development. This offers consistency and transferability as well as allowing for local interpretation.

7.10 From our interviews it appears harmonisation of IBA learning and development opportunities is an area that requires further development, for example by encouraging further harmonisation with possibly a lower number of high quality programmes. There are clear advantages with using E-learning and distance learning modules. Promoting these further would allow more alcohol staff to benefit from them, especially ensuring that specific, individual needs are met by blending them with a mix of other types of face-to-face, formal and/or informal learning.

7.11 Further harmonisation of IBA would be especially important if as two of our interviewees suggested, night time economy staff will be increasingly more involved in engaging alcohol misusers at initial point of contact. This will also be important if future trends place emphasis on training those who work with young people, as suggested by a number of our interviewees.

7.12 Also in terms of specific learning needs for the future, from our interviews it seems clear that more learning and development should be available that combine psychosocial skills with specific medical skills. This would be particularly relevant if, as one of our interviewees suggested, there will be an increase in the numbers of Alcohol Health Workers.

Appendix A: Discussion guide for phase 1

Developing the Alcohol Workforce

A Who is the alcohol workforce?

Definitions

- What does the phrase 'alcohol workforce' mean to you in your current role?
- Has the meaning of this phrase changed in the recent past?

B Mapping the workforce

Roles

- What specialist alcohol-related roles are there within the alcohol workforce?

    – Strategic
    – Managerial
    – Operational

- What role do IBA (identification and brief advice) staff play?

    – Do they play a role?
    – Are they part of the alcohol workforce?
    – Would they recognise themselves as part of the alcohol workforce?

Structure

- Where is this workforce located? What organisations are involved?

    Prompts: Public
                   Private
                   Voluntary

- Do they fit/work well together? If so, how?

    Prompts: Referral mechanisms
                   Formal partnerships
                   Meetings
                   Other informal ways

C Job descriptions

- Do you have any job descriptions or job adverts for the types of roles you've been talking about?

D Learning and training

Discussion linked to the above

E Further contacts

- In scoping the alcohol workforce and assessing their learning and training needs we would like to have conversations with people in different roles. Could you provide us with any contact details for individuals that could give us further views on the questions we've asked you or could provide some job descriptions?

    Prompts: PCTs
    GPs
    Pharmacies
    GUM clinics
    Community health trainers
    SHAs (especially education commissioners, workforce development leads)
    Others…

- We would like to contact training providers as part of assessing the supply of learning and training courses to the alcohol workforce. Do you have any contacts that may assist us?

    Prompts: Universities
    Colleges
    Private providers

Appendix B: DANOS not used in job descriptions

When mapping 50 job descriptions against DANOS to identify emerging nationally transferrable roles, we found that the following DANOS were not used in any of the job descriptions:

DANOS Code	DANOS Competence
PHARM 07 (AH8)	Receive prescriptions from individuals
PHARM 08 (AH8)	Confirm prescription validity
PHARM 09 (AH8)	Assemble prescribed items
PHARM 10 (AH8)	Issue prescribed items

Appendix C: NTR competences not covered in learning and development packages

The following Specific competences were not covered by the learning and development packages we mapped.

Role	DANOS code	DANOS competence
Alcohol Co-ordinator	BC4	Assure your organisation delivers quality services
	HSC32	Promote, monitor and maintain health, safety and security in the working environment
	BG5	Making and recording payments
	BG6	Maintaining financial records and preparing accounts
	M&L A3	Develop your personal networks
	M&L D1	M&L D1 (BI1)
Specialist Practitioner	M&L D1 (BI1)	Develop productive working relationships with colleagues
	HSC31 (BI5)	Promote effective communication for and about individuals
	HSC3100 (BI7)	Participate in inter-disciplinary team working to support individuals
Provider of IBA	M&L D1 (BI1)	Develop productive working relationships with colleagues
	HSC31 (BI5)	Promote effective communication for and about individuals

Appendix D: Discussion guide for learning providers

In April 2008 the Department of Health published the Alcohol Improvement Programme (AIP) which aims to help reduce Alcohol-related Hospital Admissions across the NHS. To reach this aim CPD (continuing professional development) is essential. The Mackinnon Partnership has been commissioned by the Department of Health and Skills for Health to assist them in mapping current training provision and assess where there are gaps.

Questions:

Current training

1. What training courses are you currently delivering to the alcohol workforce?

    a. Specific alcohol workforce courses
    b. Generic substance misuse courses

2. How were these training courses developed?

    a. Use of market research?
    b. Were NOS used when developing the course?
    c. How long has the training course been running

3. Specifically who are you delivering each training course to?

    a. We need to be quite specific here as we're trying to map training courses to roles (ie course X is specifically designed for alcohol nurses)
        i. Possibly roles may include: alcohol nurses, other nurses, alcohol service co-ordinators, outreach staff and others

Changes in delivery

We want to know a about the past and also a bit about the future.

4. Do you have any new training courses in the pipeline?

    a. If so what led to them being developed?
        i. Were NOS used when developing the course?
    b. Who will the new courses be marketed to?

If you have any queries about our work or giving us this information then you can contact Will Youngman at will@themackinnonpartnership.co.uk or Rudaba Osmani at rudaba@themackinnonpartnership.co.uk. Both are also available on 020 8799 3120.

Appendix E: Discussion guide for alcohol workforce representatives regarding learning and development

In April 2008 the Department of Health published the Alcohol Improvement Programme (AIP) which aims to help reduce Alcohol-related Hospital Admissions across the NHS. To reach this aim CPD (continuing professional development) is essential. The Mackinnon Partnership has been commissioned by the Department of Health and Skills for Health to assist them in mapping current training provision and assess where there are gaps.

Discuss the following areas:

- The breadth of learning and development packages the alcohol workforce uses

    - eg formal accredited qualifications
    - any informal learning such as in-house training

- If there are specific roles where formal training is particularly useful, including

    - whether respondents think more accredited learning and development is required for their alcohol workforce roles
    - whether formal training is flexible enough (eg whether it is being delivered in bite-sized chunks that allow easy workforce planning, or whether they have to send staff on long full-time courses)

- The availability of learning and development packages, ie

    - whether there are any gaps (eg a training course in X would be really useful)
    - whether the courses used are fit for purpose, addressing the right aspects of the their roles

- Whether they are currently experiencing any skills gaps or skills shortages in the alcohol workforce

- How respondents see the alcohol workforce developing or changing in the future.