Alcohol, Drugs and Tobacco in Lancashire

Alcohol technical report

March 2012

Intelligence for Healthy Lancashire (JSNA)

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Introduction

There is substantial public health and medical evidence available that shows that people who use and misuse alcohol, drugs and tobacco experience poorer health outcomes than those who do not, and these behaviours are associated with increased morbidity and mortality. These negative effects often extend to affect the health and wellbeing of family members, friends and the wider community.

Increased use and misuse of alcohol, drugs and tobacco is strongly associated with deprivation and poverty[1] [2]. In 2010, the Marmot Review[3] highlighted the significance of the 'social gradient' and its effect on health, and argued that reducing inequalities is a matter of social justice and fairness. In Lancashire, a county with areas of extreme deprivation and poverty as well as areas of affluence and wealth, large inequalities are expected in terms of alcohol, drug and tobacco use and misuse, as well as health outcomes between the affluent and the deprived. In 2009 the JSNA team assessed health inequalities in Lancashire by deprivation and highlighted the ten most significant[4]. Many of these inequalities, including liver disease, numerous cancers, coronary heart disease, extreme anxiety and depression, diabetes and accidents, are related to the use and misuse of alcohol, drugs and tobacco. Reducing the use of these substances was therefore identified as a goal to address these inequalities and improve the health and wellbeing of Lancashire residents.

It is anticipated that this joint strategic needs assessment (JSNA) will be able to provide data, analysis and recommendations to aid commissioners to make informed decisions to narrow these inequalities across Lancashire for the benefit of Lancashire residents. Specifically the JSNA is designed to provide a focus for commissioners from a variety of organisations so that the services they

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[1] Jarvis and Wardle (2006) 'Social patterning of individual health behaviours: the case of cigarette smoking,' p.224 in Marmot and Wilkinson (eds), *Social Determinants of Health* (2nd edn). Oxford: Oxford University Press.
[2] Marmot and Wilkinson (2003) *Social Determinants of Health: the Solid Facts* (2nd edn), p. 24. World Health Organisation.
[3] Marmot, M (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post-2010*. Available online: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review [accessed March 2012].
[4] See: http://www.lancashire.gov.uk/corporate/web/?siteid=6117&pageid=35405&e=e

commission complement and enhance each other rather than work in isolation. This holistic approach – commissioning based on need rather than organisational boundaries – is one of the strengths of the JSNA approach.

This JSNA is also an opportunity to inform how Lancashire responds to changes in national policies, such as those outlined in *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug-Free Life*[5]; and *Healthy Lives, Healthy People: A Tobacco Control Plan for England*[6], published in December 2010 and March 2011 respectively. It is also an opportunity to assess and identify how to respond to the changing demographics of those that use and misuse alcohol, drugs and tobacco.

National policy and legislation require that a JSNA is produced for each upper tier authority. In Lancashire, is has been agreed to conduct a combined JSNA covering Lancashire County Council, Blackburn with Darwen and Blackpool and their respective PCTs. It is believed this will allow those contributing to and using the JSNA will be able to make comparisons across the whole of Lancashire more straightfoward, as well as simplify and rationalise the work, enabling it to be carried out more efficiently.

Policy Context

This JSNA is being prepared during a time of extensive upheaval and reorganisation in the NHS and local government which will inevitably affect how services are commissioned and provided. Any findings and recommendations from this JSNA will therefore necessarily need to be responsive to these changes. In addition, revised national strategies and guidance for alcohol, drugs and tobacco have recently been published and this JSNA will need to complement these.

An outline of these reforms and revised policies are provided below.

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[5] http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010
[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

Health Reforms

There are four elements to the new health and wellbeing system: system management and co-ordination; public health; accountability and public involvement; and service-specific commissioning. Currently the reforms are due to be completed and the new system operating by April 2013, with shadow structures in the new system being established from 2011 and 2012.

The strategic co-ordination of the system will include the establishment of a health and wellbeing board for each upper-tier local authority, increased emphasis on the JSNA, and the development of the health and wellbeing strategy. The health and wellbeing board in each area will be a statutory committee of upper-tier local authorities that will be responsible for:

- Assessing the needs of the local population and leading the statutory integrated strategic needs assessment (JSNA).
- Promoting integration and partnership working by encouraging joined–up commissioning plans across the NHS, social care and public health.
- Supporting joint commissioning and pooled budget arrangements when applicable.
- Reviewing major service redesigns of health and wellbeing related services provided by the NHS and local government.

From April 2013 the local authority and the clinical commissioning groups, together with the local HealthWatch, will be required to prepare a JSNA which includes a comprehensive analysis of the current and future health and wellbeing needs and assets of their area. Based on the priorities emerging from the JSNA, the Lancashire health and wellbeing board will develop a joint, high-level, health and wellbeing strategy for Lancashire. The health and wellbeing strategy is intended to inform the commissioning decisions made by local partners to ensure they meet the needs of service users and communities, and tackle the factors that affect health and wellbeing across organisational boundaries. The health and wellbeing strategy will also need to take account of the NHS commissioning board's mandate from the Secretary of State for Health.

Local authorities, clinical commissioning groups and the NHS commissioning board will be required to produce commissioning plans that pay due regard to the local JSNA and health and wellbeing strategy to ensure their plans complement each other and address agreed priorities.

The public health aspect of the new health and wellbeing system includes a new national public health organisation, Public Health England, will be established as an executive agency within the Department of Health. It will have three main functions:

1. Delivering services to national and local government, the NHS and the public.
2. Leading for public health.
3. Supporting the development of the specialist and wider public health workforce.

It is expected that Public Health England will have four regional hubs, in addition to a national office, to support and deliver local services with local authorities and other organisations. Public Health England will operate alongside a local public health service, which will transfer to upper-tier local authorities from primary care trusts. A 'ring-fenced' grant for public health will be used by upper-tier local authorities to commission a range of public health services. Local authorities will be mandated to ensure the provision of:

- Appropriate sexual health services (excluding termination of pregnancy services which will be commissioned nationally).
- Plans to protect the health of the population.
- Public health advice to NHS commissioners when required.
- the national child measurement programme (NCMP).
- NHS health check assessment.

The local authority public health functions will be expected to commission a wide range of additional public health services across the life cycle in response to local health and wellbeing priorities such as:

- Stop smoking and tobacco control services.
- Workplace health services.
- Drug and alcohol services services.
- Dental public health.
- Affordable warmth.
- Preventing infant deaths.

In addition public health in Lancashire will commission:

- Alcohol and drug misuse services.
- Public health services for children and young people aged 5-19 (and in the -longer term all public health services for children and young people).
- Interventions to tackle obesity.
- Public mental health services.
- Accidental injury prevention.
- Interventions to reduce and prevent birth defects.
- Campaigns to prevent cancer and long-term conditions.

- Health protection plans including immunisation and screening.
- Health protection incidents, outbreaks and emergencies.
- Initiatives to reduce excess deaths as a result of seasonal mortality.
- Public health aspects of community safety and violence prevention.
- Initiatives to tackle social exclusion.

In Lancashire a director of public health will be appointed by April 2012, with public health staff appointed on 1st April 2013.

The accountability and public involvement element of the new health system includes the overview and scrutiny panel and HealthWatch. *Liberating the NHS* stresses the importance of capitalising on opportunities to strengthen the role of local authority health scrutiny following the reforms, although to date there has been little guidance on this nationally. In addition, one of the intentions of the reforms is for local communities to have a greater say in decisions about services. To realise this ambition, local people will be empowered through the local HealthWatch to have their say about their health and social care needs to ensure that services act upon feedback and can demonstrate that they have done so. The local HealthWatch will need to be accountable to:

- The local community it serves and represents.
- HealthWatch England, which will set relevant standards.
- The local authority commissioning HealthWatch services, who will be responsible for ensuring that HealthWatch is effective and represents good value for money.

Local HealthWatch will be established by April 2013, with HealthWatch England established from October 2012 to provide leadership and support to local HealthWatch.

Finally, as the service specific commissioning element of the new health and wellbeing system, clinical commissioning groups (CCGs) will commission the majority of NHS services. In addition the national commissioning board will commission general practice services and some specialist services. It will authorise CCGs and ensure they are effective commissioners of NHS services.

By April 2012 all CCGs across the country should meet their legislative requirements and will take over responsibility for commissioning from April 2013. Currently there are six clinical commissiong groups in Lancashire, one for Blackburn with Darwen, and one for Blackpool:

- Chorley and South Ribble CCG
- Greater Preston CCG – including Longridge
- Lancaster, Morecambe, Carnforth and Garstang CCG
- Pennine CCG - including Pendle, Burnley, Rossendale, Hyndburn and Ribblesdale (excluding Longridge)
- West Lancashire CCG (exploring close working with Sefton)
- Wylde CCG - Wyre and Fylde including Fleetwood
- Blackburn with Darwen CCG
- Blackpool CCG

Further details about the reforms of the health and wellbeing system are available from a number of national policy documents:

- *Equity and Excellence: Liberating the NHS*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
- *Healthy Lives, Healthy People White Paper: Our Strategy for Public Health in England* and *Healthy Lives, Healthy People White Paper: Update and Way Forward.* Available from: http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

- Health and Social Care Bill 2011. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm
- *Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies Explained*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131702
- Department of Health Factsheets - *Public Health in Local Government*. Available from: http://healthandcare.dh.gov.uk/public-health-system/

Alcohol Strategies and Policy

A number of key policy documents and strategies have recently been published for alcohol, including:

- NICE (2010) *Public Health Guidance 24: Alcohol-use Disorders: Preventing Harmful Drinking*.
- NICE (2011) *Clinical Guideline 115: Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence*.
- NICE (2007) *Public Health Guidance 7: Interventions in schools to prevent and reduce alcohol use among children and young people*.
- NICE (2010) *Clinical Guideline 100: Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications*.
- Department of Health (2010) Signs *for Improvement: Commissioning interventions to reduce alcohol-related harm*.
- Department of Health (2007) *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*.
- HM Government (2012) *The Government's Alcohol Strategy*.

- Department of Health (2011) *The Public Health Responsibility Deal*.
- HM Government (2011) Police Reform and Social Responsibility Act 2011 Chapter 13
- NHS National End of Life Care Programme (2012) *Deaths from Liver Disease: Implications for End of Life Care in England*.

Report Limitations

Every attempt has been made to ensure that the JSNA is comprehensive. Despite this, we know that the data on alcohol, drugs and tobacco is far from complete and not always available for all areas of Lancashire. Any gaps have been highlighted within the document and recommendations made to address these where appropriate or possible.

The analysis in the document is primarily based upon secondary data and it would be useful in the future to carry out some primary research to further understand how people use and misuse alcohol, drugs and tobacco.

Report Structure

This report is section one (alcohol) of three (drugs; and tobacco) that form the complete alcohol, drugs and tobacco JSNA. Each section has a summary of relevant national and local strategies and policies; outlines relevant data and analyses; and contains recommendations and priorities for each topic.

A Profile of Lancashire

Geography

The county of Lancashire, although a historic and geographic whole, is currently administered for NHS and local government purposes by five Primary Care Trusts (PCTs), three upper-tier local authorities and twelve district authorities.

Three of the primary care trusts (PCTs) – Central Lancashire PCT, East Lancashire PCT and North Lancashire PCT – administer the area managed by Lancashire County Council. Twelve district councils operate on this same 'footprint'. Blackburn with Darwen Care Trust Plus and Blackpool PCT share a boundary with Blackburn with Darwen and Blackpool unitary authority, respectively. From April 2013 the commissioning functions for the NHS currently provided by the PCTs will be managed by clinical commissioning groups (CCGs).

County councils and unitary authorities – collectively referred to as ‘upper-tier’ authorities - have responsibility for social services for children and young people and adults.

Table 1 - PCT and administrative areas covered

Council with Social Services Responsibilities	Local Authority District	PCT	Future CCG
Lancashire County Council	Chorley	Central Lancashire PCT	Chorley and South Ribble CCG
	South Ribble		
	Preston		Greater Preston CCG
	West Lancashire		West Lancashire CCG
	Burnley	East Lancashire PCT	East Lancashire CCG
	Hyndburn		
	Pendle		
	Ribble Valley		
	Rossendale		
	Fylde	North Lancashire PCT	Fylde and Wyre CCG
	Wyre		
	Lancaster		Lancaster, Morecambe, Carnforth and Garstang CCG
Blackburn with Darwen Borough Council		Blackburn with Darwen Care Trust Plus	Blackburn with Darwen CCG
Blackpool Council		Blackpool PCT	Blackpool CCG

The geographical area administered by Lancashire County Council, the twelve district councils and Central, East and North PCTs will be referred to in this report as the county of Lancashire or 'Lancashire-12' (referencing the number of district councils). The Lancashire sub-region (or Lancashire-14) is used to refer to the area administered by Lancashire County Council, Blackburn with Darwen and Blackpool unitary authorities, along with their respective PCTs.

Population

The sub-region of Lancashire is home to more than 1.4 million people, which is projected to increase but at a rate below both regional and national averages. Areas such as Burnley, Blackburn with Darwen and Hyndburn are projected to experience a reduction or very low rates of population growth over the period which stems from the decline of the manufacturing sector as a primary employer. Conversely, the

districts on the M6 corridor such as Chorley, Lancaster, Preston and South Ribble are predicted to experience stronger population growth as a result of economic growth experienced in recent years.

Ethnicity

The Lancashire sub-region is a less ethnically diverse area than the average for England. Approximately 90.9% of the population is white, the majority of these white British, compared to 87.5% nationally. Of the remaining ethnicities, Asian or Asian British comprise 6.5% of the Lancashire population, or approximately 94,000 individuals.

Deprivation

Lancashire has some of the most deprived parts of the country within its boundaries. Blackpool, Burnley, Blackburn with Darwen, Hyndburn, Preston and Pendle are ranked as being in the most deprived 50 local authorities nationally according to the 2010 Index of Multiple Deprivation (IMD).

More detailed demographical information about Lancashire is available from Lancashire Profile[7].

[7] http://www.lancashire.gov.uk/profile

Alcohol Consumption

Alcohol has been produced and consumed by humans for thousands of years and is an accepted part of our society today. When drunk in moderation, alcohol can provide enjoyment and encourage social cohesion. However, many people in the UK drink in a way that is harmful and a smaller number are dependent on alcohol. Excessive consumption is viewed as a serious problem with a range of health, social and economic consequences.

Existing Consumption Guidance

Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. In the longer term, harmful drinkers may go on to develop high blood pressure, cirrhosis, heart disease and some types of cancer, such as mouth, liver, bowel or breast cancer[8].

To clarify the terms used in association with alcohol consumption and its risks, the Department of Health now recommens the use of the following terms because these are more readily understood by the general public and reflect the increased level of risk incurred by drinkers as their consumption increases:

- Lower risk.
- Increasing risk.
- Higher risk.

The Department of Health terms correlate closely with the World Health Organisation terms, although they are not exactly the same.

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[8] NICE (2011) *Alcohol-use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence*. Available online: http://guidance.nice.org.uk/CG115/NICEGuidance/pdf/English [accessed January 2012].

Table 2 - Department of Health and World Health Organisation categories of alcohol consumption

Department of Health	World Health Organisation
Lower risk	Sensible
Increasing risk	Hazardous
Higher risk	Harmful

Lower risk

This group drink alcohol in line with the government's recommended lower risk limits. For women this is two to three units per day and for men this is three to four units per day. The term 'lower risk' implies that no level of alcohol consumption is completely safe, although people in this group are not generally considered to be misusing alcohol. The context in which alcohol is consumed can also determine the level of risk, for example drinking and driving.

Increasing risk

People in this, the higher risk and dependent groups are considered to be misusing alcohol. Increasing risk drinking is the largest group of people misusing alcohol and is made up of those who regularly drink over the recommended limits for lower risk drinking but are not regularly drinking at higher risk levels.

These drinkers might not currently be experiencing harm from their drinking but are at increasing risk of physical and mental ill-health and of being a victim of crime, contracting a sexually transmitted disease and, for women, are more likely to have an unplanned pregnancy. There are also risks to others such as aggression towards family members, general disorder, accidents and assaults.

Higher risk

This group regularly drink well over the recommended limits. Higher risk drinkers are men who regularly drink more than 50 units a week or eight units a day; and women who regularly drink more than 35 units a week or six units a day.

Although a smaller group than increasing risk drinkers, this group is at much greater risk of the wide range of alcohol-related health harms and the consequent costs, and so effective prevention and treatment can have a particularly powerful benefit in individuals who receive them.

Dependent Drinkers

Alcohol dependence is a particular form of higher risk drinking and has a particular set of characteristics. Rather than being defined by intake, dependency is essentially typified by an increased drive to use alcohol and difficulty controlling its use, despite negative consequences. There is also a risk of alcohol withdrawal on stopping. This group is relatively small compared to lower, increasing or higher risk drinkers.

Binge Drinking

Binge drinkers are a group of people who have episodes of drinking during which they drink to intoxication or to get drunk. This is commonly defined for epidemiological purposes as women drinking more than six units in any one day or men drinking more than eight units in any one day.

The government advises that people should not regularly drink more than the daily unit guidelines of three to four units of alcohol for men (equivalent to a pint and a half of 4% beer) and two to three units of alcohol for women (equivalent to a 175ml glass of wine). 'Regularly' means drinking every day or most days of the week. These guidelines are currently under review but current evidence suggests that in the context of the current daily guidelines, people should be advised to take at least two alcohol-free days a week[9].

[9] House of Commons Science and Technology Committee (2012) *Alcohol Guidelines Eleventh Report of Session 2010-12,* p. 3. Available online: http://www.publications.parliament.uk/pa/cm201012/cmselect/cmsctech/1536/1536.pdf [accessed January 2012].

Children and Young People

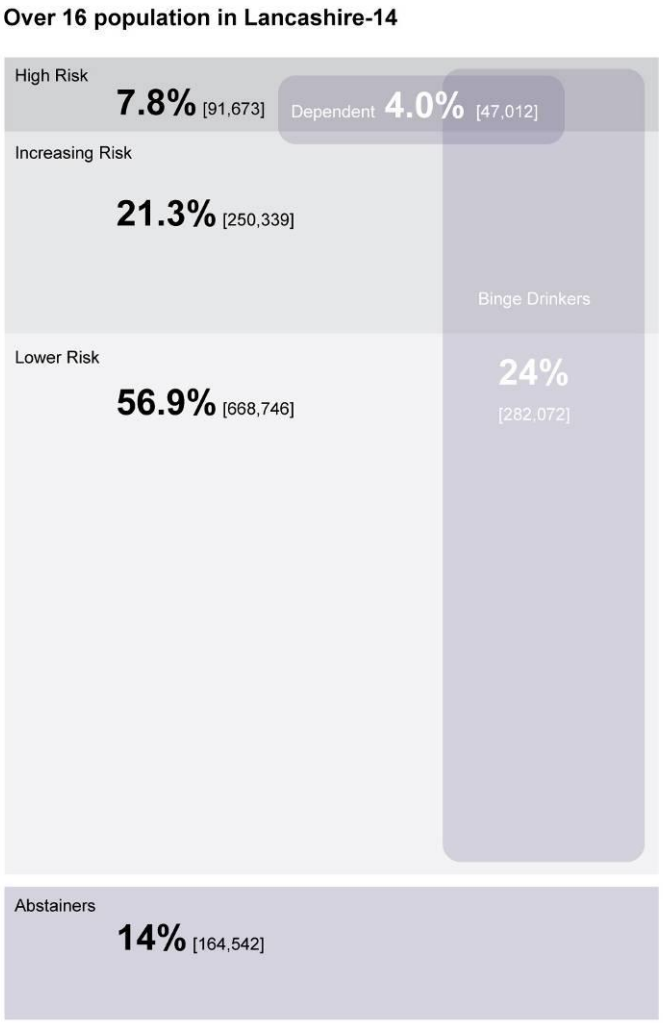
Until 2009, alcohol consumption guidelines had been produced only for adults. The Chief Medical Officer for England published specific guidance on the consumption of alcohol by children and young people in 2009. The advice was that:

- An alcohol-free childhood is the healthiest and best option.
- If children do drink alcohol, they should not do so until at least 15 years old.
- If 15 to 17 year olds drink alcohol, it should be rarely and never more than once a week. They should always be supervised by a parent or carer.
- If 15 to 17 year olds drink alcohol, they should never exceed the recommended adult daily limits and, on days when they drink, consumption should usually be below such levels.

Alcohol Consumption in Lancashire

The figure right summarises the percentage and number of people aged 16 and over who abstain or are lower risk, increasing risk, or higher risk drinkers in Lancashire.

Approximately 4% of drinkers – the vast majority of whom are high risk drinkers – are classified as dependent drinkers, or approximately 47,072 individuals in Lancashire. Additionally, it is estimated that 24% of all those who drink (lower, increasing, and higher risk drinkers) are binge drinkers, equating to approximately 282,072 individuals in Lancashire.



Estimates derived from the Dept of Health publication "Signs for Improvement: Commissioning interventions to reduce alcohol-related harm".

Alcohol Consumption by District

In Lancashire-14:

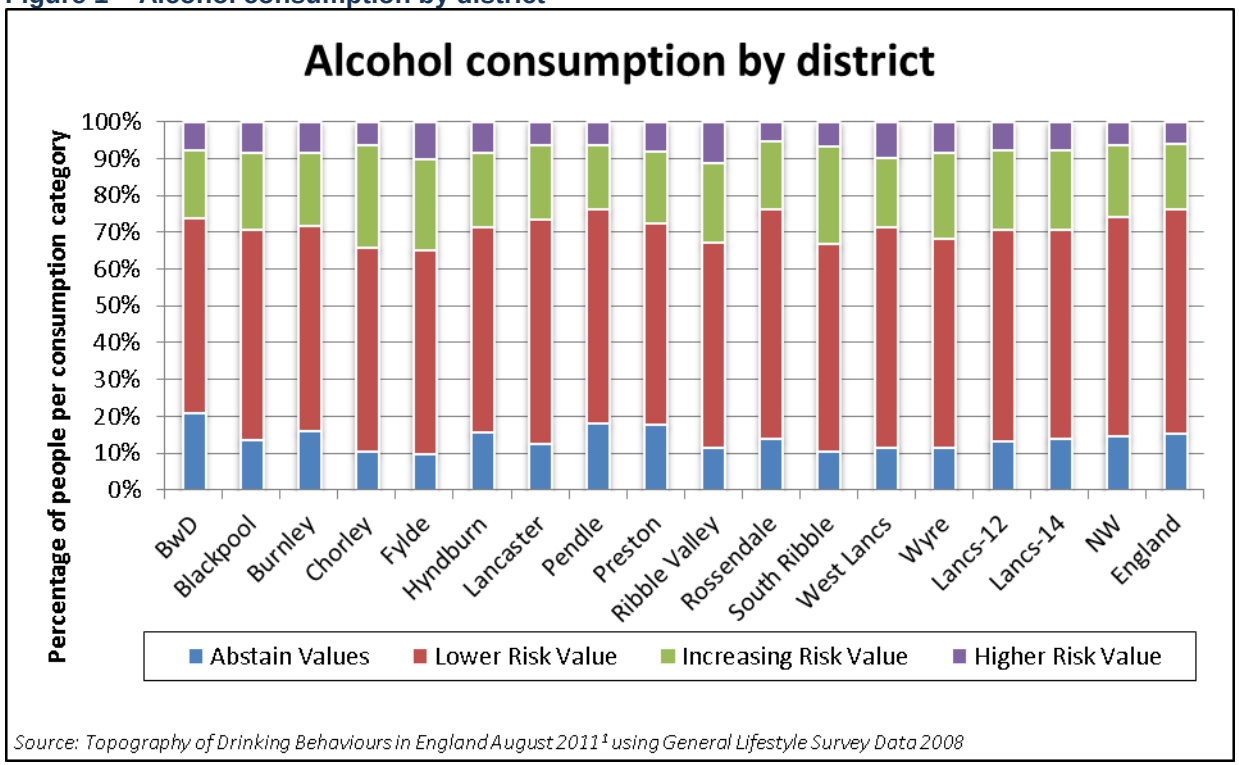
- 14% of the population abstain from alcohol.
- 57% consume alcohol at lower risk levels.
- 21% consume at increasing risk levels.
- 8% at higher risk levels.

There is no statistically significant difference between the 14 districts in Lancashire, or between the Lancashire figures and the England average. This could be a limitation of the survey method since it uses low numbers of respondents in each district. However, from the results:

- Fylde had the lowest proportion of abstainers at 9.7%, while Blackburn with Darwen had the highest at 20.9%.
- Ribble valley has the highest proportion of higher risk drinkers at 11.1%, while Rossendale had the lowest at 5.3%.

The England average for the synthetic estimates of binge drinking in people aged 16 years and over is 20.1%. In Lancashire 14, Blackpool, Burnley, Chorley, Ribble Valley and Rossendale all have synthetic estimates significantly higher than England average.

Figure 1 – Alcohol consumption by district



Source: Topography of Drinking Behaviours in England August 2011[1] using General Lifestyle Survey Data 2008

Binge Drinking

The table below is a synthetic estimate of the percentage of young people and adults aged 16 years and over that consume at least twice the daily recommended amount of alcohol in a single drinking session (eight or more units for men and six or more units for women).

Table 3 - Synthetic estimate of the percentage of the population aged 16 years and over who report engaging in binge drinking (2007-2008)

Area	Lower confidence interval	Value	Upper confidence interval
Blackburn with Darwen	16.1	19.2	22.7
Blackpool	20.9	24.7	28.9
Burnley	21.9	25.8	30.2
Chorley	22.8	26.2	30.0
Fylde	19.2	23.1	27.6
Hyndburn	19.3	23.2	27.6
Lancaster	18.0	21.0	24.4
Pendle	18.9	23.2	28.2
Preston	20.6	23.9	27.5
Ribble Valley	22.2	26.1	30.4
Rossendale	25.7	29.5	33.7
South Ribble	18.5	21.7	25.3
West Lancashire	19.5	22.5	25.9
Wyre	17.3	20.4	23.8
North West	**21.2**	**23.3**	**25.5**
England	**19.4**	**20.1**	**20.8**
Source: LAPE alcohol profiles			

The level of binge drinking in the districts of Blackpool, Burnley, Chorley, Ribble Valley and Rossendale is statistically significantly higher than the England average. Only the district of Rossendale is statistically significantly worse than the North West average. However, there

are limitations around the wide confidence intervals due to the methodology used and the relatively low sample on which the district calculations are based, so this is unlikely to offer an accurate picture of the level of binge drinking.

Ethnicity

Very little data is available at a Lancashire level for alcohol consumption by ethnic group. A review explores research on abstinence and drinking patterns among minority ethnic groups in the UK over the last fifteen years[10]. It looks at whether rates of alcohol use are changing among ethnic groups, and the possible impact of changes in drinking behaviour on support and services needed. Key points from the study are:

- Most minority ethnic groups have higher rates of abstinence and lower levels of drinking compared to people from white backgrounds, particularly those from Pakistani, Bangladeshi and Muslim backgrounds.
- People from Bangladesh are less likely to consume alcohol than other ethnic groups, and drinking rates are low amongst this group.
- Pakistani men who drink consume more alcohol in units compared to other minority ethnic groups. A similar pattern emerges for Muslims: Muslim men and women are both likely to abstain, but those who do drink tend to drink more compared to other religious groups.
- People from Indian, Chinese, Irish and Pakistani backgrounds on higher incomes tend to drink above recommended limits.
- People from minority ethnic groups have similar levels of alcohol dependence compared to the general population, despite drinking less.

[10] Joseph Rowntree Foundation (2010) *Ethnicity and Alcohol: A Review of the UK Literature*, p. 1. Available online: http://www.jrf.org.uk/sites/files/jrf/ethnicity-alcohol-literature-review-summary.pdf [accessed October 2011].

- Services are not responsive enough for minority ethnic groups:
    - Minority ethnic groups are under-represented in seeking treatment and advice for drinking problems, despite having similar rates of alcohol dependence to the general population.
    - Problem drinking may be hidden among women and young people from South Asian ethnic groups in which drinking is forbidden.
    - Greater understanding of cultural issues is needed in developing mainstream and specialist alcohol services.
- Some research shows that patterns of drinking in second generation minority ethnic groups may start to resemble the drinking habits of the general population.

Recommendation: community engagement should be used as a method of reaching hidden drinkers. Involving local agencies and stakeholders in consultations is key in developing services for such groups.

Deprivation

There are strong links between alcohol consumption and deprivation[11]. People who live in the most deprived areas nationally are nearly three times more likely to be dependent on alcohol than those from the least deprived areas.

[11] Marmot and Wilkinson (2003) *Social Determinants of Health: The Solid Facts*, p. 25. Available online: http://www.euro.who.int/en/what-we-publish/abstracts/social-determinants-of-health.-the-solid-facts [accessed October 2011].

Figure 2 - Relative risk of dependence (with most affluent set at 1)

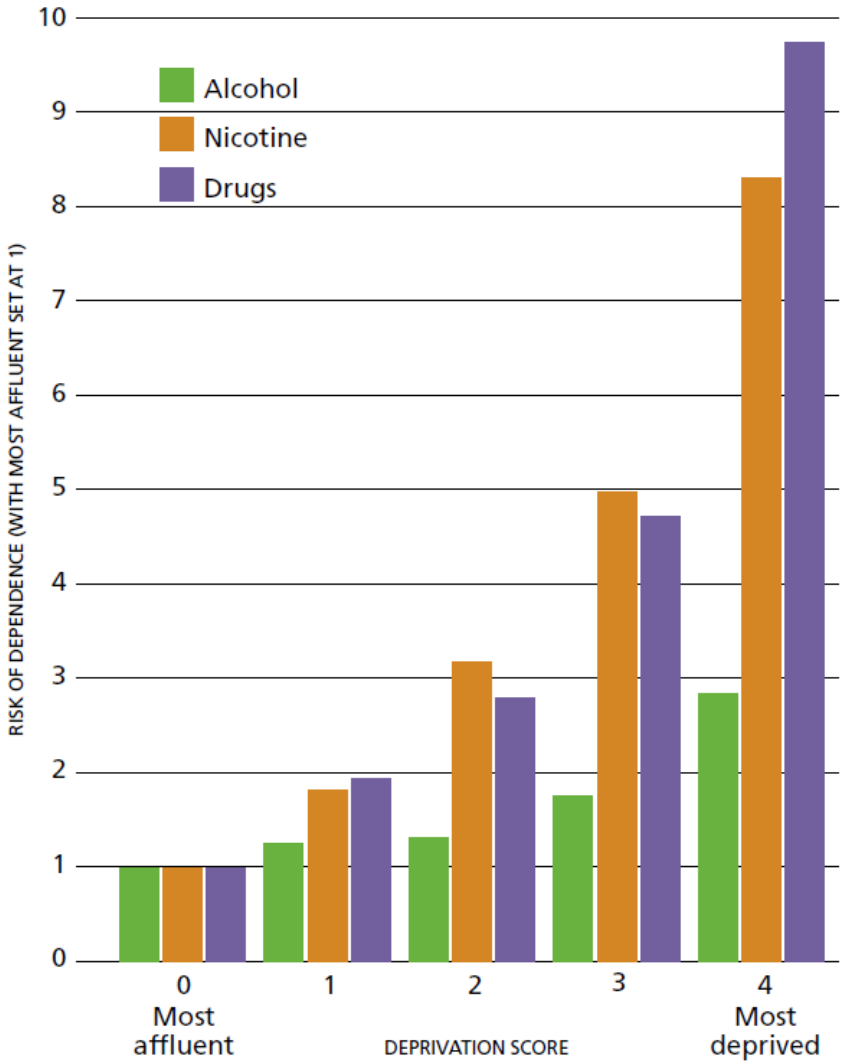


Figure source: Wardle, J et al (1999) in Marmot and Wilkinson (2003) *Social Determinants of Health: The Solid Facts* (2nd edn). Available online: http://www.euro.who.int/en/what-we-publish/abstracts/social-determinants-of-health.-the-solid-facts [accessed October 2011].

Age – Older People

Different age groups drink at different levels and for different reasons, with older age groups tending to consume less alcohol overall[12] [13]. However, this masks the number of 'hidden drinkers' in older aged groups. In 2009 the Welsh Health Survey found that 34% of men aged 65 and over, and 22% of women aged 65 and over had drunk more than the guideline amounts[14]. This is compared to 22% of men and 7% of women in 2003-04[15], and just 17% of men and 7% of women in 1994[16].

The ageing population in the UK means that by 2031 over 7.9% of the population will be over 85 years of age, compared to just 1.6% in the 1950s[17]. Alcohol-related falls and hospital admissions are indicating that increasing numbers of older people are at risk from alcohol-related health problems, yet alcohol consumption among older people remains a hidden issue at both policy and practice levels.

Older drinkers are often considered as one of three categories:

- Survivors – people who developed a problem with alcohol early in their life and have continued this pattern.
- Reactors – people who begin problematic drinking in later life, often in response to traumatic life events such as bereavement, loneliness, pain or retirement.
- Binge drinkers – people who use alcohol occasionally but to excess.

The report by Age UK[18] took a qualitative approach and the findings were based on group interviews with 61 people of various ages from 60 to 93 years old. Some of the highlighted issues from the report are listed below:

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[12] Institute of Alcohol Studies (2010) *Alcohol & the Elderly*, p.3. Available online: http://www.ias.org.uk/resources/factsheets/elderly.pdf [accessed November 2011].
[13] Royal College of Psychiatrists (2011) *Our Invisible Addicts: First Report of the Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists*, p. 7. Available online: www.rcpsych.ac.uk/files/pdfversion/CR165.pdf [accessed June 2011].
[14] Alcohol Concern (2011) *Hidden Harm?: Alcohol and Older People in Wales*, p.1. Available online: http://www.alcoholconcern.org.uk/publications/other-publications/hidden-harm [accessed November 2011]
[15] Ibid, p.2.
[16] Institute of Alcohol Studies (2010) *Alcohol & the Elderly*, p.3. Available online: http://www.ias.org.uk/resources/factsheets/elderly.pdf [accessed November 2011]
[17] Age UK (2009) *Older People and the Consumption of Alcohol in the Lancashire County Area.*
[18] Ibid.

- Current social marketing campaigns reinforce older peoples' belief that alcohol dependence or problems do not relate to them.
- The perception of some older people is that alcohol is medicinal, for example it will help them sleep or cure a cold.
- Sources of advice regarding alcohol consumption are unconvincing to older people as they have heard so many conflicting pieces of advice from 'professionals' that they no longer believe them.
- Older people assign a great deal of stigma to over-consumption of alcohol which has an impact on all aspects of its management.
- Service providers feel uncomfortable raising issues around drinking with older people and are unsure as to how to deal with concerns. They noted that they found it difficult to identify the point at which a 'pleasure changes into a problem.'
- Current alcohol services are not relevant or suitable for the needs of older people.
- Older people are increasingly drinking in their own homes due to the changing pub culture and the way pubs now focus on younger people and younger adults.
- The increasing number of older people taking early retirement seems to add to the problem of over-consumption as people find themselves having disengaged from one set of activities but still feel too young for the next set.

Recommendations for older people:

- **Ensure specific social marketing campaigns are designed with older people as the target audience.**
- **Involve older people in the design of treatment services to ensure they are accessible and appropriate for their needs.**
- **Focus on providing training for all care staff on alcohol brief interventions.**
- **Routinely include advice about the potential dangers of increasing alcohol consumption in pre-retirement courses.**

Age – Children and Young People

A recent survey by Trading Standards North West (2011) revealed that the proportion of 14-17 year olds claiming to:

- Drink alcohol once a week or more has continued to decline (53% in 2005; 31% in 2011).

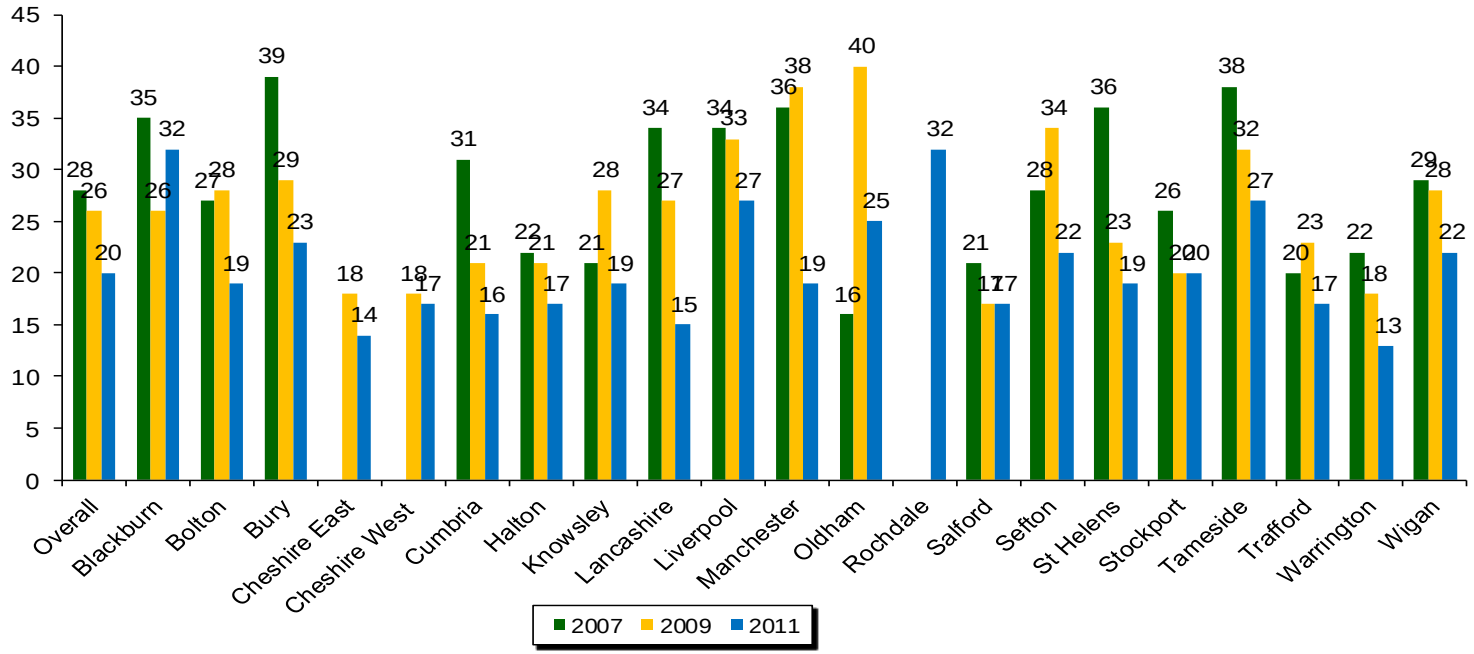
- Drink twice a week or more has fallen (30% in 2007; 17% in 2011).
- Binge drink regularly (five or more alcoholic drinks at least once a week) has reduced by 19%.
- Purchase their own alcohol has fallen significantly (38% in 2005; 15% in 2011).

Although there have been significant improvements in this data, Lancashire is still above the North West average for many of the behaviours reported through the survey:

- 80% of 14-17 year olds in Lancashire surveyed said they drink alcohol and 65% claimed they binge drink.
- Of the 14-17 year olds that report that they drink alcohol, 17% drink alcohol twice a week or more and 20% binge drink at least once a week.
- Of the 14-17 year olds that report that they drink alcohol, 22% said they mostly drink outside.
- Of the 14-17 year olds that report that they drink alcohol, 25% said they have been violent or in a fight whilst drunk and 15% said that they regretted having sex after drinking.[19]
- Most 14-17 year olds claim to get alcohol from their friends and family. There has been an 8% increase since 2007 (59% in 2011 – which is above the North West average) in parents and or/guardians supplying alcohol.
- The percentage of 14-17 year olds claiming to buy alcohol themselves has remained consistent or fallen for most local authorities. Lancashire had one of the lowest percentages for 14-17 year olds purchasing alcohol themselves (15%), 5% below the regional average (20%).[20]

[19] North West Child Matters intelligence briefing: "*Young people's lifestyle choices and related health indicators: local area profile for Lancashire"*; November 2011.
[20] Source: Trading Standards North West (2011) *Young Persons Alcohol and Tobacco Survey 2011*.

Figure 3 - Percentage of 14-17 year olds claiming to buy alcohol themselves by local authority



Base: 2007 – 9410; 2009 – 10,802; 2011 – 10,004
Balance: Not stated
Source: "Young Persons Alcohol and Tobacco Survey 2011", Trading Standards North West

Enforcement Strategies

Evidence suggests that strict enforcement of the Licensing Act, which bans the sale of alcohol to minors, only has a limited impact on the general access and availability of alcohol to young people. Therefore the focus in Lancashire has been to break the link between alcohol and anti-social behaviour and reduce the availability of alcohol to young people through a combination of education, training and enforcement, involving children, parents, support agencies and retailers.

Test Purchasing

Test purchasing operations have targeted retailers suspected of selling alcohol to children. Lancashire Trading Standards conducts approximately 500 alcohol test purchase compliance visits per year. Retail compliance has increased from 74% in 2005/06 to 85% in 2011/12. In Blackburn with Darwen the compliance rate was 82% in 2011/12 based on 141 test purchases. The latest Trading Standards North West survey conducted in 2011 reveals a significant decrease in the number of young people claiming to purchase alcohol themselves, falling from 38% in 2005 to 15% in 2011 in Lancashire. The survey includes responses from over 13,000 14-17 year olds across the North West, 1,461 of whom are from Lancashire.

To supplement formal enforcement action a retailer due diligence resource (AgeCheck) has been produced by Lancashire Trading Standards and distributed to over 7,000 retailers across Lancashire that sell age restricted products like alcohol and tobacco. The award-winning resource is designed to provide retailers with skills and knowledge to assist them in preventing illegal underage sales. This resource has contributed to the increase in retail compliance across Lancashire. The resource is currently being updated to include more specific information around proxy sales for a further distribution run to retailers across Lancashire.

Community Alcohol Networks

Community alcohol networks (CAN) are a problem-oriented partnership which have been designed and implemented by Lancashire Trading Standards and Lancashire Constabulary:

- To reduce young people's access to alcohol with the aim of reducing binge drinking, risky drinking and anti-social behaviour resulting of alcohol consumption.
- To reduce the number of alcohol sales to minors and tackle attempted purchasing and proxy purchasing through enforcement activity in identified hotspots and effective education.

- Develop the perception among enforcers and the wider community that retail staff are a key part of the solution rather than part of a problem.
- To raise awareness of alcohol-related health and social issues among young people, parents and the wider community.

A pilot community alcohol network was established in Accrington. Over the six month period from June 2011 until November 2011 juvenile anti-social behaviour was reduced by 53% (170 down to 80) and total anti-social behaviour has reduced by 32% (859 down to 580) when compared to the same period in 2010. Compliance rates for licensed premises during subsequent test purchasing operations improved from 73% to 100%.

Young people were recognised for contributing to community safety and most were aware of the CAN. Residents, previously affected by anti-social behaviour, had noticed less underage drinking and felt the area had improved. A local resident was recognised at an awards ceremony for her contribution to the CAN. Licensees felt safer; noticed less under-18s attempting to buy alcohol and a reduction in underage drinking; and would like the CAN extended to other areas. Parents, carers and professionals felt informed and supported. The CAN was extensively reported in the local press.

Recommendation: Identify funding to expand the community alcohol network.

Adverse Effects of Alcohol

The adverse effects of alcohol can be acute or chronic.

Acute Effects

Acute effects are where alcohol consumption puts individuals at an increased risk of falls, injuries from alcohol related violence or fire injuries. The following table summarises the acute effects of alcohol consumption.

Table 4 - Acute adverse effects associated with the use of alcohol

Physical		Psychological/psychiatric
Mortality	**Morbidity**	
Large doses (blood alcohol concentrations greater than 3-4 g/L) may lead to: ▪ Coma and death. ▪ Asphyxiation. ▪ Respiratory depression.	Violence and injuries Increased morbidity associated with violence (e.g. assaults) and accidents.	Organic/neurological ▪ Impairment in memory, planning and judgement (psychomotor and cognitive impairment). ▪ Temporary loss of the ability to form new memories (anterograde amnesia). ▪ Memory blackout.
Increased mortality associated with accidents including: ▪ Road traffic accidents. ▪ Drowning. ▪ Deaths from fire. ▪ Workplace accidents. ▪ Falls.	Physiological responses ▪ Low blood sugar (hypoglycaemia). ▪ Raised blood pressure. ▪ Irregular heartbeat (arrhythmia). ▪ Sleep disturbance. ▪ Decrease in sharpness of vision, hearing, and other senses. ▪ Decreased coordination and loss of balance (ataxia). ▪ Drowsiness, loss of consciousness. ▪ Facial flushing. ▪ Hypothermia. ▪ Increased rate of urination (diuresis). ▪ Dehydration.	
Heavy drinking episodes associated with: ▪ Acute pancreatitis. ▪ Cardiovascular deaths.	Gastrointestinal complications ▪ Gastritis, vomiting and acid reflux from acute intake of large amounts of alcohol. ▪ Diarrhoea, nausea.	Personality/mood ▪ Reduced inhibitions. ▪ Argumentative and aggressive behaviour. ▪ Thoughts about suicide (suicidal ideation)

	▪ Rupture of the oesophageal mucosa; associated with vomiting after drinking (Mallory-Weiss tears).	may be intensified with alcohol use.
Source: Department of Health (2011) *A Summary of the Health Harms of Drugs*		

Chronic Effects

Chronic effects are conditions that can be wholly related to alcohol consumption, for example mental and behavioural disorders, due to intoxication, cirrhosis of the liver and liver cancer. The table below summarises the chronic effects of alcohol consumption.

Table 5 - Chronic adverse effects associated with the use of alcohol

Physical		Psychological/psychiatric	Dependence/withdrawal/tollerance
Mortality	**Morbidity**		
<u>Violence and injuries</u> Increased risk of premature mortality from accidents, suicide and violence. <u>Liver disease</u> ▪ Alcoholic hepatitis. ▪ Liver cirrhosis. <u>Cardiovascular complications</u> ▪ Disease of the heart muscles (cardiomyopathy). ▪ Coronary heart disease. ▪ Abnormal heart rhythm (arrhythmia). <u>Neurological complications</u> ▪ Haemorrhagic stroke. <u>Cancers</u> ▪ Mouth and throat (lip, oral cavity, pharynx and larynx). ▪ Digestive system	<u>Neurological complications</u> Risk factor for first epileptic seizure. <u>Infectious diseases</u> Risk factor for incidence and re-infection of tuberculosis. <u>Muscle, joint and bone</u> ▪ Damage to the peripheral nervous system (peripheral neuropathy / polyneuropathy). ▪ Muscle weakness and pain (myopathy). <u>Cardiovascular complications</u> ▪ High blood pressure (hypertension). ▪ Alcohol-related heart failure (alcoholic cardiomyopathy). <u>Gastrointestinal complications</u>	<u>Organic/neurological</u> ▪ Neurobiological brain injury. ▪ Alcoholic cerebellar degeneration. ▪ Deficiency of vitamin B1 (Wernicke–Korsakoff syndrome). ▪ Memory loss, memory blackouts. <u>Personality/mood</u> ▪ Psychotic symptoms during intoxication or withdrawal (including depression, paranoia and anxiety). ▪ Loss of self-esteem.	<u>Dependence</u> ▪ *Moderate dependence* – characterised by raised level of tolerance, symptoms of alcohol withdrawal and impaired control over drinking. ▪ *Severe dependence* – characterised by severe alcohol withdrawal and high tolerance; individuals may have experienced withdrawal fits or delirium tremens, and they may drink to avoid symptoms of withdrawal. <u>Withdrawal</u> ▪ Withdrawal can be fatal. ▪ Convulsions. ▪ Tremors. ▪ Anxiety. ▪ Paranoia. ▪ Hallucinations. ▪ Sudden and severe mental or neurological changes (delirium tremens). <u>Tolerance</u>

(oesophagus, colon and rectum). ▪ Liver. ▪ Breast. <u>Gastrointestinal complications</u> ▪ Gastrointestinal bleeding. ▪ Pancreatitis. ▪ Gastritis. ▪ Peptic ulcer disease (evidence is inconclusive but higher prevalence in patients with liver cirrhosis). ▪ Enlarged and damaged veins in the lower oesophagus.	▪ Pancreatitis. ▪ Gastritis. ▪ Peptic ulcer disease (evidence is inconclusive but higher prevalence in patients with liver cirrhosis). ▪ Enlarged and damaged veins in the lower oesophagus. <u>Liver disease</u> ▪ Fatty liver disease. ▪ Alcoholic hepatitis. ▪ Cirrhosis of the liver. <u>Reproductive disorders</u> ▪ Disrupts the menstrual cycle and ovulation. ▪ Can reduce chances of conception. ▪ Long-term alcohol abuse has been linked to sexual dysfunction and impairment of sperm production in men. <u>Complications in pregnancy</u> ▪ Spontaneous abortion. ▪ Still birth. ▪ Preterm delivery and decrease in length of gestation. ▪ Decreased foetal growth and birth weight. ▪ Foetal-alcohol syndrome – a clearly-defined disorder particularly seen in heavy drinkers.		▪ Tolerance to the toxic effects may not develop in parallel with tolerance to the central nervous system depressant effects – increases the likelihood of drug induced organ damage. ▪ Increased capacity to metabolise alcohol (declines after several weeks of abstinence).

	▪ Foetal-alcohol spectrum disorder – a more recent categorisation that acknowledges the likely wider impacts of varying levels of alcohol consumption on the developing foetus.		
Source: Department of Health (2011) *A Summary of the Health Harms of Drugs*.			

Alcohol-Related Admissions and Alcohol-Specific Admissions and Deprivation Factors

The link between alcohol-related hospital admissions and deprivation is well documented, with a number of studies showing a link between alcohol-related admissions and deprivation. A study by the North West Public Health Observatory found a strong relationship between alcohol-attributable conditions and deprivation, with increasing deprivation being linked to increasing hospital admissions[21]. Findings of a study in Finland also suggest a link between high alcohol-related admission rates and higher deprivation levels[22]. Another study by Yorkshire and Humber Public Health Observatory (2011)[23] also found evidence of a strong positive relationship between these admissions and deprivation: the higher level of deprivation, the higher rate of alcohol-related admission. The Marmot Review[24] mentions an association between alcohol-related hospital admissions and high levels of deprivation for both men and women, with particularly high rates of admission for those areas among the most deprived quintile of England and Wales. In terms of employment and alcohol-

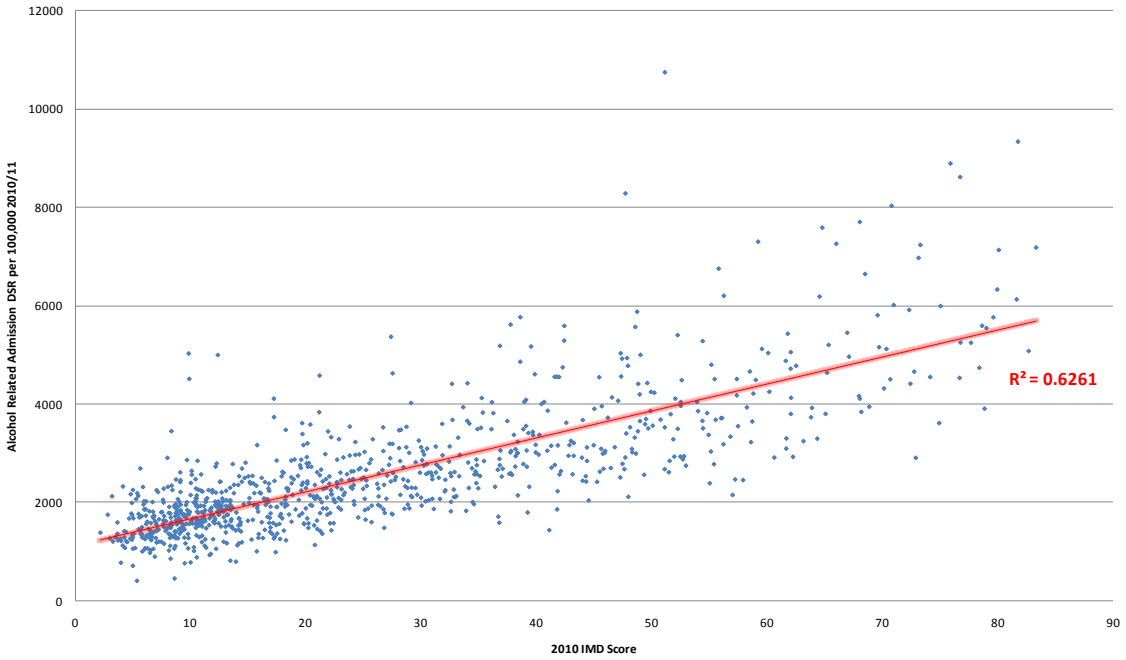
[21] North West Public Health Observatory (2010) *Alcohol-attributable hospital admissions: segmentation series report 3*.
[22] Makela P., et al (2003) 'What underlies the high alcohol related mortality of the disadvantaged: high morbidity or poor survival?' in *J Epidemiol Community Health*, no. 57: pp981-986.
[23] YHPHO (2011) *Alcohol–related hospital admissions, Data Bites Issue 3*.
[24] Marmot Review (2010) *Strategic Review of Health Inequalities in England post 2010: Fair Society, Healthy Lives*.

attributable admissions, a review by Portsmouth City Council found areas of deprivation and high unemployment to have higher rates of alcohol-attributable hospital admissions[25].

Each point on the scatterplot below represents a Lower Layer Super Output Area (LSOA) within the Lancashire-14 area. These are plotted according to their index of multiple deprivation score (IMD) and the rate of alcohol-related admissions. The red line is a line of best fit. R^2 is a number between 0 and 1 that reveals the strength of association between the two variables (i.e. IMD score and rate of alcohol-related admissions). An R^2 equal to 1 suggests a strong association between the two variables (i.e. alcohol-related hospital admissions are strongly related to deprivation), while an R^2 value of 0 suggests no association (i.e. alcohol-related hospital admissions are unrelated to deprivation).

[25] Portsmouth City Council (2011) *Health Overview & Scrutiny Panel - Review of alcohol-related hospital admissions*.

Figure 4 - Correlation between alcohol-related hospital admissions and deprivation – Lancashire-14 LSOAs



The high r^2 value (0.63) shows a clear correlation between rates of alcohol-related admissions and overall deprivation score. Therefore the most deprived areas tend to have the highest rates of alcohol-related admissions, while the least deprived areas have the lowest rates.

The IMD score is calculated based on nine domains of deprivation. The association between each domain of the IMD and alcohol-related admissions are summarised in the table below.

Table 6 - Correlation (r squared) between alcohol-related admissions and the domains of deprivation

Deprivation Domain	R^2
IMD Score	**0.63**
Employment Deprivation	0.63
Health Deprivation and Disability	0.62
Income Deprivation	0.55
Income Deprivation Affecting Children	0.53
Education, Skills and Training	0.50
Income Deprivation Affecting Older People	0.46
Crime and Disorder	0.42
Living Environment	0.29
Barriers to Housing and Services	0.02

The table shows there is a strong association between alcohol-related admissions and employment deprivation and health deprivation and disability. There is a fairly strong correlation between alcohol-related admissions and income deprivation; income deprivation affecting children; education deprivation; income deprivation affecting older people; and crime and disorder. There is a weak or no correlation between alcohol-related admissions and the living environment or barriers to housing and services.

It would be reasonable to assume that if there is a rise in employment deprivation or health deprivation in an area there would also be a rise in alcohol-related admissions.

Recommendation: Further investigate and highlight employment and health deprivation as priority areas.

Recommendation: Examine opportunities for early identification of those facing employment or health issues.

The same method was used to examine the correlation between alcohol-specific admissions and deprivation. This group of patients are likely to be those that have a very high level of dependence over a long period of time or who engage in extreme episodes of binge drinking. No correlation was found, suggesting that this relatively small group of individuals live in all types of areas throughout Lancashire.

Recommendation: Areas of affluence should not be excluded from alcohol interventions.

Alcohol-Attributable Hospital Admissions

The Department of Health and North West Public Health Observatory has produced national guidance for monitoring alcohol-attributable hospital admission rates. This identifies a list of 12 conditions that are wholly attributable to alcohol and 25 conditions that are partially attributable to alcohol. Each condition is assigned an Alcohol Attributable Fraction (AAF). All admissions that are wholly attributable to alcohol have an AAF of 1. All admissions that are partially attributable to alcohol have an AAF between 0 and 1. The AAF is dependent on the age, gender and condition of the patient. In the Lancashire-14 admissions for conditions that are wholly attributable to alcohol make up 27% of all alcohol-attributable hospital admissions.

Alcohol-attributable hospital admissions are monitored by a patient's area of residence, not which hospital they are admitted to – i.e. a patient who lives in Chorley but is admitted to a hospital in Manchester is still included as a Chorley patient.

Admitted to Hospital with Alcohol-Attributable Conditions

The table below identifies rates of alcohol-attributable hospital admissions in each of the Lancashire local authorities in 2009/10. It shows that in all of the 14 local authorities alcohol-attributable hospital admission rates are higher in males than females. Alcohol-attributable hospital admissions rates also increase significantly with age and are highest in individuals aged over 75 years.

Blackburn with Darwen and Burnley have the highest rates of alcohol-attributable hospital admissions in 2009/10, and Fylde and Ribble Valley have the lowest rates. The table below lists the ten most common alcohol-attributable conditions in Lancashire-14. It shows that hypertensive diseases, mental and behaviour diseases due to the use of alcohol, and cardiac arrhythmias alone are responsible for over 71% of all alcohol-attributable hospital admissions. Hypertensive diseases alone equate to 37.5% of all alcohol-attributable admissions.

The conditions that are included in the definition of alcohol-attributable hospital admissions do not have to be the primary reason for admission. For example, in over 90% of admissions recorded as hypertensive diseases the patient is primarily admitted to hospital for another condition.

Table 7 - Alcohol Related Admissions 2010/11 by AAF Diagnosis Group – Lancashire-14

Code	Alcohol Attributable Condition	Proportion of Total Admissions
209	Hypertensive Diseases	37.5%
102	Mental and Behavioural Disorders Due to Use of Alcohol	18.2%
210	Cardiac Arrhythmias	15.7%
208	Epilepsy and Status Epilepticus	8.4%
108	Alcoholic Liver Disease	4.6%
110	Ethanol Poisoning	3.5%
224	Fall Injuries	1.7%
231	Intentional Self-Harm / Event of Undetermined Intent	1.7%
216	Chronic Hepatitis / Fibrosis and Cirrhosis of Liver	1.1%
218	Psoriasis (Excluding Cirrhosis)	1.0%
	All Other Alcohol Attributable Conditions	6.6%
Source: Secondary Uses Service (SUS) via CLCBS		

Recommendation – Improve effective prevention and management of hypertensive diseases in order to make a significant contribution to reducing alcohol-related hospital admissions.

Admitted to Hospital with Conditions that are Wholly Attributable to Alcohol

The 12 conditions that are wholly attributable to alcohol are a subset of the total 37 alcohol-attributable conditions. In all of the 14 local authorities in Lancashire, admissions to hospital for conditions that are wholly attributable to alcohol are higher for males than females, and highest for individuals in the 35 to 65 year old age group. This is notably different to the age profile of individuals admitted to hospital for alcohol-attributable conditions. Blackburn with Darwen and Blackpool have the highest rates of admissions to hospital for conditions that are wholly attributable alcohol in 2009/10, and Fylde and Ribble Valley have the lowest rates.

Mental and behavioural disorders due to use of alcohol is the most significant condition that is wholly attributable to alcohol. It accounts for 18% of all alcohol-attributable hospital admissions and 66% of all conditions that are wholly attributable to alcohol. Mental and behavioural disorders due to use of alcohol is made up of alcohol withdrawal; alcohol dependence; and acute intoxication.

Recommendation: Identify and examine how life expectancy can be increased in patients admitted to hospital for conditions that are wholly attributable to alcohol.

Recommendation: Improve prevention, treatment and management of alcohol dependent individuals to reduce levels of dependent drinkers being admitted to hospital.

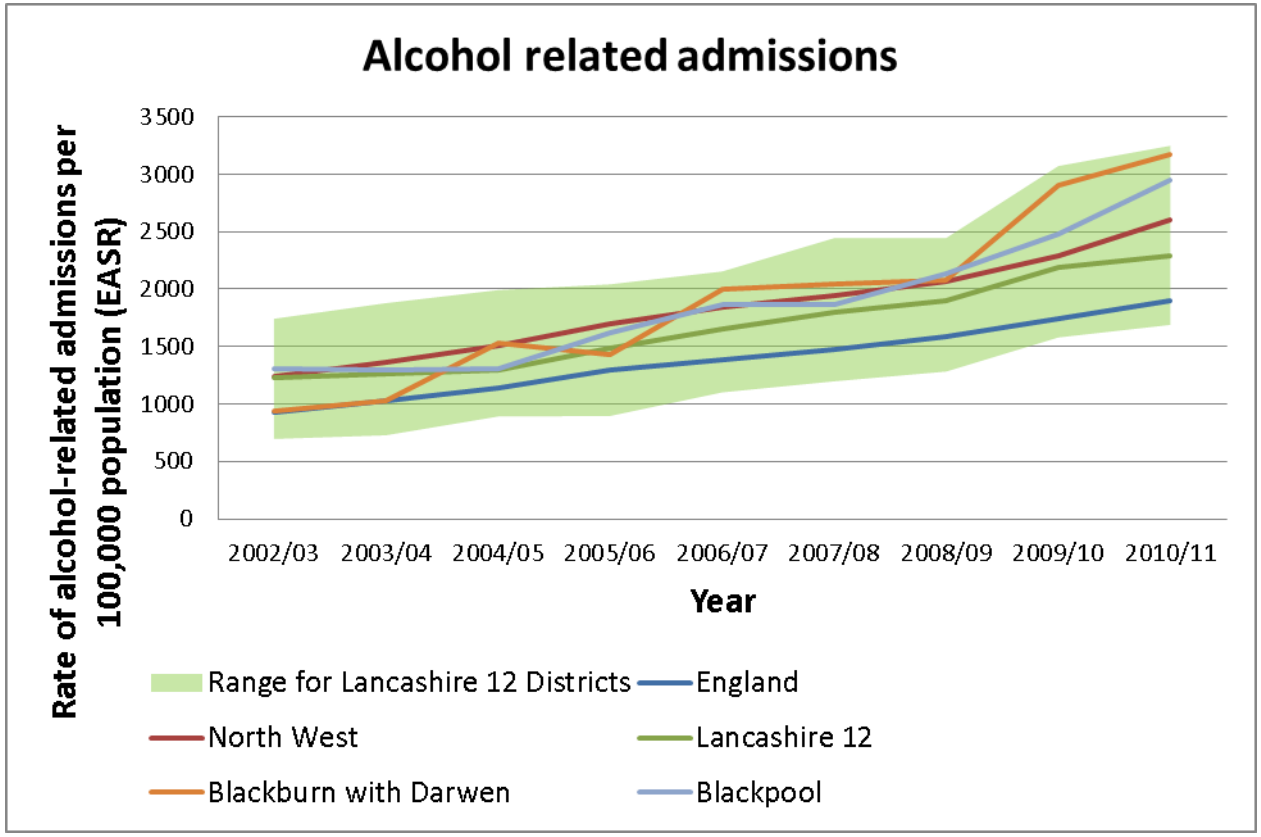
Hospital Admissions Time Series Analysis

Admissions to hospital for conditions that are attributable to alcohol have increased consistently over the period 2002/03 to 2010/11. In all Lancashire-14 local authorities we have seen an overall increase in alcohol-attributable hospital admissions, but there are variations in the rates of increase.

Recommendation: an important observation to note is the significant increase in 2009/10 in admissions to East Lancashire NHS Trust. This is relevant to local authorities in the east of Lancashire and requires further investigation.

In 2010/11 there were 41,988 admissions to hospital due to alcohol within Lancashire-14. This highlights the significance of this issue to all agencies involved. The chart below illustrates the rate of alcohol-related admissions per 100,000 population in Lancashire compared to the North West and England. See table in appendix for further details of the rate of alcohol-related admissions per 100,000 population.

Figure 5 - Rate of alcohol-specific admissions per 100,000 population



Mortality

The LAPE profiles contain nine mortality indicators, covering alcohol-specific and alcohol-attributable mortality, and all deaths from chronic liver disease.

Given the wide confidence intervals associated with the LAPE data it is difficult to specify with any certainty whether districts in Lancashire generally perform worse than the England average. However, for males the districts of Blackburn with Darwen, Blackpool, Preston and Rossendale; and for females Blackpool and Burnley perform significantly poorer than the England average.

In the districts of Blackburn with Darwen, Blackpool, Preston, and Rossendale there are statistically significant inequalities in mortality between males and females, with poorer outcomes for males.

The North West has the highest average annual number of deaths from alcoholic liver disease in the country with a rate of 14.9 per 100,000 average over 2001-09, compared to just 6.4 per 100,000 in the east of England[26]. Additionally, the number of deaths overall has been steadily increasing across England (9,231 deaths from all liver disease in 2001, to 11,575 in 2009)[27].

Sex

Health inequalities associated with alcohol are clearly evident. Alcohol-related death rates and deprivation in England and Wales show a strong association, with alcohol-related death rates more than five times higher among males and more than three times higher among females for those living in the most deprived areas. Months of life lost due to alcohol varies considerably between districts in Lancashire. For males it ranges from 7.5 months to 20.8 months; for females it ranges from 3.9 months to 9.1 months.

Foetal Alcohol Spectrum Disorders

Internationally, 0.97 per 1,000 live births are affected by foetal alcohol syndrome (FAS)[28]. Between 2002-03 and 2007-08, 987 babies were diagnosed with FAS in England[29]. Unfortunately there is limited information available in the UK and regionally about FAS and foetal

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[26] NHS National End of Life Care Programme (2012) *Deaths from Liver Disease: Implications for End of Life Care in England,* p. 11. Available from: http://www.endoflifecare-intelligence.org.uk/resources/publications/deaths_from_liver_disease.aspx

[27] Ibid, p. 8.

[28] Morleo, M et al (2011) *Under-reporting of foetal alcohol spectrum disorders: an analysis of hospital episode statistics*, p.2. BMC Pediatrics, 11:14.

alcohol spectrum disorders (FASD). Available data indicates that the North West region does not have higher rates of FAS and FASD than nationally, suggesting an under-reporting of these conditions[30].

Safeguarding

Obtaining safeguarding data where alcohol is a factor is problematic since this information is not routinely coded in a database that can be easily searched. Typically, Lancashire County Council receives approximately 3,440 safeguarding alerts per year[31]. It is believed a significant proportion have alcohol as a contributory factor, but it is not possible to say with any certainty what proportion this is.

Recommendation: systematic coding of safeguarding incidents where alcohol is a contributory factor.

Child Deaths

The Lancashire, Blackburn with Darwen and Blackpool Child Death Overview Panel (CDOP) reviewed a total of 298 child deaths in Lancashire-14 between April 2008 and April 2009. Of these, 74 had a 'modifiable factor' relating to the death (n=74). 8 cases (10.8%) identified alcohol use or misuse in the parent as a factor in the child's death; and in 2 cases (3%) alcohol use or misuse in the child was a factor in the child's death.

This data has the following limitations, however. First, there will be some variance in how individual professionals gather and record information. Second, these factors are often present together or alongside other factors such as domestic violence.

Recommendation: ensure effective dissemination and implementation of recommendations from lessons learned reports.

Recommendation: ensure all commissioned services have policies to address 'hidden harm.'

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[29] Op cit, p. 3
[30] Op cit, p.5
[31] Lancashire County Council Adult and Community Services

Incapacity

Nationally the number of people claiming incapacity benefit or severe disablement allowance (IB/SDA) for reasons of alcoholism is 103.7 per 100,000. This is significantly higher in the North West where 173.4 per 100,000 people claim these benefits for reasons of alcoholism.

The districts of Blackburn with Darwen, Blackpool, Burnley and Lancaster are statistically significantly worse than the North West rate, suggesting significant problems of alcoholism in these areas. Conversely, the districts of Chorley, Fylde, Ribble Valley, South Ribble West Lancashire and Wyre have a statistically significantly lower rate than the North West rate.

Similarly, Blackburn with Darwen, Blackpool, Burnley, Hyndburn, Lancaster, Pendle, Preston, and Rossendale are statistically significantly worse than the England rate. It is worth noting that the rate of benefits claimants for reasons of alcoholism is approximately three times higher than the England rate in Blackburn with Darwen, Blackpool and Burnley, and approximately twice the England rate in Lancaster and Preston.

The rate in Ribble Valley, South Ribble, and West Lancashire are statistically significantly lower than the England rate.

Community Safety

****Restricted: data contained within this section should only be used in relation to this report and is not for public quotation or further dissemination without prior approval****

Alcohol is a key contributory, and often causing, factor in many types of criminal behaviour. The negative impact of alcohol misuse has been reported as a significant issue in all local area community safety strategic assessments in 2011.

Although crime in general is reducing in Lancashire, violent crime and violence with injury is expected to have increased by around 5% during the year ending March 2012. About a third of all violence crimes are given an alcohol marker but this is likely to be an under-

recording of the real issue. A large proportion of violence against the person is either centred around the night-time economy or is domestic abuse.

The night-time economy – where bars, pubs, clubs and fast food outlets are clustered – is drawn out by most districts where violent crime is a key issue as problematic and an influencing factor in the levels of violent crime. Victims and offenders tend to be typically males aged between 15 and 25, although this age group is also the most prolific for females. The weekend is when most incidents occur and incidents are centred around night-time economy locations such as central Preston, central Burnley, central Lancaster and central Blackpool. Blackpool accounts for almost a quarter of recorded violence with injury across Lancashire and a higher proportion of these crimes (38%) have an alcohol marker than the Lancashire average. Central Blackpool also has the highest density of licensed premises in the county.

Alcohol is often a contributory factor in the escalation of violence in domestic abuse cases, although other issues such as other substance misuse, mental or physical health, employment, social services intervention and civil or criminal interventions are factors as well. These issues affect both the victim and perpetrator. 73% of probation clients who are domestic violence perpetrators have alcohol misuse issues[32].

A quarter of all sexual offences and 35% of serious sexual offences were alcohol-related between April 2010 and March 2011. The LAPE alcohol-related sexual offences profile shows that Blackpool and Burnley both had the highest rates at 0.23 per 1,000 population, followed by Preston at 0.20. This is above the England and North West rates of 0.13. Drinking alcohol makes victims more vulnerable to this kind of crime because it reduces awareness of danger.

Alcohol is also an influencing factor, along with drugs, in the enticement of victims for child sexual exploitation. The relationship between victim and offender is a complex one; the grooming process often relies upon the victim not regarding themselves as such. In many cases

[32] OASys

it is the victim's emotional vulnerability and need to form attachment that is exploited. Gifts, for example cigarettes, alcohol, food, money, mobile phones and drugs, have all been used to entice victims.

Complaints to the police about anti-social behaviour (ASB) have been steadily reducing over the last three years. However, there are still a significant number of calls and alcohol is a contributory factor. Between April 2010 and March 2011, 12% of all ASB incidents and 17% of rowdy and inconsiderate behaviour ASB incidents had an alcohol marker recorded against them. This is likely to be an under-recording of the true involvement of alcohol. There were 2,230 incidents of street drinking in Lancashire between April 2010 and March 2011, a reduction of 25% on the previous year. Lancaster and Fleetwood had higher numbers of incidents than other localities in the county.

Drink and drugs is one of the 'fatal four' factors in collisions, along with speeding, use of seatbelts and mobile phone use. The 16-24 age group have been involved in 36% of all road traffic collisions during 2011/12 and 33% of KSI collisions (those leading to fatality or serious injury). Some of these incidences could have been caused by alcohol or drug use.

The LAPE profile shows that five of Lancashire's districts have had a higher rate of deaths from land transport accidents due to alcohol than the England average. Rossendale was highest with 1.84 per 1,000 population, followed by Chorley with 1,79 per 1,000, Hyndburn with 1.74 per 1,000, South Ribble with 1.69 per 1,000 and Lancaster with 1.56 per 1,000.

Assault

Between January and December 2011 there were 2,309 attendances at accident and emergency departments (AED) in Preston and Chorley for reason of an assault. Of these, 60% (1,394) had consumed alcohol in the last three hours prior to the assault (Trauma and Injury Intelligence Group).

Although it is problematic to extrapolate the proportion of alcohol-related assaults based on these two areas to Lancashire, it does indicate that up to 33,680 assaults across Lancashire were due to alcohol during this period (56,134 assaults total).

Based on a sample size of 884 completed surveys where the assault was related to alcohol, two thirds (66%) had drunk alcohol in a pub, bar or nightclub; 23% had drunk alcohol in a private home (11% at a friend's home, 12% in their own home); and 4% in a street or park.

Recommendation: continue funding TIIG to obtain data from other hospital trusts and quality assure the data. This will build a better picture of how many assaults in Lancashire are alcohol-related.

The current reoffending rate in Lancashire is 11.31%. The main offender pathways affecting reoffending are alcohol, relationships, and attitudes, thinking and behaviour. Although there are variations in offender need across the county, alcohol is consistently a significant factor in all districts. Lancashire Probation Trust regularly assesses the alcohol misuse status of offenders subject to case management. Data from these assessments provides evidence that 14% of offenders in Lancashire have a significant alcohol misuse problem, although this is higher in Lancaster and Preston (16%) and Ribble Valley (20%), and 37% report regularly drinking excessively. 27% of offenders report having had a severe alcohol consumption issue at some point in their lives, although this is significantly higher in Blackpool (35%). From a national perspective, 41% of offenders under probation supervision with a history of violent offending had a direct risk of reoffending due to alcohol misuse[33]. This compares to 33% of Lancashire offenders. There is evidence to make a connection between alcohol consumption and violent offending in 45% of Blackpool and Ribble Valley cases, and 44% of Lancaster cases. 24% of offenders report regular binge drinking, often directly related to incidents of offending. This is more prevalent in Ribble Valley (35%), West Lancashire (29%) and Lancaster (27%). On a positive note, the majority of offenders recognise the connection between alcohol misuse and their offending behaviour, and are motivated to address it; only 3% of offenders demonstrate little motivation to address their behaviour. There are some disparities with those people that blame specific situations or circumstances rather than recognising the significance of alcohol as a facilitating factor in their behaviour. 35% of Ribble Valley offenders partially accepted the degree to which

[33] NOMS Commissioning Intentions 2012/13

alcohol affected their offending behaviour, Chorley 24%, Blackburn and Blackpool 22%. 35% of offenders are assessed as presenting serious concerns in relation to risk of harm in connection to the misuse of alcohol. This risk is greater in South Ribble (40%) and Chorley (38%). Alcohol is a significant factor linked to reoffending for 55% of offenders, although in Ribble Valley this is 73%, Rossendale 60%, Lancaster 59% and Blackpool 58%.

Lancashire Probation Trust continue to refer offenders into appropriate alcohol treatment based on need and risk and work with the three DAATs to co-commission effective services. The trust provide alcohol brief interventions for low risk alcohol users and deliver alcohol treatment requirements (ATR) for high risk offenders. The aim of the ATR is to reduce violent and other alcohol-related offending, and facilitate improvements in the health, lifestyle and social functioning of individual offenders. Treatment consists of interventions to address those social and community integration issues that are significantly associated with offending, including improving the offender's circumstances in relation to lifestyle, health, accommodation, education and employment. An ATR is usually made for a six month period and is intended to target a relatively small group of offenders whose offending will be alcohol-related, of high seriousness and probably violent in nature. The trust is currently developing a specified activity requirement (SAR) to target low and medium risk offenders which should be available to the courts later this year as a sentencing disposal.

Recommendation: treatment providers continue to invest in and deliver appropriate services for offenders referred with alcohol misuse issues, specifically ATRs and alcohol specified activities.

Fires

In the course of their community engagement activities and post-fire investigations, Lancashire Fire and Rescue Service have identified the impact of alcohol and substances in relation to fire incidents. Due to recording systems both substances are linked together under one heading, but alcohol is regarded as the most common factor.

A review of casualties in 2009/2010 and 2010/2011 revealed that alcohol and substances featured in approximately a quarter of incidents. The table below shows the variation across Lancashire.

Table 8 - Percentage of casualties from accidental dwelling fires that are linked with alcohol or substances (09/10 - 10/11)

Area	Percentage of accidental dwelling fires linked with alcohol or substances
Lancaster	41
Rossendale	39
Preston	35
South Ribble	34
Burnley	30
Fylde	30
Blackburn with Darwen	28
Blackpool	28
Hyndburn	27
West Lancashire	24
Chorley	21
Pendle	18
Ribble Valley	14
Wyre	10
Source:	

Community safety work by the fire service has resulted in a reduction in the number of accidental dwelling fires, but the percentage rate linked to alcohol or substances has not reduced.

When reviewing statistics the fire service have focused on incidents that have received injuries, as the recording processes for these cases supports the recording of contributory factors, but alcohol is a feature in many other incidents. Some fire services report as many as 47% of their incidents are linked with alcohol or substance use. These incidents incur a considerable cost, not just to the fire service, but to other providers and society. During 2009/2010 and 2010/2011 Lancashire Fire and Rescue Service dealt with 174 casualties from accidental dwelling fires where alcohol or drugs was a factor. The table below shows the socio-economic cost of dealing with those fires, based on the category of injury.

Table 9 - Cost of fires in Lancashire 2009/10 and 2010/11

Category	Cost[34]	Number of injuries in Lancashire	Cost
Fatalities	£1,546,688	3	£4,640,064
Non-fatal injury involving burns	£174,354	10	£1,743,540
Non-fatal injury involving overcome by fumes/smoke	£44,019	132	£5,581,508
Other (including precautionary check-up)	£574	32	£18,368
Total			£11,983,480
Notes: Fire property damage and fire service operational costs are not included in total costs below, so the total cost to Lancashire is higher than stated.			

Alcohol and substances affect individuals in varying ways. The risk of being subject to a fire incident is increased by the impact of the alcohol or substance on the individual's behaviour. The ability of an individual to be alerted is impaired, and how they subsequently respond to or assess a situation has the potential to be compromised. It will also have an impact on the ability to both physically and mentally recover from an incident.

The fire service, through their community safety work, in association with partner agencies and membership of the Lancashire Alcohol Network, have been raising the profile of the risks associated with alcohol through the delivery of brief safety interventions. At times this has proved challenging for community members and professionals alike. To address this, a cohort of LFRS staff have received training specifically designed to increase awareness in relation to the consumption of alcohol and how to advise individuals the service engages with in the delivery of home fire safety visits. Through partnership working with services that support those that use substances, community members that are assessed by professionals as at greater risk are offered a coordinated package that takes account of the needs of the individual.

Recommendation: all organisations engaged in recognising alcohol as a factor that is impacting on an individual to signpost those community members to LFRS, allowing for an assessment of the likelihood and potential severity that a fire-related

[34] Source: Communities and Local Government (2008) *Fire and Rescue Service Partnership Working Toolkit for Local Area Agreements.*

incident would have on the individual and their family members, and to work with Lancashire Fire and Rescue Service to help improve the safety of these individuals and begin to reduce the economic cost of such incidents to society.

Ambulance Service

The ambulance service do not provide an alcohol marker for the data they collect on callouts, so it is impossible to determine how many ambulance attendances were for reasons of alcohol. However, up to 60% of presentations at accident and emergency departments are related to alcohol consumption, and it is possible this is a similar proportion for ambulance attendances.

Between February 2011 and January 2012 there were 2,989 ambulance incidents where the presenting complaint was assault or rape; 370 gunshot or stabbing; and 711 incidents of fire, burns, or explosions. This would equate to approximately 1,793 ambulance callouts for assault or rape; 222 callouts for gunshots or stabbings; and 427 callouts for fire, burns or explosions where alcohol is a contributory factor.

The Department of Health estimate that ambulance callouts for reasons of alcohol cost the NHS £372.4m nationally in 2008[35].

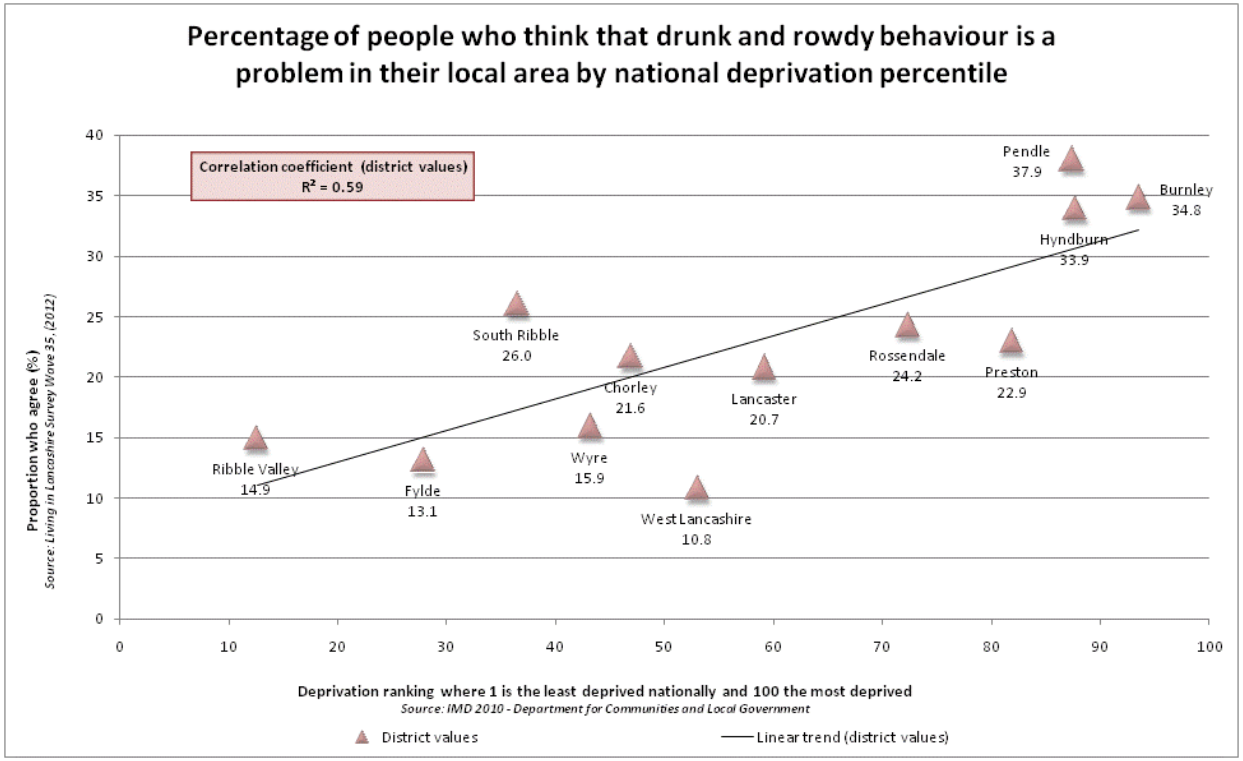
Recommendation: improve the quality of recorded ambulance callout data.

Perceptions of Alcohol Use

Previous analysis conducted by Lancashire County Council suggests that there is a strong association between deprivation and perceptions that drunk and rowdy behaviour is a problem in an area. This correlation was analysed in 2009 using the 2007 Index of Multiple Deprivation (IMD) and National Indicator 41: "the percentage of people who think that drunk and rowdy behaviour is a problem in their local area" from the 2008 Place survey. The chart below uses the most current data and shows a very similar correlation, although this should be interpreted with caution as perceptions data is no longer available for Blackburn with Darwen or Blackpool.

[35] Department of Health (2008) *The Cost of Alcohol Harm to the NHS in England: An Update to the Cabinet Office (2003) Study*, p. 7. [Available online: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_086412?IdcService=GET_FILE&dID=169373&Rendition=Web]

Figure 6 - Percentage of people who think that drunk and rowdy behaviour is a problem in their local area by national deprivation quintile (IMD 2010)



The percentage of people who think drunk and rowdy behaviour is a problem in their area ranges from 14.9% in Ribble Valley (the least deprived Lancashire district) to 37.9% in Pendle (the third most deprived Lancashire district).

Financial Cost

Harmful use of alcohol is currently ranked as the third leading factor for disease and disability in the world36. Around 90% of adults drink alcohol. When consumed responsibly and in moderation alcohol is an enjoyable aspect of everyday life which has positive benefits for the wider economy and employment, for example in the manufacturing, hospitality and leisure industries. There are at the time of writing 6,804 active licensed premises for on and off sales across Lancashire. However, some people drink in a way that causes problems for themselves and those around them.

Nationally, the cost of alcohol misuse is estimated to be around £20billion per year. These costs are made up of alcohol-related health disorders and disease; crime and anti-social behaviour; loss of productivity in the workplace; and problems for the families of those who misuse alcohol, including domestic violence. A recent report highlights the cost of alcohol to our society and has been broken down into four main areas: NHS costs; crime and licensing costs; workforce and wider economic costs; and social services costs. In Lancashire the total cost burden of alcohol in 2010/11 is £458 per person, which is 18% above the national average of £387 per person37.

- Cost of alcohol to the NHS in Lancashire for 2010/11 is £141.92m, or approximately £98 per head.
- Cost of alcohol in crime and licensing in Lancashire for 2010/11 is £207.14m, or £143 per head.
- Cost of alcohol to the workforce and economy in Lancashire for 2010/11 is £272.33m, or £188 per head.
- Cost of alcohol to social services in Lancashire for 2010/11 is £42.2m, or £29 per head.

A detailed breakdown of the district costs for Lancashire-14 will be available from late May 2012. See www.lancashire.gov.uk/jsna > Lifestyle > Alcohol > *The Cost of Alcohol to the North West Economy*.

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[36] World Health Organisation (2010) *Alcohol.* Online: http://www.who.int/mediacentre/factsheets/fs349/en/index.html [accessed March 2012].
[37] Drinkwise North West (2012) *The Cost of Alcohol to the North West Economy*.

Interventions and Treatment

Across Lancashire-14 there are a range of interventions that take place around reducing alcohol-related harm but more still needs to be done. In 2009 the Department of Health identified a number of high impact changes which are calculated to be the most effective actions for the reduction of alcohol related harm[38]:

1) Work in partnership.
2) Develop activities to control the impact of alcohol misuse in the community.
3) Influence change through advocacy.
4) Improve the effectiveness and capacity of specialist treatment.
5) Appoint an alcohol worker.
6) IBA – provide more help to encourage people to drink less.
7) Amplify national social marketing priorities.

The first three high impact changes are necessary enabling actions that set the scene for success. The latter four changes are services and activities that can be commissioned and that are calculated to be the most effective interventions to reduce alcohol-related harm and slow the rise of alcohol-related admissions.

Improve the Effectiveness and Capacity of Specialist Treatment

The Rush model[39] classifies the following levels of access for alcohol dependent individuals entering treatment per year:

[38] Department of Health (2009) *Signs for improvement – commissioning interventions to reduce alcohol related harm*.
[39] Ibid.

- 20% of alcohol dependent individuals entering treatment (1 in 5) as a high level of access.
- 15% of alcohol dependent individuals entering treatment (1 in 7.5) as a medium level of access.
- 10% of alcohol dependent individuals entering treatment (1 in 10) as a low level of access.

The report recommended that PCTs provide at least a 'medium' level of access (i.e. 15% of estimated alcohol dependent individuals enter treatment per year). The estimated alcohol dependent population in Lancashire-14 in 2010/11 is 47,012, while the number in treatment was approximately 4,052, or only 8.6% of the dependent population.

Recommendation: As a minimum, organisations in Lancashire should be treating 1 in 10, or approximately 4,700, alcohol dependent individuals (a 'low' level of access). Optimally, 1 in 7.5, or approximately 7,050, alcohol dependent individuals should be in treatment (a 'medium' level of access) to bring Lancashire in line with recommendations from the Department of Health.

2,732 alcohol clients were in contact with treatment during 2011, 70% of whom were starting a new treatment journey[40]. Most treatments were between two and six months in duration (47% of cases), while 29% were seven to 12 months in duration, and nearly a fifth (19%) of patients were in treatment for more than a year.

In total 7% of patients in treatment for the year up to Q3 2011 were in receipt of tier 4 interventions (4% inpatient and 3% residential rehabilitation). The following table summarises the number of patients receiving various tier 3 and tier 4 treatments.

[40] Alcohol Treatment Data (2012)

Table 10 - number of new alcohol interventions in Lancashire-14

		Lancashire County Council		Blackburn with Darwen		Blackpool	
Tier	**Treatment**	**Q2 2011/12**	**Q3 2011/12**	**Q2 2011/12**	**Q3 2011/12**	**Q2 2011/12**	**Q3 2011/12**
Tier 4	Inpatient detox	70	87	6	7	4	7
	Residential rehabilitation	57	75	2	2	8	9
Tier 3	Prescribing	205	266	2	2	27	29
	Psychosocial	709	814	0	0	447	515
	Day programme	93	97	43	48	75	106
	Drug	293	311	101	120	191	227
	YP	42	43	47	55	3	3
	Other intervention	836	957	171	208	68	90

Source: NDTMS Alcohol Treatment Data Q3 2011 (2012)
Notes: Some patients may receive more than one treatment so the total number of treatments may not be the same as the number of patients.

Recommendation: A consistent way of measuring treatment journeys is needed, especially for tier two. Currently NDTMS data only captures tier three and four figures and outcome measures.

Recommendation: complete equity audit of treatment and intervention services.

Tier 4 In-Patient Detox

Historically tier 4 alcohol services used to fall within the national definition set as one of the services to be commissioned by specialised commissioning groups. The most recent review of the national definition set has seen tertiary substance misuse services fall outside of the revised set. It was then the intention that the responsibilities for commissioning these services be passed back to the PCTs.

In 2010 the five PCTs, Lancashire County Council, Blackburn with Darwen Borough Council and Blackpool Borough Council re-commissioned all in-patient detox services for people with both alcohol and drug problems. The services were integrated to ensure an

inclusive service could be provided. The re-commissioning meant for the first time people in Lancashire are able to choose where they access detox and can access a programme suitable for their level of need, instead of being required to attend a 21 or 28 day.

There are ten provider units contracted within a framework agreement, some within the boundaries of Lancashire, easily accessible for those people with families and positive relationships.

Tier 4 Residential Rehabilitation

Following on from a detox, whether community based or as an in-patient, Lancashire County Council, Blackburn with Darwen and Blackpool regularly place people with complex substance misuse issues in therapeutic environments. Placements vary in length of duration and are dependent on need, and factors such as home environments or family commitments. The stay is usually between three and nine months, and in Lancashire the number of placements for people with alcohol issues is significantly larger than those for people with drug issues. In a typical year Lancashire County Council would place approximately 230 people in treatment. For comparison, in Blackpool with Darwen nine people received residential rehabilitation in 2011/12 (eight for alcohol only and one for alcohol and drugs) and eight people were in treatment in 2010/11 (seven for alcohol only and one for alcohol and drugs). In Blackpool over a similar year between 14 and 31 people would be placed in treatment. Of the 230 people placed in treatment by Lancashire County Council, approximately two thirds (175) would be people with significant alcohol issues.

A recent development in Lancashire is the introduction of personalisation into rehabilitation programmes to ensure that the treatment journey is as effective as possible for the individual by ensuring it meets the needs of the individual and not the service.

- In Central Lancashire the area with the highest number of referrals into tier 4 services for both genders with complex alcohol problems is Preston, followed by Chorley and South Ribble.
- In East Lancashire the area with the highest number of referrals into tier 4 services is Hyndburn, then Pendle and Rossendale (104 referrals in 2010). Ribble Valley has the lowest number of referrals in East Lancashire (11 in 2010).

- In North Lancashire, the area with the highest number of referrals into tier 4 is Lancaster, but referrals from Fylde and Wyre are not significantly lower.

Appoint an Alcohol Worker

The Department of Health recommend PCTs appoint an alcohol worker to manage patients with alcohol problems within the hospital and liaise with community services. In Lancashire each of the PCTs have developed this recommendation in slightly different ways depending on need and resources.

Blackpool

- Have four alcohol liaison nurses and one specialist midwife at acute hospital supported by community link nurse.
- They have senior clinical champions including the gastro consultant and the clinical director, and have support from the chief executive.
- Repeat alcohol attendees are identified by the alcohol liaison nurses and outreach practitioners work to engage clients in specialist treatment.
- IBA is delivered extensively across the hospital by staff and volunteer health mentors.

Central Lancashire

- The alcohol design team, set up by the chief executive of Lancashire Teaching Hospitals working with support from partners, developed a plan of appropriate and sustainable interventions that would help reduce hospital admissions. An event is being planned to look at a general question of 'how can we together generate an integrated recovery approach for and with people who end up repeatedly in A&E for alcohol related problems?'
- The young people's substance misuse service delivers a service from each of the two Central Lancashire A&E departments.
- Each of the two Central Lancashire acute hospitals have a model of enhanced referral in place with the community adult substance misuse service. This means that any adult hospital inpatient referred into the community substance misuse service will be seen in the hospital environment within 48 hours.

- An alcohol CQUIN has been negotiated between NHS Central Lancashire and Lancashire Teaching Hospitals NHS Foundation Trust which requires:
    - An audit to be incorporated into the admission process for all adult hospital admissions.
    - Delivery of brief advice where appropriate.
    - Referral into substance misuse services where appropriate.
    - Training in IBA for relevant staff.

East Lancashire and Blackburn with Darwen

- East Lancashire and Blackburn with Darwen PCTs are working in partnership.
- The alcohol liaison nurse model has been agreed and is being implemented. The model is based on a virtual team approach. Funding has been made available for an alcohol hospital nurse liaison, a community substance misuse service in East Lancashire, and a community substance misuse service in Blackburn with Darwen.
- A steering group has been established since July 2011 comprising of commissioning leads, senior managers from provider organisations, medicines management, a consultant gastroenterologist, a modern matron, and a data analyst.
- The project has been expanded to support all people attending for ED.
- It has been agreed that a focus of the alcohol hospital liaison model will be to contribute towards ELHT and QOF quality indicators:
    - Reduction in seven day unplanned A&E attendances to 5%.
    - Reduction in the number of patients leaving A&E before treatment recorded.
    - Reduction in hospital re-admissions within 30 days.
    - QOF quality productivity indicators emergency admissions.

North Lancashire

- A business case and service specification have been approved in principle by the urgent care board and by the relevant clinical consortia board. Discussions are ongoing with the relevant acute trusts to implement the service.
- A lifestyle screening pilot is currently being rolled out across the Royal Lancaster Infirmary. An evidence-based lifestyle screening tool has been established incorporating screening tools for alcohol, tobacco and obesity. Participating ward staff receive training in the use of the screening tool and information regarding referral routes into local community services.

Recommendation: resources be made available to put the most effective model in place.

Identification and Brief Advice (IBA)

The Department of Health recommend PCTs provide more help to encourage people to drink less. There are a number of agencies which provide IBA and IBA training in Lancashire**.**

Pharmacy Interventions

Alcohol IBA has become available across an increasing number of environments in recent years. Community pharmacies offer a unique trusted but 'non-establishment' venue where some people may be more responsive to an intervention. Blackpool has operated a pharmacy IBA scheme for 18 months. Ten community pharmacies across a range of locations provide an alcohol identification and brief advice service. Customers are identified by their age, gender and medication history and offered the opportunity to complete an AUDIT questionnaire. Trained pharmacy staff will assess the AUDIT score and provide brief advice or offer to refer customers to a specialist if appropriate. The service framework, tariff, and criteria are in line with the agreed North West Pharmacy IBA framework to ensure continuity between different locations, avoiding disruptive price negotiation.

During the first year each pharmacy was capped at 100 IBAs per year. Some pharmacies achieved this cap within two months and others failed to achieve 20 in total. This will have in part been driven by the demographics of their customers. Consequently the cap has been

lifted for the 2012/13 year. Of those completing an AUDIT approximately 40% required further interventions in the form of brief advice or referral to specialist services. Of those who were followed up four weeks later, all reported to have reduced their alcohol consumption. A study is currently being carried out by LJMU and UCLAN to review the effectiveness of the interventions across the six PCT areas currently providing the North West framework.

In the past five years East Lancashire community pharmacies have played a proactive role in raising awareness of consequent dangers, in the broadest sense, of drinking alcohol including;

- The number of units in various alcoholic drinks.
- The increased risk of harm to health with drinking alcohol.
- The increased risk of accidents, violence and crime.
- The increased risk of unsafe sex, STIs, and pregnancy.
- The potential for interaction with other drugs – illicit, over-the-counter (OTC) and prescribed.
- The social costs of drinking alcohol to the individual, family and friends.

Pharmacy staff have received appropriate resources to distribute, and have been supported by lunchtime briefing sessions and more recently by podcasts created in-house on the specific alcohol theme for the year.

The Healthy Living pharmacy accreditation is a concept developed by NHS Portsmouth at the request of the Department of Health. These accredited pharmacies offer a wide range of NHS services, as well as having specialist in-store expertise available for things like stopping smoking, weight loss, contraception, sexual health, advice on alcohol consumption and support for making changes towards a healthier lifestyle. The scheme is currently at pathfinder status and NHS East Lancashire and NHS Blackburn with Darwen Care Trust Plus have jointly been selected as one of 20 national pathfinder sites in the country, and is one of only two sites in the North West to have achieved this.

The two trusts are making good progress in taking forward the Healthy Living pharmacy concept. Nineteen community pharmacies in East Lancashire and five in Blackburn with Darwen signed up in the first wave of applications, with another twenty signed up to the second wave. In order to take the first step towards achieving the accredited status of a Healthy Living pharmacy, a member of staff is required to undertake training to become a qualified Healthy Living champion.

Recommendation: findings of the review are due during July 2012 and these should be used to inform the structure of any Lancashire-wide provision and encourage the implementation of trained healthy living champions in pharmacies across the county to deliver IBA and healthy lifestyle messages which include alcohol.

Recommendation: IBA training to become mandatory in statutory and non-statutory organisations in Lancashire.

Primary Care

NHS employers and the general practitioners committee of the British Medical Association agreed five new directed enhanced services (DES) as part of the 2008/2009 contract negotiations. One of these five areas aimed to address alcohol-related harm by rewarding practices for screening all newly registered patients aged 16 and over for alcohol consumption levels. The DES required the utilisation of AUDIT-C or FAST to initially screen individuals, followed by an AUDIT screen for individuals that were scored as positive from the initial screen. Brief advice is provided or patients are referred to specialist services based on the AUDIT score.

Recommendation: optimise implementation of the DES across Lancashire and advocate the incorporation of best practice techniques in its delivery.

Recommendation: develop IBA within primary care by developing a consistent approach across Lancashire by developing and implementing a lifestyle identification, brief advice and referral locally enhanced service (LES) that targets at risk populations across primary care practice registers.

Recommendation: establish a register of abstinent, lower, increasing and higher risk patients through the development of appropriate read codes.

Recommendation: maximise opportunities for early intervention by rewarding appropriate referral into substance misuse services.

Amplify National Social Marketing Priorities

Recommendation: develop effective partnership communication networks to develop consistent messages based on social marketing insight work.

Recommendation: implement the seven high impact changes and the 12 NICE recommendations as a minimum to address alcohol related harm.

Recommendations from Alcohol JSNA

To reduce alcohol-related harm in Lancashire a combination of interventions are needed. A lot of excellent work has been carried out in Lancashire to reduce the impact of alcohol related harm which needs to continue and be developed upon.

The main recommendation would be to ensure that interventions developed address the High Impact Changes identified by the Department of Health and that the NICE guidance documents for alcohol are followed. The more specific recommendations below have been developed with both these documents in mind.

Table 11 - Summary of alcohol recommendations

High Impact Changes	Nice Guidance
Working in partnership	Price
	Availability
Develop activities to control the impact of alcohol misuse in the community	Marketing
	Licensing
Influence change through advocacy	Resources for screening and brief interventions
	Supporting children and young people aged 10 to 15 years
Improve the effectiveness and capacity of specialist treatment	Screening young people aged 16 and 17 years
	Extended brief interventions with young people aged 16 and 17 years
Appoint an alcohol worker	Screening adults
	Brief advice for adults
IBA provide more help to encourage people to drink less	Extended brief interventions for adults
Amplify national social marketing priorities	Referral

Advocacy and Lobbying

- Advocate for the importance of tackling low cost alcohol. There is a clear relationship between price and consumption of alcohol. Price increases generally reduce heavy drinkers' consumption by a greater proportion than moderate drinkers, as heavy drinkers

tend to choose cheaper drinks. It also impacts significantly on harm to young people by reducing access to 'pocket money' priced drinks.

- Engage licensing authorities not already engaged in relation to health issues and alcohol, raising awareness and understanding of health impacts to licensing officers and elected members who make licensing decisions.
- Lobby for further changes to licensing legislation for public health to be a consideration in the licensing process.
- Lobby to introduce measures to reduce the exposure of children to the marketing of alcohol products

Interventions

- Interventions need to be targeted at individuals and on a population level.
- Ensure that treatment services are able to meet the diverse needs of the population.
- Apply good practice learned from the IBA pilot in Blackpool and East Lancashire pathfinder pharmacy healthy trainers model.
- Ensure each AED in Lancashire has systems in place to reduce alcohol related hospital admissions.

Communications and Community Engagement

- Support the development of intelligence-led social marketing approach to reducing levels of alcohol consumption in Lancashire, focusing on issues such as the 'silent majority' – home drinkers, preloading, underage drinking and parents supplying alcohol, older people and dementia as the target audience.
- Community engagement should be used as a method of reaching targeted populations.
- Support and resource the community alcohol networks trading standards programme which raises awareness of the dangers of providing alcohol to young people.

- Routinely include advice about the potential dangers of increasing alcohol consumption in pre-retirement courses.

Community Safety

- Utilise the trauma injury intelligence group (TIIG) data to identify trouble spots and intervene to reduce harm and anti-social behaviour.
- Explore a co-ordinated approach to the night-time economy.
- Review training of licensing staff.
- All organisations that work with or recognise alcohol as a factor which is impacting on an individual to consider their safety and that of their families.
- To work with Lancashire Fire and Rescue Service to help improve their safety in the home, including home fire safety checks.
- The use of regulatory powers should be maximised.

Data and Intelligence

- Develop a co-ordinated approach to data collation, analysis and dissemination across Lancashire utilising MADE to its full potential.
- Ensure that data is used appropriately to inform commissioning, target service provision and validate impact.
- Maximise the contribution partners can make through their core business to the alcohol agenda.
- Further investigate and highlight employment as a priority area and examine opportunities for early identification of those facing employment issues.
- Further investigate and highlight health inequality as a priority area.

Appendices

Morbidity

Alcohol-Attributable Conditions

Table 12 - admissions with alcohol-attributable conditions

Local Authority	Admitted to hospital with alcohol attributable conditions: Males, all ages, DSR per 100000 population (2009/10)			Number of males admitted to hospital with alcohol specific conditions, all ages (2009/10)	Admitted to hospital with alcohol attributable conditions: Females, all ages, DSR per 100000 population (2009/10)			Number of females admitted to hospital with alcohol specific conditions, all ages (2009/10)
	Lower 95% CI	Indicator value	Upper 95% CI		Lower 95% CI	Indicator value	Upper 95% CI	
Blackburn with Darwen	2057.1	2166.9	2280.9	1477.5	1153.1	1233.8	1318.6	917.2
Blackpool	1930.0	2030.9	2135.5	1625.2	1080.7	1157.8	1238.6	980.4
Burnley	2069.8	2206.5	2349.7	1010.7	1140.2	1239.6	1345.0	631.4
Chorley	1565.6	1667.4	1774.1	1030.5	1033.1	1119.2	1210.3	695.2
Fylde	1107.9	1207.2	1312.5	637.1	719.3	807.7	902.5	435.5
Hyndburn	1867.6	2001.0	2141.3	861.3	1048.4	1147.6	1253.3	540.7
Lancaster	1510.5	1600.5	1694.3	1258.9	802.4	867.0	935.2	780.1
Pendle	1598.2	1713.7	1835.2	845.2	978.0	1068.8	1165.4	562.3
Preston	1900.8	2005.9	2115.2	1404.7	1167.6	1250.0	1336.5	928.8
Ribble Valley	1096.6	1214.9	1341.9	436.5	690.0	788.5	894.7	299.7
Rossendale	1697.1	1836.0	1983.1	671.2	903.7	1003.0	1109.9	405.1
South Ribble	1438.9	1536.0	1637.9	978.0	916.2	994.5	1077.4	670.6
West Lancashire	1608.7	1712.9	1822.0	1097.1	848.0	920.8	997.8	673.7
Wyre	1161.5	1247.3	1337.5	915.0	718.5	788.4	862.5	622.7
North West	**1793.8**	**1807.4**	**1821.2**	**69099.8**	**1034.6**	**1044.8**	**1055.1**	**43976.8**
England	**1395.9**	**1400.3**	**1404.7**	**406872.6**	**786.9**	**790.1**	**793.4**	**256408.2**

Source: LAPE alcohol profiles

Table 13 - Rate of alcohol-related admissions per 100,000 population (EASR)

	Financial Year									Percentage change on previous year							
Local Authority	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2002/03 - 2003/04	2003/04 - 2004/05	2004/05 - 2005/06	2005/06 - 2006/07	2006/07 - 2007/08	2007/08 - 2008/09	2008/09 - 2009/10	2009/10 - 2010/11
Blackburn with Darwen	941	1031	1531	1426	1999	2039	2078	2904	3167	9.5%	48.6%	-6.9%	40.2%	2.0%	1.9%	39.7%	9.1%
Blackpool	1311	1296	1311	1615	1865	1866	2134	2479	2954	-1.2%	1.2%	23.2%	15.5%	0.0%	14.3%	16.2%	19.2%
Burnley	1699	1879	1993	1783	2114	2196	2072	3072	3249	10.6%	6.1%	-10.5%	18.6%	3.9%	-5.7%	48.3%	5.7%
Chorley	1439	1400	1214	1806	2034	2244	2192	2370	2346	-2.7%	-13.3%	48.8%	12.6%	10.4%	-2.3%	8.1%	-1.0%
Fylde	870	862	891	983	1167	1220	1365	1595	1853	-0.9%	3.4%	10.3%	18.7%	4.6%	11.9%	16.8%	16.2%
Hyndburn	811	880	1373	1342	1693	1879	1938	2548	2754	8.5%	56.0%	-2.3%	26.1%	11.0%	3.1%	31.5%	8.1%
Lancaster	1250	1346	1463	1455	1551	1791	2035	2031	1922	7.7%	8.7%	-0.6%	6.6%	15.5%	13.6%	-0.2%	-5.4%
Pendle	1386	1517	1640	1479	1783	1802	1833	2300	2443	9.5%	8.1%	-9.8%	20.6%	1.1%	1.7%	25.5%	6.2%
Preston	1742	1668	1466	2043	2154	2445	2446	2711	2878	-4.3%	-12.1%	39.3%	5.5%	13.5%	0.0%	10.8%	6.2%
Ribble Valley	696	728	897	896	1102	1198	1283	1597	1689	4.7%	23.1%	-0.1%	22.9%	8.7%	7.1%	24.5%	5.8%
Rossendale	1247	1399	1545	1622	1730	1787	2026	2437	2569	12.2%	10.5%	5.0%	6.7%	3.3%	13.4%	20.2%	5.4%
South Ribble	1367	1241	1097	1605	1738	1934	2108	2169	2146	-9.2%	-11.6%	46.4%	8.3%	11.3%	9.0%	2.9%	-1.0%
West Lancashire	1083	1236	1193	1424	1540	1629	1854	2070	2210	14.1%	-3.5%	19.3%	8.2%	5.8%	13.8%	11.6%	6.8%
Wyre	855	828	916	1079	1159	1242	1417	1580	1773	-3.2%	10.6%	17.8%	7.4%	7.2%	14.1%	11.5%	12.2%
England	926	1023	1145	1291	1389	1473	1582	1743	1898	10.5%	11.9%	12.8%	7.6%	6.0%	7.5%	10.1%	9.3%
North West	1235	1362	1510	1697	1840	1940	2068	2295	2600	10.2%	10.9%	12.4%	8.4%	5.4%	6.6%	11.0%	8.0%
Lancashire 12	1229	1265	1299	1480	1655	1796	1901	2193	2293	2.9%	2.7%	14.0%	11.8%	8.6%	5.8%	15.4%	4.6%
Lancashire 14																	

Source: LAPE Alcohol Profiles

Alcohol-Specific Conditions

Table 14 - Alcohol-specific conditions

Local Authority	Admitted to hospital with alcohol specific conditions: Males, all ages, DSR per 100000 population (2009/10)			Number of males admitted to hospital with alcohol specific conditions (2009/10)	Admitted to hospital with alcohol specific conditions: Females, all ages, DSR per 100000 population (2009/10)			Number of females admitted to hospital with alcohol specific conditions (2009/10)
	Lower 95% CI	Indicator value	Upper 95% CI		Lower 95% CI	Indicator value	Upper 95% CI	
Blackburn with Darwen	759.5	827.3	899.6	552	310.8	354.5	402.4	241
Blackpool	841.6	912.0	986.7	642	410.6	461.6	517.1	312
Burnley	702.8	787.0	878.5	325	345.4	404.0	469.6	174
Chorley	411.1	466.3	526.9	264	290.1	339.5	394.9	176
Fylde	315.1	375.1	442.6	152	180.8	232.3	292.7	85
Hyndburn	688.2	773.3	866.0	305	290.6	346.6	410.1	139
Lancaster	533.3	590.4	651.9	405	236.2	274.8	317.6	193
Pendle	471.0	537.6	610.8	241	260.0	310.1	367.0	138
Preston	673.4	737.5	806.0	498	344.2	391.3	442.9	259
Ribble Valley	241.1	306.2	382.6	87	153.7	205.4	267.8	62
Rossendale	527.1	609.5	700.9	204	242.7	297.7	361.3	105
South Ribble	376.5	430.3	489.7	237	225.9	268.6	316.9	145
West Lancashire	476.4	538.6	606.5	291	236.7	279.1	326.9	163
Wyre	305.6	355.5	410.9	200	209.6	251.3	298.4	146
North West	**657.9**	**666.4**	**675.1**	**23402**	**341.8**	**348.1**	**354.4**	**12249**
England	**427.6**	**430.1**	**432.7**	**113977**	**208.8**	**210.5**	**212.3**	**55934**

Source: LAPE alcohol profiles

Mortality

Months of Life Lost Due to Alcohol

Table 15 - Months of life lost due to alcohol

Local Authority	Months of Life Lost due to alcohol: Males aged less than 75 years (2007-2009)	Months of Life Lost due to alcohol: Females aged less than 75 years (2007-2009)
Blackburn with Darwen	13.1	4.0
Blackpool	20.8	9.1
Burnley	13.1	6.6
Chorley	12.0	5.1
Fylde	9.2	3.9
Hyndburn	14.2	6.8
Lancaster	10.4	5.5
Pendle	10.2	5.0
Preston	14.6	5.8
Ribble Valley	7.5	4.5
Rossendale	13.6	4.4
South Ribble	10.2	4.8
West Lancashire	8.7	5.6
Wyre	9.2	4.2
North West	**12.0**	**5.9**
England	**9.1**	**4.2**

Source: LAPE alcohol profiles

Alcohol-Specific Mortality

Table 16 - Alcohol-specific mortality directly standardised rate per 100,000

Local Authority	Alcohol-Specific Mortality: Males, all ages, DSR per 100000 population			Number of male deaths specifically due to alcohol, all ages (2007-2009)	Alcohol-Specific Mortality: Females, all ages, DSR per 100000 population (2007-2009)			Number of female deaths specifically due to alcohol, all ages (2007-2009)
	Lower 95% CI	Indicator value	Upper 95% CI		Lower 95% CI	Indicator value	Upper 95% CI	
Blackburn with Darwen	14.8	20.7	28.1	41	2.9	5.7	10.0	12
Blackpool	28.0	35.4	44.2	81	11.5	16.6	23.0	36
Burnley	10.1	16.2	24.6	22	6.9	12.1	19.7	16
Chorley	11.0	16.4	23.6	29	3.5	6.9	12.1	12
Fylde	8.5	14.4	22.6	19	2.3	5.5	10.9	9
Hyndburn	12.7	19.7	29.2	25	3.4	7.2	13.5	10
Lancaster	8.8	13.3	19.4	28	4.6	8.2	13.3	17
Pendle	8.2	13.7	21.4	19	3.9	8.0	14.4	11
Preston	17.7	24.3	32.4	46	5.5	9.4	14.9	18
Ribble Valley	3.5	8.7	17.6	8	2.1	5.9	12.9	6
Rossendale	8.7	15.1	24.2	17	2.4	6.1	12.6	7
South Ribble	8.5	13.4	20.2	23	6.4	10.8	17.1	18
West Lancashire	10.9	16.5	23.9	29	6.1	10.2	15.9	20
Wyre	7.7	12.2	18.3	24	2.9	5.7	10.2	12
North West	**18.2**	**19.0**	**19.9**	**2021**	**9.3**	**9.9**	**10.5**	**1088**
England	**12.8**	**13.1**	**13.3**	**10384**	**5.9**	**6.1**	**6.3**	**5047**

Source: LAPE alcohol profiles

Alcohol-Attributable Mortality

Table 17 - alcohol-attributable mortality directly standardised rate per 100,000

Local Authority	Alcohol-Attributable Mortality: Males, all ages, DSR per 100000 population (2009)			Number of male deaths attributable to alcohol (2009)	Alcohol-Attributable Mortality: Females, all ages, DSR per 100000 population (2009)			Number of female deaths attributable to alcohol (2009)
	Lower 95% CI	Indicator value	Upper 95% CI		Lower 95% CI	Indicator value	Upper 95% CI	
Blackburn with Darwen	33.5	48.8	68.6	33	6.3	13.3	24.1	11
Blackpool	51.4	69.4	90.0	56	17.7	29.0	43.4	24
Burnley	29.5	47.9	72.3	22	11.8	24.1	42.3	12
Chorley	21.1	34.7	52.1	22	11.0	21.5	36.6	14
Fylde	14.3	27.8	45.6	15	4.3	12.3	24.7	9
Hyndburn	28.2	46.7	72.1	20	13.2	26.6	45.9	13
Lancaster	26.6	40.2	57.1	31	9.6	18.5	30.5	17
Pendle	26.4	43.0	65.8	21	6.6	15.6	28.9	10
Preston	39.5	56.1	77.0	39	13.0	23.1	37.4	17
Ribble Valley	14.0	30.5	56.0	11	5.0	16.6	34.4	7
Rossendale	41.4	66.4	98.4	24	6.7	17.3	35.2	8
South Ribble	26.1	41.1	61.0	25	5.7	13.4	26.1	9
West Lancashire	19.1	31.2	47.8	22	10.9	21.4	35.2	16
Wyre	24.2	37.9	55.8	28	6.2	14.2	26.1	13
North West	**43.6**	**45.7**	**48.0**	**1729**	**18.2**	**19.6**	**21.0**	**853**
England	**35.2**	**35.9**	**36.6**	**10289**	**14.4**	**14.9**	**15.3**	**5111**

Source: LAPE alcohol profiles

Mortality from Chronic Liver Disease

Table 18 - mortality from chronic liver disease, directly standardised rate per 100,000

Local Authority	Mortality from Chronic Liver Disease: Male, all ages, DSR per 100000 population (2007-2009)			Number of male deaths, all ages, from chronic liver disease (2007-2009)	Mortality from Chronic Liver Disease: Females, all ages, DSR per 100000 population (2007-2009)			Number of female deaths, all ages, from chronic liver disease, (2007-2009)
	Lower 95% CI	Indicator value	Upper 95% CI		Lower 95% CI	Indicator value	Upper 95% CI	
Blackburn with Darwen	17.3	24.2	31.0	48	5.5	9.7	13.9	21
Blackpool	37.3	46.3	55.3	105	14.9	20.9	26.9	50
Burnley	14.2	22.1	30.1	30	7.2	13.3	19.5	19
Chorley	10.3	16.3	22.2	29	4.2	8.4	12.7	16
Fylde	11.5	19.0	26.5	26	2.3	6.3	10.2	11
Hyndburn	18.7	28.1	37.4	35	7.7	14.1	20.5	20
Lancaster	11.5	17.0	22.5	39	5.6	9.8	14.0	22
Pendle	7.4	13.5	19.6	19	5.4	10.8	16.2	17
Preston	15.5	22.2	29.0	42	5.8	10.4	15.0	20
Ribble Valley	3.0	9.6	16.2	9	3.0	8.4	13.8	10
Rossendale	13.7	22.6	31.6	25	3.7	9.3	14.8	11
South Ribble	10.9	17.1	23.3	30	4.9	9.4	14.0	17
West Lancashire	9.3	15.3	21.2	27	4.4	8.6	12.8	17
Wyre	11.8	17.6	23.4	38	4.1	8.0	11.9	19
North West	**19.7**	**20.6**	**21.5**	**2223**	**10.7**	**11.3**	**11.9**	**1308**
England	**13.6**	**13.8**	**14.1**	**11198**	**7.0**	**7.2**	**7.3**	**6429**
Source: LAPE alcohol profiles								

Incapacity

Table 19 - Claimants of IB/SDA for alcoholism

Local Authority	Claimants of IB/SDA whose main medical reason is alcoholism: Persons, crude rate per 100,000, working-age population (Aug 2010)			Number of claimants of IB/SDA whose main medical reason is alcoholism (Aug 2010)
	Lower 95% CI	Indicator value	Upper 95% CI	
Blackburn with Darwen	249.8	284.7	323.1	240
Blackpool	322.5	362.4	405.8	300
Burnley	264.7	311.0	363.1	160
Chorley	97.6	123.1	153.2	80
Fylde	65.8	92.1	125.5	40
Hyndburn	130.5	164.6	204.8	80
Lancaster	188.9	218.9	252.3	190
Pendle	117.5	148.2	184.4	80
Preston	156.4	183.8	214.6	160
Ribble Valley	14.2	29.6	54.5	10
Rossendale	153.1	193.1	240.3	80
South Ribble	56.3	75.8	100.0	50
West Lancashire	56.6	76.3	100.5	50
Wyre	101.8	128.4	159.8	80
North West	**169.5**	**173.4**	**177.5**	**7,360**
England	**102.6**	**103.7**	**104.8**	**33,260**

Source: LAPE alcohol profiles

Community Safety

Calls Made to the Police with an Alcohol Marker

Table 20 - number and percentage of calls made to the police with an alcohol marker

	Apr 10 to Mar 11		Apr 09 to Mar 10		Apr 08 to Mar 09	
District	**No**	**%**	**No**	**%**	**No**	**%**
Burnley	2300	4.6	2185	4.4	2711	4.7
Chorley	2323	6.9	2741	8.0	2743	7.6
Fylde	898	4.0	1101	5.2	1136	5.4
Hyndburn	2151	5.5	2598	6.5	2399	5.7
Lancaster	4334	7.5	4990	8.5	4951	7.6
Pendle	1857	5.2	1537	4.3	1751	4.5
Preston	4060	5.7	4485	6.5	4440	5.7
Ribble Valley	676	5.0	726	5.4	645	4.8
Rossendale	956	4.2	909	4.1	1216	4.9
South Ribble	1567	4.0	1898	4.8	2043	4.9
West Lancashire	1617	5.0	2091	5.9	1896	5.4
Wyre	2563	7.2	3014	7.9	2671	6.8
Lancashire 12	25302	5.6	28275	6.2	28624	5.8
Blackburn with Darwen	4068	5.8	4795	6.9	4348	5.9
Blackpool	5354	6.0	6732	7.7	6458	6.9
Lancashire 14	34724	5.6	39840	6.5	39494	5.9
Source: Multi-Agency Data Exchange (MADE)						

Similarly, the table below shows the number of crimes with an intoxication qualifier. It should be noted that the increase in numbers is likely the result of a drive to improve data quality and to correctly record the intoxication flag; there has been no corresponding substantial increase in the number of crimes recorded and the number of calls to the police related to alcohol.

Table 21 - number of crimes with an intoxification qualifyer

	Apr 10 to Mar 11		Apr 09 to Mar 10		Apr 08 to Mar 09	
District	**No**	**%**	**No**	**%**	**No**	**%**
Burnley	499	5.9	364	3.9	100	0.9
Chorley	665	11.7	368	6.4	56	0.9
Fylde	377	12.4	205	5.7	37	1.0
Hyndburn	509	9.1	263	4.7	69	1.2
Lancaster	1189	12.5	426	4.1	127	1.2
Pendle	312	5.3	193	3.0	63	0.9
Preston	1639	12.6	968	7.1	180	1.2
Ribble Valley	175	10.4	60	3.5	11	0.6
Rossendale	232	6.1	121	3.3	40	0.9
South Ribble	550	9.3	292	5.0	47	0.7
West Lancashire	508	8.6	245	3.8	55	0.8
Wyre	695	12.4	304	5.2	70	1.1
Lancashire 12	7350	9.9	3809	4.9	855	1.0
Blackburn with Darwen	969	8.4	569	4.7	134	1.0
Blackpool	2697	16.2	1428	8.6	251	1.4
Lancashire 14	11210	10.9	5871	5.5	1290	1.1
Source: MADE						

Alcohol related Violence Against The Person

Table 22 - number of alcohol-related violence against the person with an alcohol marker

	April 2011 to January 2012			April 2010 to March 2011			April 2009 to March 2010		
DISTRICT	Alcohol Marker	All	%	Alcohol Marker	All	%	Alcohol Marker	All	%
Blackburn	483	1843	26%	624	2240	28%	756	2438	31%
Blackpool	1297	3562	36%	1707	4425	39%	1593	4219	38%
Burnley	283	1461	19%	297	1505	20%	443	1602	28%
Chorley	309	1093	28%	403	1287	31%	455	1208	38%
Fylde	185	585	32%	225	631	36%	243	682	36%
Hyndburn	289	921	31%	327	1112	29%	327	1116	29%
Lancaster	618	1616	38%	780	2090	37%	737	2143	34%
Pendle	176	871	20%	209	1141	18%	251	1248	20%
Preston	698	1910	37%	948	2531	37%	998	2859	35%
Ribble Valley	82	259	32%	93	289	32%	85	275	31%
Rossendale	112	552	20%	146	637	23%	181	664	27%
South Ribble	215	910	24%	366	1227	30%	361	1152	31%
West Lancashire	238	957	25%	372	1248	30%	330	1183	28%
Wyre	388	959	40%	463	1183	39%	438	1238	35%
Not-geocoded	114	448	25%	114	381	30%	50	187	27%
Lancashire	5373	17499	31%	6960	21546	32%	7198	22027	33%
Source: Lancashire Constabulary/MADE									

Police Incidents: Street Drinking

Table 23 - number of street drinking incidents by district

District	2008-09	2009-10	2010-11
Blackburn with Darwen	182	242	154
Blackpool	162	229	204
Burnley	485	269	213
Chorley	296	320	186
Fylde	28	46	36
Hyndburn	101	98	81
Lancaster	326	481	365
Pendle	214	141	156
Preston	176	189	138
Ribble Valley	23	37	26
Rossendale	136	94	69
South Ribble	233	229	188
West Lancashire	144	183	70
Wyre	195	405	327
Lancashire 12	**2357**	**2492**	**1855**
Lancashire 14	**2706**	**2964**	**2230**
Source: MADE/Safer Lancashire			

Recorded Crimes Attributable to Alcohol

Table 24 - recorded crimes attributable to alcohol, crude rate per 1,000 population

Local Authority	Recorded crime attributable to alcohol: Persons, all ages, crude rate per 1000 population (20010/11)			Number of all recorded crime attributable to alcohol (2010/11)
	Lower 95% CI	Indicator value	Upper 95% CI	
Blackburn with Darwen	7.7	8.2	8.7	1142.4
Blackpool	13.1	13.7	14.3	1918.4
Burnley	8.7	9.3	10.0	797.3
Chorley	5.3	5.8	6.3	604.6
Fylde	3.3	3.7	4.2	284.0
Hyndburn	6.0	6.5	7.1	528.2
Lancaster	6.3	6.7	7.2	940.8
Pendle	5.7	6.2	6.8	555.3
Preston	8.4	8.9	9.5	1203.5
Ribble Valley	2.2	2.7	3.1	152.7
Rossendale	4.6	5.2	5.7	346.7
South Ribble	4.9	5.3	5.8	573.5
West Lancashire	5.1	5.5	5.9	604.6
Wyre	4.5	5.0	5.4	549.4
North West	**7.1**	**7.2**	**7.2**	**49435.4**
England	**7.6**	**7.6**	**7.6**	**392786.8**

Source: LAPE alcohol profiles

Violent Crimes Attributable to Alcohol

Table 25 - violent crimes attributable to alcohol, crude rate per 1,000 population

Local Authority	Violent crimes attributable to alcohol: Persons, all ages, crude rate per 1000 population (2010/11)			Number of all violent crimes attributable to alcohol (2010/2011)
	Lower 95% CI	Indicator value	Upper 95% CI	
Blackburn with Darwen	5.8	6.2	6.7	871.0
Blackpool	11.2	11.8	12.3	1645.0
Burnley	6.1	6.7	7.3	571.7
Chorley	4.2	4.7	5.1	486.9
Fylde	2.7	3.0	3.5	232.0
Hyndburn	4.7	5.1	5.7	416.6
Lancaster	5.2	5.5	5.9	773.7
Pendle	4.4	4.9	5.4	435.9
Preston	6.7	7.2	7.7	966.8
Ribble Valley	1.6	1.9	2.3	110.6
Rossendale	3.2	3.7	4.2	247.2
South Ribble	3.9	4.2	4.6	458.4
West Lancashire	3.9	4.3	4.7	469.9
Wyre	3.6	3.9	4.3	438.1
North West	**5.1**	**5.2**	**5.2**	**35609.5**
England	**5.4**	**5.5**	**5.5**	**283108.1**

Source: LAPE alcohol profiles

Sexual Crimes Attributable to Alcohol

Table 26 - sexual crimes attributable to alcohol, crude rate per 1,000 population

Local Authority	Sexual crimes attributable to alcohol: Persons, all ages, crude rate per 1000 population (2010/11)			Number of all sexual crimes attributable to alcohol (2010/11)
	Lower 95% CI	Indicator value	Upper 95% CI	
Blackburn with Darwen	0.10	0.16	0.23	21.84
Blackpool	0.16	0.23	0.33	32.89
Burnley	0.13	0.23	0.35	19.37
Chorley	0.05	0.10	0.18	10.40
Fylde	0.02	0.06	0.14	4.81
Hyndburn	0.08	0.15	0.26	12.48
Lancaster	0.07	0.12	0.19	16.90
Pendle	0.05	0.10	0.19	9.36
Preston	0.13	0.20	0.29	27.17
Ribble Valley	0.00	0.03	0.11	1.69
Rossendale	0.04	0.10	0.20	6.50
South Ribble	0.05	0.11	0.19	11.57
West Lancashire	0.04	0.09	0.15	9.49
Wyre	0.05	0.10	0.18	11.18
North West	**0.12**	**0.13**	**0.13**	**863.85**
England	**0.13**	**0.13**	**0.13**	**6732.44**

Source: LAPE alcohol profiles

Land Transport Accidents

Table 27 - land transport accidents due to alcohol, crude rate per 100,000 population

Local Authority	Deaths from land transport accidents due to alcohol: Persons, all ages, crude rate per 100000 population (2007-2009)			Number of observed deaths due to land transport accidents attributable to alcohol (2007-2009)
	Lower 95% CI	Indicator value	Upper 95% CI	
Blackburn with Darwen	0.23	0.70	1.17	3.18
Blackpool	0.29	0.81	1.33	3.53
Burnley	0.13	0.77	1.41	2.12
Chorley	0.86	1.79	2.73	5.30
Fylde	0.02	0.85	1.67	1.77
Hyndburn	0.77	1.74	2.71	4.59
Lancaster	0.85	1.56	2.28	7.06
Pendle	0.20	0.85	1.49	2.47
Preston	0.79	1.46	2.12	7.06
Ribble Valley	0.35	1.24	2.13	2.82
Rossendale	0.73	1.84	2.95	3.88
South Ribble	0.81	1.69	2.57	5.30
West Lancashire	0.21	0.75	1.29	2.82
Wyre	0.24	0.76	1.28	3.53
North West	**1.27**	**1.36**	**1.46**	**298.64**
England	**1.48**	**1.52**	**1.55**	**2480.18**
Source: LAPE alcohol profiles				