Health and Wellbeing Board
Meeting Date
Shropshire Alcohol Strategy 2016 -2019 update and next steps.

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1. Summary

1.1 This report provides the Health and Well-being Board with an update of progress on the implementation of Shropshire Alcohol Strategy 2016-2019 and next steps.

1.2 The implementation and delivery of the Shropshire Alcohol Strategy 2016-2019 has been overseen by the Alcohol Strategy Group (ASG) formed by key stakeholders. Meetings have been held quarterly with the main purpose of reviewing the action plan and refining as necessary. The ASG is accountable to Shropshire Community Safety Partnership.

1.3 Progress in a number of areas has been achieved to support structural change to the management of alcohol related harm within communities. This has included the revision and publication of the Licensing Policy Statement providing a blueprint for the day and night-time economy; revision of the joint working protocol between children and family services and substance misuse services and the development of an evidence based school programme and policy on managing drug and alcohol related incidents.

1.4 Since 2016 there have been a number of national initiatives to promote improved management of alcohol related harm. Shropshire was one of 42 areas that supported the Local Alcohol Action Area initiative supporting improved data sharing between police, the hospital and local authority. In 2017, Shropshire Community Health Trust adopted the national CQUiN for the *Prevention of ill Health* through the delivery of identification and brief intervention to reduce alcohol related harms.

1.5 Nationally, alcohol consumption remains a key risk factor for ill-health and premature deaths. In Shropshire alcohol related hospital admissions for people aged 65 and over is above the national average for both men and women using the narrow measure (where admission was wholly attributable to alcohol). Fewer adults in Shropshire abstain from drinking alcohol than other areas within England and alcohol related road traffic accidents remain above the England average (Appendix A).

1.6 Following a review of this strategy it was agreed by the Shropshire Community Safety Partnership that the synergies between interventions to reduce alcohol related harm and drug misuse warranted a joint approach. A Shropshire Drug and Alcohol Strategy is currently been developed and is due to be published in April 2020. It is proposed the HWBB receive regular reports on the progress of this strategy which will support a range of activities to reduce drug and alcohol related harm across the County.

1.7 An interim alcohol strategy plan has been agreed by the Shropshire Community Safety Partnership to support continued delivery of the Alcohol Strategy for 2019 -2020.

2. Recommendations

It is recommended the Health and Wellbeing Board (HWBB):

a) Note the progress to date.

b) Agree to receive the consultation document in the autumn and provide feedback through the consultation process.

c) Support implementation on the future drug and alcohol strategy 2020 by ensuring activities to reduce alcohol related harm are implemented within the organisations they represent through both policy and procedure.

d) Agree to receive regular reports on the progress of the future drug and alcohol strategy once it has been agreed by the Shropshire Community Safety Partnership..

REPORT

3. Risk Assessment and Opportunities Appraisal

3.1 A key risk to delivery of the strategy is the financial implications and continued reductions in the Public Health grant and the financial constraints of key partners to support delivery. Whilst the public health grant only supports part delivery of the strategy, it is key in the delivery of specialist drug and alcohol services and supporting local work on public protection. Going forward the continued funding of public health generally and activity for drug and alcohol services is not clear.

3.2 The budget to support the delivery of specialist alcohol and drug services was substantially reduced in 2019/2020 as part of the Council's saving plan and further reductions will compromise delivery and level of reach the service will have.

3.3 A further risk is the implementation of the interim plan and the capacity to deliver on the key areas without full stakeholder involvement.

3.4 There are no Human Rights, or environmental consequences contravened through the implementation of this strategy. Its overall aim is to improve the health and well-being of people by introducing measures to reduce alcohol related harm at both a community and individual level.

3.5 Alcohol can cause problems across the social scale however, health harms from alcohol are more pronounced in communities that suffer higher levels of deprivation despite the fact they usually have lower levels of consumption (based on affordability). This phenomenon is known as the alcohol paradox, recent studies have found poor nutrition and higher rates of smoking may amplify the risks of alcohol related harm within deprived communities. The impact of the alcohol paradox and other associated health harms in more deprived communities is considered within its implementation and targeting of resources within key communities

3.6 Delivery of the strategy is dependent on the buy-in from partners to support the objectives and direct activity to achieve outcomes. It is important to have identified leads within key stakeholder organisations to achieve this and utilise opportunities to reduce alcohol related harm through the day to day business of organisations.

3.7 The STP plan provides the opportunity to increase prevention of alcohol related harm across the system.

4. Financial Implications

4.1 The level of Public Health ring fenced grant allocated to support delivery of specialist treatment interventions has been substantially reduced in 2019/2020. The new contract will deliver the service utilising through efficiencies and new ways of working.

4.2 There is still the expectation the new contract will deliver on the key public health outcomes for improving sustained recovery from drug and alcohol misuse and reducing the spread of blood borne viruses through the delivery of harm reduction services.

5. Background

5.1 Alcohol is the third most significant risk factor for ill health and premature death after smoking and obesity[1]. In England, for people aged 15-49 years old, alcohol is now the leading risk factor for ill health, early mortality and disability, and the fifth leading risk factor for ill-health across all age groups[2].

5.2 In 2016 the Shropshire Alcohol Strategy was published. Ambitious in its vision, the aim of this strategy was to galvanise key stakeholders to adopt approaches within their working environment that would support harm reduction and promote sensible drinking to achieve the key outcomes:

- Promote Safer Communities.
- Improve Health and Well-being
- Protect Children and Young People
- Create Capacity

5.5 It was agreed the Health and Wellbeing Board would receive regular updates on the implementation of the Shropshire Alcohol Strategy 2016 -2019 across its life course.

5.6 Progress has been made in most of the outcome areas, and below is a summary of activities undertaken to support delivery.

Promote Safer Communities

- Publication of the Statement of Licensing Policy for Shropshire Council 2019 -2024, setting out the expectations of the Council's on applicants and licence holders to promote the four licensing objectives.
- Continued delivery and development of Alcohol Treatment Requirements (ATR) as part of a community sentencing plan to reduce alcohol related crime and disorder.
- Development of an integrated community management approach was not achieved. Although a successful pilot was undertaken in Shifnal it was resource intensive and partners felt it could be adequately managed through the usual mainstream pathways.
- Improved screening and management of victims of domestic abuse within drug and alcohol treatment services following review and implementation of NICE guidance PH50
- Improved management of perpetrators of domestic abuse through a pilot perpetrator programme.

Improve Health and Well-being

- Roll out of Identification & Brief Advice (IBA) in Community Hospitals, Mental Health residential units, Shrewsbury and Telford Hospitals (achieved through the national CQUIN programme *Prevention of ill Health*).
- 72 Shropshire Community Health staff trained in IBA.
- A twelve month IBA pilot is currently underway with Job Centre Plus as part of this initiative to support identification to improve job readiness and remove barriers to work for people with alcohol problems. All staff at the Shrewsbury Job Centre have been trained to provide brief advice and people are being followed up at 3 months to review impact of intervention.

For those identified at drinking at higher risk levels they are referred to treatment through a local booking process. The pilot will be evaluated in the summer.

- Supporting people with co-occurring mental health and substance misuse through a no-wrong door approach is progressing through the eider work on the NHS Five Year Forward View.
- A dedicated outreach worker has been appointed to support homeless populations as part of the new commissioned specialist drug and alcohol service.
- Promotion of national campaigns, including alcohol awareness week and Dry January through a range of social mediums.

Protect Children and Young People

- Development and delivery of the Shropshire Respect Yourself Relationship and Sex Education Programme. The programme also won a prestigious national award 'Children and Young People Now Award 2017.
- Strengthening pathways to specialist substance misuse services, following NICE guidance for young people who present to A&E.
- Review and implementation of the Joint Working Protocol between Children and Family Services and Substance Misuse services, to improve identification and support for families affected by drug and alcohol misuse.
- Development and dissemination of the *Schools Drug and Alcohol Policy* providing guidance for schools on managing incidents using the evidence base.
- The expansion of brief interventions into children's services following NICE guidance PH24 was not achieved.
- Strengthening commissioning arrangements between children's services, mental health and domestic abuse was not achieved.

Create Capacity

- Development of the Public Health Licensing Tool to support decision making.
- Improved recording of data within A&E setting to support crime and disorder locations as part of the Local Alcohol Action Area programme 2 initiative.
- In total 501 staff trained (includes 72 from Shropshire Community Health Trust) in IBA, working with parents who misuse substances; autism and the use of substances and alcohol; safeguarding and substance misuse; alcohol in the community and an introduction to substance misuse.

Challenges to delivery

5.2 The HWBB should note a fundamental element of this strategy was the commitment and adoption to the principles of the strategy within organisations. At times it has been difficult to engage key stakeholders in its implementation due to conflicting priorities and capacity of the teams involved slowing progress.

Measuring Impact

5.3 Measuring impact is difficult to assess within a short time frame, due to the nature of the problem. Measures to reduce health related harm using IBA methods will not be visible within a three year strategy due to the fact symptoms of health related harm are slow in presentation. Liver disease can take up to 20 years of regular higher risk drinking levels to become symptomatic, as can the identification of cancers where alcohol is a contributing factor. Preventative measures with young people will not be realised until well into adulthood, although there is some national indication fewer young people are drinking than they did ten years ago[4].

5.4 Alongside measures at an individual level there does need to be other measures to reduce availability and therefore consumption. The new licensing statement published by the local

authority is part of the environmental approach to shaping both the night-time and day-time drinking economy and the availability of alcohol within the county.

5.5 All of the preventative measures undertaken have been underpinned by the evidence based providing some assurance that activity undertaken now will help to slow the rate of alcohol related harm in the future.

Next Steps

5.6 The Shropshire Community Safety Partnership have agreed that in the future strategies to reduce drug and alcohol related harm should be delivered through a joint strategy due to the synergy that exists between the two agendas.

5.7 A new drug and alcohol strategy is due to be published in April 2020, this coincides with the completion of the Crime and Disorder Reduction Strategy for Shropshire 2017-2020.

5.8 In the interim it has been agreed by the Shropshire Community Safety Partnership the following activities will be undertaken:

- Continue the roll out of IBA
- Develop a Responsible Authorities Group
- Undertake a review of Alcohol Treatment Rehabilitation requirements
- Explore responses to children affected by parental alcohol misuse
- Develop a systematic response to those identified as Treatment Resistant' using blue light methodology.

6 Additional Information

6.1 There is a close relationship between levels of alcohol consumption and the prevalence of alcohol related harm and dependence. Since 1980 sales of alcohol has risen by 43%, peaking in 2008, the increase in sales is driven by affordability, increased consumption by women and a shift in drinking location, the majority of alcohol is purchased from shops to be drunk at home. Research has suggested more recently there is a decline in alcohol consumption and an increase in levels of abstinence, although it is unclear whether much of the decline is due to people drinking less or more people choosing not to drink.

6.2 Alcohol related mortality has increased by 400% since the 1970s. The average age of those dying from a specific cause is 54.3 years compared to the average age of death from all causes is 77.6 years[2].

6.3 It is estimated that 68.6% of dependent drinkers in Shropshire are not in treatment, this is an estimated 1,977 individuals (Appendix A).

6.4 The rate of admission episodes for alcohol-related conditions among females aged 40 – 64 years in 2016/17 rose above the England average (Appendix A).

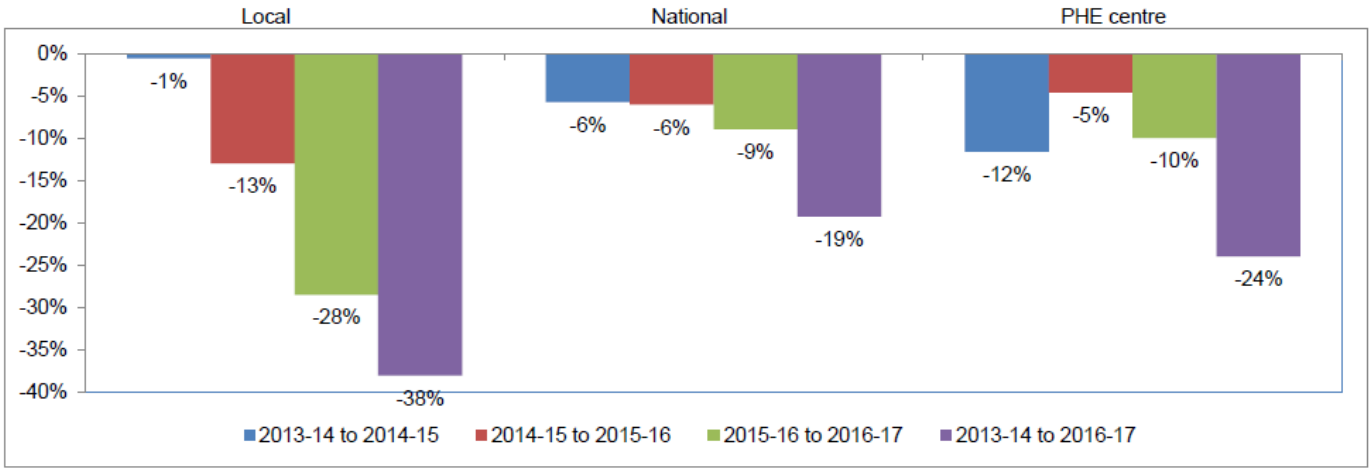
6.5 In Shropshire there is a higher proportion of people aged 65 and over admitted to hospital for alcohol related conditions than the England average, this rate has been increasing since 2014/2015[3].

6.6 Alcohol can cause problems across the social scale however, health harms from alcohol are more pronounced in communities that suffer higher levels of deprivation despite the fact they usually have lower consumption (based on affordability). This phenomenon is known as the alcohol paradox, recent studies have found poor nutrition and higher rates of smoking may amplify the risks of alcohol related harm within deprived communities.

6.7 For the period from 2011 to 2014, 8.6% of Shropshire's respondents to Health Survey for England aged 18 years and older said they were abstainers. This is significantly less than the percentage for the West Midlands (16.6%) and for England (15.5%). Shropshire is the third worst area in the West Midlands region for this measure (Appendix A).

6.8 Data from the National Cancer Registration and Analysis Service for 2014 -2016 found that women suffer the highest amount of harm for alcohol related cancers, both nationally and within the county. For men in Shropshire, the data shows rates of alcohol related cancer in the county is at higher harm levels than rate for men nationally.

6.9 Since the strategy was published there has been a decrease in the number of people presenting to alcohol services for treatment. This is a national issue and as Shropshire was one of 8 areas that had experienced a significant drop, a deep dive was undertaken by PHE to understand what was happening. The overall findings by PHE could not find one conclusive reason, but the integration of drug and alcohol services, reduction in alcohol only workers and reduced funding was all cited as possible causes. In Shropshire, the removal of the alcohol clinics from key GP practices was identified as a possible contributing factor to the 28% reduction in presentations for the period 2015 -2017 as this coincided with the providers decision to remove the clinics.



7 Conclusions

7.1 The Shropshire Alcohol Strategy 2016-2019 has started to lay the foundations to tackling alcohol related harm through a range of activities, including the development of PHSE programmes, the blueprint for future licensing through the latest Statement of Licensing Policy and the roll-out of IBA within key areas of the system. Fundamental to reducing alcohol related harm is the delivery of evidence based interventions throughout the system and acknowledgment of its role in causing a range of societal and individual harm when developing new policies and interventions.

7.2 Though work at the local level supports reducing alcohol related harm, the health and social care gains will not be achieved through local action alone. A new national alcohol strategy is anticipated within the next few months which will provide the direction of travel over the coming years in the national response to reducing alcohol related harm.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)

1. (2019) Public Health England: Health Matters https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence

2. (2016) the public health burden of alcohol and the effectiveness and cost effectiveness of Alcohol Control Policies: An evidence review: Public Health England.

3. (2019) Local Alcohol Profiles for England

4.(2018) Investigating the growing trend of non-drinking among young people: repeated analysis of cross sectional surveys BMC Public Health

Cabinet Member (Portfolio Holder)

Cllr Dean Caroll
Cllr Rob Gittens (Deputy Portfolio Holder – Public Health)

Local Member

Appendices

Needs Assessment for Substance Misus

Appendix A. Needs Assessment for Substance Misuse