



Improvement

Customer led transformation programme

Case study – Birmingham

Drugs and alcohol

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The Customer Led Transformation programme

Birmingham's work has been funded under the Customer Led Transformation programme. The fund aims to embed, at a strategic level, the use of customer insight and social media tools and techniques across the public sector to support place-based working.

The programme is overseen by the Local Government Delivery Council (supported by LG Improvement and Development).

The fund was established specifically to support collaborative working between councils and their partners, focussing on using customer insight and social media to improve service outcomes. These approaches should improve customer engagement by gathering insight into preferences and needs, the evidence and intelligence needed to redesign services to be more targeted, effective and efficient.

About Birmingham

Birmingham is the largest city outside London. It has a population of over a million people. Located at the heart of the West Midlands, it is at the centre of England's road, rail and air networks. Over the last few years the city centre has been transformed into a thriving commercial and cultural centre. It's also a green city with 3,400 hectares of park and open space and many miles of canals.

Birmingham's economy has undergone a significant change over the past three decades with the service sector replacing manufacturing as the principal source of employment. Manufacturing continues to be a key element of the city's economy though, with an increasing focus on high-technology production.

Birmingham has some of the most deprived areas in England, unemployment is high and people's health is quite poor. For example, Birmingham's unemployment rate was 11.3 per cent in September 2010, compared to 5.1 per cent across the United Kingdom as a whole¹, and according to latest figures available the all-age all cause mortality rate was approximately ten per cent higher than the national average².

After years of population decrease, linked to the decline in manufacturing industries, Birmingham is growing again. The population is becoming increasingly diverse. More than a third of the population is now from black, Asian and ethnic minority communities, and by 2026 it is expected that no single ethnic group will form most of the city's population. Birmingham is a comparatively young city – in 2006, almost half of the population was under 30. But the over-85s age group is expected to increase significantly.

1 Unemployment Key Facts, Published 13 October 2010 by Birmingham City Council

2 Mortality Monitoring Bulletin, Published 28 October 2010 by the Department of Health and the National Statistics Office

Background

Birmingham is a city of a million people, receiving over £7,500 million of public spending and investment each year. Whilst services are regarded as being well run individually, some critical outcomes have remained poor for decades. For example:

- many residents are without work for several years
- health and wellbeing is highly variable and below national norms
- adult skills are low
- around 11,000 people remain problematic drug misusers.

The six themes of Birmingham's total place pilot addressed these poor outcomes. These themes were:

- early intervention
- drugs and alcohol misuse
- mental health
- learning disability
- gangs
- locality-based 'Total Community'.

The Customer Led Transformation programme funded Birmingham City Council and her partners to undertake insight work that was specifically focused on drug and alcohol misusers. This insight work was in support of Birmingham's drugs and alcohol themed work-stream.

In shaping their approach to their total place pilot, Birmingham consciously built on work they had already begun. Before embarking on the pilot, Birmingham had already completed a financial mapping of the public sector funding coming into the city and its alignment with strategic priorities. This mapping illustrated that one cause of

continuing poor outcomes was an excessive focus on symptoms rather than on causes.

For example, in employment, 93 per cent of Birmingham spend is on out-of-work benefits and less than 7 per cent on interventions to help people into work. In health, 96 per cent of spend is on treating illness and less than 4 per cent on keeping people well.

A small number of people incur extremely high costs. Around 6 per cent of Birmingham children are permanently excluded from school, with each costing £12,250 in additional services alone. Only 2 per cent of children are in care but they cost £35m per year. Each of Birmingham's 6,400 crack addicts averages £833k of social costs in their lifetime, whilst most crimes (56 per cent) are drug related.

National evidence shows each £1 spent on drug treatment yields £9.50 in savings. Whilst in Birmingham drug treatment services are working well (84 per cent of people achieve the 12 week treatment target), on average it takes six attempts over six years to "get clean" with only 15 per cent drug free within a year. Users are clear that a more holistic approach, focussing on the individual rather than the addiction, would enable them to sustain recovery quicker and more effectively – for each addict, each year off drugs will save £50,000 in unnecessary social costs.

The Customer Led Transformation programme funding supported Birmingham to gather insight and evidence to inform their approach to their themed area of the treatment of drug addition and alcoholism in the city (see 'Objectives').

Objective

Customer insight formed a critical part of Birmingham's wider total place programme.

The Customer Led Transformation programme funded insight project specifically set out to undertake insight work with regards to the current Drug and Alcohol Services, and was focused on providing a customer centric and data driven perspective to identify and inform potential improvements. The ambition was to identify opportunities to:

- re-design services around proactive and preventative support that focused on key trigger moments in people's lives
- remove duplication across the public sector to realise and reinvest resources where they can more effectively employed
- join up existing services to make better use of existing information and existing resources – moving towards a single point of commissioning
- make better use of the third sector and community groups to deliver the same services at lower cost and through channels that may be seen as less 'intrusive' and perhaps less 'judgmental'
- make better use of social media to enable customers to share advice and experiences, and provide support – or help service providers share insight and experiences.

Approach

The project took the approach of looking at the current provision of drug and alcohol treatment services from the perspective of service users and their needs. The work was focused upon identifying actionable improvements, rather than simply review the existing arrangements, and hence the nature of the findings is focused on reducing the operating cost of the systems and upon driving better outcomes for service users and citizens. Given the project's objectives, involving current service users in the work was essential.

The principal elements to the work were as follows:

- identifying and mapping of the data that relates to customers and performance that is held across the system
- interviewing citizens to capture and document their journeys, experiences and perceptions as drug and alcohol users/abusers and also as service users of the DAAT treatment, prevention and harm reduction services
- interviewing service providers to capture their views on what and how improvements could be delivered.

The project worked with practitioners from a range of drugs and alcohol service providers to engage service users, and sought data from relevant services provided by the city council, the fire, the police, probation, courts, prison, and GPs in order to profile their needs and behaviours.

For a description of the findings from this work, and how it has contributed to service improvements, see 'Findings' on page 15.

Project governance

The project team reported to the Drugs and Alcohol Steering Group of Birmingham's total place programme. The Steering Group comprised representatives from:

- Birmingham City Council
- Birmingham Drug and Alcohol Action Team
- West Midlands Police
- Birmingham Health and Wellbeing Partnership.

The Steering Group played an active part in guiding the project, checking progress against milestones, providing access to key people and facilitating introductions where necessary.

Mapping the 'Circle of Need'

The project began by conducting a desk-based and telephone-based exercise to:

- identify all of the current services from across the public sector that are provided to the customer segment group.
- map these services to the needs of the customer segment.
- assess the contribution or role of these services in terms of what they actually provide to the customer and how this helps to meet their need.

The findings from this exercise are reflected in Figure 1, the Drugs and Alcohol Data Map.

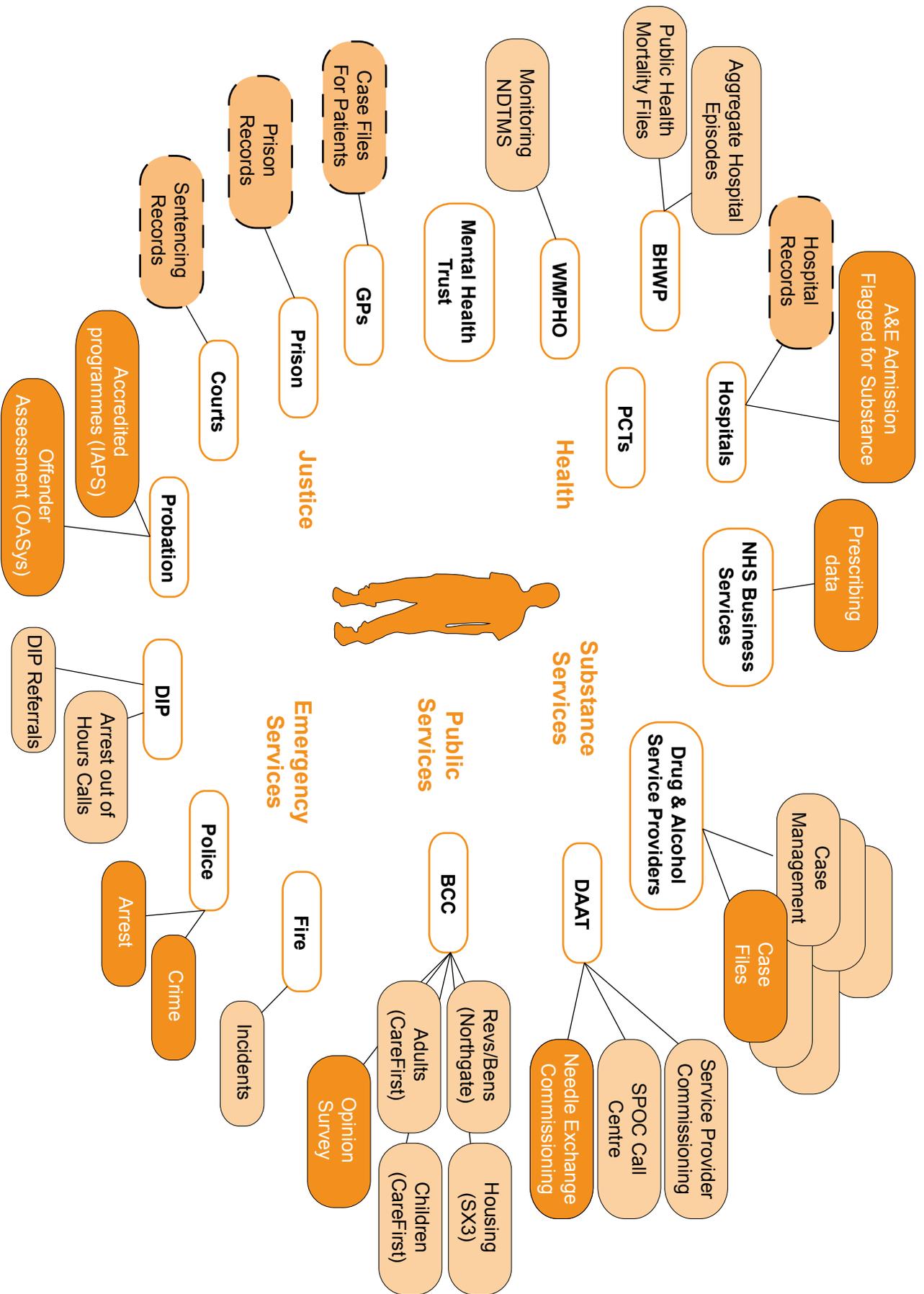
Profiling

The project used multiple sources of data to profile drug users and alcoholics in Birmingham. The ambition was to highlight:

- their unmet needs and associated risks
- the services from across the public and third sectors that are provided to this segment to meet these needs
- the contribution these services make to meeting their service users needs
- the geographical distribution of drug and alcohol use and the location of relevant services.

Multiple sources of data were used as part of this profiling. The "Drugs and Alcohol Data Map" depicted in Figure 1 illustrates the range of potentially relevant sources of data. Those areas highlighted in red indicate the sources of data that the project successfully obtained. For further information on the project experience or extracting and assembling data from service providers, see 'Challenges and lessons learnt'.

Figure 1. Drugs and Alcohol Data Map



As well as data from the police, probation, NHS and drug and alcohol providers, and Birmingham City Council, the project also used drugs-related information from the British Crime Survey as well as socio-demographic data from CACI including:

- Health Acorn – which provides an indication of the general health and well being of people within each area
- alcohol spend data – which indicates the general level of spending on alcohol across the area.

By combining these data sets, the project produced consolidated views on the local demand for services that arose from drug and alcohol abuse, and a consolidated view of the costs that arise as a result (see figures below). These indices were mapped to locality.

The Consolidated Demand Index arising from Drugs Misuse combines data from:

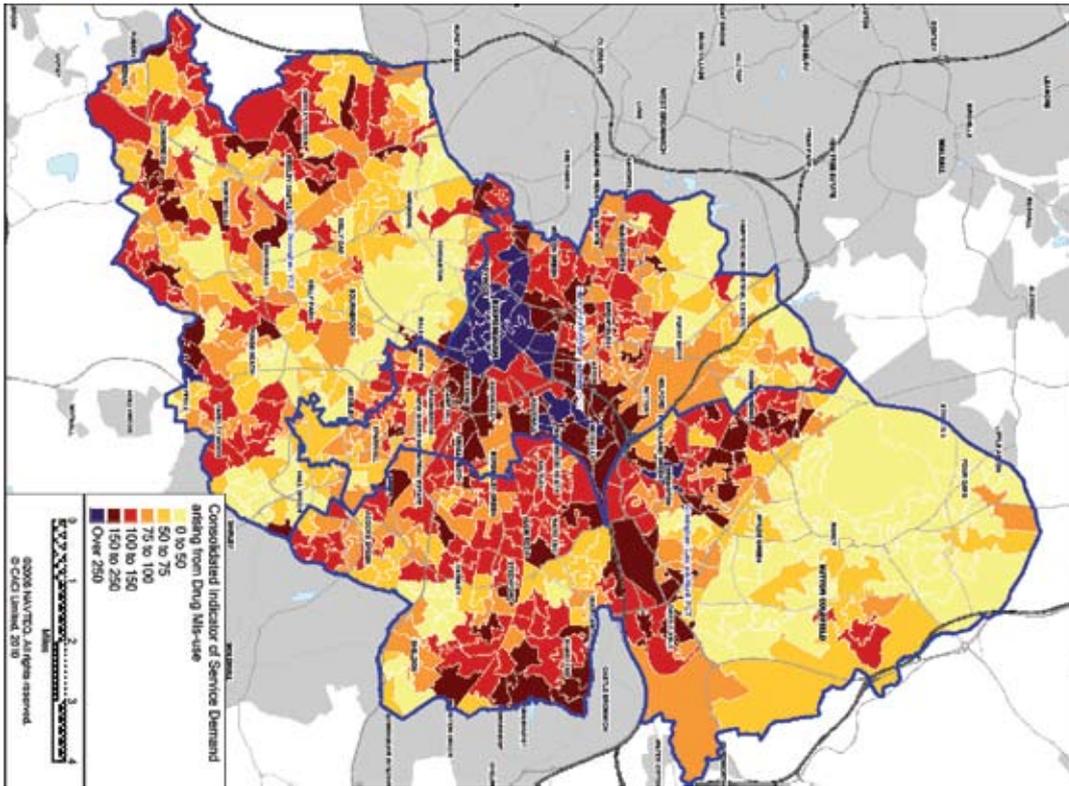
- DAAT Needle Exchange Volumes – Pharmacy Level aggregated to Ward
- NHS Business Authority – Spend on prescriptions relating to Opiate Dependence
- Police Data – Drug Possession Offenders
- Probation Service OASys – Drug Offenders with Criminogenic Need
- Demographic Propensity – derived from ACORN profile of Drug Offenders.

The Consolidated Cost Index arising from Drugs Misuse:

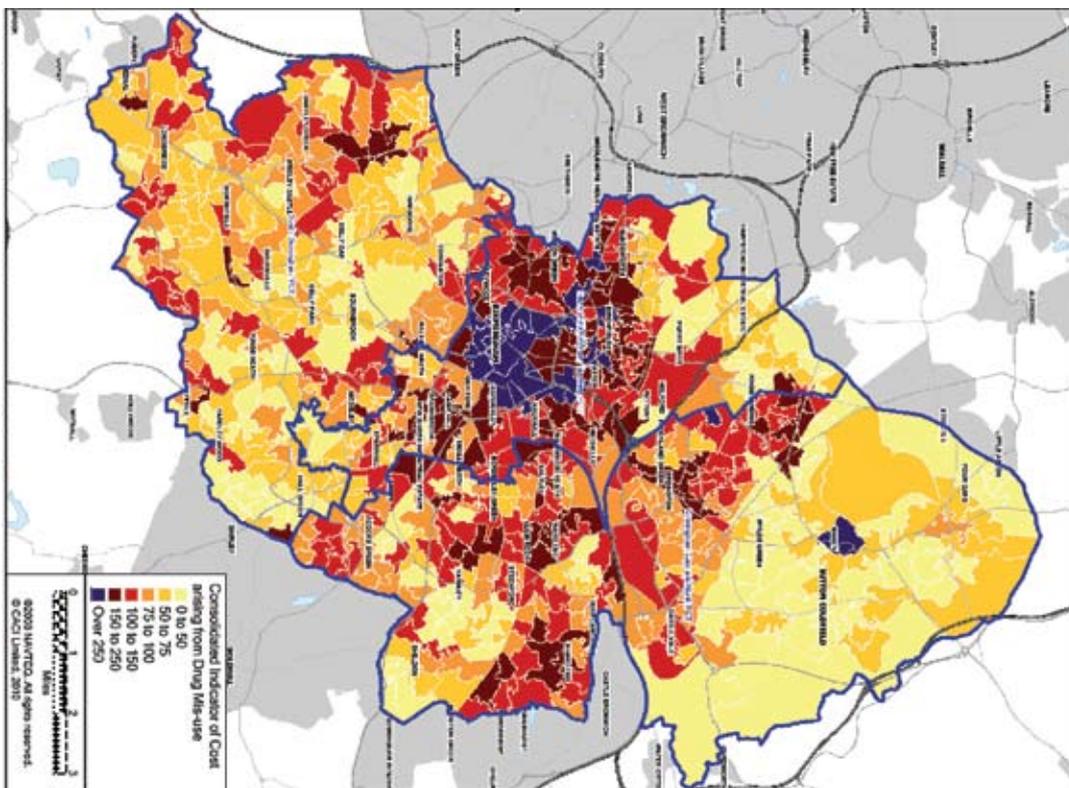
- Birmingham Opinion Survey – Proportion who say that people using/ dealing drugs in the local area is a big problem
- Police Data – Instances of Drug Possession crime
- HES Data – Inpatient Admissions for Drug Misuse.

For example, the Consolidate Index may highlight areas where the Probation Service records indicate a high number of people with a drug addiction, and where the pharmacies are prescribing a high number of drug substitutes. Their proximity to drug users (or – from the perspective of the customer – the lack of an alternative pharmacist) explains why certain pharmacists deal with many more drug substitutes prescriptions than others. Such a finding would be a powerful message for strategic directors with regards to allocating resources.

Consolidated indicator of **service demand** arising from drugs misuse



Consolidated indicator of **cost** arising from drugs misuse



Facilitating focus groups

To complement the qualitative data, the project worked with DAAT to identify and recruit participants for two focus groups – one focus group was with drug users, the other with alcoholics. The ways these participants were invited to the focus groups was critical to their chance of success, as the way they were invited would impact their attitudes in the workshop. For example, the project worked with organisations who had existing trusting relationships with the service users (such as Alcoholic Anonymous) to engage people to attend the event.

Similarly, the workshops were facilitated by independent consultants. No professionals from the service providers were invited as their presence would also likely influence what the participants said.

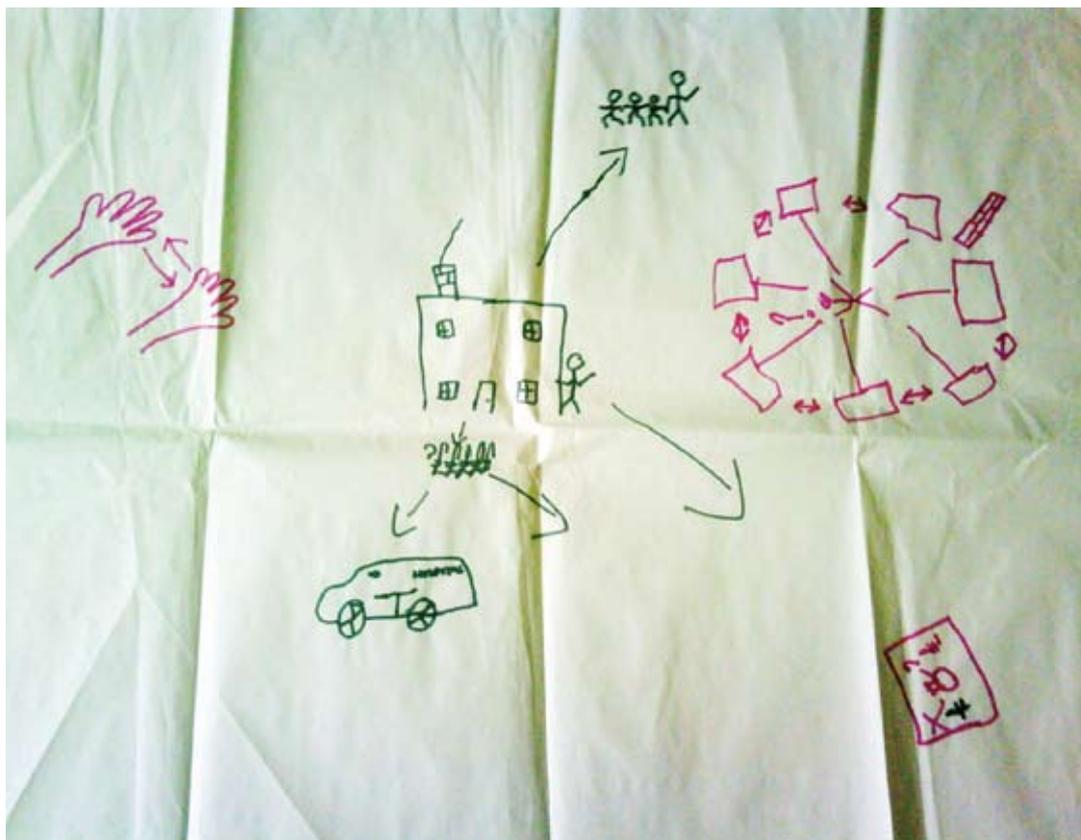
The facilitators worked with the participants on a series of exercises designed to encourage them to depict and articulate:

- their perspective of their needs, aspirations, fears and expectations
- the role that they perceived local government and the public sector should play in helping and supporting them in fighting or containing their addictions
- the services that they currently received or are aware of and their views of how these help or otherwise (including their views of how these might be better presented and targeted)
- their journey through their experiences of their addiction – identifying what they believed were key stages, moments and triggers where they moved deeper into or moved away from their addictions
- the potential gaps they perceived exist where different support might provide greater opportunity for success.

In one exercise, drug addicts were asked to depict their perception of services, and how they functioned from their perspective. Figures 2–4 illustrate their view that:

- there are many services, but they are disjointed (“the left hand doesn’t know what the right hand is doing”)
- the central role of housing in their life
- the costs of all these services (illustrated with pound signs).

Figure 2. What does services look and feel like to you? How easy is it to engage?



Generally, focus group facilitators found the participants candid and direct – and very knowledgeable about the services and how the system could be improved. In another exercise, service users were asked to describe the public service interventions and events that “helped” and “hindered” their recovery (for an example see Figure 3. Drugs – What helps?) The project then analyses their feedback to identify common themes (Figure 4).

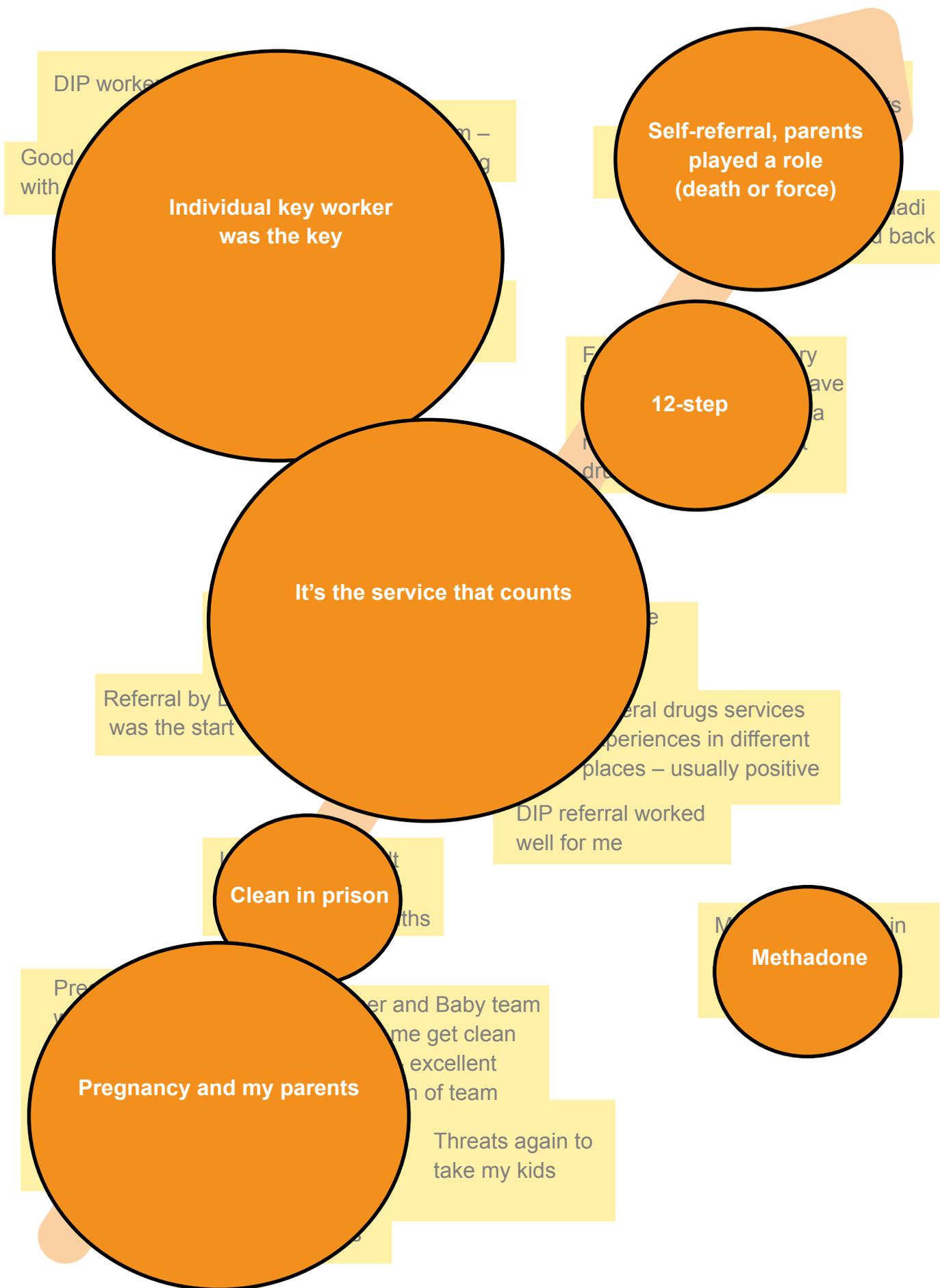
“Look, I just think it’s mad I’ve been sent to prison umpteen times and every time I wanted to dry out while I was there and they wouldn’t let me. They pumped me full of methadone instead of letting me go cold turkey through prison and dry out and come out clean. I can understand them wanting to do that. It’s much easier if you’re drugged up to the eyeballs to deal with. You’ll become sedated for the weeks you’re in. But that’s no good to you when you get out.”

Comment from focus group participant

Figure 3. Drugs – What Helps?



Figure 4. Drugs – What Helps? Themes

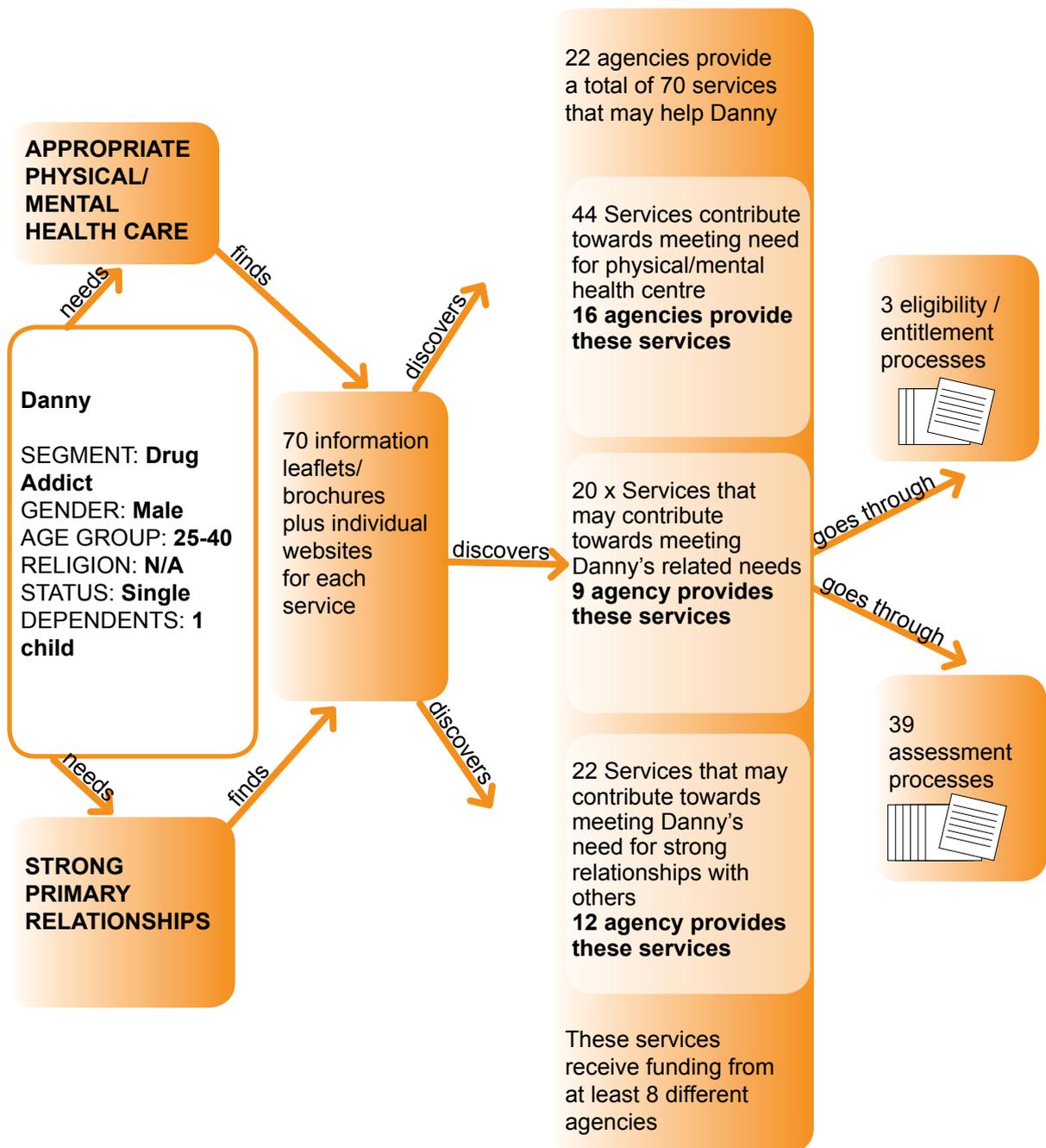


Mapping the customer journey

Having reviewed the data from the partners and the information from the workshops, the project prepared the following customer journey maps. These were reviewed and discussed, alongside the projects recommendations (see below), during a final workshop with key stakeholders.

Service architecture customer journey

This diagram below is a composite summary of the feedback from the focus groups and more in-depth interviewing with one drug addict – “Danny”. This illustrates the steps Danny has to go through in order to discover, commission and receive all the services that may help him and others like him.



Longitudinal customer journey map

The project developed two longitudinal journey maps based on in-depth interviewing with two long-term users of drug and alcohol services. An example is given overleaf.

“We want you to find my pain point and push it...Look, for me it was only when I buried my two parents, both of whom were drugs misusers. And I know I am, but I realised that I was going to follow them if I didn't do something.”

Comment from Focus Group Participant



Reflections

Challenge workshop and improvement report

The project then documented and circulated a report comprising the analysis and customer journey maps to key stakeholders. The project presented the findings and associated recommendations (see below) to the total place Drugs and Alcohol Steering Group in order to build understanding of the current state from the customer's perspective and to develop strong ownership of the need to change the current model.

Findings

Based on the input from users and providers of services, the project drew the following findings:

- There is limited systematic evidence and insight into what treatment, harm reduction or prevention strategies really work and for which types of people.
- There is no shared ongoing visibility across the system of the total population of substance abusers, how many people are receiving support, their referral routes into these services and the cost and impact of substance abuse on other service areas.
- The system is structured and managed based upon stand-alone services and contracts commissioned and managed to spend these individual budgets, rather than being driven by a coordinated programme of tailored pathways and treatment plans that are informed by shared insight, to deliver better outcomes for service users and better value for money.

There is little evidence around what works for whom.

A key finding was that the system relies upon a one-size fits all approach. There is no differentiated approach within the system that allows for the fact that different people may respond to different treatment or support in different ways.

Whereas evidence at a national level suggests that alcoholism as a problem is indiscriminating with regards to the types of people who become addicted, all of the service users who attended the alcohol workshop had very similar backgrounds and upbringing. This may be due to the way the participants were recruited by service providers for the workshops or it may suggest the current range of services only provides appropriate support to a narrow range of people.

In the same vein, attendees of the drugs workshops all had similar experiences and backgrounds to each other – although these were stark contrast to the typical profile of the attendees at the alcohol workshop. The attendees at the drugs workshop were predominantly middle-class, educated and articulate – and relied on ongoing support from family. However, the composition of the workshops was neither ethnically representative given Birmingham's demographics, nor consistent with the depiction of drug abuse outlined by the National Drug Strategy 2008 – which emphasised it as a predominantly working-class problem.

Hence the cohorts within the system appear – on the basis of this research – to be biased.

Furthermore, the attendees at the drug user workshop also expressed frustration with the current choice and flexibility for both harm reduction and treatment. In particular, the view was broadly shared that the current role and approach to methadone did not match what they felt were their needs and did not match the approach they would like to take to managing their recovery.

The drug system is more developed than for alcohol and does offer broader and more widely prescribed alternatives, but there remained a perception that greater choice and control/ownership would be valued. When viewed against the oft-held view that “I have to want to give up for it to work”, then this ownership would seem to be critical. The perception from the workshop is that the lack of choice results in many people electing to not seek or not to stay in treatment due to the fact that it didn’t fit with their views about what they needed or how they approach their recovery.

The research also indicates a potential risk that service providers are seeking in supporting people who are “easy to reach”. For example, many of the alcohol service users had been receiving support over five years (and a few over 10 years).

No shared visibility of performance

The way drugs and alcohol services are managed is unusual for a public service, insofar as there is a single budget and responsibility assigned to Birmingham’s DAAT on behalf of the contributing agencies to address the issue. There was also a shared target through the local area agreement as regards some of the related outcomes (ie National Indicator 40: Number of drug users recorded as being in effective treatment). This provided a robust starting point to make a difference as a service providers in a “place”.

However, it is not clear from the workshops that this shared target actually drives behaviour outside the BDAAT budget and there is an absence of monitoring and reporting that would enable some assessment of progress.

The funding is primarily a health contribution, which drives the focus on treatment, where the total place analysis indicates that the impacts of drug and alcohol abuse are also significantly felt by other agencies.

Based on the interviews with service providers and the workshops, it would seem that the contribution by other agencies to identifying, targeting, supporting and referring problem users would seem to be very low. From a need perspective, it is clear that housing and social care, for example, are responsible for supporting many of the issues that may be influencers in a journey towards substance abuse, yet there seemed to be no evidence of proactive referral from these agencies.

The absence of a clear understanding of what lies behind drug and alcohol misuse therefore severely restricts the drive to improve outcomes and improve performance. Moreover, there is no shared reporting about outcomes, percentage of drinkers in treatment, numbers of people in treatment (and per cent of substance abusers that this represents), or referral routes. Furthermore, there is no shared ongoing assessment of the impact of substance abuse (on domestic violence, employability, housing churn, crime etc) that might allow a better understanding of the impact of the problem and provide the tracking of how well the system is working. This shared insight, with a focus on outcomes (as well as current service consumption and referral processes), could also usefully be broken down geographically to allow ongoing understanding of the size of the problem and where is happening.

On a more positive note, the research identified many strengths of the current system, but it is worthy of note that perhaps one of the greatest strengths is the commitment of the people interviewed who work within the system. This is reflected in one of the key findings reported that almost all of the service users referred to their key contacts and key-workers in glowing terms and place great significance in the role that those individuals are playing and have played in their current or previous recoveries.

Recommendations

Based on the insight generated, the project recommended the following actions, and a number of pilot initiatives.

- To establish outcome tracking and service demand – including a clear reporting process that identifies the numbers of substance abusers (at differing levels – hazardous, harmful and dependent for example), the numbers getting support and the type of support, and, the cost and impact on other service areas. This will help provide the necessary data for analysis and reporting by demography and geography.
- Undertaking a review and tightening of all contracts and the DAAT operation – this was highlighted as a priority (see ‘Local Commissioning to drive efficiencies’ overleaf).
- Drive transformation through a number of pilot projects (see below for an outline of some of the ones considered) – this should be owned and positioned as important for the City and ensure the appropriate engagement from all agencies – this could be seen as an incremental approach towards total place.

The main focus is on developing a shared responsibility between the various service teams and understanding the various financial and social impacts that alcohol and drugs misuse can have – for example being clear on what percentage of crime or domestic violence is driven by substance abuse.

The recommended pilots are as follows and are outlined in more detail over the following pages.

- Creating Social Media Support Networks for alcohol service users
- Life Event Triggered Interventions around Customer Need
- Using advocates to Join Up Services toward Desired Outcomes
- Self Directed Personalised Support for drug service users
- Local Commissioning to Drive Service Efficiencies
- Local Culture Change to Drinking.

Creating social media support networks for alcohol service users

Almost all of the service users interviewed had been in service for in excess of ten years and consumed services from a broad range of providers – leading to a dependency on key workers. Creating social networks to provide dependents with mutual support could reduce the risk of dependency upon these key-workers. A project to pilot this approach has gained further funding from the Customer Led Transformation Programme (see Next Steps).

Life event triggered interventions around need

The insight highlighted the need for agencies such as Housing, Adult Care, Childrens' Services and GPs to increase the number of referrals to Drug and Alcohol Agencies. Tragic life events such as bereavement, family break-down or job-loss seemed to be clearly part of the history of many individuals – particularly within the alcohol service user workshops. Early, pre-emptive referral could help prevent addition emerging.

Intensive Measures for 'Frequent Flyers'

Birmingham's Drug and Alcohol Action Team have launched the Heartlands Hospital project which targets people who are frequently admitted to hospital due to their addiction and are costing the public purse substantial sums.

In response to this problem, the project has deployed a dedicated specialist team in the hospital comprising a social work, a psychiatric nurse and support workers to target these frequent service users with intensive measures including single assessment and access to wrap-around services such as housing.

Using advocates to join up services toward desired outcomes (such as increasing the treatment success rate)

The project found that many key-workers already work to join-up services, but through increased training, legitimising the approach and creating referral processes, the approach could be imbedded more clearly into the role of the key-worker.

Self directed support

The drug service users who attended the workshop seemed to be very financially aware and astute. They recognise that the system is very money-centric and are extremely aware of the range of services available and have firm views on what might work for them. The project proposes a pilot that targets substance users who have been through previous failed cycles of detox – the focus of all services users interviewed was about the detox process. They should be provided with a "budget" for procuring services comprising units of support. They should then be helped to define their own treatment programme over say an 18 month period and look to define at which stage they would like the detox.

Local commissioning to drive efficiencies

Alongside the anonymous nature of the service, this structure results in many service users commissioning multiple services. Meanwhile, most of the service users were engaged with a number of providers. This drives up the cost of the system. The approach to needs assessment and commissioning does not set out that service users are limited to only consuming one service, but the evidence would seem to suggest that the budget is consumed by a low percentage of all dependents and harmful drinkers. Commissioning of services featured as a theme in findings from across Birmingham's total place programme, and remains as a priority at corporate and local strategic partnership level.

Local culture change to drinking

The pilot should provide awareness of the effects of alcohol and awareness of the support that is available. Cultural acceptance and the extent to which it is engrained into society and also its association with success and celebration has a key influence over the level of alcoholism in society.

Moving towards a future performance dashboard

Although not included as a pilot, the project recommends moving towards a system that is owned by all stakeholders will demand better ongoing sharing of performance information. This reporting should identify the total estimated numbers of substance abusers across the city, the numbers receiving treatment, the impact and cost of substance abuse on issues such as health, domestic violence, crime and other social disruption that drives cost in other budgets. This ongoing view will help drive shared ownership of the issue.

Resourcing the project

The project was lead by Birmingham City Council's Head of Customer Knowledge, supported by an in-house business analyst. The socio-demographic data was procured from CACI, with CACI and Consulting firm Aperia undertaking the collection and analysis of the quantitative and qualitative data.

Challenges and lessons learnt

The key challenges the project encountered are functions of the scale of Birmingham, and the timescales of the total place programme.

Accessing the data needed to populate the indices of demand and cost required substantial effort. The scale of Birmingham City Council and the range of agencies

People Cost

	CACI		Aperia		Insight Republic	
	Senior Consultant	Analyst	Senior Consultant	Analyst	Senior Consultant	
Set up project Management	5.5	0	3	0	1.5	
Profiling and Engagement	1.5	8.5	3	3	0	
Circle of Need and Customer Journey Mapping	1	2	8.5	5	0	
Challenge and Report	1	0	2	2	1	
Total	9	10.5	16.5	10	2.5	48.5

£42,186

Date Licenses (Annual)

Alcohol spend estimates
Health Acom
BCS Information on Drugs by Acom type

£2,250
£7,500
£1,500
£11,250

£53,436

that operate in the area meant that it was often difficult to readily identify the appropriate people to approach. This scale also contributes to a lack of familiarity and trust between managers that impeded data sharing.

Another challenge was that services collect data for the own operational reasons, and this can result in being disjointed and difficult to combine.

The timescales also proved challenging, as they did not permit the project to review case files of service users, or to conduct ethnographic research with users which would have enhanced their understanding of the customer's perspective. Despite this, one of the lessons that the project highlights is the value of combining insight from profiling, segmentation and customer journey mapping.

The project also recognises that their work succeeded in engaging those people from the drug and alcohol user groups that were the most "easy-to-reach". Gaining the perspective of "harder-to-reach" users – such as those that have disengaged from public services, would produce valuable insight but require additional investment in terms of time and effort.

Benefits

"The insight work – both looking at the data but also looking at the end-customers and talking to them, has really brought the customer into the room for us."

Jason Lowther, Director of Policy Delivery, Birmingham City Council

The Customer led transformation work highlighted the need for improved data

collection, a reduction in the number of assessments, less complicated care pathways and a need to look at the life situation of the individual.

As a result, work has begun to improve intelligence and now BDAAT has access to all anonymised patient data, which will lead to greater planning at a local and pan Birmingham level. The data is being used as an integral part of establishing its annual needs assessment and redesign programme. It is also now used to help local delivery groups understand the impact of drugs and alcohol within their own area to help draw up action plans in tackling crime in their area.

The assessment and eligibility process is also under review in order to establish a single Birmingham wide assessment form for both drugs and alcohol. The form has a greater focus on recovery and the family, ensuring issues such as employment and safeguarding are dealt with at an early stage. The form follows the client throughout their treatment journey, being updated accordingly, reducing the need for multiple assessments.

The customer journey project has also stimulated the further development of systems to target individuals who are at risk of developing alcohol and drug problems at an early stage, so to avoid problems becoming more serious and entrenched, as well as costly to address in terms of public service responses. Strategies have been developed to ensure that the necessary range of services are made available to individuals with substance misuse problems which complement direct treatment, these include access to employment agencies, housing support, mental health services and others.

Information sharing has improved and continues to develop to better facilitate cross agency working.

A key finding of the research was the apparent chaotic lifestyle of those with alcohol problems. This could mean that there were issues across a wide range of areas that might touch on a number of public services eg benefits, housing, police as well as health. This often results in numerous costly appearances within hospital settings, the criminal justice system as well as other social costs. It was recognised that the more cost effective way to work was in a joined up more holistic manner looking at the life situation of the individual and attempting to address the chaos in the round rather than piece meal.

The Birmingham DAAT in association with its partners has as a result established a one year ‘test and learn’ programme aimed at working with this group of problem drinkers. This is a service that will address the individual and attempt to meet the need regardless of where or to which authorities that need may fall. A £200,000 budget was secured from the Local Strategic Partnership to run this programme. It is a small dedicated team that has a life expectancy of 12 months with the overall aim of informing what is commissioned in the future very much with a view of cost reduction, prevention and improved efficiency. The service evaluates the profile of the individual better, determines what engages them and then looks at the full range of services required bringing them together. The project will be evaluated at the end of the 12 months and has some specific measurable outcomes associated with cost reduction due to, for example, reduction in hospital presentations, reductions in offending rates, reductions in the breakdown of tenancies and increased opportunities to realise employment and training positions.

Next steps

Birmingham’s Drug and Alcohol Action Team are implementing the Heartland Hospital project which combines a range of practitioners to apply a package of intense measures to address the needs of “frequent flyers” – people who are frequently admitted to hospital due to their addiction.

Since the conclusion of the Customer Insight project Birmingham City Council has conducted an exercise using the same blueprint – comprising data assembly and mapping customer journeys developed on this project – to generate insight into the causes and consequences of worklessness across the city. This was one of the wider objectives of the Customer Led Transformation programme – that funded projects should transfer the learning both to other areas within their own organisation and more widely across the sector.

Birmingham City Council has also successfully bid for additional funding to trial a social media approach to helping alcohol misusers. The aims of this project are to help alcohol misusers live healthy lives with less reliance upon expensive service provider support. The initiative sets out to explore the opportunities to use social media to enable those citizens who are willing and able to use this approach to better self serve and therefore get support as and when they need it, as well as provide support for their peers. The objective from the initial project is to provide evidence that there is a sufficient “market” of alcohol misusers to justify the main effectiveness stage.

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