

Warrington

Joint Strategic Needs Assessment (JSNA)

Alcohol 2014/15

March 2015

Version control

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3.0	Amendments from proof reading actioned	19/01/2015
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The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities

EXECUTIVE SUMMARY

Scope of the Chapter

This chapter provides an update to the 2011 core refresh, it considers alcohol consumption and identifies 'at risk' groups at both national and local levels. At a local level, the chapter includes data about levels of alcohol consumption, such as alcohol-related crime, young people and alcohol, hidden harm, mortality from alcohol-related conditions and hospital admissions due to alcohol-related and alcohol-specific conditions. The data has been analysed by a number of geographical areas and population groups. The chapter identifies current service provision for people from Warrington, provides evidence of best practice and predicts future trends in alcohol specific hospital admissions.

Further information on young people and alcohol can be found in the Children and Young People Substance Misuse chapter.

Introduction

The impact of alcohol misuse is widespread, encompassing alcohol-related illness and injuries as well as significant social impacts including crime and violence, teenage pregnancy, loss of workplace productivity, and homelessness. Levels of alcohol consumption in Warrington have risen sharply. Warrington Health, Lifestyle and Wellbeing Survey 2013 reported that 21.0% of Warrington respondents indicated that they drank more units per week than is considered safe. This represented an increase on the 2006 figure of 19.6%. Women demonstrated an even greater increase from 13.8% in 2006 to 17.4% in 2013. Variation in alcohol consumption within Warrington does not follow the traditional deprivation pattern, with people living in deprivation quintile 4 and deprivation quintile 1 (20% most deprived areas) reporting lowest levels and deprivation quintile 5 (20% least deprived areas) highest. However, when looking at alcohol-related harm by analysing alcohol-related admissions there is a strong correlation with deprivation.

Key Issues and Gaps

- Co-ordination and delivery of alcohol harm reduction work addressing the needs of young people, particularly in schools and other youth settings.
- Lack of robust data of the prevalence of hidden harm for those people not engaged in adult alcohol treatment provision.
- Need to concentrate on addressing high levels of alcohol related hospital admissions – both for adults and under 18's from quintile 1.
- The development and delivery of campaigns and interventions that challenge the drinking cultures and relationships that exist with alcohol, targeted specifically at communities of Warrington such as young people, older people, those identified in the public health lifestyle survey, the eastern European community etc. to encourage low-risk alcohol consumption.

Recommendations for Commissioning

- To develop clarity and co-ordination for the delivery of alcohol harm reduction work to address the needs of young people.

- To establish data sharing protocols to allow data to inform neighbourhood and licensing health action plans.
- To biannually review the impact of the Brief Intervention Training currently being delivered in Warrington to understand impact of training and its long term effectiveness on residents.
- To continue to address the high levels of alcohol admission wholly attributable to alcohol (AAF¹) from quintile 1.
- To regularly review the function and relevance of the delivery plans of operational groups in the light of the Joint Strategic Needs Assessment (JSNA) and the annual Community Safety Partnerships (CSPs) needs assessment.
- To ensure that the neighbourhood action plans are informed by the JSNA and CSP needs assessment.
- To review the performance of the current strategy in its broadest sense.
- To implement the review of the Tier 4 service within a new preferred provider list to be in place for November 2014.
- To launch and embed the one year focussed piece of work around complex alcohol cases, which will be looking at those more chaotic alcohol users and ensure that their treatment pathways are robust and impact on services appropriate.
- To review the hospital in reach and outreach services to ensure appropriate referrals pathways are in place for those leaving hospital with an alcohol related illness.

¹ *Alcohol Attributable Fractions (AAF) or conditions that are related to alcohol were created as it was believed that the previous method of monitoring hospital admissions relating to alcohol-specific conditions did not capture the magnitude of the problem of alcohol. The methodology for the AAF definition of alcohol-related harm was based on international evidence and takes into consideration a range of diseases that are wholly and partially related to alcohol. Partially related to alcohol conditions include hypertension, epilepsy and accidents.*

1) WHO IS AT RISK AND WHY?

Despite the fact that the harms of long-term alcohol abuse are increasingly known, alcohol misuse remains a serious and growing public health issue in the UK. Whilst the latest evidence suggests that the overall trend in drinking is beginning to reduce, over the last 20 years alcohol consumption in the UK has increased and we now have a culture in which alcohol is used as never before. National data tells us that:

Men are more likely to drink more heavily than women. 38% of men and 16% of women consume more alcohol than is recommended (for men 3-4 units per day, women 2-3 units per day) (Department of Health, University of London 2005). Higher risk drinkers are at significantly greater risk of developing alcohol-related health harms.

Those from higher income households are more likely to drink at higher levels than those in lower income households. However, the most deprived 20% of the UK population suffer two or three times greater loss of life attributable to alcohol and two to five times more alcohol-related hospital admissions than wealthier areas. This pattern is reflected in Warrington.

Men and women from minority ethnic groups, are less likely to drink alcohol than the general population and are more likely to drink in smaller quantities. Results from a few studies in the UK suggest that there are higher levels of alcohol misuse among gay, lesbian and bisexual members of the population (BMA, 2008).

Those with mental health problems are at an increased risk of alcohol misuse, with some cases of depression, anxiety, schizophrenia and suicide being associated with alcohol dependence (BMA, 2008). Alcohol-related health problems are uncommon in people with learning disabilities (BMA, 2008). Alcohol is most commonly associated with the following forms of violence: domestic violence, sexual assault, common assault, and assault with injury.

Table 1 illustrates the increased risk of health conditions in people defined as harmful drinkers.

Table 1: Increased Risks of Ill Health to Harmful Drinkers (Anderson, 2007)

Condition	Men	Women
Hypertension	4 times	Double
Stroke	Double	4 times
Coronary heart disease	1.7 times	1.3 times
Pancreatitis	Triple	Double
Liver disease	13 times	13 times
Cancers of mouth, neck & throat	4-5.5 times	4-5.5 times
Breast cancer	-	1.5 times

2) THE LEVEL OF NEED IN THE LOCAL POPULATION

2.1) Alcohol Consumption: It is estimated that 23.8% of the Warrington population, aged 16 years and above, have reported that they binge drink². The percentage for Warrington is higher than the North West (but not significantly) and significantly higher than England. The estimated percentage of increasing risk drinkers is higher in Warrington (20.7%), but not significantly higher than the North West (19.9%) or England (20.0%). Warrington has a lower estimated percentage of higher risk drinkers (6.2%) when compared to the North West (6.6%) and England (6.8%), but the percentage for Warrington is not significantly lower (Local Alcohol Profiles for England, 2012).

A comprehensive, large scale survey of adults in Warrington was undertaken early in 2013 to update the information held from previous local lifestyle surveys that were done in 2001 and 2006. The survey collected information on a wide range of factors that impact on an individual's health and wellbeing.

Survey respondents were asked questions regarding their drinking habits. From these responses, it is possible to determine unsafe drinking levels. Latest Department of Health guidance states that in order to protect health, men should not regularly exceed 3-4 units per day, and women should not regularly exceed 2-3 units per day. At population level, and in order to derive comparative figures, the risk categories are defined based on average weekly consumption: for men 21 units or less per week is deemed 'low risk', 22 to 49 units 'medium', and more than 50 units per week is 'high' risk. For women the equivalent figures are: 14 units or less 'low risk', 15 to 35 units 'medium' and more than 35 units per week 'high' risk.

The prevalence of any alcohol consumption amongst adults is high, with men drinking more than women. 90% of male respondents and 83% of females reported that they drink alcohol at least occasionally. Directly comparable national figures are not available, the Health Survey for England results indicate that across England as a whole 87% of males and 81% females drink, but these figures are based on a 16+ population.

In terms of levels of unsafe alcohol consumption; overall, of those who drink, 21% of respondents indicated that they drink more units per week than considered safe. This represents an increase on the 2006 figure of 19.6%.

In all age-bands, and across all deprivation quintiles, a greater proportion of men than women drink to unsafe levels; (24.5% of men overall in Warrington, compared with 17.4% of women). However, the proportion of women drinking unsafely has increased considerably from the 13.8% figure reported in 2006. Highest rates of unsafe levels of alcohol consumption for both sexes are amongst the 40-64 age band (28.0% men; 21.2% women). Amongst older drinkers (aged 65+) substantially more men than women drink to unsafe levels (22.9% compared with 11.8% amongst women).

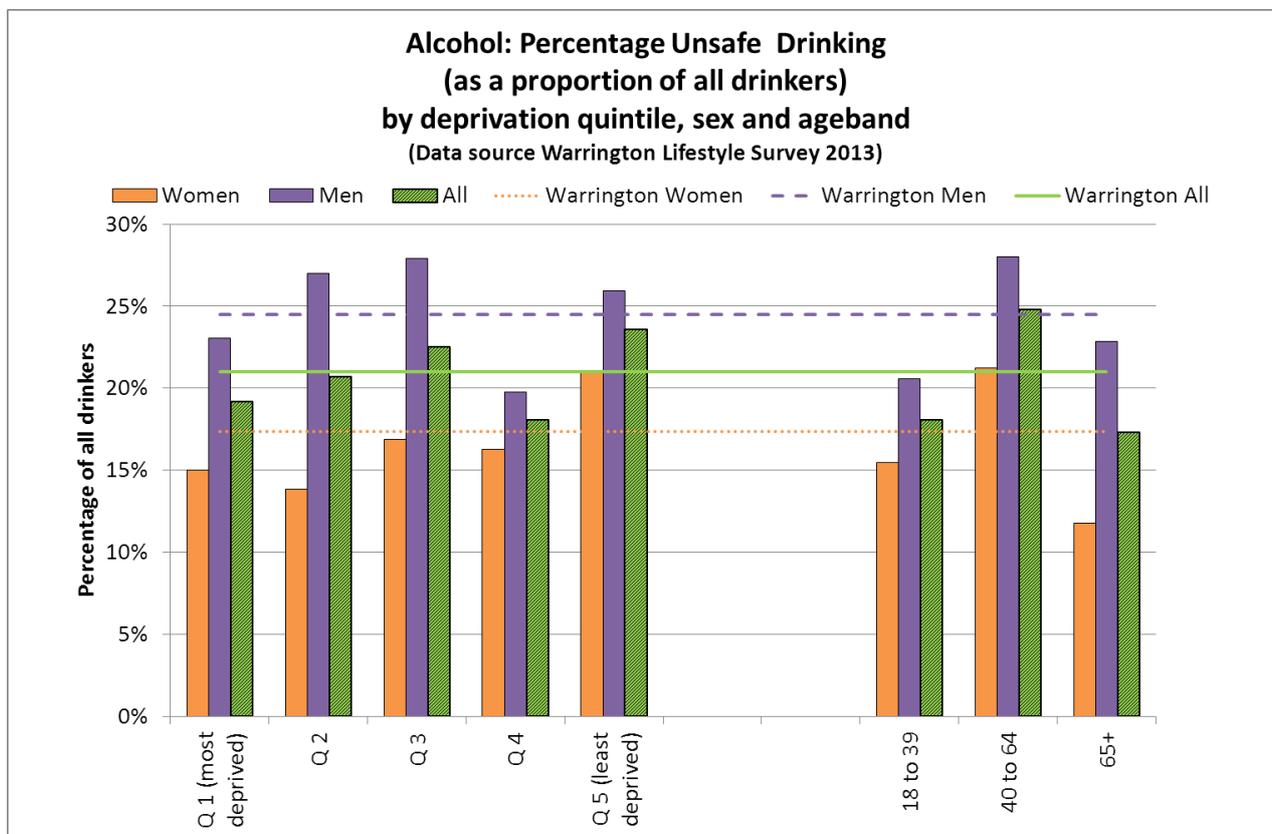
Whilst there is variation within Warrington, it does not follow the traditional deprivation pattern. For men there is no real association between deprivation and high levels of unsafe consumption. Amongst women, there is an inverse association; rates increase as deprivation decreases; the

² *Definitions of drinking:*

- *Binge Drinker- Where a person consumes at least twice the daily recommended amount of alcohol (8 units for men and 6 units for women) in a single drinking session.*
- *Increasing Risk- Where the consumption of alcohol is between 22 and 50 units per week for males and 15 to 35 units per week for females.*
- *High Risk- Where the consumption of alcohol is above 50 units per week for males and above 35 units per week for females.*

highest rate is amongst women from the least deprived quintile (21%), compared to 15% in the most deprived. This is illustrated in chart 1.

Chart 1: Prevalence of Unsafe Levels of Alcohol Consumption



2.2) Admissions to Hospital Due to Alcohol: Hospital admissions due to alcohol are monitored using three different methods which were introduced during 2014 based on the results of a consultation led by Public Health England (PHE). The first method is alcohol specific conditions; these include causes of admission that are wholly related to alcohol or are alcohol-specific, for example, alcohol liver disease and toxic effects of alcohol. The list of conditions that are described as being alcohol-specific altered slightly in 2014. The alterations were made based on new evidence and research that has been conducted since the original list of alcohol specific conditions was released in 2008.

The second and third method of monitoring hospital admissions is the use of Alcohol Attributable Fractions (AAF) or conditions that are related to alcohol. AAF was created (in 2008) as it was believed that the previous method of monitoring hospital admissions relating to alcohol-specific conditions did not capture the magnitude of the problem of alcohol. The methodology for the AAF definition of alcohol-related harm was based on international evidence and takes into consideration a range of diseases that are wholly or partially related to alcohol. Conditions partially related to alcohol include hypertension, epilepsy and accidents.

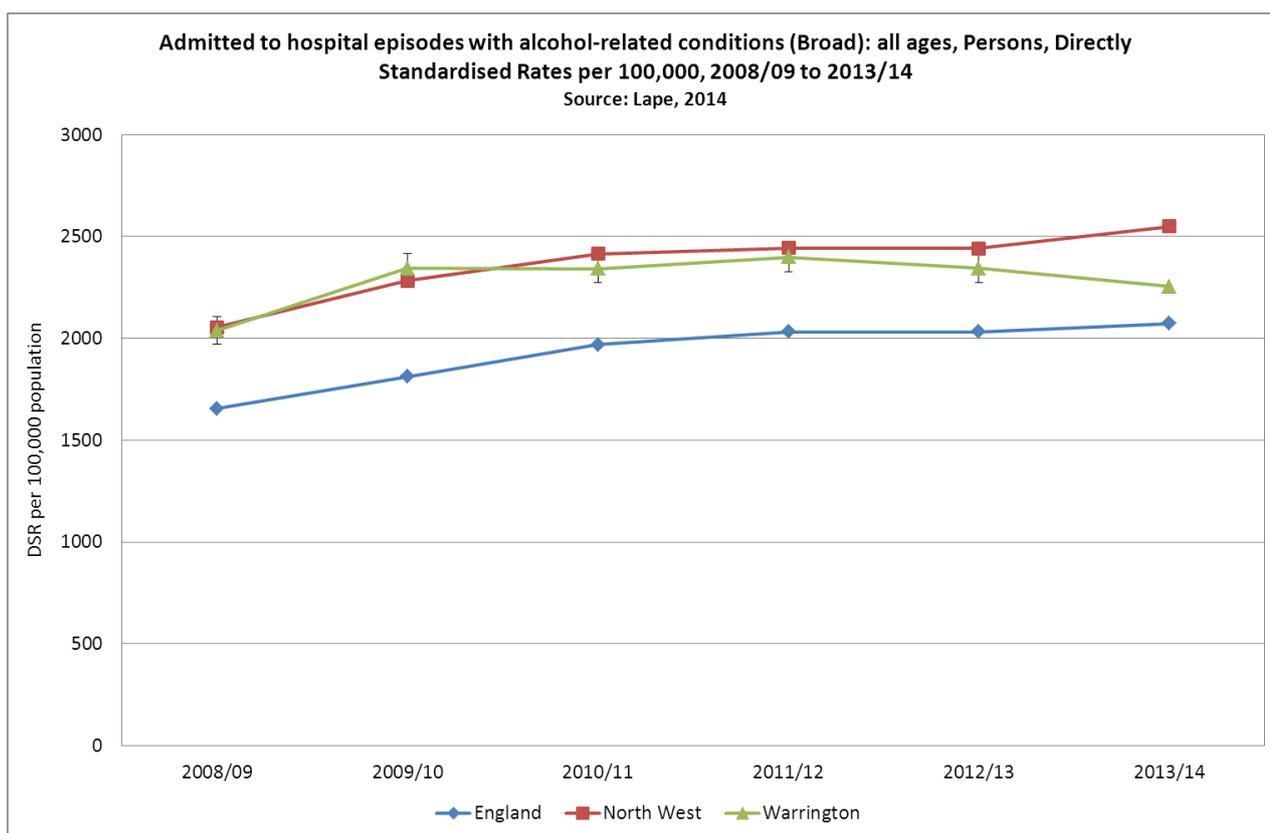
However, limitations to this methodology have been highlighted in recent years, namely improvements in hospital coding of secondary causes of hospital admissions which have inflated AAF admission rates. This has meant that it is not appropriate to look at trends in the rate of admission as rates from earlier time periods are not directly comparable to recent data. Also, comparing admission rates between areas may not be advisable as different providers may be better at recording and diagnosing the full range of secondary conditions relating to alcohol.

Findings from the PHE consultation resulted in two methods to monitor AAF admissions, broad and narrow alcohol related admissions.

The broad alcohol related admissions are very similar to the previous AAF methodology, with the exception of two differences. Firstly, the AAFs have been altered based on current alcohol research. Previously AAFs were calculated for 52 conditions; 20 were wholly attributable to alcohol whilst 32 were partially attributable to alcohol. The new broad alcohol related admissions now include five new wholly attributable conditions and three new partially attributable chronic conditions. The second difference is in relation to how the admission rate was calculated, the new broad alcohol related admissions have been calculated using an up to date (2013) European Standardised Population (ESP) whilst any pre 2014 rates will have been calculated using the 1976 ESP. Therefore, any AAF analysis that has been produced before 2014 should not be compared to the broad alcohol related admissions.

However, the limitations stated above with regards to the AAF methodology also apply to the broad alcohol related admissions method; the narrow alcohol related admissions methodology was developed to address this. The narrow alcohol related admissions is a new measure that allows for accurate trend analysis as it is not affected by any changes over time in coding.

Chart 2: Rate of Hospital Admissions for broad Alcohol-Related Harm per 100,000 Population, 2008/09 to 2013/14



(Source: LAPE, 2014 (Local Alcohol Profiles produced by Public Health England))

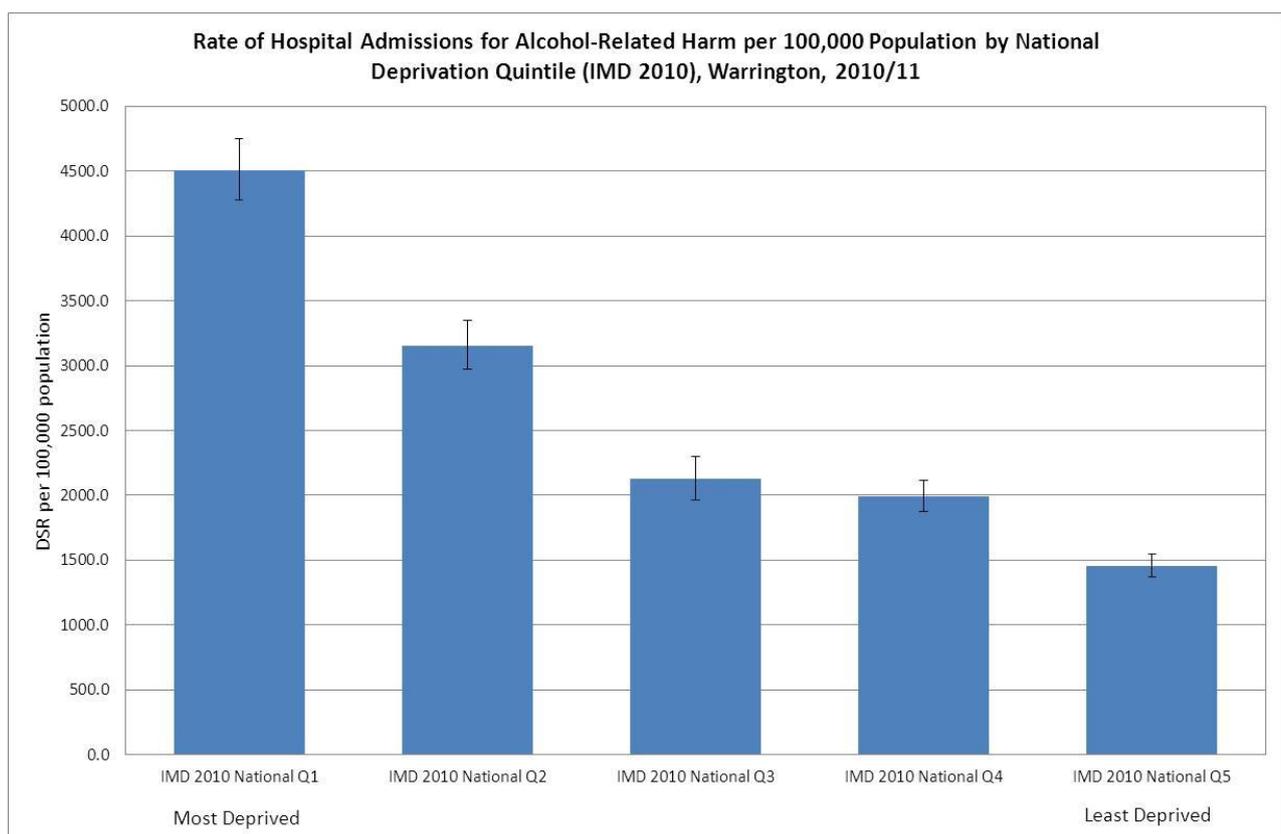
Chart 2 illustrates that hospital admission rates due to broad alcohol related conditions had increased steadily between 2009/10 and 2011/12 nationally, before levelling out during 2012/13 followed by another increase in hospital admissions during 2013/14, the same pattern was also observed for the North West. Hospital admission rates for Warrington had also shown a steady increase between 2009/10 and 2011/12, however positively the hospital admission rate reduced in 2012/13 and again during 2013/14. Hospital admission rates are significantly higher for men when

compared to women (this is seen locally, regionally and nationally). Warrington has consistently had admission rates that were significantly higher than England during the time period presented above.

At present it is not possible to produce analysis for this indicator at a sub Warrington level due to access restrictions to hospital admissions data; however, the following chart and map is based on analysis conducted in 2011 for the first version of this JSNA chapter and displays hospital admission rates by deprivation quintile and ward. As stated previously, the new broad alcohol related admissions data cannot be compared to any previous analysis; however, the following chart and map presents the differences in admission rate by deprivation quintile and ward – it can be expected that these same patterns of hospital admissions are still likely to occur for the new broad alcohol related conditions.

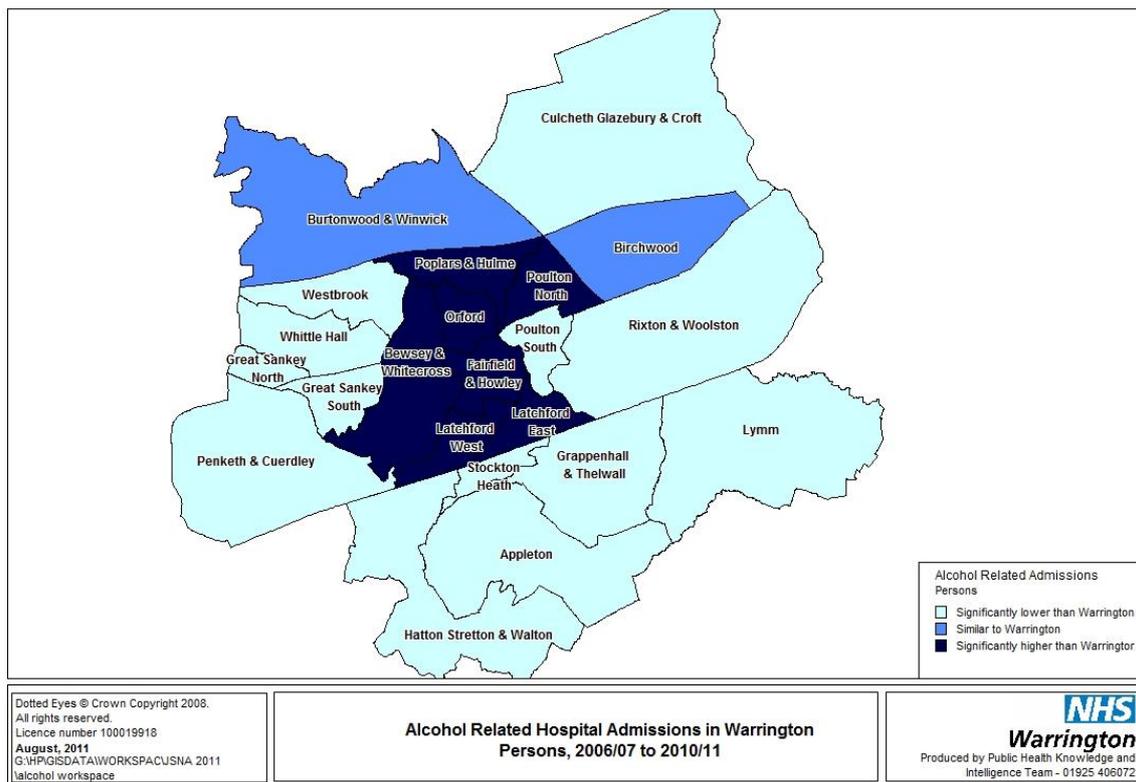
When examining the rate of admissions by deprivation quintile, there are stark differences in the rate of admissions; the rate of admission for the population living in the 20% most deprived areas was significantly higher than the remaining four quintiles and quintile 2 had significantly higher admission rates than quintiles 3, 4 and 5. Quintile 5 (the least deprived quintile) had a significantly lower admission rate when compared to the other deprivation quintiles (see chart 3).

Chart 3: Rate of Hospital Admissions for Alcohol-Related Harm per 100,000 Population, by National Deprivation Quintile (IMD 2010), Warrington, 2010/11



(Source: NHS Warrington, Oracle Data Warehouse, 2011)

Map 1: Alcohol-Related Hospital Admissions in Warrington, Persons, 2006/07 to 2010/11

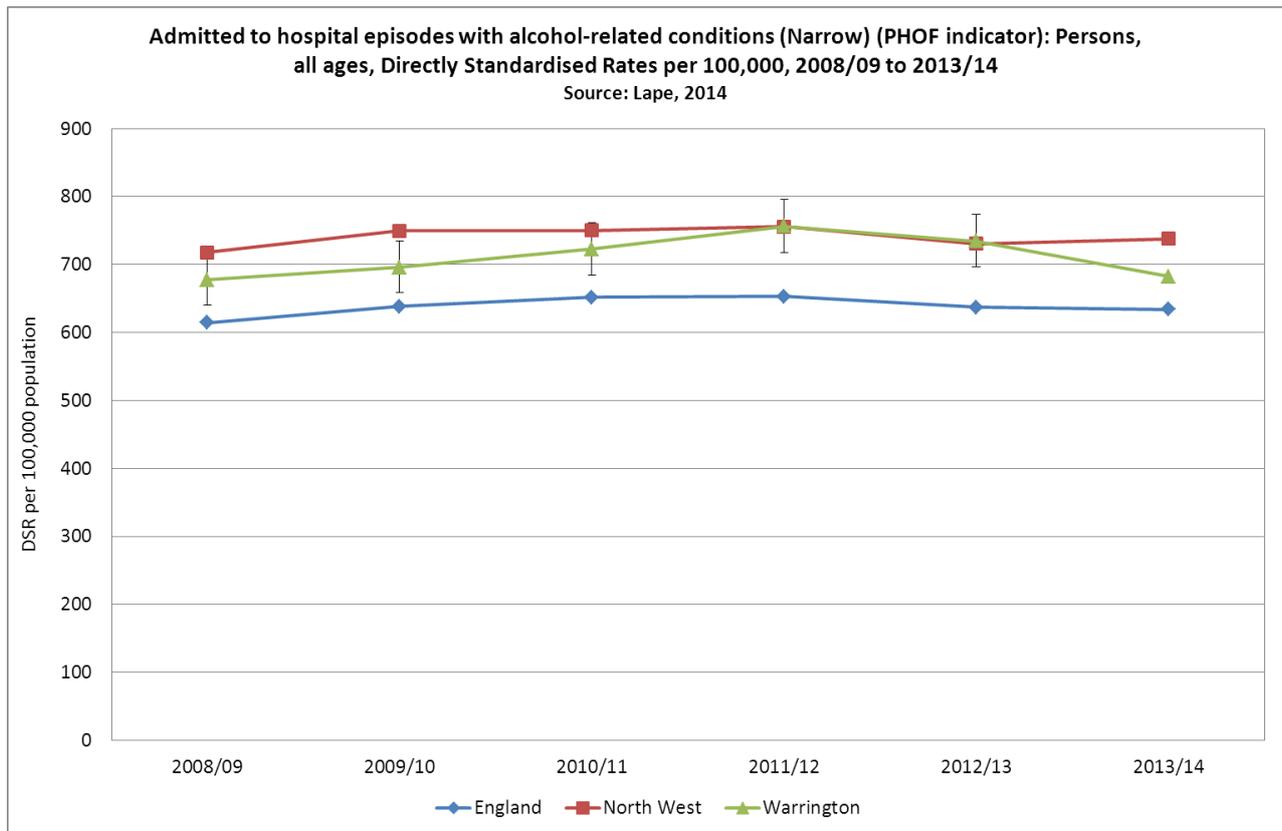


Map 1 illustrates the rate of alcohol-related admissions by electoral ward in Warrington. The wards with the highest rate of admissions are clustered in the centre of Warrington, which are also the more deprived areas of the borough. The ward of Bewsey and Whitecross had the highest admission rate in Warrington (4,138 per 100,000 population, CI³ 3,965 to 4,316 per 100,000 population). The admission rate for Bewsey and Whitecross was nearly twice as high as the overall rate for Warrington.

Males had a higher admission rate than females in Warrington; this pattern was seen in each ward in Warrington. The ward with the highest rate of admissions for males was Bewsey and Whitecross, whilst, for females, it was Fairfield and Howley. When examining the most common cause of alcohol-related admissions from the list of conditions used in the AAF calculation, hypertension was the most common condition, followed by mental and behavioural disorders. Mental and behavioural disorders were the most common cause of admission in four out of 22 two wards.

³ Confidence Interval (CI) - Shows the range within which it is confident that the true result from a population will lie 95% of the time. The narrower the interval, the more precise the estimate. This is necessary as studies are conducted on samples and not entire populations.

Chart 4: Rate of Hospital Admissions for narrow Alcohol-Related Harm per 100,000 Population, 2008/09 to 2013/14

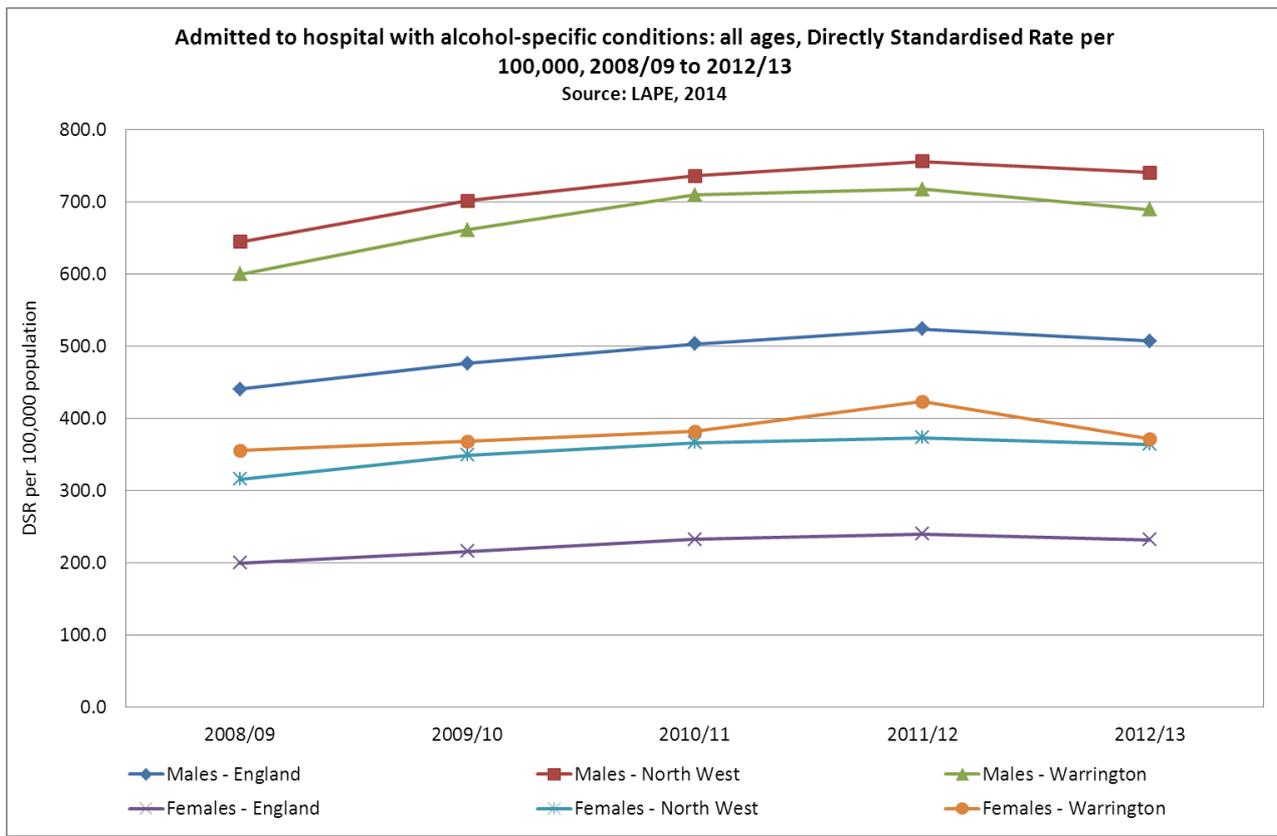


(Source: LAPE, 2014 (Local Alcohol Profiles produced by Public Health England))

The chart above illustrates the hospital admission rates for the narrow alcohol related conditions. The chart shows that for Warrington there was a steady increase in hospital admissions between 2009/10 and 2011/12, and then a decrease in the rate during 2012/13 that continued into 2013/14.

Hospital admissions due to alcohol specific conditions have shown a similar trend as the data presented above. After a year on year rise in hospital admissions between 2009/10 and 2011/12, a reduction in the admission rate was seen during 2012/13. The following chart presents this data by gender; the chart shows that both men and women from Warrington had admission rates that were significantly higher than England. The rate of admissions for males from Warrington was consistently lower than the North West; however, the rate of alcohol specific admissions for women from Warrington was consistently higher than the North West.

Chart 5: Rate of Emergency Admission Due to Alcohol-Specific Conditions, Warrington, 2009/10 to 2012/13

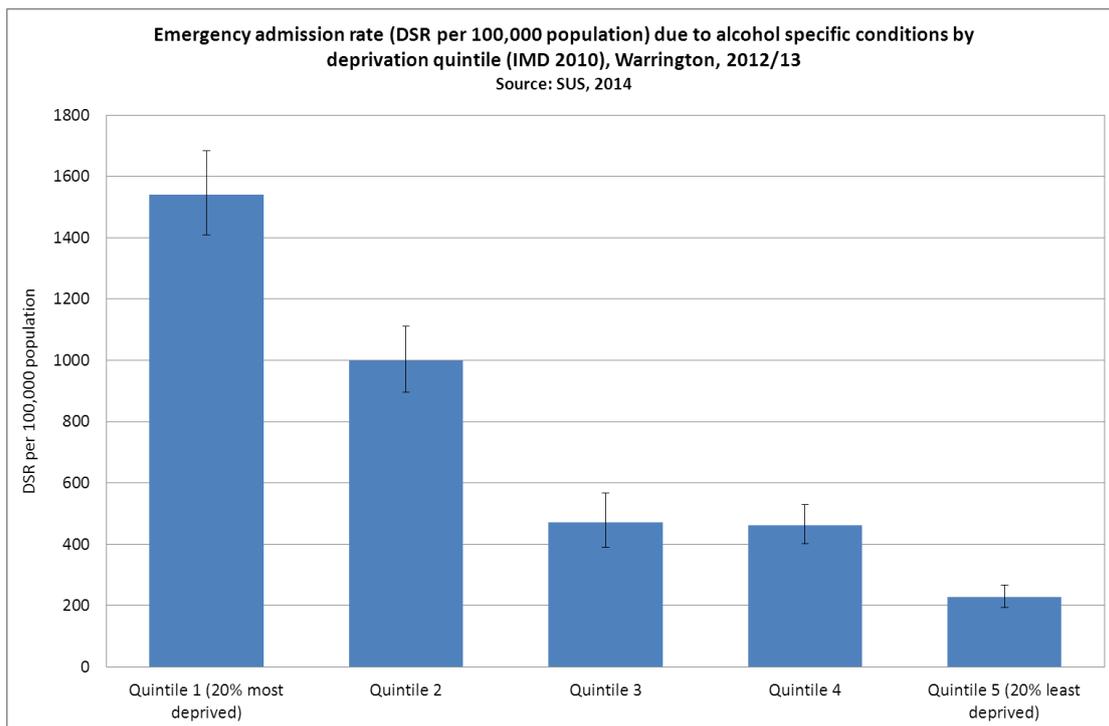


(Source: LAPE, 2014 (Local Alcohol Profiles produced by Public Health England))

As mentioned previously it is not possible to compare any alcohol admissions analysis produced in 2014 onwards to any older analysis which will have been based on a different definition of alcohol specific conditions. Also, at present it is not possible to conduct sub-Warrington analysis due to data access restrictions. Therefore, the following analysis presented below is sourced from the 2011 Alcohol JSNA chapter. It should not be compared to the analysis presented above, but does display differences in alcohol specific hospital admission rates by deprivation quintile and ward.

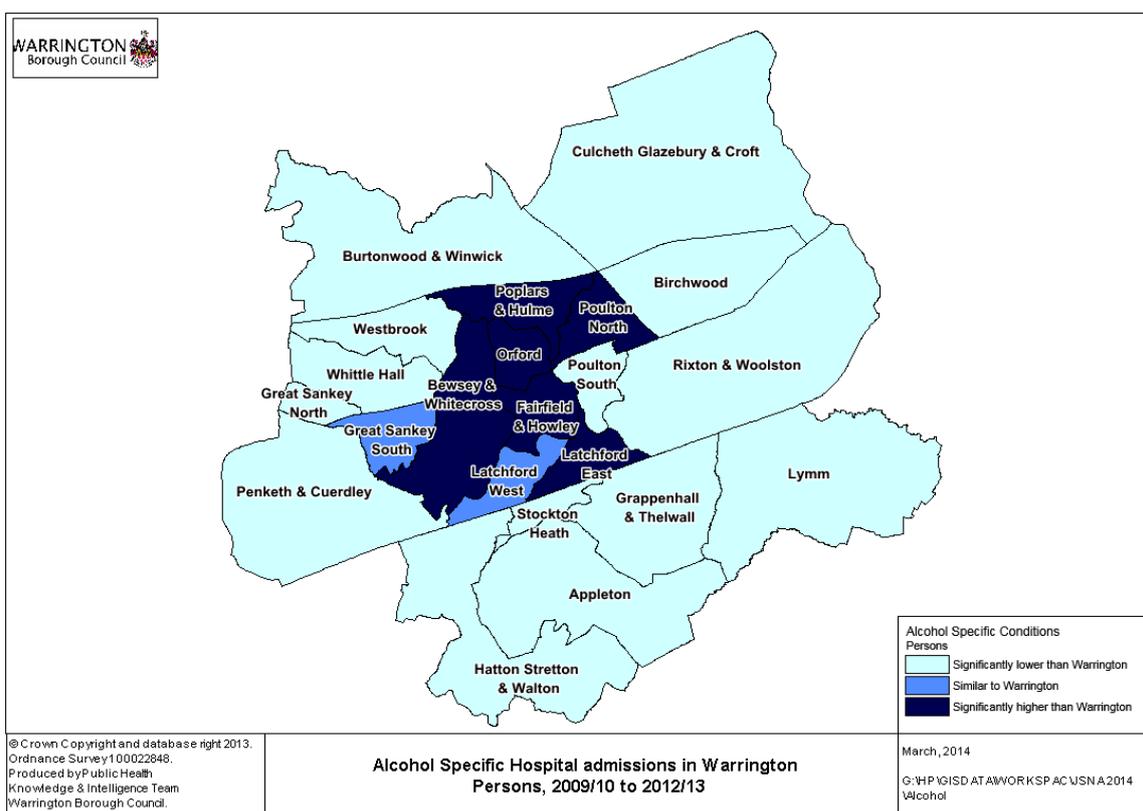
Analysis by deprivation quintile has shown that hospital admission rates were significantly higher in the most deprived areas of Warrington. Hospital admission rates were significantly higher in deprivation quintiles 1 and 2 when compared to the remaining deprivation groups as illustrated in chart 6. Further analysis by deprivation decile has revealed that those who live in the 30% most deprived areas had hospital admission rates significantly higher than the Warrington average. Hospital admission rates were lowest in the least deprived quintile (quintile 5). However, quintiles 3, 4 and 5 had admission rates that were significantly lower than the Warrington admission rate.

Chart 6: Emergency hospital admission rate due to alcohol specific conditions by deprivation quintile, 2012/13



Map 2 illustrates the wards with significantly higher or lower admission rates when compared to the overall Warrington admission rate. The map shows a very similar to pattern to map 1, where the wards with significantly higher admission rates are located in the centre of Warrington.

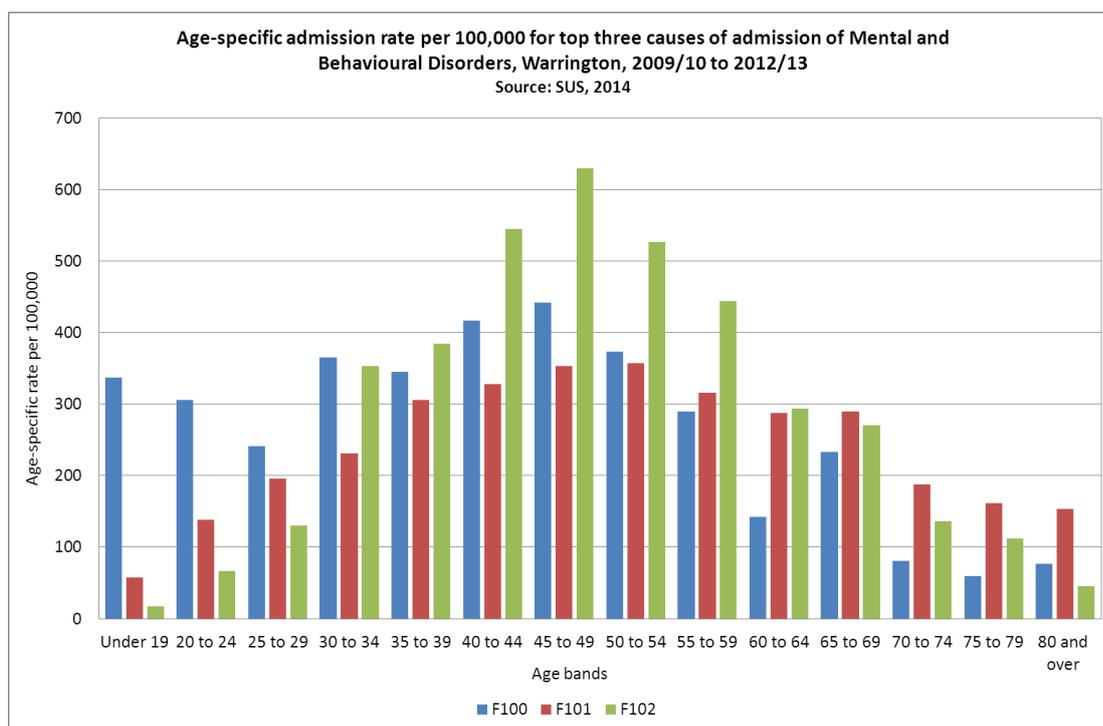
Map 2: Alcohol Specific Hospital Admissions in Warrington per 100,000 population, Persons, 2009/10 to 2012/13



In each ward within Warrington, admissions due to mental and behavioural disorders were the most common cause of admission to hospital. Mental and behavioural disorders include acute intoxication, dependence and withdrawal of alcohol.

Chart 7 shows that admissions for acute intoxication due to alcohol (F100⁴) were higher in the age range of 30 to 54 years. This is a differing picture from the 2011 JSNA chapter which saw admission rates due to acute intoxication highest in the younger age groups of 15 to 24 years, and then the admission rate decreased with age. Admissions for harmful use of alcohol (F101) peaked at the age band 50 to 54 years and this cause of admission was the most common type for the older age groups of 65 years and above. Admissions due to dependence syndrome due to alcohol (F102) were the most common reason for admission out of the mental and behavioural disorders category. Rates of admission were highest in the population aged 35 to 64 years.

Chart 7: Age-Specific Admission Rate per 100,000 Population for Top Three Causes of Admission for Mental and Behavioural Disorders, Warrington, 2009/10 to 2012/13



⁴ The F codes presented within the text and the chart are International Classification of Disease codes version 10 (ICD10) that are used to code causes of hospital admission and deaths. *F100 - Acute intoxication due to alcohol; F101 - Harmful use due to alcohol; F102 - Dependence syndrome due to alcohol*

2.3) Mortality from Alcohol: Mortality rates in Warrington from alcohol-specific causes, chronic liver disease and alcohol-attributable causes were not significantly different when compared to rates for England and the North West. Table 2 presents various sets of alcohol-related mortality data.

Table 2: Alcohol-Related Mortality Rates, 2010-12

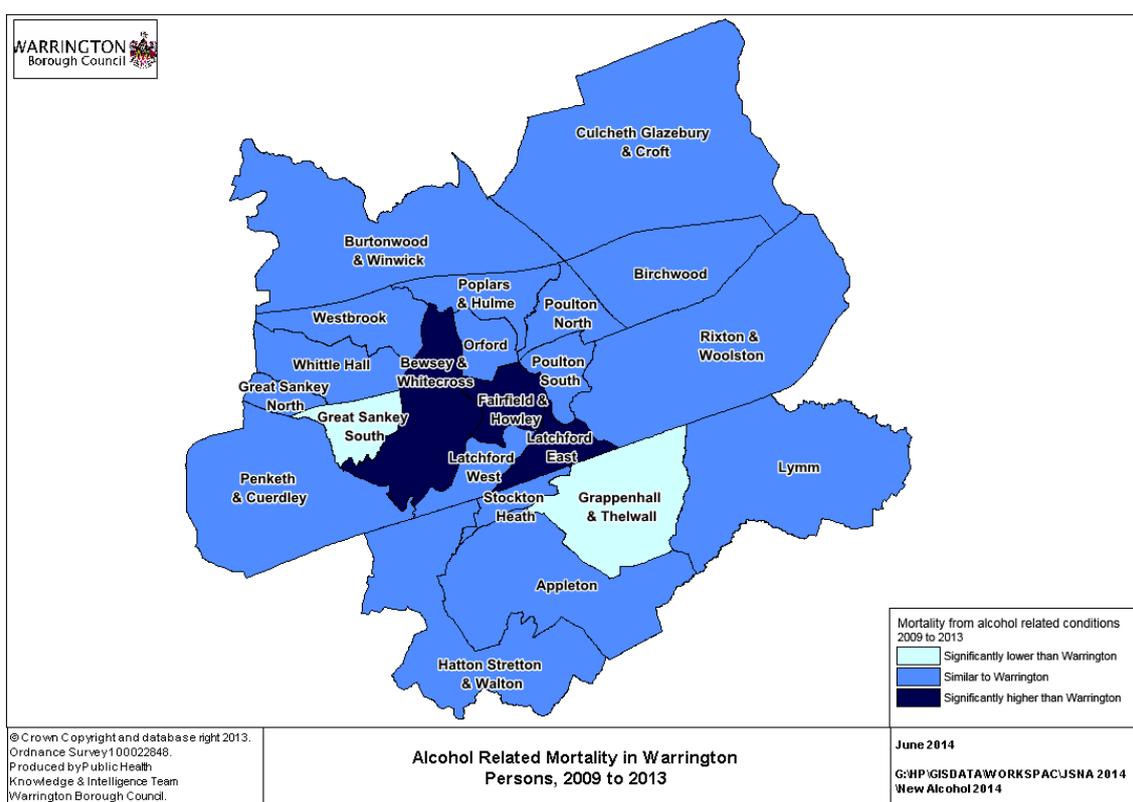
	England		North West		Warrington	
	Male	Female	Male	Female	Male	Female
Months of life lost due to alcohol	11.5	5.4	14.8	7.2	13.6	7.6
Alcohol specific mortality, rate per 100,000	14.6	6.8	20.2*	10.6*	20.3*	12.9*
Mortality from chronic liver disease, rate per 100,000	15.8	8.3	22.0*	12.3*	21.4*	15.2*
Alcohol related mortality, rate per 100,000	63.2	28.1	76.6*	34.1*	64.4*	31.7

*significantly higher than England

(Source: LAPE, 2014 (Local Alcohol Profiles produced by Public Health England))

Mortality from alcohol-specific conditions at ward level in Warrington was not analysed as the number of deaths were too small to produce robust analysis. Between 2009 and 2013 there were 154 deaths in Warrington where the cause of death was due to alcohol. However, analysis at ward level for mortality from alcohol-related causes has been possible by using alcohol attributable fractions. Map 3 illustrates that the wards of Fairfield and Howley and Bewsey and Whitecross and Latchford East had significantly higher mortality rates when compared to the overall mortality rate for Warrington.

Map 3: Alcohol-Related Mortality in Warrington per 100,000 population, Persons, 2009 to 2013



2.4) Hidden Harm: In addition to the direct impact of alcohol on an individual's health, there is the associated, but often hidden, problem of the harm to children of parents with alcohol-related problems. Evidence shows that exposure to parental alcohol abuse is highly associated with adverse childhood experiences. Estimates of alcohol-related hidden harm vary. In 2004, the Cabinet Office (Prime Minister's Strategy Unit) report 'Alcohol Harm Reduction Strategy for England' estimated that between 780,000 and 1.3 million children are affected by parental alcohol problems annually (Cabinet Office, 2004).

More recently, Manning and colleagues (Manning, 2009) examined responses from both the Health Survey for England (2004) and the General Household Survey (2004) which generated consistent estimates: approximately 30% of children under 16 years (3.3 - 3.5 million) in the UK lived with at least one binge drinking parent, 8% with at least two binge drinkers and 4% with a lone, binge drinking parent. The National Psychiatric Morbidity Survey (NPMS) indicated that, in 2000, 22% of children (2.6 million) lived with a hazardous drinker and 6% (705,000) with a dependent drinker.

There are approximately 39,000 children aged under 16 years living in Warrington (ONS Mid 2012 population estimates). Applying the national estimates to the Warrington population suggests that there are just under 11,700 children in Warrington living with at least 1 binge drinker and just over 3,100 with a dependant drinker. Table 3 provides further estimated numbers of Warrington children potentially affected by parental alcohol use.

Table 3: Estimated Numbers of Under 16's in Warrington Affected by Alcohol Use

Estimates of Children (under 16 years)	Estimated Number in Warrington
Living with at least 1 binge drinker	11,697
Living with 2 binge drinkers	3,119
Living with lone binge drinking parent	1560
Living with hazardous drinker	8578
Living with dependant drinker	2339

(Source: Health Survey for England, General Household Survey and National Psychiatric Morbidity Survey estimates applied to ONS Mid 2012 population estimates for Warrington)

2.5) Young People and Alcohol: The Trading Standards North West (TSNW) conducted a regional survey to understand teenage relationships with alcohol. The 2013 survey was completed by 683 teenagers aged 14 to 17 years in Warrington. The frequency of drinking alcohol in Warrington was very similar to the regional pattern. 10% responded that they drank alcohol twice or more in one week, compared to 9% in the North West. However, 18% responded that they never drink alcohol, compared to 32% in the North West.

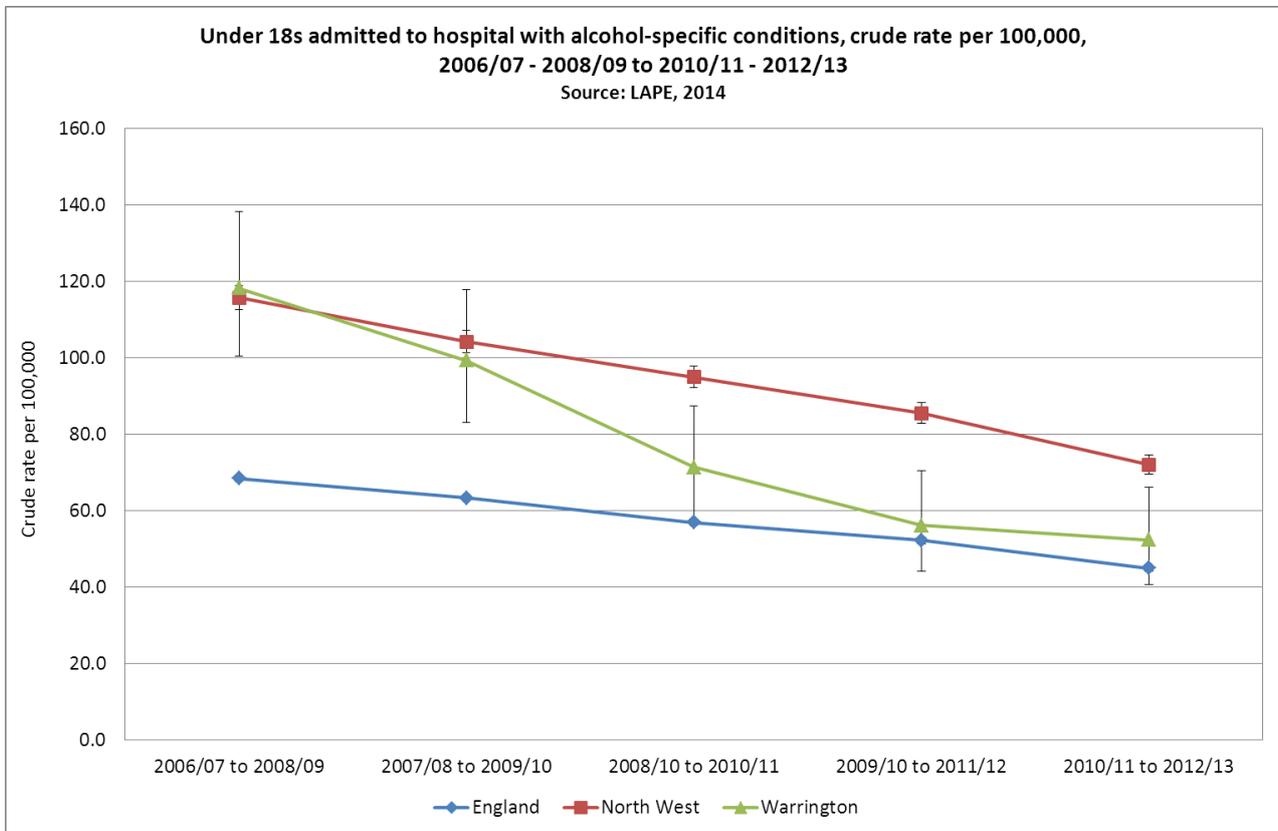
Warrington had a very similar percentage of regular binge drinkers (12%) than the North West (11%). A regular binge drinker was defined as binge drinking one or more times in one week. A slightly higher percentage of occasional binge drinkers were found in Warrington (52%, compared to 43% in the North West). An occasional binge drinker was defined as binge drinking on three or less occasions per month (TSNW, 2013).

In Warrington, 11% of the TSNW (2013) survey respondents reported that they consume alcohol in pubs and or clubs, which was lower than the North West (14%). However, 19% of Warrington respondents reported that they drank alcohol outside (14% in the North West). This would indicate that a lower proportion of the young people surveyed were being served alcohol in Warrington, although this has resulted in a higher percentage drinking in public areas.

When comparing the TSNW results between 2009 and 2013, the percentage of teenagers buying alcohol for themselves has reduced, both locally and regionally. In 2009, 17% of respondents stated they had bought alcohol themselves, but this reduced to 13% in 2013.

When examining alcohol-specific hospital admission rates for under 18 year olds (crude rate per 100,000 population), there have been reductions observed at national, regional and local levels. Significant reductions in admission rates have been seen for Warrington between 2006/07 to 2008/09 through to 2010/11 to 2012/13. During the time period 2006/07 to 2008/09 Warrington had an admission rate that was significantly higher than England and the rate was also slightly higher than the North West. By 2010/11 to 2012/13 the admission rate for Warrington had reduced significantly to a level that was similar to England (slightly higher, but not significantly) and significantly lower than the North West. For more information about young people and alcohol, please see the Children’s and Young People Substance Misuse JSNA Chapter.

Chart 8: Alcohol-Specific Hospital Admission - Under 18s, 2006/07-2008/09 to 2010/11-2012/13



(Source: LAPE, 2014 (Local Alcohol Profiles produced by Public Health England))

2.6) Crime and Disorder Data: Table 4 shows the trend over the last three years regarding alcohol-related crime for the Neighbourhood Policing Units (NPU) in Warrington – data is for period 2011/12 to 2013/14. The table shows that there has been a steady reduction in the number of alcohol related crimes for Warrington as a whole. The number of crimes was highest in the Town Centre, whilst lowest in Warrington East. The number of crimes has reduced steadily in Warrington West, South and East, whilst for town centre and central the number have fluctuated. Overall, the number of reported crimes has reduced by a third between the years 2011-12 and 2013/14.

Table 4: Alcohol-Related Crime by NPU in Warrington

	2011-12	2012-13	2013-14
Warrington Town Centre	464	246	260
Warrington West	229	215	150
Warrington Central	204	149	163
Warrington South	169	164	143
Warrington East	102	97	72
Total reported incidents	1,168	871	788

Table 5 shows the trend in the number of alcohol related anti-social behaviour incidents in Warrington by NPU. The number of reported incidents of alcohol related anti-social behaviour has fluctuated during the last three years, 2013/14 saw a slight increase in reported incidents when compared to the previous year. as with the table above, the number of reported incidents was highest in the town centre, whilst lowest in Warrington East. The number of crimes has reduced steadily in Warrington West, South and East, whilst for town centre and central the number have fluctuated. Overall, the number of alcohol related anti-social incidents reported in Warrington reduced by 9% between 2011/12 and 2013/14.

Table 5: Alcohol-Related Anti-Social Behaviour incidents by NPU in Warrington

	2011-12	2012-13	2013-14
Warrington Town Centre	529	458	567
Warrington West	391	309	282
Warrington Central	356	332	384
Warrington South	301	256	240
Warrington East	159	143	113
Total reported incidents	1,736	1,498	1,586

3) CURRENT SERVICES IN RELATION TO NEED

The strategic responsibility for alcohol harm reduction in Warrington sits with the Public Health Department within Warrington Borough Council.

Warrington's Alcohol Harm Reduction Strategy (2012-15) is the driver of activity locally to reduce alcohol harm and also the key means of co-ordinating joint working on this agenda. Work is currently underway to develop a new Strategy for 2015-2018

The aim of the strategy for 2012-2015 is to reduce the actual and potential harm caused by alcohol misuse to individuals and communities in Warrington whilst ensuring that alcohol can still be enjoyed safely and responsibly.

The strategy contributes to the overall vision for 'A healthier, stronger Warrington enabling people to thrive' with a comprehensive multi-agency action plan containing a range of interventions and activity under four core themes:

- Changing attitudes and early intervention
- Reducing Harms to Health
- Reducing the impact of alcohol misuse on communities
- Reducing the impact of alcohol misuse and harm on the family structure.

Workforce Development

To ensure that all agencies working with drug and alcohol users in Warrington have suitably qualified and competent workforces, the DAAT continue to invest in training to help staff, mentors and volunteers to develop the competence and confidence needed to work with substance users and address their needs as part of their duties. An annual Workforce Development Programme is developed and commissioned to reflect the needs and requirements for Warrington's workforce around drugs and alcohol.

Community Alcohol Treatment Service

In June 2013, CRI – Pathways to Recovery, were appointed as the commissioned provider to deliver community alcohol treatment services in Warrington. The services that CRI provide include:

- Alcohol screening and assessment of need
- Assignment of individual's own recovery worker
- Brief interventions to develop personal strategies to manage alcohol consumption
- Access to one-to-one sessions and group work to support shared learning and manage alcohol consumption
- Key work sessions, counselling and complementary therapies
- Medically assisted community detoxifications treatment
- Community needs assessments that can lead to funding for residential rehabilitation
- Health and Wellbeing screening, advice and referral
- Community outreach work
- Delivery of alcohol awareness training for local employers, partners and community groups etc
- Delivery of Alcohol Identification and Brief Advice (IBA) for front-line workers from partner organisations, local employers etc.

Numbers in Treatment

In Warrington 529 individuals have been in Alcohol Treatment over the rolling 12 month period of 2013/14. At Quarter 4 2013/14 (March 2014) 83% of those who did not initially engage, fully entered treatment after a visit from the Attrition Worker who specialises in re-engagement with those reluctant individuals. Engagement into service is an area that has always proved difficult especially with new service users and entrenched drinkers. This re-engagement initiative has demonstrated significant success and has facilitated individuals to access treatment fully at an earlier stage in their addiction. This will hopefully lead to long term successful completions from alcohol misuse and in turn reduce the number of health implications overall for the individual and services.

Brief Interventions

The number of sites where Brief Interventions is delivered from continued to rise quarter on quarter during 2013/14. A total of 347 sessions were delivered during the year with 401 individuals attending at the end of March 2014.

One to One and Group Work

Detox

During 2013/14, 70 individuals were in Detox, with 94% successfully completing. The commencement of the new contract has seen the introduction of Neighbourhood Centre based Detox Clinics. Home Detox has also proved to be popular with 67% accessing Home Detox during the year.

Rehab

For the Alcohol Treatment Service, those accessing Rehab in 2013/14 (1% of the treatment population), did so for the first time. This could be linked to those new clients engaged successfully and re-engaged where there is reluctance as part of the Attrition work. However, the opportunity to detox whilst remaining in the community is a popular choice with many service users, as this allows daily life to continue and impacts on families minimized by preventing long absences from home. This is particularly significant where children may be impacted.

Health and Wellbeing Screening

During 2013/14 72% of individuals accessing Alcohol Treatment Services received a comprehensive Health and Wellbeing Assessment. 21% of this group of individuals were referred to Physical Health Services and 8% referred to Mental Health Services. 1% were referred to Sexual Health Services, whilst 16% received advice on Communicable Diseases. This demonstrates the varied health impacts that need to be addressed as part of the full recovery package. Whilst good developments are being made to address individual complexities, work still needs to be done to ensure all receive the right treatment and expertise.

Outreach

16 targeted outreach Initiatives for the Homeless were conducted throughout 2013/14. As a result of this Outreach, a number of individuals accessed Alcohol Treatment Services. 86 individuals engaged in Health, Social Needs, Physical, Psychological and Social Harm Reduction talks and received information and advice only. This development is encouraging. With many street homeless engaging in substance misuse, the more outreach that can be provided, the more people the service can engage in to service and in to stable accommodation. This is again part of the whole recovery package and ensuring those who find themselves homeless are given the support to

access secure accommodation, employment and training opportunities, family and lifestyle support which is core to their success.

Two Police led Night Time Economy initiatives have also been conducted during 2013/14. This had an alcohol focus, promoting harm reduction messages to those revellers enjoying Warrington night life. 24 Licensed Trade Establishments have also engaged with the Alcohol Treatment Provider during the year. This is an encouraging step to ensuring that all those who have a link with Alcohol are signed up to promote safe and responsible consumption across the borough.

Work within the Criminal Justice area has seen 46 individuals receive an in cell Alcohol Assessment, and receive Brief Interventions as a result. All those seen were referred to Alcohol Treatment Services with 35% connected to support services prior to release and attending Treatment Services following their release. 81% maintained contact with Support Services following release. Throughout the year 52 individuals were linked to Community Sentencing Options and Fines (ATR).

Criminal activity and substance misuse often have strong links. Therefore any advice and information that can be shared at any point when contact is made with those individuals engaged in substance misuse is important. Although many choose not to attend treatment services, for those who do, the success of these individuals in maintaining treatment and support service connections is evident.

Alcohol Awareness Training

Harm Reduction & Identification and Brief Advice (IBA)

Sharing harm reduction messages across the borough to all members of the community is important. The treatment service has conducted 10 Community Harm Reduction Awareness Sessions throughout 2013/14 along with 215 Community Mentor Advice Sessions.

Cocaine and Alcohol Harm Reduction Awareness Sessions have been delivered to 28 individuals during 2013/14, with some engagement with the Treatment Service evident following this.

Eight workplace connections have been established with ten Harm Reduction and Awareness Sessions conducted.

Four older people support groups and charities have connected with the Alcohol Treatment Service with one training session being provided so far on alcohol screening tools.

Connections have also been made with six colleges and university establishments throughout the year. Three training sessions have been provided to teachers, lecturers and support staff and twelve young people have been referred to the Alcohol Treatment Service as a result of this link.

21 connections have been made throughout 2013/14 with Children and Young People's Social Care Common Assessment Framework Team or Education and Health Visitors, as part of the safeguarding process, and as part of the ongoing work of the treatment service to remove some of the fear for service users when working with family orientated support services. 56% of the alcohol treatment population have children. Therefore safeguarding is paramount to a service users recovery plan to ensure all children who could be impacted by substance misuse and the individual complexities that can arise with this are dealt with quickly.

6% of the Alcohol Treatment population are identified as needing domestic violence victim support, whereas 2% are identified as needing perpetrator support.

Demographics

The majority of service users (18%) consumed between 501 and 600 Units of alcohol per month when entering treatment. There are also large numbers reporting the consumption of between 201 to 300 units (14%), 301 to 400 (11%), 401 to 500 (105), 101 to 200 (9%) and 1000+ units (7.5%).

The initial units breakdown demonstrates that Warrington has some very entrenched drinkers, with 46% of service users consuming 500+ units. The service is also engaging those who are beginning to drink excessively with 54% consuming between 1 and 500 units initially.

Initial AUDIT scores (Alcohol Use Disorders Identification Test – An Alcohol Screening Tool devised by the World Health Organisation) highlight that the majority of service users have an AUDIT Score of 20+, the highest level on the Screening Tool. As mentioned above, there are also high numbers with an AUDIT score of 0 to 7, the lowest on the screening tool. This again appears to suggest Warrington is engaging with those at the lower and higher risk drinking thresholds. Warrington does show some evidence of engaging with those with a score of between 8 to 15 and 16 to 19, but this is considerably lower than the upper and lower thresholds.

The majority of service users report drinking beer and cider (37%) as their alcohol type. Alcohol unspecified (24%) is also high, with large numbers reported against spirits (16%), wine and fortified wine (14%) and a mixture of alcohol (9%).

There is some evidence of adjunctive drug use with 4% reporting the use of cannabis as well as alcohol. 3% report the use of other drugs, 1% using opiates or crack and less than 1% using legal highs. It is important to note here that 92% of adjunctive drug use is none or missing. This suggests that the majority of those clients accessing treatment services use alcohol only.

A drill down in to the second drug of choice highlights the use of cannabis herbal (Skunk), cannabis unspecified, cocaine hydrochloride, cocaine freebase (Crack), beer or cider, NPS other – predominantly stimulant, Amphetamine Sulphate (Speed), Amphetamine unspecified, Antihistamines unspecified, Benzodiazepines unspecified, Buprenorphine (Subutex), Codeine prescription, Opiates unspecified, spirits and wines and fortified wines.

At the end of March 2014 the majority of service users are male with 61%, with females representing 39% of the alcohol treatment population.

The age group of 35 to 44 represents the largest proportion of the treatment population with 33%. 28% of the population are aged between 45 and 54. This is followed by the age group 25 to 34 (17%), 55 to 64 (13%), 65+ (5%) and 24 and under (4%). This data evidences those age populations with higher engagement, however, this may not be reflective of need, but rather the willingness and commitment to treatment that those in the age group 45 to 54 have. It is possible that those age groups with a lower proportion of the treatment population are reflective of the work and engagement that still needs to be done across the borough.

71% of the alcohol treatment population are unemployed. 28% are employed and 1% other (for example, retired). As mentioned previously, full recovery and all of the lifestyle and skills needed to engage fully in the community are important and employment and skills is a significant part of this. This gives individuals a sense of independence and the opportunity to experience and choose which path they take as part of their future development. As the majority of the Alcohol Treatment population are unemployed, this is an area of focus for the Service, particularly with the roll out of the Welfare Benefits conditions and the potential impact on Housing for individuals. At the end of 2013/14 15% of the Alcohol Treatment population had Housing Problems. It is important that this proportion receive assistance with these problems and that any potential risk to other service users is addressed as part of their Recovery Plan.

5% of the alcohol treatment population are military veterans. Warrington has a significant number of individuals in the forces and therefore the potential impact on Warrington services is recognised once or if individuals return to the area. Substance misuse can often play a part, along with physical and mental health implications such as Post Traumatic Stress Disorder (PTSD). It is therefore essential that Warrington's treatment services address the multitude of complexities that can present along with substance misuse. It is also important to note that the lifestyles adopted in the military can have an adverse effect on those returning to their areas as a civilian and therefore being able to support through this transition is paramount.

The wards within Warrington reporting the highest number of service users are Bewsey and Whitecross, Fairfield and Howley and Latchford East. This is reflective of some of the most deprived wards in the Borough. This suggests that engagement with these areas is good, however, the research referenced earlier in this chapter suggests that alcohol admissions are also higher from some of the more affluent wards in the area. Therefore this gap needs to be addressed to ensure all those engaging in potentially harmful alcohol consumption are reached as effectively as possible.

Length of Time in Treatment Comparison

Alcohol treatment figures have not been put into Cluster Groups at this time, as this is a new addition to the Public Health England Diagnostic Outcome Measurement Executive Summary Report (DOMES). For those in treatment under 3 months, Warrington is below the mean average (36.2%) with 32.1%. This places Warrington 24th out of 61 local authorities. The highest value reported under this category was 74.2%.

For those in treatment between 3 and 6 months Warrington reports 23.3% of the treatment population in this group. The mean average is 23.2% and ranks Warrington 34th out of the 61 authorities. The highest value reported is 100% compared to the lowest of 0%.

30.5% of Warrington's alcohol treatment population have been in treatment between 6 and 12 months. This places Warrington at 54th out of 61 authorities. The highest reported level being 40.2% compared with the lowest of 0%. The mean average for this treatment period is 23.2%. Warrington is therefore considerably above this.

The proportion of those in alcohol treatment for over 1 year is 14.3% for Warrington. The mean average across the 61 local authorities is 17.3% and therefore Warrington is below this. The highest value in this group is 39.4% compared with 0% at the lowest. Warrington is ranked 28th.

Warrington reports an average length of time in treatment of 0.6 years. Although the ranking of the authorities would place Warrington 32nd, the average of 0.6 years is reported for 9 local authorities in total. The highest value is 1.6 years compared with the lowest of 0.2 years.

Overall this data suggests Warrington's alcohol treatment population may have a range of complexities and therefore supports the varied length of time in treatments reported. The average for Warrington is less than a year, which is encouraging and suggests the movement through the treatment system does maintain momentum. The majority of service users are engaged in service for longer than 3 months, and figures suggest the highest proportion is engaged between 3 to 6 months. The caution for the treatment provider is to ensure entrenched service users are kept to a minimum. Whilst relapse is an acknowledged part of treatment and successful recovery should be encouraged when an individual is ready, it is also important individuals do not remain static during the process and therefore recovery plans should continuously be revisited to highlight the next step in a persons journey.

Public Protection

There have been 78 underage sales and fake ID training delivered to the trade through Public Protection. A number of adults have attended this training and training and resource packages have been provided to both on and off licenses.

20 licences have been consulted on following applications. This supports the authority to look at responsible supply of alcohol as part of the harm reduction objectives across Warrington.

24 alcohol test purchases have been conducted based on intelligence led information from the Police, public and personal local knowledge. Partnership work and sharing intelligence across the borough allows public safety to be assessed and ensure compliance with standards.

10 premises have been attended to perform On Licence Risk Assessments and three premises attended to perform Off Licence Risk Assessments. This again is part of the harm reduction initiatives across the borough.

Four individuals have attended Restorative Justice Sessions as a result of Public Protection involvement.

Warrington's Young Person's Drug and Alcohol Team offer specialist support and intervention on a one-to-one basis for young people who are affected by their own or their families' substance misuse.

Young people can self-refer to the service or can be referred by any professional or agency with the young person's consent. Working in partnership with other agencies as appropriate, they offer young people a care plan that focuses on making changes to their substance use to support recovery, reducing risk and limiting the problems or negative effects which substances may have on their lives.

Residential and Inpatient Treatment (Tier 4): Turning Point/Smithfield are currently the sole provider offering in-patient alcohol detoxification for people who have needs requiring specialist supervision that are unsuitable for community based detoxification. Alcohol in-patient detoxes are the majority of the detoxes taking place.

There is a preferred provider list for residential rehabilitation which is managed by Warrington Borough Council (WBC) contracts department. This list is currently under review and there is a requirement that a new list is in place from November 2014.

Recovery agenda: within Warrington there are a range of providers offering skill set support within the Recovery Hub which is used by those service users for both drugs and alcohol in recovery. Services being delivered are provided by Creative Remedies, the Collegiate and CRI. Areas of development include money management, job skill preparation (interviews, application for jobs) and a full time ETE (Employment Training and Education worker) which is enabling service users to find employment or volunteering opportunities.

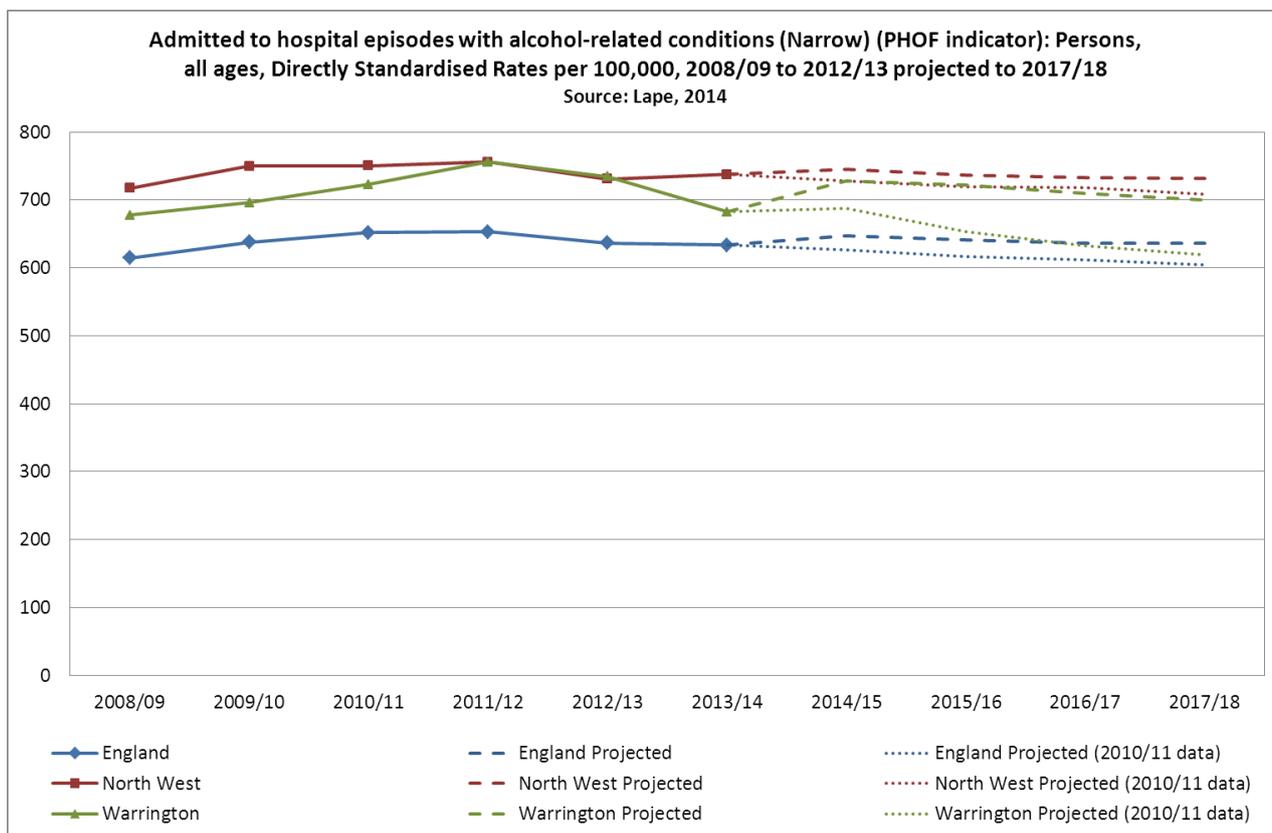
Alcohol Liaison Nursing Service, Warrington Hospital: there is a designate service based within Warrington and Halton Hospitals Foundation Trust (WHHFT) which covers those individuals in hospital for alcohol related illnesses. Alongside this service, CRI also provide an alcohol in-reach provision, again focussing on those hospital attendees. This in-reach/outreach provision will be reviewed for effectiveness from April 2014 to ensure better referrals back to community alcohol services are in place.

4) PROJECTED SERVICE USE AND OUTCOMES

Chart 9 illustrates the projected rate of alcohol-related admissions if historical trends were to continue, this does not take into account any changes in national or local policy. Projections for the North West and England have also been included to illustrate how Warrington will compare to these areas. Two sets of projections have been calculated for each area, the dashed lines are projections based on calculations that used data from 2008/09 through to 2012/13, whilst the second projections (dotted lines) have been calculated using data from 2010/11 to 2012/13.

Two sets of projections have been calculated as the first projections include large increases in admission rates observed between 2008/09 and 2010/11, which has resulted in a projected large increase in hospital admission rates. The second projections look at a much smaller time period which does result in less robust analysis, however this analysis is influenced to a greater extent by the reductions in admission rates that were seen during 2012/13 and 2013/14, which is hopefully the start of a downward trend in alcohol related admissions.

Chart 9: Projected trend in the rate of alcohol-related hospital admissions, based on historical admissions data, 2009/10 to 2017/18



5) EVIDENCE OF WHAT WORKS

There is a body of evidence around effectiveness in alcohol interventions, including new guidance published by the National Institute for Health and Clinical Excellence (NICE):

NICE Alcohol use disorders: preventing harmful drinking - Evidence Update March 2014

NICE Alcohol use disorders: harmful drinking and alcohol dependence - Evidence Update January 2013

NICE Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence – Clinical guidelines, CG115, Issued: February 2011

NICE public health guidance 24: Alcohol-use disorders: preventing the development of hazardous and harmful drinking (NICE, 2010b). This guidance complements the previous PH7 guidance on school-based interventions on alcohol.

NICE clinical guideline 100: Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications (NICE, 2010a). This guidance covers key areas in the investigation and management of the following alcohol-related conditions in adults and young people (aged 10 years and older):

- Acute alcohol withdrawal, including seizures and delirium tremens
- Wernicke's encephalopathy
- Liver disease
- Acute and chronic pancreatitis.

'**Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence**' was published in February 2011. This clinical guideline covers identification, assessment, pharmacological and psychological/psychosocial interventions, and the prevention and management of neuropsychiatric complications (NICE, 2011a).

Review of the effectiveness of treatment for alcohol problems: This outlines the evidence base for screening, brief interventions, less-intensive alcohol treatments, specialist treatment, detoxification and self-help (Raistrick et al., 2006).

NICE guidance PH7 for alcohol: NICE published 'School-based alcohol interventions 2007,' which describes the role of schools in education and brief advice to prevent alcohol misuse (NICE, 2011b).

It is expected that NICE will release guidance in relation to **Alcohol: Preventing harmful alcohol use in the community** in December 2014

Other key guidance documents include:
Models of Care for Alcohol Misusers: This provides best practice guidance for health organisations in delivering an integrated local treatment system and sets out a tiered approach for alcohol interventions (Department of Health, 2006).

Signs for improvement: Commissioning interventions to reduce alcohol-related harm: This publication describes how organisations should be commissioning interventions to reduce alcohol-related harm. It includes some evidence base for the 7 High Impact Changes (Department of Health, 2009).

Safe Sensible Social: The 2007 update on the National Alcohol Harm Reduction Strategy originally published in 2004 (HM Government, 2007).

Choosing Health - the public health strategy: This strategy has alcohol harm reduction as a major theme and identifies a number of 'big wins' related to combating alcohol misuse (Department of Health 2004).

Licensing Act 2003: Governs the management and control of licensed premises (Licensing Act 2003) and the **Violent Crime Reduction Act 2006**.

New GP contract 2004: Identified a Nationally Enhanced Service for alcohol.

Alcohol Misusing Offenders – A Strategy for Delivery 2006: A strategy for addressing alcohol misuse for offenders (National Probation Service, 2006).

Youth Matters: A Government White Paper that sets out the vision for empowering young people, giving them somewhere to go, something to do and someone to talk to (Department for Education, 2005).

Youth Alcohol Action Plan 2008: Sets out particular steps to tackle alcohol misuse among young people (Department for Children, Schools and Families, The Home Office, Department of Health, 2008).

Alcohol - A Case for Secondary Case Change: The Chief Executives Group 2010 assessed the impact of a range of interventions on alcohol-related hospital admissions (Dalton, 2010).

The North West Public Health Observatory conducted a review into the cost-effectiveness of individual level lifestyle behaviour changes. The alcohol review concluded that the greatest level of effectiveness and cost savings could be achieved through the implementation of identification and brief advice in a primary care setting. It estimated that, within Cheshire and Merseyside, if 1,000 patients were screened, there would be 18 A&E attendances and 17 hospital admissions averted, resulting in £13,300 being saved at an investment cost of £3,613 (North West Public Health Observatory, 2011).

6) (TARGET) POPULATION/SERVICE USER VIEWS

Centre of Public Health research project

The findings from a research project undertaken by the Centre of Public Health, Liverpool John Moore's University in January and February 2012 have provided the following helpful public and service user perspectives on a number of drug and alcohol issues in the borough:

- Participants generally considered Warrington to have a 'problem' with drugs and alcohol (generally as a result of antisocial behaviour and crime), and in particular with respect to alcohol and cannabis. However, overall, alcohol was perceived by all participants to be a greater problem in Warrington than illegal drug use.
- Treatment and rehabilitation of users was believed to be the most important response to substance use, but education and prevention campaigns (including those delivered by the family and schools) were also thought to play their part and could contribute to reducing substance related problems.

- The belief that alcohol was too readily available was a prominent theme of the focus groups interviewed, with participants believing that '24 hour drinking' was responsible for much of the alcohol-related harm and disorder in the town centre.
- Measures to address alcohol related problems suggested by research participants included imposing greater penalties on licensees who sold alcohol to under 18s (mirroring national alcohol policy priorities), as well as restricting bar/nightclub opening hours.
- Despite good scientific evidence for its effectiveness, alcohol minimum unit pricing did not seem to be a popular form of intervention.
- All types of participant showed a high level of awareness of local treatment services, indicating that Warrington residents are receptive to local media campaigns.
- Public opinion on the most effective ways for public authorities to reduce alcohol related problems in Warrington was for education and prevention campaigns (21%) followed by tougher pub and licence conditions (17%) and tougher measures for licensees who sell to under 18 year olds (16%).
- In comparison, service user respondents chose treatment and rehabilitation of alcohol addiction (26%), education and prevention campaigns (25%) and reduction of poverty (16%) as the three most effective ways for public authorities in Warrington to reduce alcohol related problems.

DAAT Service User Consultations

Service user consultations take place 4 times per year at the Recovery Hub in the town centre of Warrington. They are facilitated by a DAAT staff member and attended by drug and alcohol clients. They give the opportunity for open communication and are a way of sharing information. They provide a mechanism for feedback, which informs best practice. Opportunities are shared and service users are encouraged to be working towards recovery and increasing their skills by attending training, volunteering, accessing education or finding employment. Attendance, engagement and participation is high and the consultations are always well received.

They run their own service user led meetings every 4 weeks, which have an agenda, minutes and a chair person, these have been initiated by service user need and developed and organised by them in this way. These meetings also mean a collective voice and overall feedback can be collated and fed back by service user/s attending DAAT and partnership meetings, events, conferences, workshops and training. Service users are encouraged and invited to attend these so their voice is heard, they are involved and they have an understanding of the wider picture. Such opportunities allow them to develop and participate in building their own skills, knowledge and confidence and their contribution is integral to the work of the DAAT. Service users have also been part of DAAT tender / commissioning processes, once again informing future need and having an input into the shape of future services.

7) UNMET NEEDS AND SERVICE GAPS

- Co-ordination and delivery of alcohol harm reduction work addressing the needs of young people, particularly in schools and other youth settings.
- Lack of robust data of the prevalence of hidden harm for those people not engaged in adult alcohol treatment provision.
- Need to concentrate on addressing high levels of alcohol related hospital admissions – both for adults and under 18's from quintile 1.

- The development and delivery of campaigns and interventions that challenge the drinking cultures and relationships that exist with alcohol, targeted specifically at communities of Warrington such as young people, older people, those identified in the public health lifestyle survey, the eastern European community etc. to encourage low-risk alcohol consumption.

8) RECOMMENDATIONS FOR COMMISSIONING

- To develop clarity and co-ordination for the delivery of alcohol harm reduction work to address the needs of young people.
- To establish data sharing protocols to allow data to inform neighbourhood and licensing health action plans.
- To biannually review the impact of the Brief Intervention Training currently being delivered in Warrington to understand impact of training and its long term effectiveness on residents.
- To continue to address the high levels of alcohol admission wholly attributable to alcohol (AAF) from quintile 1.
- To regularly review the function and relevance of the delivery plans of operational groups in the light of the Joint Strategic Needs Assessment (JSNA) and the annual Community Safety Partnership (CSPs) needs assessment.
- To ensure that the neighbourhood action plans are informed by the JSNA and CSP needs assessment.
- To review the performance of the current strategy in its broadest sense.
- To implement the review of the Tier 4 service within a new preferred provider list to be in place for November 2014.
- To launch and embed the one year focussed piece of work around complex alcohol cases, which will be looking at those more chaotic alcohol users and ensure that their treatment pathways are robust and impact on services are appropriate.
- To review the hospital in reach and outreach services to ensure appropriate referrals pathways are in place for those leaving hospital with an alcohol related illness.

9) RECOMMENDATIONS FOR NEEDS ASSESSMENT WORK

Alcohol hospital admissions (both specifically related to alcohol and alcohol-related) are monitored on a quarterly basis. At this time, it is not necessary to conduct a needs assessment based on alcohol hospital admissions.

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