Sheffield Alcohol Needs Assessment - 2014

Sheffield Drug and Alcohol Co-ordination Team

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Table of Contents

Report Summary

The Government's National Alcohol Strategy 2012 acknowledges that the vast majority of people drink sensibility (an estimated 73.5% drink within Department of Health safer limits or abstain) but there is a cohort (estimated 20% increasing risk, 6.5% higher risk and 20.1% binge) who drink at levels higher than DH recommendations. Drinking at such levels can have negative repercussions on an individual's health, social functioning and offending. Alcohol consumption can also have wider societal impacts on anti-social behaviour, health system costs and capacity, criminal justice system cost and capacity, children and adult social care and other public sector services.[1]

Local data suggests that Sheffield is similar to the national picture, with an estimated 71.4% drinking within national NHS guidelines or abstinent. However an estimated 28.6% of Sheffield's adult population (17.7% increasing risk, 10.9% higher risk and 26.9% binge) drink at levels greater than the DH recommendations.

In Sheffield there is an established night-time economy promoting a safe and enjoyable city centre culture. This is a product of partnership working with South Yorkshire Police, Sheffield City Council licensing and trading standards, health services, and Sheffield DACT. Sheffield's Purple Flag status (2011 and re-assessed and awarded in 2014) is a symbol of such positive work. However, the effects of binge drinking are still apparent: fixed penalty notice waivers continue to be issued in response to minor alcohol specific offences; and audits completed in A&E still find a significant proportion of their caseload at weekends are for alcohol related injuries.

One of the methods of identifying the extent of the negative effects of alcohol in Sheffield is to benchmark against the national average and a number of core cities. Local Alcohol Profile for England (www.lape.org.uk) data demonstrates that Sheffield performs well compared to other 'core cities' being in the top three cities for health and crime indicators. Local Alcohol Profiles for England (2014) data shows there are three indicators where Sheffield fares significantly better than national average; alcohol related admissions to hospital (Broad) which is where the primary or secondary reason for admission was alcohol attributable; the percentage of Sheffield employees working in bars; and alcohol specific admissions to hospital for under 18s. Sheffield has three red indicators (significantly worse than England average) which are Alcohol specific mortality –males; admission episodes for alcohol related conditions (narrow); and binge drinking synthetic estimates. The remaining 21 indicators are found 'not significantly different to the England average.

Despite better than average performance on many of the LAPE measures, Sheffield should not be complacent. Trend data shows that the rate of alcohol related admissions (both broad and narrow) has increased between 2008/09 and 2012/13. CCG activity data shows that there were over 2,200 admissions for alcohol specific conditions in 2013/14, equating to just under 2,000 individuals. This is an average of 1.58 admissions per patient per year. There are an increasing number of individuals accessing health services, increasing costs to the health economy. There is a significant need for high impact change to reduce the increasing alcohol admissions trends observed.

Whilst focusing on hospital admissions there is also a significant need for prevention and early intervention. Over the last few years one of the key initiatives has been to increase the use of alcohol screening tools which identify those at risk and provide brief advice (IBA). Such tools can be used with targeted populations or - more controversially - for universal screening. In Sheffield over a 2 year period, more than 2,000 individuals have been screened for increasing risk alcohol use through a new locally designed electronic screening tool based on AUDIT PC[2]. 76 GP surgeries are signed up to an alcohol screening DES in 2014/15 covering 88% of the Sheffield patient population, the highest since its introduction. In addition all those who receive an NHS health check in 2014/15 will be asked alcohol screening questions. Although increased identification and brief advice is efficacious in its own right[3], there is a local emphasis on ensuring onward referral for those drinking at increasing risk e.g. scoring 15+ on AUDIT.

Specialist treatment should be offered to all those drinking at higher risk and dependent levels (with AUDIT scores of 20+ and drinking greater than15 units per day). Onward referral should be offered by all professionals working with such individuals including hospitals, GPs, social services, health visitors, midwifery, criminal justice services, domestic abuse services etc. Referral data shows that despite referrals to alcohol services increasing year on year there are still some sectors with low or no referrals to specialist alcohol services.

Rush (1990) is the most widely used tool to estimate the number in a population who would require alcohol treatment in any given year. Applied to Sheffield, the estimate indicates that around 1,800 dependent drinkers (of the 18,000 dependent drinking population) should attend/ require treatment in any given year or a ratio of one in ten[4]. The

[1] https://www.gov.uk/government/publications/alcohol-strategy

[2] Alcohol Use Disorders Identification Test (AUDIT) developed by the World Health Organisation (WHO) is the gold standard for identification. AUDIT –C is a revised version with the first 3 questions being asked and the remaining questions asked if the score is above 5. AUDIT-PC an adapted version for use in Primary Care. http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4896

[3] http://www.sips.iop.kcl.ac.uk/

[4] The Rush model is generic and not tailored to specific localities.

England average is slightly higher than this with a one in eleven prevalence service user ratio (PSUR). Sheffield is significantly higher with one in 16 drinkers accessing specialist treatment in 2013/14 or 954 individuals (NATMS) accessing specialist alcohol treatment however not all of these will be dependent drinkers.

These individuals used 1,133 treatment places of the commissioned 1,373 (PSI, prescribing, inpatient detoxification and residential rehabilitation) available. Whilst this shows an under utilisation of commissioned capacity (around 82% capacity was used in 2013/14) this is the highest utilization achieved over the 4 years of current contracts. Activity has been growing annually; a positive reflection of initiatives and promotions by DACT and the treatment services. As services approach capacity, there is likely to be an impact on operational efficiency and waiting times. The capacity currently commissioned would not achieve the recommended 1 in 10 ratio as highlighted by the Rush Model. Therefore further investment will be made in additional treatment places when the integrated end-to-end Alcohol Service is procured in 2015 and will achieve a balance between forecast need and actual demand.

Alcohol outcomes are complex. Local and national data on specialist treatment outcomes measures successful treatment exits. Nationally reported data also measures exits and the proportion that re-present within 6 months of the completion. This captures those who relapse and seek further help only. Local treatment outcomes are within the national average and this includes the proportion who represent to treatment with 6 months (11.8% Q4 2013/14). Hospital admissions data suggests 80% of those detoxed for alcohol within Sheffield Teaching Hospitals relapse within 100 days and 55% are readmitted to the hospital[5].

There is a growing network of recovery initiatives in Sheffield, outside of the formal commissioned treatment system. Local initiatives include a recovery café and monthly Dry Road event at St Mary's Church as well as a number of local SMART and AA groups. All Sheffield libraries now have AA core texts to borrow or to consult as reference copies.

However, there will continue to be treatment resistant alcohol users who either refuse treatment or only peripherally engage when in crisis. These individuals may not meet the threshold for Vulnerable Adults at Risk Management Model (VARRM), Vulnerable Adults Panel (VAP), or adult safeguarding. Some individuals have mental capacity and are therefore entitled to make unwise choices, for others there may be grounds to suspect alcohol related brain injury is impacting on their decision making ability. These individuals may be very prominent drinkers in their communities and create a negative impression that there is little help for alcohol users or little being done. A vulnerable service refuser post has been recently created within substance misuse services to address the small number of individuals who do not engage and cause serious concern. Local intelligence from housing providers tells us that there are known alcohol misusers who would be unlikely to present to treatment in a city centre location but would benefit from an intervention in their own community. One aspect of the vulnerable service refuser post is to address this need.

The paper 'Working with Older Drinkers'[6] highlighted the potential that the UK may experience an epidemic of alcohol related harm amongst older people. It states that 1.4 million people in the UK aged 65 and over currently exceed recommended drinking limits, with 3% of men and 0.6% of women aged 65 – 74 being alcohol dependent. Alcohol misuse in older people is associated with physical, mental, social and practical problems. This cohort of drinkers has specific needs and screening tools and specialist services can provide a higher quality and more appropriate service for these people. The report also finds that older people are just as likely to benefit from treatment as younger people.

It is therefore important that alcohol services have the ability to meet the needs of these clients and provide the appropriate care and support.

In conclusion; comparing Sheffield to other cities (LAPE 2014) is reassuring but there are still major issues to address, notably rising alcohol admissions (including re-admissions) which are a major cost to the local health economy; and treatment resistant drinkers, who cause significant problems to social housing providers including Sheffield City Council Housing, to anti-social behaviour teams and to South Yorkshire Police.

[5] Proposal for an Alcohol Care Team, D Gleeson, January 2014
[6] Working with Older Drinkers, S Wadd, K Lapworth, M Sullivan, D Forrester, S Galvani, August 2011

Gaps Identified

List of known gaps
Write a new five year alcohol strategy for Sheffield with the following aims:- • Including; prevention, early intervention, reducing alcohol related violence, reducing hospital admissions, increasing longer term recovery. • Align to the recommendations of the national strategy, PHE, the local Health and Wellbeing board strategy, the JSNA and the PCC priorities. • Review the success of the previous Sheffield alcohol strategy 2010-2014 and build on the work already established and effectively implemented. • Explore new local developments/ initiatives to address the most pressing and relevant issues. • Identify stuck areas and focus on areas where there is greatest need. • Create an effective culture of working together in all areas: strategically, in commissioning and clinically.
Review the current treatment offer to assist with future treatment commissioning, taking into account both the number of alcohol related and specific hospital admissions alongside a growth in numbers accessing the treatment system. • More places are currently commissioned than demand for treatment, increasing numbers project that 85% of the commissioned capacity will be utilised by the end of 2014/15. However in some areas capacity is likely to be achieved in the next year or two if commissioned places remain the same and there is a continued increased rate of engagement. • The Sheffield estimated PSUR of 16.7 means for every 16 dependent drinkers in Sheffield one accessed structured community based treatment (this excludes hospital admissions and GP treatment activity) in 2013/14. Given this is lower than the England PSUR rate of 1:11, commissioners should continue to identify key initiatives to encourage more dependent drinkers into treatment with a view of reducing the PSUR rate.
Referrals into treatment - • There is a need to increase referrals for dependent drinkers into treatment services. • 100% of all referrals to go via SEAP and along the clinical pathway whilst receiving a personally tailored service based on their need. • Work with specific services is still required to increase their referrals into SEAP, since there are gaps from services where it is known there are likely to have a high proportion of alcohol misusing individuals on their caseloads. This includes domestic abuse services - which despite receiving training on the screening tool have not formally referred to SEAP in the last year- the housing sector and smaller voluntary sector services. • Work with specific referral sources to reduce the DNA following referral. The combined DNA and cancellation rate differs by referral source, understanding this and working with referral sources to refer the right people and provide the right encouragement to clients could help to reduce these rates.
There is a need to understand the factors influencing why individuals cancel their appointment and do not reschedule and whether they then subsequently get referred back into treatment at a later date.
Pharmacological treatment - • Commissioned capacity – During the last three years the difference between total places utilised and the commissioned capacity has closed and in 2013/14 there was between 10%-13% unused capacity. Whilst being mindful that some individuals will remain with their GP, there is a continued need to increase capacity/investment to provide more treatment places.
Psychosocial treatment- • Patient placement criteria are required to ensure the most appropriate psychosocial intervention is offered and provided. • To understand the numbers of individuals with an alcohol misuse condition and receiving IAPT.
Successful exits from treatment • Improve data - There is a noticeable difference between the number of treatment exits for Pharmacological and PSI interventions reported locally and by PHE. Further work is required to understand the difference. • Introduce new measures for monitoring success with further contact with clients at set time periods following exit to review AUDIT scores (no change) and recovery goals (progressing).
Residential rehabilitation - • There is a gap in NATMS reporting, with only two residential rehabilitation centres used reporting client activity in 2013/14. Given PHE have started reporting alcohol activity on the DOMEs report it is imperative that this is addressed in 2014/15.

Mutual Aid -

- To complete the outstanding actions on the Mutual Aid action plan
- Review the effectiveness of local mutual aid provision: - To increase local knowledge on the level of support clients receive from MA and better understand the proportion of those in treatment and those successful from treatment who attended a mutual aid group.

Undertake patient profiling to better understand the service user response to treatment in Sheffield,

- What has their experience/s of treatment been? This should be done in conjunction with the outcomes for this client's treatment episode in order to relate it to treatment effectiveness.
- What their history of alcohol misuse has been, hospital admissions.
- Whether they were offered alcohol treatment outside of the hospital, where they received it, reason why they started treatment, reason why they were successful (for those who have exited), number of times they have tried treatment (other questions can be asked)

Work towards improving data reported to PHE so future reports can be used for performance management of the new alcohol contract. Therefore in 2014/15 the checking and auditing of NATMS data between commissioner an provider.

IBA and alcohol screenings

Further work is required of GP practices to actively encourage referrals into specialist treatment following the outcome of an AUDIT score that reveals a patent is a high risk or dependent drinker and would benefit from Pharmacological or psychosocial treatment intervention.

SHSC and the electronic screening tool

- To continue to work with GP practices to increase the number of practices trained on the tool and to increase the usage of the tool in practices where it is consider underused.
- Further work is ongoing in children's social care to increase the use of the tool in assessment cases from 30%.
- Consider the tool in its current form and how it could be adapted to address the overlap with other tools and work to meet DES requirements. E.g. include mental health follow up screening questions, and investigate the potential to alter the tool to make it more tailored for different groups, e.g. older drinkers.
- Identify new organisations to launch and rollout the tool e.g. Mandy Craig's paper recommended exploring the options in:-
    - Community Midwives to screen pregnant women.
    - Health visitors to screen clients when undertaking their 6 to 8 week old baby home visit. Ideally use with both parents (if present) and the practice would support the 'Safe Sleep' message.
    - Family Intervention Workers to use with families accessing a family support service.
    - Housing Plus Workers to use with families accessing housing support.
    - The Probation service
    - Children's A&E (and adults) on parents and carers of vulnerable children
    - Police Officers following a domestic abuse incident
    - On parents whose child is accessing CAMHS (Child and Adolescent Mental Health Service)
- SHSC-FT to better monitor the number of referrals received via the electronic screening tool.

Include YAS in the consultation process to be undertaken for the new strategy on IBA and the work they undertake with alcohol misusers.

GP data on alcohol presentations is limited and is not routinely available to commissioners.

A&E -

- There is still a need to identify some big, real change initiatives to implement and keep long term in A&E
- Alcohol coding is still not routine, although has improved.
- Targeting or universal alcohol screening has been tried in A&E but is not routine.
- An alcohol lead is not present 27/4 in the service.
- Create a formal referral process between A&E and community alcohol services.

Hospital referrals to commissioned treatment

- Given that the alcohol liaison nurse role has operated for a number of years, it is worthwhile considering a review of the current model with consideration given to the following:-
    - The role of the alcohol liaison nurse has not yet become embedded and become mainstreamed practice. The evidence for this is that performance (referrals into treatment) reduced when the model changed for 6 months (the ALN role was not present daily). Therefore to remove the role would likely reduce the numbers referred from hospital to community treatment.
    - There remains a significant difference between the number of people admitted to hospital with an alcohol condition (1,397 -alcohol specific patients in 2013/14 which does not include patient's admitted with non-specific conditions) and the number who take up the offer for a referral into alcohol treatment (430 in 2013/14).
    - The ALN role does not cover 100% of either hospital, but focuses on 'hotspot wards', it also operates differently in NGH to RHH. Should it cover 100% of the hospital? What role should the ALN have at RHH given that the ward it operates on will relocate to NGH in autumn 2014 and should it differ to that of NGH?
    - There are low referrals to SEAP from wards where the ALN is not present despite the guidelines on how to refer *'Cessation of drinking for adults with alcohol use disorders'.* Is it the role of the ALN to undertake this work or is it the role of each ward, and therefore should the referral pathway be more widely promoted?

Introduce a specific focus on revolving door clients – those who enter and re-enter treatment by introducing specific initiatives to increase engagement and successful long term exit.
Integrated commissioning – confirm the agreements in place for the future commissioning of pilot initiatives and for the CCG and LA to work together / be aware of all work in progress and share outcome reports.
Ensure all wards where there is known high levels of alcohol misuse are part of a Substance Misuse Group; Broomhill ward is not part of the Central Substance Misuse Group and is not covered by any of the other, which is a potential issue given that it is known for its high level of binge drinking, given the student population.
Partnership working needs to be a priority and have practical benefits to all alcohol initiatives. This is paramount given the new national strategy which reinforces this and also the rollout of integrated commissioning as part of the Better Care Fund. These arrangements are likely to have a positive impact.
Social marketing options need to be reviewed, considered and planned; linking into national promotions and promoting the local changes in drinking habits (e.g. home drinking, pre-loading, binge drinking) and consider linking into to other public health campaigns (e.g. healthy eating, smoking etc).

Report Introduction

Background and Purpose

This is the third full needs assessment for alcohol but the first to be completed on behalf of Sheffield City Council, the two previous assessments were completed when the DACT was part of Sheffield Primary Care Trust.

This means the Alcohol needs assessment has a greater scope than previously, with a focus not only on the alcohol harms caused by alcohol misuse but also on the social impact of alcohol misuse, including alcohol related crime and anti-social behaviour, the night-time economy and licensed and non-licensed premises.

The purpose of this needs assessment is four fold:-

1. To act as a resource for LA commissioners when commissioning community alcohol treatment.
2. To update the alcohol data from three years ago with current data and add new data where available.
3. To support the writing of the four year alcohol strategy for Sheffield.
4. To support the updates of citywide strategic needs assessments

In scope

The alcohol needs assessment is for alcohol use and misuse, for individuals aged 18 and over. Conjunctive drug and alcohol misuse is discussed in the Drug needs assessment http://sheffielddact.org.uk/drugs-alcohol/resources/needs-assessments/ and young people and alcohol misuse is discussed in the Young people's drug and alcohol needs assessment.

Alcohol treatment discusses community based commissioned treatment and excludes specifics on treatment provided by Sheffield Teaching Hospitals and that of general practitioners, as these areas are commissioned by the Clinical Commissioning Group (CCG) and NHS England, however where activity and initiatives are known they are mentioned. The ideal would be to have an integrated needs assessment.

Reference is made to some alcohol initiatives happening in other LAs and may be of interest/ could be adopted in Sheffield.

Current Position - 2014

A number of strategic, performance and initiatives have been launched since 2011/12 when the last needs assessment was written, the below provides a summary of some of the main changes:-

National changes

The Government's Alcohol Strategy was published in March 2012 and a review was published in July 2013.

The Licensing Act 2003 has issued new guidance under section 182 and The Police Reform and Social Responsibility Act 2011 has been introduced. These laws give more autonomy to Local authorities including; giving them greater powers to fine and shut down businesses which are selling alcohol to underage drinkers. Licensing applications and subsequent permits have become more flexible and contrastingly there are now greater powers to revoke licenses. Local residents and communities can be consulted on licensing decisions and changes have been made to requests for Temporary Event Notices.

The latest NICE guidance on the identification and subsequent treatment of alcohol misuse (at all levels) are as follows:-

- Alcohol dependence and harmful alcohol use (CG115), February 2011
- Alcohol dependence and harmful alcohol use quality standard (QS11), August 2011
- Alcohol-use disorders: physical complications (CG100), June 2010
- Alcohol-use disorders: preventing harmful drinking (PH24), June 2010

Local

LAPE 2014 data http://www.lape.org.uk/ shows Sheffield compared to the England Average on 26 indicators (Appendix 1). LAPE data is mainly health data in relation to alcohol misuse, prevalence of alcohol misuse and alcohol related crime data.

Sheffield is not significantly different to the national average for 20 of these indicators, however three indicators are green which means 'better than the England Average' statistically. These are alcohol specific admission to hospital for under 18s, Alcohol related hospital admissions (broad) which means either the primary or a secondary reason was alcohol attributable and the % of Sheffield employees that work in bars.

Sheffield fares well to its core city comparators, with the least number of 'red' indicators. The three indicators which are red 'statistically worse than the England Average' are; Alcohol specific mortality - males, admission episodes for

alcohol related conditions (narrow) which means the primary reason at admission was for an alcohol attributable condition or a secondary reason was a external e.g. assault and synthetic estimates for binge drinking (the data has not been recalculated therefore it remains the same as it did in 2012).

The four year Sheffield Alcohol Strategy ends in 2014 with the majority of the actions completed at the time of writing. A new strategy is underway and will be in place during 2015.

Sheffield won the nationally recognised Purple Flag award in 2009 (an initiative in the national strategy) and has been re-awarded Purple Flag status in October 2014.

The Annual Best Bar None Awards were held in February 2014, with 59 licenced premises accredited, the most since its launch in 2009 (an initiative in the national strategy).

Strategic Links

The alcohol needs assessment is intrinsically linked to the citywide strategies and needs assessments:-

- The Sheffield Joint Health and Wellbeing Strategy – 2013-18
- Joint Strategic Health Needs Assessment 2013
- Sheffield Joint Strategic Intelligence Assessment 2013

The Government's alcohol strategy – acknowledges the difference between alcohol use and alcohol misuse; '*the majority of people who drink do so in an entirely responsible way… and in moderation, alcohol consumption can have a positive impact on adults' wellbeing, especially where this encourages sociability. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in our local communities. And a profitable alcohol industry enhances the UK economy*'[7].

However the strategy also recognises the negative aspects of alcohol *'but too many people still drink alcohol to excess. The effects of such excess – on crime and health; and on communities, children and young people – are clear*'[8].

The impact of alcohol misuse is costly, impacting not only on individuals but on the wider society.

The costs associated with alcohol misuse

A Public Health England report[9] estimates that the national cost of alcohol misuse use is around £21.3billion per annum, with £4.1 billion to the NHS (19.2%), £6.9billion (32.5%) to crime and licensing, £8.9billion (41.7%) to the workplace/wider economy and £1.7billion (8%) on social services for children and families affected by alcohol misuse.

In Sheffield it is estimated that the total cost of alcohol misuse use is £205.38 million per annum, £37.97 costs associated to the NHS[10] (18.5%), £67.78million (31.8%) to crime and licensing, 81.5million (39.7%) to the workplace/wider economy and 20.55 million (10%) on social services for children and families affected by alcohol misuse.

The average cost per head for Sheffield is £372, which is less than both the Yorkshire and Humber Public Health (PH) region average of £397 per head and the England average of £402. Sheffield's average NHS cost per head for is ranked favourably, at 70 out of 72 Health Authorities in the Northern Public health region - (£69 per head compared to the Northern PH Region average of £88 per head) whilst the average cost per head for CRIME and LICENSING in Sheffield is £123, which is less than both the Yorkshire and Humber Public Health (PH) region average of £129 per head and the England average of £131 which ranks Sheffield 32 out of 72 PH Northern Local Authorities.

The physical health costs associated with alcohol misuse

The current national recommended healthy drinking guidelines are as follows:-

- Men should drink no more than 21 units of alcohol per week, no more than four units in any one day, and have at least two alcohol-free days a week.

[7] *The Government's Alcohol Strategy (2012)* https://www.gov.uk/government/publications/alcohol-strategy
[8] *The Government's Alcohol Strategy* (2012) https://www.gov.uk/government/publications/alcohol-strategy
[9] *The Cost of alcohol in Sheffield local Authority 2011/12*, Public Health England 2013.
[10] Health costs are calculated using a combination of the 2008 methodology *'The cost of alcohol harm to the NHS in England'.* Costs were updated for hospital admissions related to alcohol using 2011/12 hospital tariffs, outpatient visits for higher risk dependant drinking (estimated using LAPE and General House Hold survey), A&E attendances, ambulance call outs GP consultations using LAPE and General Household Survey findings that 28.5% of GP visits are related to alcohol misuse for higher risk drinkers and the same percentage of visits to a practice nurse by higher risk drinkers, number and costs associa6ted to the prescribing of alcohol misuse prescription items, the costs for alcohol treatment and for other related health care were inflated from 2008/9 figures to account for inflation to 2011/12 prices, , using unit costs of Health and social care 2012.

- Women should drink no more than 14 units of alcohol per week, no more than three units in any one day, and have at least two alcohol-free days a week.

The Government's Alcohol Strategy asked for a review of the healthy drinking guidelines by the Chief Medical Officer, with an outcome expected in the summer of 2014. *These needed to be noted since this needs assessment is based on the current drinking guidelines which were available at the time of writing.*

All individuals are grouped into one of four drinking categories based on their weekly alcohol consumption (units per week). The first two categories (abstinent and lower risk) are within the recommended limits as advised by the Department of Health (above):-

1. Abstinent from drinking – consumption is 0 (zero) units per week.
2. Lower risk drinking – consumption is between 1 and 21 units per week for a man and between 1 and 14 units per week for a female
3. Increasing risk drinking – consumption is between 22 and 50 units per week for a man and between 15 and 35 units per week for a female
4. Higher risk drinking - consumption is equal to or greater than 51 units per week for a man and equal to or greater than 36 units per week for a female.

There is no category for what is known as 'Dependent drinkers' as these individuals would account for a proportion of the increasing risk and higher risk drinkers. NICE estimates suggest between 3% and 6% of the adult drinking population are dependant drinkers[11].

There is a further category, focusing on the daily intake of alcohol, 'Binge Drinking'. The definition of binge drinking is where regular daily consumption levels are double that of the recommended daily guidelines e.g. 8 units for a man and 6 units for a female. These individuals are also known to be 'at risk' and a cohort of the lower risk drinking category may also be classified as binge drinkers.

Individuals who fall into the 'risk categories' (binge drinking, increasing risk and higher risk) are more likely to have health problems associated with alcohol misuse. However the perception of those who drink at these risk levels found only 17% considered their health at risk[12].

Social impacts of alcohol misuse

The criminal costs of alcohol misuse - 49% of all violence crimes in England and Wales during 2010/11 are thought to be committed by individuals under the influence of alcohol and a fifth of all violent crime incidents are located in or around drinking premises[13] Chaplin R et al, 2011 as cited in *Protecting People Promoting Health*, 2012. The same report reports findings that include:-

- The more alcohol consumed the more likelihood of violence and that the violence will result in more serious injury.
- Victims can use alcohol as a coping mechanism
- Badly managed licensed premises can lead to environments where more crime is likely
- Alcohol misuse can be used as a tool to prepare one for violence
- Alcohol consumption can change cognitive behaviours therefore processing information and the ability to recognise warning signs for violence are skewed.
- Shared risk factors between alcohol and violence can make some people vulnerable to both behaviours.

Therefore issues in one area (alcohol misuse or violence) can cause spikes in the other and vice versa.

Anti-social behaviour - over 19% of adults perceiving that 'People being drunk or rowdy' as a problem in the local area[14].

Housing – 3% of statutory homeless people living in temporary accommodation during 2012/13 had a primary alcohol misuse problem[15].

Factors associated with drinking habits

A summary of alcohol drinking trends in the UK include:

[11] Alcohol dependence and harmful alcohol use quality standard QS11 http://publications.nice.org.uk/alcohol-dependence-and-harmful-alcohol-use-quality-standard-qs11

[12] https://www.gov.uk/government/policies/reducing-harmful-drinking Result of a YouGov poll (2010).

[13] Chaplin R, Flatley J, Smith K. *Crime in England and Wales 2010/11*. London: Home Office, 2011 as citied in *Protecting People; Promoting Health: A public health approach to violence prevention for England* (2012).

[14] '*Crime in England and Wales Year Ending'* December 2013 http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/period-ending-december-2013/stb-crime-stats-dec-2013.html

[15] Client Records &Outcomes (Housing-related support), 2012/13 https://supportingpeople.st-andrews.ac.uk/pubs.cfm

- The majority of people have heard of drinking units (92% of men and 89% of women) *however* the number who can then correctly apply them is much lower (77% of men and 73% of women who had drank wine in the last week could correctly identify the number of units in a 125ml glass of wine[16]. The less someone drank per week, the more they applied the units.
- Only 13% of those surveyed said they kept a check on how many units they drank[17]
- The number of litres of alcohol drunk per capita has reduced from 11.4 litres in 2005 to 10 litres in 2011.
- More men than women drink alcohol (66% of men drink once a week compared with 54% women)
- Men drink more frequently than women (9% of men drink every day of the week compared to 5% of women)
- The proportion of males and females drinking at increasing risk or higher risk consumption levels differs by age band. The age bands where there is a greater proportion of males and females drinking compared to other age bands is the 45 to 65 aged band for males which has between 27-29% of men drinking at these harmful levels and women aged 45 to 54 which has around 25% of females in this age band drinking at harmful levels.
- Alcohol consumption in the home has increased since 2002 whilst consumption outside of the home has decreased since 2001/02. Consumption in the home increased from 527ml in 1992 to 792ml per person per week in 2012 and decreased from 733ml to 394 ml outside of the home between 2002/03 to 2012[18] thus suggesting a potential increase in hidden alcohol misuse and that addressing such issues with these individuals is different to those who are drinking outside of the home (e.g. fixed penalty notice waivers and the benefits of best bar none scheme (e.g. refused drinks if drunk) would not have an impact or apply to these individuals.
- Young people are more likely (70%) to have drunk alcohol if they live with other people who drink alcohol compared to those who live in household where no alcohol is drunk (17%)[19].
- The Government's Alcohol Strategy[20] cites a Department of Health social marketing report - 83% who drink at increasing and higher risk levels do not believe their long term health is at risk and only 18% want to change their behaviour.
- Health inequalities & social segmenting – research finds that drinking patterns vary by socio-economic classification, with those from the higher economic groups consuming more but those in the lower economic groups who consume alcohol in the higher risk group category have more alcohol related health issues, with research suggesting other lifestyle factors (e.g. smoking and obesity) having an negative impact.
    - Those in higher socio economic groups (managerial and profession) are more likely drink on a weekly basis (75% of men and 64% of females) and 16% were likely to drink on five or more days in the week compared to routine and manual workers where 59% of male and 43% of female reported drinking weekly and 9% drinking five or more days per week[21]. The same applied to binge drinking levels with 18% of managerial and professionals drinking 6/8 units per day in the last week compared to 13% of routine and manual workers.
    - *'A recent report[22] into alcohol-related health inequalities in England and Wales was able to establish a clear association between alcohol-related mortality and socioeconomic deprivation, with progressively higher rates in more deprived areas, mainly among adults aged between 25 and 44 years. This was supported by an ONS publication[23] which found that men and women whose jobs are classified as "routine" were 3.5 and 5.7 times respectively more likely at risk of dying from an alcohol-related disease than those in higher managerial and professional jobs'.*

The needs assessments aims to summarise the latest national information available on the harms caused by alcohol misuse and focus specifically on local Sheffield data, where available. The text will take into account the prevalence of alcohol misuse in the city, the health harms caused by alcohol misuse, crime and anti-social behaviour, the city centre night time economy, those who are vulnerable to alcohol misuse, young people and explain the commissioning of an alcohol treatment system and the need for treatment.

[16] Health Survey for England 2007 (HSE07) as cited in Statistics on Alcohol: England 2014
[17] 2009 Omnibus survey report, as cited in Statistics on Alcohol : England 2014, http://www.hscic.gov.uk/catalogue/PUB14184
[18] Organisation for Economic Cooperation and Development (OECD), *Alcohol Consumption* (2013) http://www.oecd-ilibrary.org/social-issues-migration-health/alcohol-consumption_alcoholcons-table-en
[19] Statistics on alcohol: England 2014, http://www.hscic.gov.uk/catalogue/PUB14184
[20] The Government's Alcohol Strategy, March 2012, https://www.gov.uk/government/publications/alcohol-strategy
[21] Office of National Statistics 'Chapter 2 - Drinking (General Lifestyle Survey Overview - a report on the 2011 General Lifestyle Survey 2011' http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/rpt-chapter-2.html#tab-conclusions, March 2013
[22] Erskine, Sally, et al (February 2010)., 'Socioeconomic deprivation, urban-rural location and alcohol-related mortality in England and Wales', *BioMed Central Public Health,* 10: 99, Abstract as cited in *Socioeconomic groups' relationship with alcohol* http://www.ias.org.uk/Alcohol-knowledge-centre/Socioeconomic-groups/Factsheets/Socioeconomic-groups-relationship-with-alcohol.aspx#sdendnote6sym
[23] ONS (May 2011) 'Alcohol death rate greater for women and men in routine jobs', Health Statistics Quarterly 50, p. 1 as cited in Socioeconomic groups' relationship with alcohol http://www.ias.org.uk/Alcohol-knowledge-centre/Socioeconomic-groups/Factsheets/Socioeconomic-groups-relationship-with-alcohol.aspx#sdendnote6sym

Chapter 1 – Alcohol Use/ Misuse and its link to National and Local Strategies

Alcohol is a key feature in both National and Local strategies. The main aims are similar; to promote and create a safe drinking culture through healthy drinking campaigns, create a safe drinking environment alongside reducing physical harms caused by excess alcohol intake; long term health and physical injuries and reducing alcohol related crime.

The National Alcohol Strategy (2012) *'to cut 'binge drinking', alcohol-fuelled violence, and the number of people drinking to damaging levels'*[24] *has the following aims and actions:-*

We will take national action to:-

- Introduce a minimum unit alcohol price *(in 2014 this decision was deferred following extensive national and cross sector consultation).*
- Review the Mandatory code for alcohol in relation to a tackling drinking behaviour and irresponsible promotions *(introduced).*
- Consult on the alcohol anti-fraud measures *(published August 2013)*
- Work with the Portman group, Advertising Standards Authority (ASA) and Ofcom to better regulate the marketing of alcohol products to the public, including online and social media *(ongoing).*

We will ensure that local areas are able to tackle local problems and will:

- Increased powers to reduce alcohol harm though changes to public health, police and crime commissioners and rebalancing the Licencing Act *(strategic changes implemented, although local implementation has some issues)*
- Local communities to have more tools to restrict late night alcohol sales (where problems occur), control the density of alcohol licensed premises, introduce a late night levy for licensed premises open late to contribute financially to the cost of policing *(Changes applied to the Licensing Act although local implementation has some issues).*
- Increased partnership working to tackle alcohol problems 'head on' *(ongoing)*
- Increase the level of available data on alcohol crime 'hotspots' and licensing data and the sharing of hospital and local agency data *(ongoing)*
- Introduce new alcohol related injunctions as part of the reforms to anti-social behaviour tools[25] *(e.g. street drinking penalties, ASBO to remove a person from an area where they obtain alcohol, Fixed penalty notice waivers for alcohol use).*

We will drive greater industry responsibility and action in tackling alcohol misuse by :-

- Continue the Responsibility deal to encourage responsible drinking (e.g. challenge drunk behaviour)
- Encourage the alcohol industry to new commitments to drive down alcohol misuse *(The Public Health responsibility deal (alcohol network) pledge is to remove 1 billion units of alcohol from the market by 2015*[26]*).*

We will challenge people to change their behaviour by giving them the information and support they need by:-

- Review the 'healthy' alcohol drinking guidelines *(due August 2014)*
- Include alcohol screening to the NHS Health check for 40 to 75 years olds *(introduced 2013).*
- Increase social marketing on the health concerns of excessive alcohol use (Change4 life, direct to parents of young people) *(ongoing).*
- Investment into 120,000 'troubled families' to turn around their lives, some will have alcohol related problems) *(ongoing with 40,000 families benefiting so far)*. In Sheffield 1,680 families were identified and so far 1,520 have been worked with 650 families 'turned around' so far[27], by March 2014.
- Reduce alcohol related A&E attendances for under 18 year olds (*'Overall the number of attendances at A&E for under-18s with alcohol-related conditions fell from 7,821 in 2011/12 to 6,580 in 2012/13'*[28]*).*
- Commission effective alcohol interventions in four prisons *(From April 2013, the Government also proposed to grant responsibility for commissioning health services and facilities for those in prisons and other places of prescribed detention to the NHS Commissioning Board)*[29]*.*
- Increase the flexibility of the Alcohol Related Treatment orders imposed by courts to those on probation *(The LASPO Act 2012 removed the requirement for an ATR to have a minimum length of six months*[30]*).*

[24] https://www.gov.uk/government/publications/alcohol-strategy
[25] Anti-social behaviour information pack for councillors www.rtaylor.co.uk/pdf/ASB_Councillors_Guide.pdf
[26] Responsibility deal Alcohol Network, First interim report, Department of Health (2014) https://responsibilitydeal.dh.gov.uk/category/alcohol-network/
[27] Troubled Families programme: progress information https://www.gov.uk/government/publications/troubled-families-programme-progress-information
[28] BBC Radio 5Live made a freedom of information request to all NHS health boards or trusts in the UK asking for information on the number of under-18s attending A&E in the past five years for drink or drug related illnesses. Out of 189 health bodies, 125 responded. http://www.bbc.co.uk/news/uk-wales-24333109
[29] http://www.ias.org.uk/Alcohol-knowledge-centre/Crime-and-social-impacts/Factsheets/Alcohol-and-prison-services.aspx

- Pilot 'outcome by results' commissioned community alcohol treatment [31] *(pilot started July 2011, evaluation report expected 2015[32]).*

The government strategy was introduced during the lifetime of the current local Sheffield Alcohol Strategy 2010-14 which embedded The Department of Health's '*High Impact Changes*'[33] to reduce alcohol-related harm. These included increasing partnership working, developing activities to control the impact of alcohol misuse in the community, increasing the use of advocacy, improving the effectiveness and capacity of specialist treatment, appointing specific alcohol workers in hospitals, provision of identification and brief advice encouraging people to reduce their drinking, and the amplification of national social marketing priorities.

The strategy had three over-arching aims for the city;
1. A **responsible drinking culture** is present and drinking is a positive, rather than damaging, aspect of social interaction;
2. Alcohol is a positive part of the city entertainment offer and **contributes to a vibrant economy**, with both the city centre and neighbourhoods;
3. **Harm from alcohol use is minimised** through agencies and communities working effectively together to achieve cultural change in how alcohol is perceived and used.

Across the four year period of the strategy, the majority of actions have been achieved.

In terms of **encouraging a responsible drinking culture**, the following has been achieved:-
- Sheffield's Best Bar None (BBN) scheme has been introduced and is now in its sixth year becoming instrumental in raising awareness of safe licensing practice across the city;
- Licence Watch and the forum for city centre late bars and club continue to meet regularly and work together on addressing issues that occur within the night time economy;
- Trading Standards continue to run regular test purchasing exercises and ensuring that alcohol served in premises is safe and legitimate, as well as carrying out enforcement on under-age alcohol sales;
- Fixed Penalty Waiver and Conditional Caution schemes have been successfully implemented across Sheffield as a response to low level offending in the night time economy.
- A number of social marketing campaigns have been successfully delivered locally both in response to National Alcohol Awareness weeks and relevant sporting events, for example, European and World Cup football tournaments.

In terms of **contributing to a vibrant economy**, the following has been achieved;
- DACT has worked with various agencies on implementing a vision of a positive night time economy for Sheffield, including promotion of the BBN scheme through a free app for residents and visitors alike to download promoting the safe premises to visit in Sheffield;
- The City Centre Manager continues to work on the promotion of and safe running of the night time economy in the city centre.
- Polycarbonate glasses were distributed to replace glassware in all Sheffield licensed premises where any glassing incident had occurred.
- A Noise Aware scheme was launched by licensees in the city centre addressing issues of night time economy related noise where intelligence suggested this input was needed;

The areas where there has been less progress are joint working between Licensing and Planning departments and including health involvement data as part of the Licensing applications process. Given the promotion of cross partnership working to support the night time economy and this also being promoted through the Government's Alcohol Strategy further work is required in this area and needs to be factored into the new strategy.

In terms of **reducing the harm from alcohol use**, the following has been achieved;
- DACT officers have been involved in the re-tender of supported accommodation for alcohol misusers and ensured this is fit for purpose and reflects the alcohol treatment pathway for the city.
- Mutual aid groups have increased in number and have been promoted to the treatment cohort and embedded into commissioned treatment services to add value to the treatment episode and support recovery.

[30] Supporting community order treatment requirements, February 2014, National Offender Management Service
http://www.justice.gov.uk/downloads/about/noms/work-with-partners/supporting-community-order-treatment-requirements.pdf
[31] http://www.alcohollearningcentre.org.uk/Topics/Browse/Commissioning/PbR/
[32] *Alcohol Treatment within Payment by Results for Mental Health Overview and journey to date*
http://www.alcohollearningcentre.org.uk/Topics/Browse/Commissioning/PbR/?parent=6642&child=6753
[33] Signs for improvement: commissioning interventions to reduce alcohol related harm (2009) Department of Health Gateway reference 11753
http://www.alcohollearningcentre.org.uk/

- Performance has steadily improved across the commissioned alcohol treatment services with more capacity being used in2013/14 than has been seen before since DACT took over alcohol commissioning arrangements.
- Alcohol treatment is to be re-tendered during 2015/16 with a new end to end service planned to start from 1st April 2016. The range of treatment interventions available will include assessment, screening and brief intervention, extended brief interventions, prescribing treatment and psychosocial interventions. This is based on current performance trends and consultation.
- Joint work is on-going through provision of an Alcohol Liaison Nurse co-located between A and E and the Gastro ward of NGH and monitored through the Alcohol Planning and Commissioning Group.
- Domestic Abuse commissioning has been incorporated into the DACT team –allowing training of the domestic abuse workforce on alcohol screening and providing opportunities for domestic abuse risk assessment to be promoted and widely used in alcohol treatment services.

Key feature of the Alcohol misuse a key feature in the Sheffield Joint Health and Wellbeing Strategy 2013-18[34]
The Sheffield Joint Health and Wellbeing Strategy 2013-18 has ten principles to guide decisions on the health and wellbeing services paid for, delivered and supported in the city. DACT were involved in each part of the consultation process and were a stakeholder in the JSNA and Strategy writing process.

Reducing the harms caused by alcohol is included in Principle eight of the strategy:-
Breaking the cycle – we want to improve the life chances of each new generation by tackling the way in which poverty and inequality is passed through generations. We also want to stop the cycle of poverty, low aspiration, poor education entitlement, low income, unemployment, ill health and in some cases, homelessness, crime, alcohol, drug misuse and domestic and sexual abuse, which undermine the health and wellbeing of some people in Sheffield.

Reducing alcohol misuse is also included as an outcome measure in the strategy, with Outcome 2 on Improving health and wellbeing – • Sheffield children, young people and adults to be living healthily – exercising, eating well not smoking nor drinking too much alcohol – so that they are able to live long and healthy lives.
The specific action against this outcome for alcohol is to:- 2.6 commission appropriate interventions to reduce harm and promote pathways to structured treatment services for those abusing alcohol…including the hidden harm to children living in household where adults abuse alcohol…

Alcohol related needs/ gaps highlighted as part of the Joint Strategic Health Needs Assessment (JSNA) for 2013 were:-
- a lower than expected proportion of dependent drinkers access community treatment compared to the estimated prevalence figure in Sheffield,
- the concern over the potential development of an 'alcohol culture' in the city,
- the increasing prevalence of alcohol liver disease,
- the observed link between obesity and alcohol,
- the unknown impact falls caused my alcohol misuse on the health care system,
- the level of hidden drinkers not picked up by the 'system',
- the level of alcohol related recovery.

Key interventions were highlighted as:-
- promotion of alcohol community based treatment services,
- campaigns promoting safe drinking from an early age via the use of social media,
- promoting the link between alcohol and obesity
- Increasing the use of the online screening tool for GPs.

The government's expectation of Public Health England in 2014/15 is *'…to protect health and address health inequalities and …promote the health and wellbeing of the nation'*[35]. PHE actions in relation to alcohol are as follows:-
- Meet the deliverables of the Living Well for Longer deliver plan (see table 1 below) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307703/LW4L.pdf

[34] Sheffield's Joint Health and Wellbeing Strategy 2013-18 https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/joint-health-and-wellbeing-strategy.html
[35] The government's remit letter from Jane Ellison MP to PHE for 2014/15 (dated 12 June 2014) https://www.gov.uk/government/publications/phe-remit-letter-2014-to-2015

Table 1

Deliverable	Impact	Timing
Remove one billion units of alcohol from the market by the end of 2015.	Reduce the strength of alcohol in people's drinks	• Update: April 2014 • December 2015
PHE will produce a report for government on the public health impacts of alcohol and on possible evidence-based solutions by the end of March 2015.	Contribute to a reduction in alcohol harm.	• March 2015

- Expand the Longer Lives web tool to include drug and alcohol treatment recovery at LA and CCG level by December 2014. http://longerlives.phe.org.uk/
- Continue to develop and publish research on the public health impacts of alcohol and possible evidence based solutions, including reviewing the impact of obesity (with alcohol and Hepatitis C and other chronic liver diseases).

All these deliverables will increase the resources that Sheffield will be able to use and apply locally.

The recent introduction of the South Yorkshire Police and Crime Commissioner (PCC) in South Yorkshire has introduced a further spectrum and focus on alcohol misuse, with the PCC's priorities for 2013-2017 linking alcohol misuse and its association with crime with priorities specifically on:-reducing crime and anti-social behaviour, protecting vulnerable people and improving visible policing.

This section shows that there are a large number of strategic variables to consider in the new alcohol strategy for Sheffield; the most significant factors being how to best use the resources available (e.g. finance, information, systems, services) at our disposal now and over the next five years to address the pressing issues that alcohol misuse presents to our city.

Write a new five year alcohol strategy for Sheffield with consideration for the following:-

- Focus on early prevention, reducing alcohol related violence, reducing hospital admissions, increasing treatment engagement and longer term recovery.
- Heed the recommendations of the national strategy, PHE, the local Health and Wellbeing board strategy, the JSNA and the PCC priorities.
- Reviewing the success of the previous Sheffield alcohol strategy 2010-2014 and building on the work already established and effectively implemented.
- Exploring new local developments and initiatives to address the most pressing and relevant issues; being pioneers in the field.
- Identify stuck areas and areas of greatest need introducing initiatives that will break the cycle of misuse.
- Understand the relationship between hospital admissions, alcohol screening and IBA and alcohol treatment
- Creating an effective culture of working together in all areas: strategically, in commissioning and clinically.

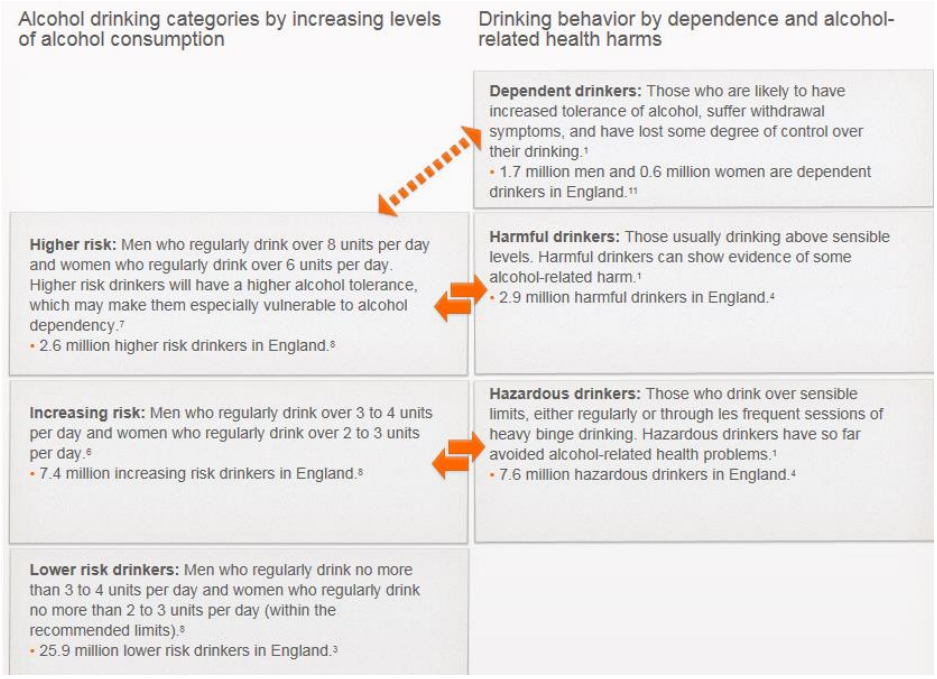
Chapter 2 - The Estimated Prevalence of Alcohol Misuse in Sheffield by alcohol category

The Estimated Prevalence of Alcohol Misuse in Sheffield

Understanding the prevalence of alcohol misuse locally is essential to ascertaining the need for treatment. The most recent resource available is the *Topography of Drinking Behaviours in England: Synthetic estimates of numbers and proportions of abstainers, lower risk, increasing risk and higher risk drinkers in local authorities in England (2011).*

Diagram 1 below shows that there are two different classifications of drinking levels, those based on the Topography, lower, increasing, higher risk (which are relatively new) and those based on health related harms, dependent, harmful and hazardous drinkers (which are more widely known and used within health services).

Diagram 1 drinking levels by category



http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map

The prevalence data is based on the topography definition which was provided in 2011, and applied to mid-2007 population estimates. The more recent 2011 census data has been published so therefore the proportions provided have been applied to the more recent 2011 population data, see Table 2 which shows the original 2007 and 2011 census data.

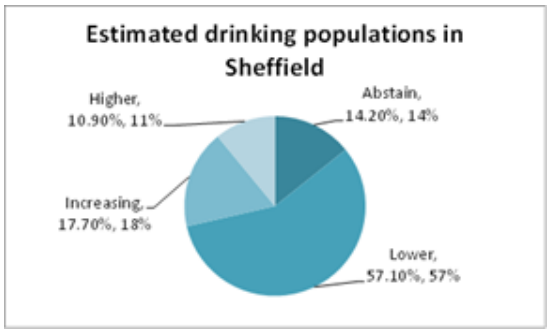
Table 2 - The estimated prevalence of drinking populations in Sheffield using the Topography of Drinking Behaviours in England (2011), using 2011 population data.

	Estimated proportion of Sheffield population by drinking category, Topography Report, as citied on LAPE 2014			Estimated number of individuals as quoted in the 2011 Topography Report	Using the estimated proportion of individuals in the 2011 Topography Report using 2011 Census data			LAPE 2014	
Drinking category	%	-95%	95%	2007 mid population estimates	2011 Census	-95%	95%	England Average	Public Health ranking (out of 326 Local authorities with 1 being the better).
Abstain	14.2%	9.7%	19.2%	61,851	64,138	43,845	86,787	16.53	54
Lower	57.1%	33.6%	73.4%	249,105	258,315	151,877	331,778	73.25	138
Increasing	17.7%	6.1%	40.4%	77,218	80,073	27,573	182,614	20	79
Higher	10.9%	4.0%	27.3%	47,723	49,488	18,081	123,400	6.75	293
Binge drinkers	26.9%	25.2%	28.7%	117,256	121,592	113,908	129,728	20.1	308
Sheffield 16+ years population				435,897			452,014		

The Topography estimates when applied to 2011 census data indicate that in Sheffield has the following:-

- 10.9%, or 49,488 individuals are Higher risk drinkers
- 17.7% or 80,073 individuals are Increasing risk drinkers
- 57.1%, or 258,315 individuals are Lower risk drinkers
- 14.2%, or 64,138 individuals are Abstinent from drinking

Chart 1 that shows the Sheffield estimates pictorially.



The most recent LAPE data published in 2014 reports that the Sheffield prevalence estimates are 'not significantly different to the England average' for lower, increasing and higher risk drinking.

Dependent drinkers – A definition of Alcohol dependence is available in NICE guidance *'characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking)'.* Dependence is categorised further into three levels; mild, moderate and severe dependence, see table below for definitions[36]:-

Dependent drinkers can be further described by the level of their dependence on alcohol:

Mild dependence: described as craving an alcoholic drink when it is not available.[9]
Moderate dependence: described as having an increased tolerance of alcohol but suffering withdrawal symptoms and losing some degree of control over drinking.[9]
Severe dependence: described as having withdrawal fits, which entail experiencing confusion or hallucinations between two to three days after the last drink consumed, and possibly drinking to escape from these symptoms.[9]

Understanding the levels of dependence is significant as these are used to estimate the number of people who require specialist alcohol treatment in a given year. However dependent prevalence estimates are not available in the Topography report which makes ascertaining a figure more complex. There are however two valid sources of dependence prevalence estimates available although both apply different methodologies, have different results and both only provide national estimates.

[36] Definitions taken from http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map

Dependence methodology 1 The Adult Psychiatric Morbidity Survey (APMS)[37] is the most recent survey (2007) and used by *PHE (Gateway number 2013453*. It uses a wider methodology than ANARP (see below). Of those surveyed who scored more than 10 on AUDIT then completed the SADQ-C questionnaire (with a score of 4+ meaning dependent). The results found that an estimated 5.9% of the population had some dependency on alcohol with the following categories:-

- 5.4% of the population had mild alcohol dependency (7.8% male and 3.2% females),
- 0.4% had moderate dependency and
- 0.1% had severe dependency,

Rates were higher for the Yorkshire and Humber region with 7.1% with any dependency. PHE recognise that the sample size was not large enough to calculate dependence at LA level; therefore this document has not applied these rates to Sheffield population data.

Dependence methodology 2 The Alcohol Needs Assessment Research Project (ANARP)[38] undertaken in 2005 uses the methodology that anyone scoring over 16 on AUDIT suggests moderate or severe dependence. They found that an estimated 3.6% of the population (2% females and 6% males) were alcohol dependent and in Yorkshire and Humber this was 5%. Since this has been cited in the most recent NICE guidance *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115),* this has been applied to ascertain the level of dependent drinkers in Sheffield.

ANARP applied to the Sheffield population suggests around 18,000 individuals will score 16+ on AUDIT aged 16 to 64 years) and are therefore dependent.

	Sheffield population (Census 2011) age 16 to 64 years	Y&H % of the total Sheffield population (16 to 64 years)	Dependence estimate based on Sheffield population and ANARP
ANARP (Y&H estimates)	366,316	5.0%	18,316
Based on the findings from the Alcohol Needs Assessment Research Project (ANARP 2005)			

Given the issues found with both methodologies further work on estimates for dependent drinkers is underway and therefore the 18,000 above is likely to change at some future date. PHE are currently undertaking a piece of research to ascertain prevalence figures for dependence levels by LA with a view of 1, understanding the proportion that would require specialist treatment, and 2, better understanding those who scored 20+ on AUDIT.

Binge Drinkers

The binge drinking estimates for Sheffield (provided by LAPE[39]) indicate that the Sheffield prevalence of binge drinkers is 26.9% (CI+/-95% = 113,908 to 129,728), compared to the England rate of 20.1%.

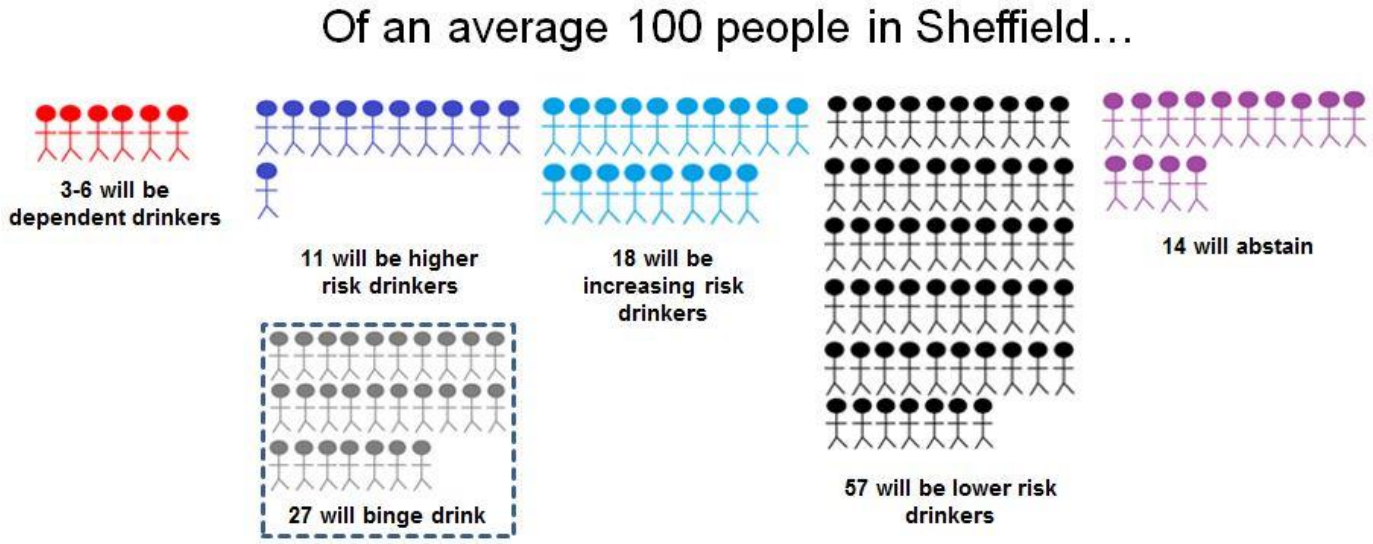
Sheffield Population	*Indicator Value*	*LCI*	*UCI*
452,014	26.9%	25.2%	28.7%
Binge drinking	121,592	113,908	129,728

LAPE 2014 reports that Sheffield is worse than the England Average for binge drinking.

In summary

Therefore based on the levels of estimated drinking in Sheffield, on average for every 100 people in Sheffield, 3-6 will be dependent drinkers, 11 will be higher risk drinkers, 18 will be increasing risk drinkers, 57 will be lower risk drinkers and 14 will abstain. 27 out of 100 will binge drink, see diagram X below.

[37] *Adult Psychiatric Morbidity in England* (2007) NHS Information Centre,
[38] http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/?parent=4644&child=4647
[39] www.lape.org.uk



Estimated number of people who require alcohol treatment per annum in Sheffield

The ANARP study applied a prevalence service user ratio (PSUR) which provided an indication of the size of their alcohol dependent population, the associated treatment needs and treatment available. In 2005 the National PSUR ratio was 18; which meant that for every 18 dependent drinkers one (1) is accessing treatment or 5.6% of those who are dependent drinkers are also accessing treatment, Yorkshire and Humber had a PSUR of 45 (2.2% or 1 in 46 dependent drinkers were accessing treatment). More recent treatment data shows the following for England and for Sheffield, see Table 3:-

Table 3 – PSUR rates for Sheffield and England, based on the findings from ANARP and recent treatment data

	16 to 64 years population (Census 2011)	Dependent drinking population*	Number in Treatment (NATMS 2013)	% of dependent drinkers in treatment	PSUR
England**	34,329,091	1,235,847	109,683	9%	11.1
Sheffield***	366,316	18,316	954	6%	16.0
*Dependent drinking population (3.6% England, 5% Y&H and Sheffield) population, based on ANARP prevalence figures					
** England treatment data from *Alcohol statistics from the National Drug Treatment Monitoring System (NDTMS), 1 April 2012 to 31 March 2013*					
***Sheffield data from www.NDTMS.net					

The Sheffield estimated PSUR of 16. This means for every 16 dependent drinkers in Sheffield one accessed structured community based treatment (this excludes hospital admissions and GP treatment activity) in 2013/14. Given this is lower than the England PSUR rate of 11, commissioners should continue to identify key initiatives to encourage more dependent drinkers into treatment with a view of reducing the PSUR rate.

The Rush Model (1990)[40] is the most widely used tool for planning resources for commissioners when planning the need for community based treatment services. Rush's research indicated that by understanding the geographic population, the estimated dependent drinkers (the in-need population), the demand population (estimated numbers who need treatment per year from the in-need population) the number of places required for the treatment system (assessment, case management treatment and aftercare) would be known.

The number of places required for the treatment system (number accessing treatment in any given year)
Rush estimated that ideally 20% would be considered the size of the demand population, however his research explained that the current service utilisation of the local treatment system needed to be heeded, given that he found utilisation rates varied between 5% and 15% (and an average of 7%) of the total in need cohort. This is not surprising since the ACMD report to the recovery committee in November 2013 said that *'research evidence (finds) that a minority of those with drug or alcohol dependence access treatment for dependence at any one time. There is evidence that those who are in drug and alcohol treatment are a cohort of the dependent population – with the most*

[40] Rush, B 'A systems approach to estimating the required capacity of alcohol treatment services', *British Journal of Addiction* (1990) 85, 49-59

severe problems. There is also research evidence that where treatment is available, those with drug and alcohol dependence will utilise treatment episodically[41].

Therefore it is not expected that 100% of the dependent population will want or require treatment at any given time. The current the Sheffield PSUR rate shows that Sheffield's utilisation rate is currently 6% of the total in need population although the Rush Model available on line (Alcohol Learning Tool) uses a 10% in-demand utilisation rate, and therefore when applied to Sheffield the:-

Anticipated demand for specialist alcohol treatment in Sheffield by dependent drinkers in any given year (10%) = 1,832

Gap
Therefore the gap between the RUSH model (estimated 1,832 to access alcohol specialist services in any given year) and the number accessing treatment in 2013/14 (1,016) was 878, see table 4, suggesting that a significant number of dependent drinkers (those who most require alcohol treatment in any given year) are not accessing services currently.

Table 4

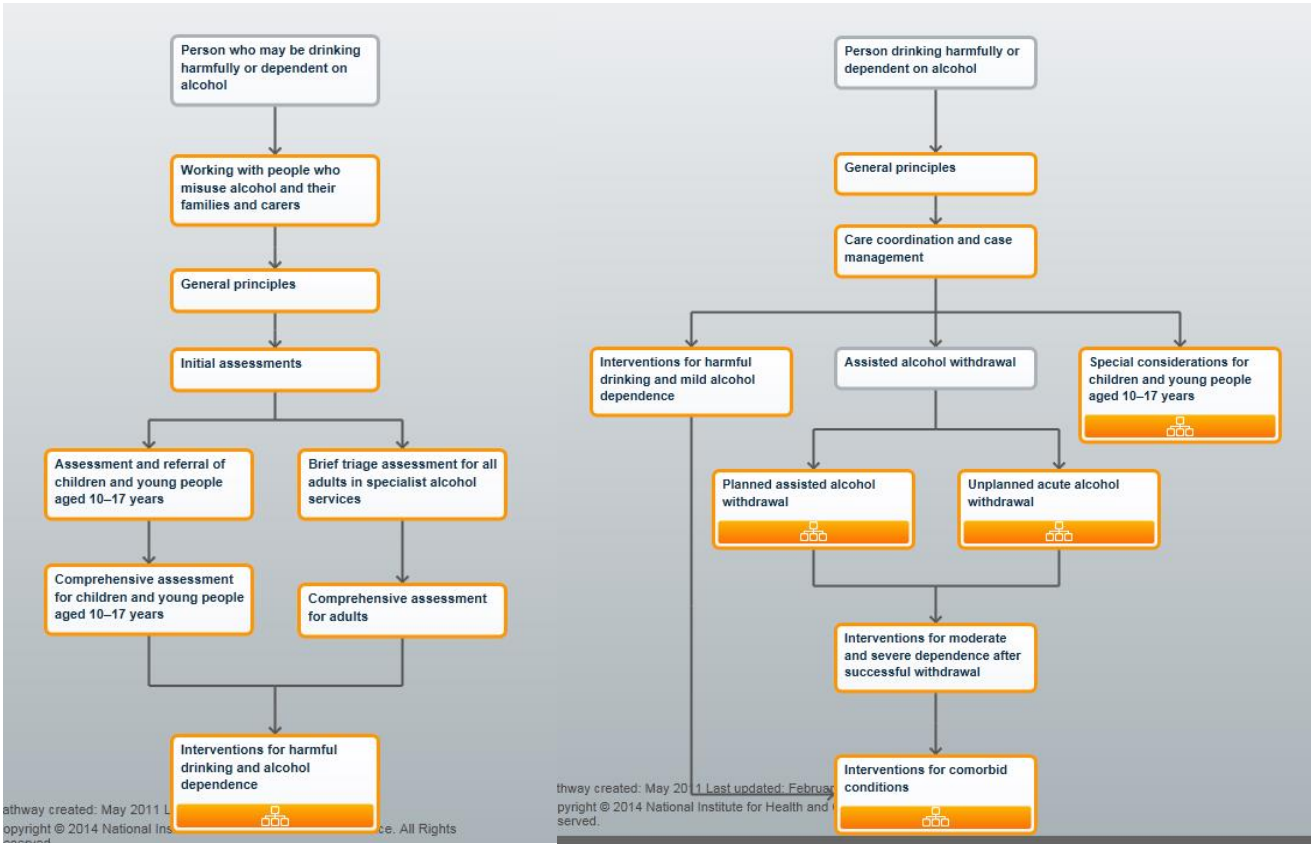
Anticipated demand for treatment (RUSH 10%)	In treatment in Sheffield 2013/14	Difference between actual in treatment and estimated demand
1832	954	878

Rush explains in his model that the 90% of dependent drinkers who do not access specialist alcohol treatment services are likely to be using other services because of their drinking; including hospitals, mutual aid groups, general practice services, be in the criminal justice system or private medical practice. In Sheffield we also know that this list extends to hostels and housing services, social service case loads and mental health case loads. Therefore if one is to just observe the rate of alcohol specific hospital admissions in Sheffield (1,397, CCG data) and the number of people likely to be visiting their GP (an average of 11 times per year for alcohol misusers) there are a number of opportunities where referrals into specialist alcohol treatment could increase.

Commissioning
The Rush model and PSUR rate reflect the capacity required for part of the treatment system, those who require Tier 3 and Tier 4 specialist alcohol treatment. HOWEVER both Models of Care for Alcohol Misuse[42] (MoCAM) and NICE (see pathway below) advise the commissioning of treatment for those drinking at harmful levels, therefore capacity should also include screening, advice, brief interventions (Tier 1, MoCAM), assessment, extended interventions, assertive outreach and outreach support and open access services (Tier 2, MoCAM).

[41] Advisory Council on the Misuse of Drugs *'What recovery outcomes does the evidence tell us we can expect?: second report of the recovery committee*, November 2013 https://www.gov.uk/government/publications/acmd-second-report-of-the-recovery-committee-november-2013
[42] Models of Care for Alcohol Misuse (MoCAM, Gateway 5899) http://www.nta.nhs.uk/uploads/nta_modelsofcare_update_2006_moc3.pdf

NICE Pathway for the treatment of alcohol misuse



http://pathways.nice.org.uk/pathways/

So what does this mean?

The prevalence of higher risk and increasing risk drinkers in Sheffield is similar to the national average with an estimated 29% drinking at higher or increasing risk levels. However, the PSUR rate shows the proportion of people in treatment to those who are estimated as dependent. In Sheffield the PSUR rate is higher than the England average (1 in 16 compared to one in 11). The Rush model suggests that over 1,800 people in Sheffield in any given year would require specialist treatment for alcohol, the activity in commissioned services is just over half this; 954 (2013/14) received tier 3 or tier 4 MoCAM treatment. This shows that there is more estimated need than demand for treatment.

Therefore further work is required in Sheffield to increase demand for treatment to match the estimated need. This would reduce the PSUR rate; thereby increasing the number of people receiving specialist treatment for their alcohol misuse per annum within the comprehensive treatment system, as per NICE recommendations for commissioning.

If this is achieved then further treatment capacity will be required, since treatment chapter 4 explains that commissioned activity has increased over the last 18 months and in some areas is nearing capacity. If the observed increase continues then current commissioned capacity will be met and capacity will not be sufficient in the longer term to both meet the needs of the 1,800 estimated by the Rush model and to reduce the Sheffield PSUR rate to the England average. It should be noted however that not all those in need of treatment will have their needs met via the treatment pathway and that some will have treatment from their general practitioner – see treatment section for further details.

Chapter 3 - Commissioning the alcohol treatment pathway in Sheffield

The commissioning of alcohol treatment in Sheffield has historically been separated between NHS and LA commissioning, with these parties working together in some specific areas using the governance structure of the now disbanded Alcohol Planning and Commissioning Group, which included provider and clinical representatives. Governance has become part of the Sheffield City Council structure in 2014/15.

The list below shows which area commissions each part of the treatment available for individuals who misuse alcohol.

- The Local Authority Sheffield DACT are the lead commissioner of community based specialist alcohol treatment provision.
- The Clinical Commissioning Group (CCG) pay the hospital tariff for all alcohol related and specific admissions and attendances at A&E.
- NHS England commissions the Direct Enhanced Service (DES) for alcohol screening undertaken by most GP practices.
- Public Health in Sheffield City Council leads on the commissioning of residential rehabilitation.
- There are 95 mental health beds paid for by CCG which allows for 5 (five) detoxification beds. SCC funds the substance misuse specific clinical input of these 5 beds.

There is and has been over the past few years joint working between the NHS and LA on some specific areas of alcohol treatment commissioning, including funding contributions to specific areas (i.e. residential rehabilitation) and specific projects (i.e. the alcohol liaison nurse). Over the next few years there is an opportunity to further integrate following the introduction of the Better Care Fund (BCF).

As part of the government's 2013 spending review, a BCF was introduced[43]. The aim is for LAs and CCGs to hold *'a single pooled budget to support health and social care services to work more closely together in local areas'.* The BCF is not alcohol specific, the Sheffield BCF vision and four key priorities include *'1. Keeping people well in their local community and 2. Intermediate care* however the outcomes include reducing unplanned hospital admissions and the cost associated with health treatment in hospital, of which alcohol illnesses are widely known to be preventable. Full details are found at https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/integration.html.

In 2014/15 the Sheffield BCF plans and scoping of actions will be formed with 2015/16 to be the first year of the pooled budget. DACT are involved in the scoping of these plans, representing alcohol treatment. The BCF has already started to impact on alcohol treatment commissioning, with the first step to end the current governance structure of the APCG and include the governance as part of the new BCF governance structure. Only at the end of this scoping process will the future of the integration of alcohol commissioning be known.

A current pressure is to complete the BCF plan and achieved sign off in 2014/15 to launch in 2015/16.

DACT Commissioning in 2014/15

The current community alcohol specialist treatment system has been commissioned in its current form since 2010/11 and is a fully integrated treatment system supplied by two providers:-

- **Sheffield Health And Social Care Foundation Trust (SHSC-FT) –** who provide the single entry and assessment point (SEAP) and referral system, brief interventions and extended brief interventions, assertive outreach, secondary care pharmacological interventions, inpatient detoxification, GP liaison nurse and a specialist alcohol liaison nurse situated in Sheffield Teaching Hospitals.
- **Turning Point Adult Treatment Services Sheffield** - provide psychosocial interventions and alcohol treatment requirements (ATR) packages. (This provision was transferred to SHSC-FT on 1 January 2015) Negotiations are on-going to transfer alcohol PSI to SHSC-FT for the remainder of the contract.

Commissioning from 2015/16

The two contracts will be tendered during 2015/16, with the current DACT contracts scheduled to end on the 31st March 2016. The procurement process to commission a new treatment system is in progress and will be an action in the new alcohol strategy (due 2015).

The procurement consultation process has been wide and included experts, providers, service users and the general public. The current proposal is to commission a one provider model, where all clients can start and end their treatment journey with the same provider. This is considered the most effective and cost efficient method to address known needs.

[43] Latest update to the Better Care Fund, 7 July 2014 https://www.gov.uk/government/news/better-care-plans-to-provide-dignity-independence-and-reduce-ae-admissions

The new contract will not remove any treatment commissioned previously but will enhance what was commissioned in the past, and includes new services.

Headlines from the new alcohol specification:-

1. **Single Entry and Assessment Point (SEAP) and Identification and Brief Advice (IBA)**
   SEAP will provide the assessment stage of treatment. Validated screening tools will be used and all will receive personalised harm reduction advice as well as appropriate onward referral into treatment.
2. **Pharmacological Interventions**
   Including community detoxification, prescribing interventions to reduce harm (for example nutritional prescribing, and prescribing to prevent relapse (Naltrexone, Disulfiram, Acamprosate).
3. **Formal Psychosocial Interventions**
   Formal PSI will be offered as either 3-6 weeks of extended brief interventions (EBI) or 6-12 weeks of Psychosocial interventions, based on clinical need.
4. **Nurse Support Services**
   A and E/Hospital Liaison Nurse and GP/Primary Care Liaison Nurse for alcohol will be provided and will identify people in primary care or hospital settings who have alcohol misuse problems alongside other health problems. The nurse support will include screening, harm reduction advice and onward referral into structured treatment where appropriate.
5. **Criminal Justice / Enforcement Routes to Alcohol Treatment**
   The service will provide appropriate interventions to those mandated to attend treatment appointments as part of criminal justice or other enforcement measures. This will be provided using screening and treatment capacity already in place for Parts 1, 2 and 3.

The contract will be awarded by Sheffield City Council using their procurement processes.

Chapter 4 - Sheffield Alcohol Treatment activity in 2013/14, compared with 2011/12 and 2012/13

NICE (PH 115) reported in 2011 that only a small proportion of those who require treatment for alcohol misuse actually receive it each year - *'Of the 1 million people aged between 16 and 65 who are alcohol dependent in England, about 6% per year receive treatment'*. Explanations as to why the proportion is so low includes under identification, long drinking careers prior to presenting for treatment and the amount of treatment commissioned nationally.

The first two issues are evident in Sheffield and have been some of the explanations as to why engagement with treatment is lower than expected, or that need indicates. Currently treatment capacity is not an issue, with more places currently commissioned than demand for treatment; however activity over the past 18 months has increased and has used 82% of structured treatment capacity. Indeed some interventions may achieve their commissioned capacity in the next year or two if places remain the same and the rate of engagement continues to increase.

The table 5 below summarises the total treatment system activity (excluding GP and hospital activity), compared to the commissioned target and the percentage each intervention achieved.

Table 5 2013/14 activity in all treatment interventions compared to the commissioned targets.

Summary of treatment activity in 2013/14			
Commissioned places 2013/14	**Summary of activity in 2013/14**	**Treatment intervention**	**% capacity achieved**
	954	**unique individuals recorded in treatment with NATMS**	
	3332	SEAP referrals	
	98	referrals (not to SEAP)	
2400	2025	triaged by SEAP	84%
756	657	pharmacological treatment	87%
533	392	new to Psychosocial interventions (PSI) which also includes ATR activity (473 when carried over included in activity)	74%
700	693	Extended brief interventions (EBI)	99%
42	69	Inpatient detoxification	164%
42	15	new places agreed for residential rehabilitation	36%
	224	Fixed penalty notice waivers	

Notes: -	
1	EBI is not recorded as in treatment with NATMS
2	A number of people will receive more than one intervention.
3	The NATMS figure will remove any duplicate activity (e.g where a client received both Pharmacological and PSI interventions)
4	The figures provided for Pharmacological and PSI includes all activity, therefore if a person has returned to treatment (ave 12% of those who are successful, unknown if unsuccessful) they will count multiple times.

All activity in this section is based on the two provider treatment system used 2010/11 to 2013/14, using data from providers and additional information from PHE (providers supply the data direct to the National Alcohol Treatment Monitoring System (NATMS)).

Referrals into the treatment system - SEAP

All referrals into the treatment system should be made to the Single Entry and Assessment Point (SEAP), commissioned by DACT and provided in the last three years by Sheffield Health and Social Care Foundation Trust (SHSC-FT). SEAP undertakes a triage assessment and a brief intervention with each individual and identifies the best treatment for the individual.

There were a total of 3,332[44] referrals into SEAP alcohol treatment during 2013/14 however 3% of all referrals into the alcohol treatment system go direct to Turning Point and not via SEAP. In 2013/14 this equated to 98 referrals[45].

[44] Sheffield Health and Social Care Foundation Trust Performance Monitoring Return 2013/14, Sheffield DACT
[45] Turning Point Adult Treatment Services - Performance Monitoring Return 2013/14, Sheffield DACT

Therefore the total referrals into alcohol treatment system in 2013/14 was 3,430 (3,332 into SEAP and 98 direct to Turning Point).

The reasons behind the referrals direct to Turning Point can be explained further when the source of the referrer is observed. Three quarters were from GPs, alcohol floating supports services and hospitals thus suggesting that the referrers clinically understood the client required PSI treatment and therefore referred direct to Turning Point. The remaining quarter was ad hoc. A couple of issues are raised here; 1. The numbers not going via SEAP are small, 2. Some referrers are bypassing SEAP, 3. Some referrers understand their client requires PSI alcohol treatment, 4. Not all individuals are receiving the same triage assessment process.

This issue has been resolved in 2014/15 therefore all referrals now go via SEAP.

The new contract will ensure that 100% of all referrals receive the same service and all go via SEAP.

Total SEAP referrals have increased over the last three years, with an 8% increase (+284) experienced in the last year (2012/13 to 2013/14[4647]), see Table 6 below.

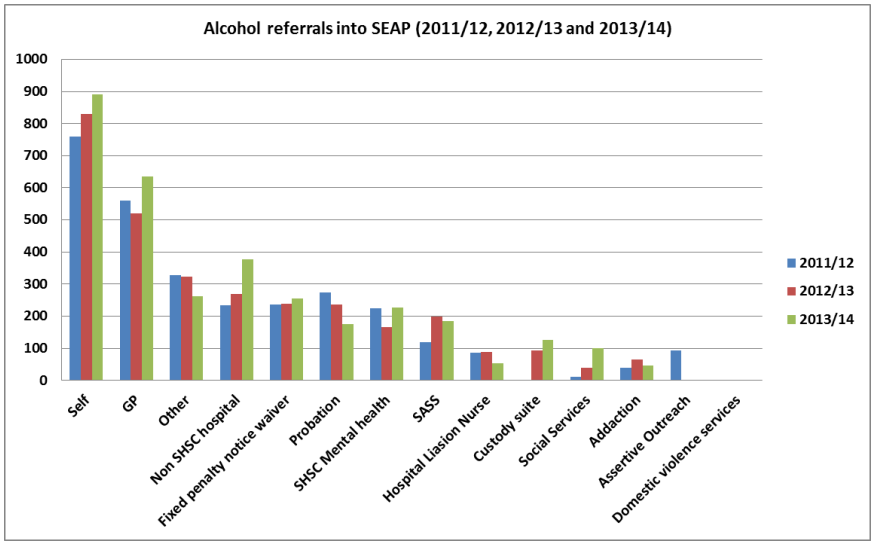
Table 6 – Referrals into SEAP, by referrer 2011/12 to 2013/14.

	Total referrals into SEAP					
Referrer	2011/12	2012/13	2013/14	Total referrals (three year period)	The referral source as a percentage of all referrals (2013/14)	% change in referrals between 2012/13 and 2013/14
Self	759	830	891	2,480	27%	7%
GP	561	519	634	1,714	19%	22%
Other	327	323	262	912	8%	-19%
Non SHSC hospital	234	269	377	880	11%	40%
Fixed penalty notice waiver	237	238	256	731	8%	8%
Probation	274	236	175	685	5%	-26%
SHSC Mental health	224	167	226	617	7%	35%
SASS	120	199	185	504	6%	-7%
Hospital Liasion Nurse	85	88	53	226	2%	-40%
Custody suite	2	93	127	222	4%	37%
Social Services	12	40	100	152	3%	150%
Addaction	40	64	46	150	1%	-28%
Assertive Outreach	92	2	0	94	0%	-100%
Domestic violence services	0	0	0	0		
YTD Total	2,967	3,068	3,332	9,367	100%	9%
Health Referrals	1,256	1,193	1,493	3,942	45%	25%
Data Source: Sheffield Health and Social Care Performance Frameworks for 2011/12, 2012/13 and 2013/14						

Referrals into SEAP come from over 13 main sources; with self-referrals remaining the highest source (27% of all referrals which are lower than the national 40% observed by NATMS[48]) and GPs are the second highest with 19% of all referrals or a total of 634. The highest sector for referrals is health services (GPs, Mental health trust, alcohol liaison nurse and hospitals) with 1,493 referrals (45% of the total) in 2013/14.

In the last three years the referral source that has experienced the highest proportional increase (150%) in referrals is social services (12 in 2011/12 to 100 in 2013/14) following the launch of the alcohol screening tool within this service. The second highest proportional increase in referrals but with the greatest increase numerically is the hospital (non SHSC and the alcohol liaison nurse) which has increased by 35% over the three year period from 319 referrals in 2011/12 to 430 in 2013/14, thus suggesting that increase is a reflection of the positive impact the ALN has had working in the teaching hospitals in the last few years[49].

[46] Sheffield Health and Social Care Foundation Trust Performance Monitoring Return 2012/13, Sheffield DACT
[47] Sheffield Health and Social Care Foundation Trust Performance Monitoring Return 2011/12, Sheffield DACT
[48] Alcohol Statistics from the National Drug Treatment Monitoring System (NDTMS) 2012-2013
[49] The impact of the ALN can be measured in a number of ways. One measure of success is the number of referrals from the hospital into community treatment.



Smaller referrers are included in the 'other' category, with only those who refer more than 16 a year listed as a separate referrer (apart from domestic abuse services).

Gaps – to increase the number of referrals

Work with referrals sources is still required to increase referrals into SEAP, since there are gaps from services where it is known there are likely to be a high proportion of alcohol misusing individuals. Most notable these are the housing sector, smaller voluntary sector services and domestic abuse services (who received training on the electronic screening tool but not formally referred to SEAP in the last year).

Did not attend following referral

The SEAP provider, SHSC has a 20% DNA to referral target. This is ambitious given that three years ago the proportion of referrals that resulted in the individuals attending their subsequent appointment was 29%. In 2013/14 there was a 26% DNA rate (or a total of 862 referrals), which shows the engagement percentage has not decreased from three years ago and that there is still work required to achieve the target of four out of five referrals attending their appointment.

In 2013/14 the definition of a DNA was a matter of debate and the definition changed to only include those who did not attend their appointment and had not contacted the provider prior to doing so (DNA) and exclude those who had contacted the service prior to the appointment to cancel (Cancellation). Therefore of the 26% who did not attend their appointment in 2013/14, 12% or 392 were DNAs and 14% or 470 were cancellations.

Whilst for operational capacity planning purposes it is important to understand the difference between the two (DNA and cancellations), what is important from a need basis is that one in four referrals does not result in the person attending their appointment.

Additionally there is variation between the referral source and the likelihood of attending the appointment, see table 7 for full details**.**

Table 7 – Total referrals into SEAP by referrer including the total DNAs or cancellations.

	2013/14 referrals	Number that DNA or cancel	% that DNA or cancel	2013/14 DNA following referral	2013/14 cancel following referral	% that DNA	% that cancel
Addaction	46	25	54%	14	11	30%	24%
Social Services	100	42	42%	9	33	9%	33%
GP	634	242	38%	107	135	17%	21%
Other	262	86	33%	27	59	10%	23%
SASS	185	51	28%	35	16	19%	9%
Self	891	238	27%	98	140	11%	16%
Probation	175	42	24%	25	17	14%	10%
SHSC Mental health	226	54	24%	26	28	12%	12%
Custody suite	127	11	9%	7	4	6%	3%
FPN	256	21	8%	21	0	8%	0%
Hospital (STH & ALN)	430	50	12%	23	27	30%	38%
YTD Total	3,332	862	26%	392	470	12%	14%

Only one in two referrals in 2013/14 from Addaction (drug treatment service) attend their appointment compared with one in ten referred from the hospital (STH & ALN) directly (12% DNA/cancel). Those with the more health problems related to their misuse (e.g. following a hospital admission, referrals which are mandated (e.g. part of a child protection conference agreement or those who are self-motivated (self-referrals) appear to have a greater likelihood of attending their appointment.

Gaps to increase engagement following referral

- **One in four referrals does not result in the person attending their appointment; therefore there is a need to reduce this gap to one in three not attending during 2015/16.**
- **There is a need for greater clarity to be provided on the DNA/cancellation target; and for the target to measure all those who do not attend their appointment (total DNA and cancellations) and monitor the activity of the two separately.**
- **There is a need to understand the reasons individuals decide to cancel their appointment and do not reschedule and whether they then subsequently get referred back into treatment at a later date.**
- **Work with specific referral sources is required to reduce the DNA following referral, since the combined DNA and cancellation rate differs by referral source.**

Assessment

A total of 2,400 triage places are commissioned of SHSC-FT per annum. This is on the low end of the 'treatment need' capacity model (Rush) and one would expect the places to be filled, particularly given the high numbers of hospital specific and attributable admissions per annum. However activity has remained under target for the last three years, see Table 8 below.

Table 8 – Total SEAP triage assessment places used in 2011/12, 2012/13 and 2013/14.

	Activity	% of target achieved	Under used capacity
2011/12	1771	74%	-629
2012/13	1729	72%	-671
2013/14	2025	84%	-375
Target	**2400**		

Last year (2013/14) experienced the highest number of people being triaged over the last three year period, with 2,025 individuals being assessed, an increase of 296 on 2012/13 and 85% of the target achieved. The main factors influencing this are the introduction of the screening tool by SHSC (see section 5), and work undertaken in the hospitals to increase referrals.

If the increase observed last financial year happens again in 2014/15 then the target may be achieved. If this happens then it would show that the capacity commissioned is sufficient for the in-demand treatment population. Given that there is further work to undertake on IBA (e.g. only 30 general practices in Sheffield have been trained on the SHSC-FT screening tool, health visitors have yet to be trained, social services not yet using the tool on 100% of cases, housing services have yet to be trained) then capacity may well be achieved. Indeed if all referrals routes are

worked on and systems become more robust then in the longer term (indeed in the lifetime of the next alcohol contract) current capacity may not be enough to meet demand.

Outcome of assessment

There are three main outcomes following assessment; pharmacological and psychosocial; structured psychosocial interventions (PSI) or extended brief interventions (EBI). In 2012/13 the following activity occurred:-

- 1,222 (60%) individuals were referred to pharmacological treatment
- 464 (23%) individuals were referred to PSI treatment
- 680 (34%) individuals were referred to EBI treatment

Other options following assessment include inpatient detoxification and residential rehabilitation.

Table 9 shows the outcome for assessments over the last three years (2011/12, 2012/13 and 2013/14)

Outcome of assessmemt						
Financial Year	Pharmacological	Total requiring psychosocial interventions (PSI or EBI)	PSI	EBI	% psychosocial interventions	% pharmacologcal
2011/12	821	1189	372	817	59%	41%
2012/13	1141	1394	306	1088	55%	45%
2013/14	1222	1144	464	680	48%	52%
Trend						

The data gives an indication of the treatment needs of those referred, only in 2013/14 did more people require pharmacological (1,222) than psychosocial (1,144) and of those who required psychosocial, and each year more people required EBI rather than the more structured PSI.

Understanding the number that requires PSI is essential. This is complex as
1. There are a number of different 'tools' used in Sheffield to determine what form of psychosocial intervention is required (although the alcohol contract specifies the use of AUDIT and the outcome score to determine which PSI to receive,
2. Current commissioning of EBI (between 3 and 12 sessions) and PSI (6 sessions) creates some overlap,
3. Since the contract started in 2010, other PSI options have become available to clinicians including Improving Access to Psychological Therapies (IAPT) which has been introduced over the last couple of years and has a specific guide for working with individuals with alcohol misuse and mental health conditions (written by The National Treatment Agency (now PHE) *'IAPT positive practice guide for working with people who use drugs and alcohol'*[50].
4. IAPT is provided by SHSC, the same Trust that provides SEAP and IAPT is also available in GP surgeries providing local access to treatment.

The overlap between EBI and PSI will be addressed in the new contract, as the one provider model will remove issues regarding referrals and the service will be able to provide short term and longer term (up to six weeks) psychological treatment, however with different payments.

To understand the numbers of individuals who are receiving psychological interventions for alcohol misuse outside of the commissioned treatment system, e.g. IAPT.

Waiting Times

In 2013/14 92% of all clients started structured alcohol treatment within 3 weeks of their referral date compared to 88% of all waits nationally[51] (NATMS 2012/13).

Pharmacological treatment – MoCAM[52] states that '*Pharmacological therapies are most effective when used as enhancements to psychosocial therapies as part of an integrated programme of care. The Review of the effectiveness of treatment for alcohol problems1 identifies three classes of pharmacotherapy that are effective in the treatment of alcohol misusers:*

- *medications for treating patients with withdrawal symptoms during medically assisted alcohol withdrawal*
- *medications to promote abstinence or prevent relapse, including sensitising agents*
- *nutritional supplements, including vitamin supplements, as a harm reduction measure for heavy drinkers and high-dose parenteral thiamin for the prevention and treatment of individuals with Wernicke's encephalopathy.*

The availability of appropriate medications will be an essential element in any comprehensive local treatment system. Prescribed medications are not a stand-alone treatment option.

[50] *'IAPT positive practice guide for working with people who use drugs and alcohol'* http://www.iapt.nhs.uk/commissioning/positive-practice-guides/
[51] *Alcohol Statistics From The National Drug Treatment Monitoring System (NDTMS) 2012-2013* https://www.ndtms.net/default.aspx
[52] *Models of care for alcohol misusers* (MoCAM) http://www.alcohollearningcentre.org.uk/_library/BACKUP/DH_docs/ALC_Resource_MOCAM.pdf

In Sheffield the DACT commissions all the above community based pharmacological treatment; although activity is not indicative of the total number of individuals receiving such treatment, as there is a proportion of individuals who receive treatment from their own GP.

In 2013/14 DACT commissioned 756 pharmacological treatment places which are provided by SHSC-FT, who is the fourth year of a five year contract. The target has remained the same for each year of the contract and capacity has not been achieved during the last three financial years. Performance has however improved annually; 63% in 2011/12, 84% in 2012/13 and last year (2013/14) 87% of the target was achieved which is the closest to the target to date. Table 10 below shows the prescribing activity for the last three years. Two sets of activity data are available for 2013/14; local data provided to SHSC and the NATMS activity reported by PHE. In 2013/14 SHSC and DACT have undertaken work to rectify the quality of the NATMS data submitted and now there is only a slight variation (+3.2% or +22 individuals) between the 657 locally reported and 679 nationally reported. Therefore for the first time both sets of data have been reported and between 87% and 90% of the target for numbers receiving pharmacological interventions per annum was achieved in 2013/14.

Table 10 Alcohol prescribing activity and commissioned places 2011/12 to 2013/14.

	SHSC local data			NATMS
	2011/12	2012/13	2013/14	2013/14
Numbers in prescribed treatment target	756	756	756	756
Prescribed clients	480	637	657	679
% of target achieved	63%	84%	87%	90%
NATMS data - Alcohol provider (by residence) Quarterly Performance Report 2013/2014, Quarter 4				
SHSC local data submitted to DACT quarterly on their Performance Framework, in 2011/12, 2012/13 and 2013/14.				

The number of individuals citywide who receive prescribing treatment for their alcohol misuse is not solely those who access treatment via the pharmacological commissioned alcohol treatment service. Indeed in Sheffield during 2013/14 a total of 83 GP practices prescribed alcohol treatment items to their patients.

Treatment in GP practices is often given following exit from hospital following an alcohol related admission, to those who do not want to access the treatment system, to those who have previously received treatment from their GP, have been referred back to their GP following treatment at SHSC or where a client's GPs may have a specialist interest in Alcohol. This does create some difficulty in ascertaining the total numbers of individuals who have received prescribing treatment, as those who are prescribed by a GP are not recorded to NATMS and there is no local database containing unique details of all in treatment in Sheffield.

Information provided by Medicines Management team in the CCG[53] on the amount of prescriptions issued for alcohol dependency by GPs during 2013/14 shows the following; a three month period (February to April 2014) had a total of 1,096 prescription items issued to an estimated 293 individuals. This amounted to items costs of £15,561.46 for Acamprosate Calc_Tab E/C 333mg, Campral EC_Tab 333mg, Disulfiram_Tab 200mg and Antabuse_Tab 200mg. The total amount spent in the year 2013/14 was £62,452.20 and 4,494 items prescribed[54].

There is a need to ensure all those who are alcohol dependent and have approached their GP for treatment are offered a range of treatment options, including the opportunity to be referred into the commissioned treatment system.

The capacity gap between treatment places commissioned and capacity used has reduced annually for the last three years to 87% in 2013/14. Whilst there is a difference (and therefore current underutilisation) the future capacity for prescribing places needs to be carefully considered since 90% capacity is a possibility in 2014/15. Therefore as further encouragement for referrals, working on reducing DNAs continues prescribing capacity may be achieved by the end of the contract period (March 2016) and therefore increasing capacity may well be a viable consideration point in the new contract. Careful monitoring of activity is required during the next financial year.

[53] Kerry Wade, Data Analyst, Medicines Management Team, NHS Sheffield Clinical Commissioning Group. For acamprosate (and Campral) BNF states an alternative dose for 16-18 year old patients and patients with a body weight less than 60kg. However, estimated patient numbers are based on six 333mg tablets per day. For disulfiram (and Antabuse) BNF states the standard dose of 200mg can be increased if necessary. However, estimated patient numbers are based on one 200mg tablet per day.

[54] Estimations for the number of individuals prescribed in GP practices for the year 2013/14 is not provided since accuracy could not be assured. The reason for this is the tendency for patients to be prescribed a number of times at separate time periods throughout the year (e.g. relapses).

Prescribing costs

The main two drugs prescribed for alcohol dependency are Acamprosate calcium (also Campral)[55] and Disulfiram (also Antabuse) although recently the drug Nalmefene has been introduced[56].

The total cost of Acamprosate calcium, Disulfiram and Nalmefene prescribing in the community was £73,978.92 (data from SHSC and GP prescribing activity provided by the CCG) during 2013/14 and a total of 6,380 items were prescribed.

Prescribing costs at SHSC only for alcohol misuse in 2013/14 amounted to £11,526.72 (the total cost of Acamprosate, Disulfiram and Thiamine[57] and a total of 1,886 items were prescribed (See Table 11), which was 30% of all items prescribed citywide.

Table 11 SHSC Alcohol dependency prescribing costs in 2013/14

Alcohol prescribing in SHSC (2013/14) - total cost of items prescribed				
BNF Name	1st Quarter 2013/2014	2nd Quarter 2013/2014	3rd Quarter 2013/2014	4th Quarter 2013/2014	Grand Total
Acamprosate Calc_Tab E/C 333mg	£ 1,742.19	£ 2,083.87	£ 1,822.02	£ 1,766.28	£ 7,414.36
Disulfiram_Tab 200mg	£ 900.78	£ 405.34	£ 914.46	£ 958.97	£ 3,179.55
Thiamine HCl_Tab 100mg	£ 132.49	£ 203.61	£ 257.54	£ 335.12	£ 928.76
Thiamine HCl_Tab 50mg			£ 0.57	£ 3.48	£ 4.05
Grand Total	£ 2,775.46	£ 2,692.82	£ 2,994.59	£ 3,063.85	£ 11,526.72

Alcohol prescribing in SHSC (2013/14) - total items prescribed					
BNF Name	1st Quarter 2013/2014	2nd Quarter 2013/2014	3rd Quarter 2013/2014	4th Quarter 2013/2014	Grand Total
Acamprosate Calc_Tab E/C 333mg	144	173	159	147	623
Disulfiram_Tab 200mg	156	72	141	129	498
Thiamine HCl_Tab 100mg	136	178	208	236	758
Thiamine HCl_Tab 50mg			1	6	7
Grand Total	436	423	509	518	1,886
Information provided quarterly to DACT, from SHSC					
Prescriptions are written on a prescription form known as a FP10. Each single item written on the form is counted as a prescription item.					
Net Ingredient Cost (NIC) is the basic cost of a drug. It does not take account of discounts, dispensing costs, fees or prescription charge income.					

There is a 53:47 ratio of Acamprosate to Disulfiram in hospital prescribing of ITEMS in England[58].

Alcohol prescribing in the community citywide during 2013/14 had a ratio of 66:34 - 66% Acamprosate to 34% Disulfiram. At SHSC the ratio was more equal at 56:44 and within GP practices the ratio was more biased towards Acamprosate (ratio of 68:32).

Psychosocial Interventions (PSI) – MoCAM[59] states that *'A range of more intensive, structured psychosocial treatment interventions will be required for people with moderate and severe alcohol dependence, for those with recurrent alcohol problems, for those with complex needs and for those who may be particularly vulnerable'*.

* Provision of Alcohol PSI was transferred to SHSC from 1 January 2015.

Referrals into PSI treatment

PSI is commissioned in Sheffield and the provider in 2013/14 is Turning Point Adult Treatment Services, who started their contract in January 2011. Contracted to provide alcohol misusers with six (6) sessions of PSI treatment the

[55] Acamprosate and naltrexone are effective treatments for relapse prevention in patients with alcohol dependence; disulfiram is an alternative. Disulfiram should only be used in patients in whom acamprosate and naltrexone are not suitable, or if the patient prefers disulfiram. Patients with alcohol dependence are at risk of developing Wernicke's encephalopathy; patients at high-risk are those who are malnourished, at risk of malnourishment, or have decompensated liver disease. Parenteral thiamine (as Pabrinex®, section 9.6.2) should be prescribed for treatment of suspected or confirmed Wernicke's encephalopathy, and for prophylaxis in alcohol-dependent patients attending hospital for acute treatment (including treatment unrelated to alcohol dependence). High-dose oral thiamine should be prescribed following parenteral treatment until cognitive function is maximised. BNF, June 2014 https://www.evidence.nhs.uk/formulary/bnf/current/4-central-nervous-system/410-drugs-used-in-substance-dependence/4101-alcohol-dependence

[56] In February 2013, nalmefene was granted a European marketing authorisation. It is indicated for the reduction of alcohol consumption in adults with alcohol dependence who have a high drinking risk level (alcohol consumption more than 60 g/day [7.5 units/day] in men and more than 40 g/day [5 units/day] in women), without physical withdrawal symptoms and who do not need immediate detoxification. It should be started only in people who continue to have a high drinking risk level 2 weeks after initial assessment. www.nice.org.uk

[57] Thiamine is sometimes prescribed to individuals who are alcohol dependent since 'People who drink heavily over a long period of time often have low levels of thiamine (also called vitamin B1)'. Lack of thiamine can lead to a condition that affects the brain and nervous system called Wernicke's encephalopathy www.nice.org.uk

[58] Health and social care information centre 'Statistics on alcohol: England 2014', May 2014 http://www.hscic.gov.uk/catalogue/PUB14184

[59] Models of care for alcohol misusers (MoCAM) http://www.alcohollearningcentre.org.uk/_library/BACKUP/DH_docs/ALC_Resource_MOCAM.pdf

service received 630[60] referrals for treatment in 2013/14, which is the highest number received in the last three financial years and a significant uplift from the previous year (52% increase[61]), see Table 12.

[60] Turning Point Adult Treatment Services performance framework 2013/14
[61] Turning Point Adult Treatment Services performance framework 2012/13

Table 12 Turning Point PSI referral, DNA and waiting times data 2011/12 to 2013/14

	Turning Point local data		
	2011/12	2012/13	2013/14
Total PSI referrals	429	414	630
of which are SEAP referrals	*397*	*334*	*532*
% of referrals into PSI from SEAP	*93%*	*81%*	*84%*
Total did not attends (DNA)	143	94	194
% Total DNA	33%	23%	31%
SEAP did not attends (DNA)	*130*	*69*	*167*
% SEAP DNAs	*33%*	*21%*	*31%*
Average waiting time (referral to treatment start date)	25 days	10 days	15 days

The increase has been influenced significantly by a 59% increase in the total referrals from SEAP (82% of their referrals in2013/14 were from SEAP) which has increased from 334 to 532 between the two years. This means that there are more referrals from SEAP, and therefore more conversations from SEAP assessment to starting PSI treatment which is positive on both sides; the referring service and the receiving service.

At the point of SEAP assessment 464 were identified as requiring PSI, however this is less than the 532 SEAP referrals and the difference can be explained by there being a proportion of individuals (around 10%) who are identified as requiring PSI treatment following the commencement of their pharmacological treatment.

There were 630 referrals to PSI in 2013/14 and a total of 194 subsequently DNA, which is 31% of the total or one in three. 84% of all referrals are from SEAP. The PSI DNA rate seems to be the same regardless of whether the referral is from SEAP (of the 532 referrals, 167 DNA) or another provider.

The current referral process between SEAP and Turning Point is as follows: - the referral is not electronic, it is generally received the day after the SEAP assessment (although this is not tracked), direct contact between the two providers is limited to liaison regarding engagement following referral and there has been no process change in the last year between the two providers. However Turning Point has introduced a DNA group, which has increased the efforts made by workers to engage new clients regardless of their referral route into treatment.
Following the SEAP referral Turning Point complete a comprehensive assessment, as further information is required of the client above the initial triage information taken at SEAP.

Number of individuals accessing PSI in treatment
Alcohol PSI is provided to any individual referred via the non-criminal justice route and for those who are on an Alcohol Treatment Requirement (ATR). Turning Point has one target of 533 new individuals to receive PSI treatment per annum. ATR activity also contributes to this target. The ATR target is 200 clients per annum to commence ATR alcohol PSI treatment. The PSI treatment offer is the same contractually; however the provider has elected to provide ATR clients with 12 weeks of treatment and by court order the provider has to comply with notifying the probation service of client engagement.

NATMS data does not separate the overall PSI activity so on the 2013/14 NATMS report for Turning Point presents the combined total for PSI and ATR PSI together.

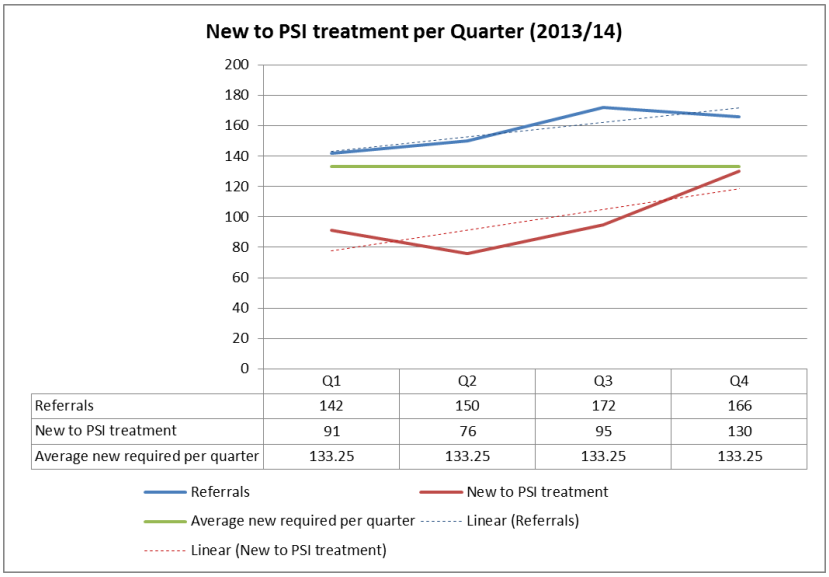
NATMS reports that 557 individuals received PSI in 2013/14; this is the highest number to receive PSI since the start of the contract three years ago. Of the total 483 were new to treatment in 2013/14 (NATMS) or 90% of treatment capacity achieved.

For the purposes of the needs assessment it is important to understand the total number of people who receive PSI but to also understand the activity for both referral routes into such treatment as targets apply to both and capacity needs to be built in for both, therefore both have been discussed separately.

PSI (non-criminal justice route)
Of the total 557 PSI in treatment during 2013/14 a total of 473 were non-criminal justice individuals, of which 392 were new to treatment in the year (which is 103 more than the previous year and a 36% increase). Around 10 individuals at any one time are in the process of between referral and starting treatment. 81 individuals were still in treatment from the previous financial year.

In order to achieve the annual target an average of 133 new PSI starts to treatment per quarter are required. Only in Q4 2013/14 was this nearly achieved (130), see graph 1 below. Quarter four is significant because despite a slight decrease in referrals (-8) from quarter 3 there was an increase of (+35) starts, reducing the DNA rate to 22% in Q4.

Graph 1



	Q1	Q2	Q3	Q4
Referrals	142	150	172	166
New to PSI treatment	91	76	95	130
Average new required per quarter	133.25	133.25	133.25	133.25

Overall 74% of the new to PSI treatment target was achieved by clients who were not on an ATR (392 of the 533) in 2013/14. This is the highest performance in the duration of the contract, compared to the 48% (2011/12) and 54% (2012/13) in previous years.

The provider explains that a re-structured team, the introduction of group PSI provision, doubling the number of assessment slots owing to a shorter initial appointment and a new DNA group are just some of the changes that have led to this uplift. Whilst last year's performance is still short of the target by 143 individuals if a similar uplift is achieved in 2014/15, then the target has a potential to achieve 90%. There are a number of opportunities to explore, such as a continued increase in referrals (52% increase resulted in a 36% increase in treatment starts) which should continue with the continued efforts of the SEAP assessment process and the electronic screening tool. However, there are foreseen risks due to the process of being in the tender process, which often leads to lower performance and if a spike in activity in Q4 2013/14 can be maintained consistently.

The target of 533 new to treatment target was 90% achieved in 2013/14 (when total PSI activity is considered). If activity continues in 2014/15 in the same way it did at the end of 2013/14 then it is likely the target will be achieved.

As with any future commissioning, consideration needs to be given to the PSI model; which as well as considering the number of places to commissioned also needs to factor in the level of qualified staff providing the treatment and the patient placement criteria on those who are offered PSI. These two final factors are likely to mean around 500 PSI places are still required in an end to end service.

Extended Brief Interventions (EBI)

– MoCAM[62] states that *'Motivational enhancement therapy is identified as the best evidenced, most effective extended brief intervention and should be regarded as an essential element in the local treatment system'.*

NICE PH[63] guidelines recommendation 11 is below:-

Recommendation 11: extended brief interventions for adults
Who is the target population?
Adults who have not responded to brief structured advice on alcohol and require an extended brief intervention or would benefit from an extended brief intervention for other reasons.
Who should take action?
NHS and other professionals in the public, private, community and voluntary sector who are in contact with adults and have received training in extended brief intervention techniques.
What action should they take?
Offer an extended brief intervention to help people address their alcohol use. This could take the form of motivational interviewing or motivational-enhancement therapy. Sessions should last from 20 to 30 minutes. They should aim to help people to reduce the amount they drink to low risk levels, reduce risk-taking behaviour as a result of drinking alcohol or to consider abstinence. Follow up and assess people who have received an extended brief intervention. Where necessary, offer up to four additional sessions or referral to a specialist alcohol treatment service (see recommendation 12).

[62] Models of care for alcohol misusers (MoCAM) http://www.alcohollearningcentre.org.uk/_library/BACKUP/DH_docs/ALC_Resource_MOCAM.pdf
[63] http://www.nice.org.uk/guidance/PH24/chapter/1-Recommendations

In Sheffield DACT commissions SHSC to provide extended brief interventions of between 3 to 12 sessions to over 700 harmful and hazardous drinkers per annum.

The total receiving EBI has increased by 30% in the last financial year, from 563 in 2012/13 to nearly 700 (693) in 2013/14 and just under the target of 700, see table 13. This is an uplift of 23% or an increase in 130 individuals receiving EBI in the last year.

Table 13 EBI activity and total sessions held (2011/12 to 2013/14)

	2011/12	2012/13	2013/14	*Change between 2012/13 and 2013/14*
Number of people who had 3 plus sessions (EBI)	317	563	693	*23%*
Total EBI sessions held	1176	2453	3179	*30%*

Individuals who require PSI should be referred to PSI, those who require EBI should only receive EBI. There should be no overlap. We don't know if there is an overlap happening and some individuals may be receiving both treatment (EBI and then PSI).

If there is no overlap then 693 and 557 individuals were in treatment for EBI and PSI respectively during 2013/14 which is a total of 1,250 individuals (or exactly half of all those who were triaged assessed by SEAP.

The commissioning of the one provider model will create greater flexibility on the delivery of PSI and will report activity separately for EBI and PSI, removing this potential overlap and creating more openness about the total activity.

There is a need to audit provider compliance with EBI and PH24 recommendations.

Inpatient Detoxification – MoCAM states this Tier four treatment intervention is *'Dedicated specialised inpatient alcohol units are ideal for inpatient alcohol assessment, medically assisted alcohol withdrawal (detoxification) and stabilisation. Inpatient provision in the context of general psychiatric wards may only be ideal for some patients with co-morbid severe mental illness, but many such patients might benefit from a dedicated addiction specialist inpatient unit'.*

Over the last three years[64] 42 inpatient detoxification places have been commissioned annually in Sheffield, however in each year the number who have received such treatment has been significantly over target (69 people in 2013/14), this is because of the careful assessment and efficiency of the process. 92% of all those receiving inpatient detoxification were successful (alcohol free) on exit.

Residential rehabilitation – purchased on a case by case basis, there is a thorough assessment and subsequent approval process (care management panel) where all new starts and treatment continuation packages (both of 12 weeks treatment duration) are approved. The care management panel (which includes social workers, the DACT Joint Commissioner and SHSC (social workers have completed the assessment process with the client) reviews each case and determines the outcome, including which residential provider to use. The choice of provider is determined by a number of decisions which include location (within 100 miles radius of Sheffield) and previous client outcomes.

A total of 15 new treatment packages[65] (100% of those presented) and 18 continuation packages were agreed in 2013/14. Of the 20 completions in the year, 16 (70%) were successful. In September 2013 budget restrictions were invoked, meaning that a prioritised waiting list was started. Although assurance was provided to known referrers that referrals for this treatment should not be halted and clients would be prioritised on a waiting list, referrals in the first half of the year (26) reduced to eight (8) in the second half of the year.

The long term effectiveness of residential rehabilitation treatment needs to be understood.

[64] Data provided by SHSC, as part of their quarterly performance monitoring framework to DACT
[65] Data provided by SHSC, as part of their quarterly performance monitoring framework to DACT

There is a gap in NATMS reporting, with only two residential rehabilitation centres reporting client activity in 2013/14. Given PHE have started reporting alcohol activity on the DOMEs report it is imperative that this is addressed in 2014/15.

Treatment Outcomes – NICE guidance *'Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults – commissioning guide'* states that commissioning should have a particular focus on outcomes from treatment (e.g. increasing access and provide recovery based treatment). This links to the Government's alcohol strategy which aims to *'increase the effective-(ness)* of *treatment for dependent drinkers'.*

Successful completions from treatment is an area of great debate and will continue, since there is one argument for the measure of success being based on the immediate outcomes at exit from treatment and a second argument for the measurement to be based on the more longer term outcomes (does the client return to treatment within a set period? Do they have a further hospital alcohol episode)?

In 2013/4 PHE have changed their reports and addresses some of the issues raised regarding recovery, the table 14 shows the 2013/14 year end performance for both Sheffield and England.

Table 14 – The number of successful completions as a proportion of the total in treatment.

	Sheffield	National
Successful completions 2013/14	**Mar-14**	**Mar-14**
Numbers in treatment - rolling 12 months	954	87,943
Total completions - rolling 12 months	387	34,561
Successful completions as a proportion of number in treatment - rolling 12 months	40.6%	39%

Sheffield had 40.6% or 387 individuals successfully completing treatment in 2013/14 out of the 954 in treatment during the year[66] which is a similar percentage to England which was 39.1% or 34,502 of those in treatment (88,216) who exited treatment successfully.

Re-presentation rates are a fairly recent addition to monitoring information.

	Sheffield	National
Representations 2013/14	**Mar-14**	**Mar-14**
Number of clients successfully completing treatment in the first 6 months	210	19,165
Number of clients successfully completing treatment in the first 6 months	25	2,295
Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months	11.9%	12.0%

Of the 210 who exited successfully in the first six months of 2013/14 only 25 returned to treatment (12%) within the following six months of exit, this compares to the 11% in England. What this data does not explain is the proportion who have lapsed and not yet presented for treatment but who may have returned to their GP or had a hospital admission subsequently.

This is the national reported data by the two providers, however data produced locally and provided to DACT by the individual providers is also reported here, since there are some differences and data can be divided by treatment intervention.

Successful completions from pharmacological treatment

Performance in 2013/14 against the first outcome finds that over 1,000 people completed prescribing treatment in 2013/14 at SHSC, which is 61% of those who exited, see table 15. This means for every three people who exit treatment, two will be successful, which is not significantly different to the national average of 58% successful.

[66] New methodology trend data compared to old methodology by substance group and local authority www.ndtms.net

Table 15 Successful completions from pharmacological treatment (2011/12 to 2013/14)

	SHSC local data		
	2011/12	2012/13	2013/14
Number exiting treatment	619	830	1008
Number of successful exits	338	486	613
% successful	55%	59%	61%
SHSC local data submitted to DACT quarterly on their Performance Framework, in 2011/12, 2012/13 and 2013/14.			

Successful completions from PSI

292 individuals ended PSI treatment in 2013/14 which is similar to the previous year; this is despite the increase in the number who started treatment, see table 16. On average 64% (or two out of three) of those in treatment are successful, which has remained stable over the last three years (66%, 68% and 64%). Each year has bettered the target of 58%.

Table 16 Successful completions from pharmacological treatment (2011/12 to 2013/14)

	Turning Point local data		
	2011/12	2012/13	2013/14
Number of treatment exits in year	180	296	292
Of which were successful	118	201	186
% of completions that were successful	66%	68%	64%

The time in treatment averages around 122 days (NATMS).

- **There is a noticeable difference between the number of treatment exits for Pharmacological and PSI interventions reported to DACT locally and the information provided to DACT from NATMS. Further work is required to understand these differences.**
- **Future contract targets for alcohol successful exits should be based on the proportion of all in treatment who exit successfully and then do not re-present within 6 months, which is the new measurement of success reported by PHE in 2014/15.**
- **Introduce initiatives for frequent clients within treatment system**
- **Introduce recovery check-ups for all client spots successful treatment to monitor long term outcomes and offer relapse prevention support.**

Mutual Aid (MA)

Mutual aid is peer led open access support for individuals who either do not wish to have formal treatment at the given time, who wish to have that additional support when in treatment or who are post treatment to aid their recovery. Usually held in groups these can be based in any location and generally have a theme (art group, music group) or a set of values and vision (Alcoholic anonymous' aim is *'to stay sober and help other alcoholics to achieve sobriety'*[67]). Mutual aid services are not commissioned; therefore DACT is not responsible for the governance of these services.

In the last couple of years support for mutual aid has increased, with active support given by both the Advisory Council on the Misuse of Drugs (ACMD) recovery committee and Public Health England.

The ACMD in November 2013 wrote a letter to the government with a recommendation that *'the roles of recovery community organisations and mutual aid, including Alcoholics Anonymous, Narcotics Anonymous and SMART Recovery, are to be welcomed and supported as evidence indicates they play a valuable role in recovery'*[68].

Recently Public Health England have raised the profile of mutual aid and are *'calling on the treatment sector to strengthen its links with mutual aid organisations, to ensure that everyone in treatment can benefit from this support*[69]. They have recommended that this should be done via two local initiatives - the first was to undertake a self-adult and the second was to promote and launch 'facilitating access to mutual aid' (FAMA).

[67] Quotes taken from http://www.alcoholics-anonymous.org.uk/
[68] Letter from the Advisory Council on the Misuse of Drugs (ACMD) to Norman Baker MP, 28 November 2013 https://www.gov.uk/government/publications/acmd-second-report-of-the-recovery-committee-november-2013
[69] Quote taken from http://www.nta.nhs.uk/.aspx

In Sheffield the DACT Mutual Aid response has been to raise the profile and encourage an increase in the number of MA groups available. This has been mainly driven by the introduction of SMART recovery and some groups have been introduced in commissioned treatment services.

DACT's role is not to commission mutual aid but to:-

- Discuss with alcohol treatment providers in their DACT review the mutual aid response by clients and their own mutual aid provision.
- Co-ordinate mutual aid provision via the SURRG, which now has mutual aid leads attend regularly from SMART recovery, AA and Jesus Army. Part of this is to co-ordinate the Sheffield response to National recovery month which happens each September. In 2013 the response was only a week of action; which included installing AA support books in Sheffield libraries. In 2014 there will be a full month of MA profile raising and additional activities available for individuals to try.
- To promote the time table of MA groups and activities available via the DACT website. DACT does not endorse any of these groups and it is for individuals to choose to attend and determine if it is the most appropriate group for them.

Sheffield has completed the PHE mutual aid action plan and is a number of actions, which are either completed or in progress. The following actions have been completed:-

- The launch of 'facilitating access to mutual aid (a PHE initiative)
- Mapping exercise of current alcohol MA groups
- All treatment services have a named mutual aid lead
- Treatment services have been briefed on MA and have increased their knowledge of MA
- Care plan audits will now include standards for mutual aid
- Weekly schedule of MA opportunities is available and is regularly updated via the service user reference and recovery group (SURRG). It is available online at the new mutual aid page on the DACT website http://sheffielddact.org.uk/drugs-alcohol/help-and-support/mutual-aid-support-groups-for-drugs-and-alcohol/.
- The new service specification will include a requirement to facilitate access to MA

Further work is required on the following actions:-

- to improve links between public health leads and mutual aid representatives,
- to invite mutual aid leads into treatment provider services,
- to ensure all treatment providers record the facilitation of mutual aid on NATMS
- to increase access to groups in treatment services (via facilitation and MA promotion) and groups being made available
- Increase the variety of alcohol MA groups available.

PHE have also endorsed 'Facilitating access to mutual aid[70]' which is a three stage process for all providers to promote mutual aid access whilst in treatment. The first stage is to raise MA with the client by gaining an understanding of their knowledge and experience and then educate the client on what is available to access locally, and encourage participation. The second stage (follow –up 1) is to follow up on the discussion and if the client has since attended a MA session, to continue to encourage attendance and further engagement/ involvement, for those who have not attended address concerns and encourage attendance. The third stage for those who have engaged, is to encourage deeper involvement and for those who have not attended continue to repeat stage 1 and 2, fielding concerns and encouraging.

Commissioned providers were given the task of rolling out a three stage system to use with clients in March 2014 at the monthly Provider Consultation Group (PAG), which is a group where commissioned and noncommissioned providers of alcohol and drug treatment meet with DACT to discuss emerging issues. The PAG in March had mutual aid as its main topic. During the meeting the mutual aid action plan was explained and the facilitating access to mutual aid PHE initiative launched. The main concern of providers was the issue of signposting and recommending groups that were not hosted by their own service.

The PSI team don't measure the proportion involved in mutual aid although the team are active in promoting the option for all clients. The service does not have a specific SMART group for alcohol only clients and attendance is anonymous so extract attendance figures are not available[71].

[70] Public Health England (2014) *Facilitating Access to Mutual Aid – three essential stages for helping clients access appropriate mutual aid and support* http://www.nta.nhs.uk/uploads/mutualaid-fama.pdf

[71] Alison Powell, Manager Turning Point Adult Treatment Service

Gap –

- **Record sub intervention activity for mutual aid in line with NDTMS definitions**
- **To complete the outstanding actions on the MA action plan.**
- **To complete the rollout of FAMA in Sheffield.**
- **Use the result of the FAMA rollout to increase our local understanding on the level of interest in MA within the client caseloads.**
- **To increase local knowledge on the level of support clients receive from MA and increase our understanding on what proportion of those who were successful from treatment also attended a mutual aid group.**
- **Understand service user response to treatment in Sheffield, what has their experience/s been like, what they like, don't like. What their history of alcohol misuse has been, hospital admissions, whether they were offered treatment outside of the hospital, where they received it, reason why they started treatment, reason why they were successful (for those who have exited), number of times they have tried treatment. (other questions can be asked)**

Chapter 5 - Treatment performance (NATMS) and information on the treatment cohort

National performance management and targets have over the last 10 years primarily focused on hospital admissions and mortality; this however is in a process of change, with an increased focus on treatment provision. This shift has started since the 1st April 2013 when the remit of PHE, specifically the role of the substance misuse division (previously a separate entity called the National Treatment Agency) increased their remit from drug treatment to include alcohol treatment. This strategic change has meant performance activity for alcohol has started to look and feel very similar to the comprehensive monitoring in place for drug treatment during 2013/14, but in 2014/15 the move has been officially made and methodological changes to data[72] recording now incorporate alcohol and drug activity as recorded on NATMS and NDTMS.

The quarterly Diagnostic Outcomes Monitoring Executive Summary (DOMES) report, which summarises the complete treatment substance misuse performance of Sheffield, now includes alcohol performance alongside drug performance. This means the regional PHE manager's feedback on where improvements are required will include alcohol.

This has a couple of advantages, since it raises the profile of alcohol treatment alongside that of drugs treatment. Additionally it provides more robust and comprehensive data on alcohol than we have had previously. There are a couple of repercussions locally (both positively and negatively) to this strategic and performance move.

1. Alcohol treatment data reported to NATMS has been poor historically; however following an overhaul of the prescribing services' data base significant improvements have been made in 2013/14, resulting in near accurate data being available in terms of the total in treatment. Work is still required and should be rectified over the coming months to show activity by accurate treatment intervention received. This move has been pleasing because it provides new information we have not had available previously, comparisons to other core cities can be made with confidence and going forward needs assessment data to be published in late 2014 will be reliable. Unfortunately there are some negative repercussions since any reference to historical data (i.e. trends and comparing Sheffield performance to previous year's activity) cannot be used. This means the alcohol graphs on the DOMES report (waiting times, successful exits and re-presentations) going back to 2010/11 and the needs assessment data provided by PHE in November 2013 (using 2012/13 data) are not indicative of true activity previously since the data is not 100% complete.

2. PHE have undertaken a methodological change in how the number of alcohol individuals in treatment is reported:-

    a. <u>Numbers in alcohol treatment</u>
    Old methodology - Prior to 2014/15 anyone who had alcohol recorded as their primary/ first drug on NATMS or NDTMS would be counted as an alcohol client. Therefore if clients had a second or third drug that was an illicit drug (heroin or cannabis) client would be counted as an alcohol client.

    New methodology - Following extensive consultation PHE have changed the process. Only clients who have alcohol as their primary drug and no other illicit drugs lists are counted as alcohol clients.

    The impact on the methodological change is observed both nationally and locally. It has resulted in a reduction in the numbers in alcohol treatment. The old methodology would have shown 1,105 in treatment during 2013/14 and the new methodology shows a reduction of -151 clients and 954 people in treatment, see table 17.

    Table 17 Treatment activity and successful exit data for 2013/14 comparing the old and new methodology for recording alcohol client sin treatment.

[72] (PHE) 'Methodological changes to reporting drug and alcohol treatment information: what these mean for you' March 2014, PHE publications gateway number 2013529

NATMS activity			
Mar-14	New methodology	Old methodology	Difference between the new and old methodology
Numbers in treatment - rolling 12 months	954	1105	-151
Total completions - rolling 12 months	387	440	-53
Successful completions as a proportion of number in treatment - rolling 12 months	40.6%	39.8%	0.7%

b. Successful exits from treatment – this has reduced since the new methodology removes the opiate and non-opiate clients from this cohort, therefore it reflects successful exits for alcohol only clients now. (387 were alcohol only successful exits compared to the previously reported 440.

3. A cautionary note, however is that the reduction observed in the numbers in treatment due to the change in methodology does not mean these individual are / were not in alcohol treatment (-151), it means that these clients now counted as drug clients but are in alcohol treatment service due to their primary dependency on alcohol.

Understanding the local picture alongside the national picture can provide a useful insight into where difference and similarities lie.

What do we know about people accessing treatment in England?
Public Health England reported[73] in 2012/13 a total of 109,683 adults (18 years and over) received alcohol misuse treatment (an increase of 1 percentage point on the previous financial year, 108,906 in 2011-12). The majority of whom (69%, 75,773 people) started a treatment journey in the year. In Sheffield there were 954 in alcohol treatment (new methodology) and around 75% of these were new to treatment in the year.

Treatment is defined as structured treatment (inpatient detoxification, residential rehabilitation, prescribing, structured psychosocial interventions (PSI), structured day programmes and other structured interventions (OSI)). Therefore the data in this section does not show the number of people who received identification and brief advice (IBA) or extended brief interventions (EBI) for alcohol misuse or any person who received treatment by a professional who did not report to NATMS.

Compounding factors – PHE have identified ten compounding factors that can impact on a client's treatment journey. These are three or more previous treatment journeys, a housing issue, dual diagnosis, unemployment, criminal justice referral into treatment, if they are living with children, if the client is pregnant, whether the client is also in treatment for Opiate and or crack use which is listed as a second or third drug or if a client has previously had a drug treatment journey. The table 18 below shows the proportion of all in treatment who had each compounding factor.

Table 18 – the compounding factors of those in alcohol treatment and the percentage who stated each issue at the treatment start.

Compounding Factors	%	Compounding Factors	%
Unemployed	60.0%	Housing Issue	13.5%
Living with Children	28.5%	Has also had a Primary Drug Journey	10.2%
Dual Diagnosis	19.8%	CJS Referral	6.4%
3+ Alcohol Treatment Journeys	17.0%	OCU 2nd or 3rd Drug	4.2%
Other 2nd or 3rd Drug	14.0%	Pregnant	0.5%

60% of all new to treatment were unemployed, 29% are living with children, 20% had dual diagnosis (a conjunctive mental health condition), 17% had been in treatment for alcohol misuse on three previous occasions[74], and 10% had previously had a drug treatment journey. The more compounding factors the more complex the client is likely to be. Nationally 85% of clients have one or more compounding factors meaning that 15% of all clients (11,082) did not have any of the factors listed. However 31% had one, 30% had two, 16% had three and 8% had four or more factors (see table 19 below).

[73] Alcohol Statistics from the National Drug Treatment Monitoring System (NDTMS) 2012-2013, www.ndtms.net
[74] Public Health England, Alcohol Client Profiling Tool 2012/13 – New Treatment journeys in 2012/13

Table 19 – The number of compounding factors for all in treatment for England and Sheffield

	Compounding Factors				
	0	1	2	3	4+
England	15%	31%	30%	16%	8%
Sheffield	15%	28%	33%	15%	8%
Source - Alcohol client profiling 2012/13, PHE for England and Sheffield					

Sheffield's treatment cohort has a similar profile to that nationally, with 85% having one or more compounding factors; 28% had one factor, 33% had two, 15% had three and 8% had four or more. The most frequent combinations of two of the complexities were unemployment and children, unemployment and dual diagnosis, unemployment and three or more treatment journeys.

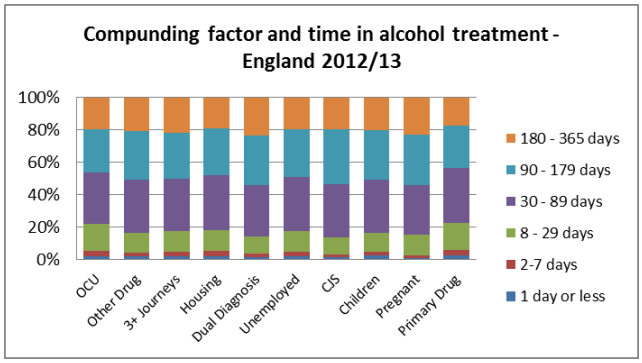
Time in treatment varies, with 33% (one in tree) having a treatment journey between 30 to 89 days however 20% (one in five) are in treatment for between 6 months and one year. 18% (just under one in five) will stay under one month (1 to 29 days) in treatment see table 20 for a breakdown.

Table 20 – The proportion pf people and their time in treatment

Time in treatment	
1 day or less	2%
2-7 days	3%
8 - 29 days	13%
30 - 89 days	33%
90 - 179 days	30%
180 - 365 days	20%

The duration of treatment does not appear to be affected by the type of complexity, with graph 2 showing no significant difference by factor; however the data available does not provide time in treatment by the number of complexities which may impact on outcomes (e.g. increased time in treatment, successful exit).

Graph 2 – Compounding factors and time in treatment



In Sheffield during 2013/14 the average number of days in treatment was 117 (122 for prescribing and 82 days for PSI), with 388 (35%) of those in treatment during 2013/14 still in treatment on the 31st March 2014.

Type of treatment received

NDTMS shows in 2012/13 65% of all in treatment received a psychosocial (PSI or OSI) intervention, 12% were prescribed and had a psychological intervention and 3% received only prescribing interventions. However the data is likely to hide the much larger number and proportion of people who received a pharmacological intervention as we know here in Sheffield that prescribing in primary care settings is not reported to NATMS and research shows that 94%[75] of individuals are prescribed in a primary care setting. Indeed the number of prescription items amounted to over 178,247 for Acamprosate Calcium and Disilfiram[76] in 2012, or a ratio of 315 items per 100,000 population.

Research also shows that around 10% of males and 7% of female respondents to the Omnibus Survey 2009 by the Office of national statistics had a conversation about alcohol use with their GP in the last year[77].

[75] Statistics on Alcohol England 2013
[76] Also known as Antibuse
[77] Statistics on Alcohol England 2013

Demographics

- Gender - Males account for 67% of those in treatment in Sheffield and 33% are female compared to 64% male and 36% female nationally.
- Age range - In Sheffield the age ranges with the highest number of people in treatment for:-
    - Males were those aged 35 to 54 years which is a slightly broader and younger age group compared with the 40-49 years observed nationally.
    - For females was the 45 to 54 years age group (which is a smaller range to the males in Sheffield) and also a smaller range when compared to the most frequent age group for female nationally, 40-49 years.
- Ethnicity - 85% of all in treatment in Sheffield were white British, which is just less than the 17% BME population (Census 2011). In England 92% of the treatment population have a white ethnicity, this is higher than the 86% white ethnic population in England and Wales observed by the Census in 2011, therefore there is a bias towards white ethnic clients in treatment nationally. Given that national alcohol prevalence estimates do not provide a breakdown of ethnicity it difficult to estimate the proportion of people from each ethnic group that need and therefore would be in treatment, however the comparisons to the local BME population and local BME activity data would suggest that services are not hidden or unutilized by individuals in the BME communities in Sheffield.

Additional client information found that in Sheffield:-

- At entry into treatment 29% reported drinking every day of the last 28 days period, the same percentage reported 1 to 7 days in the last 28 days and 24% were not drinking.
- Of those who drank in the last month (801); just under 10% (74) were drinking over 1, 000 units per month (8% females and 10% males) and 36% were drinking above 400 units per week (33% females and 38% males).
- Data was an issue for the prescribing service on Dual diagnosis and housing needs therefore the information here is only for those in treatment at the PSI service. 30% or 143 individuals had dual diagnosis (where the client also has a diagnosed mental health condition) and 4% had either an urgent housing problem or were of no fixed abode (NFA), however the majority (90%) cited no housing problem.
- The majority of clients did not have children or had no child contact (52%) however of those with children 14% (120) had a child/ren living with them, 1% were living in a household with another child who was not their own, and 31% had child contact but were not living with that child (see table 21 below).

Table 21 Parental status of individuals receiving support for alcohol use

	Number	Percent
Parent living with own children	120	14
Other child contact: Living with children	7	1
Other child contact: Parent not living with children	261	31
Not a parent / no child contact	428	52
Both fields blank or "declined to answer"	15	2

Whilst local NATMS data is improving, there are still checks required before full confidence can be given to the data, therefore in 2014/15 the checking and auditing of NATMS data will continue working closely with the provider, so the PHE reports can be used for performance management prior to the start of the new contract.

Chapter 6 - Alcohol identification/ screening and brief advice (IBA)

Evidence[78] shows that screening the general population and specific targeted screening on their alcohol use can help identify those at risk of health harms associated with excessive alcohol intake. It is one of the high impact changes recommended on *Signs for Improvement*. Evidence of effectiveness include:-

- *Moyer et al (2002) found that 'For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels'[79].*
- *IBA would result in the reduction from higher-risk to lower-risk drinking in 250,000 men and 67,500 women each year (Wallace et al, 1988).*
- *Higher risk and increasing risk drinkers who receive brief advice are twice as likely to moderate their drinking 6 to 12 months after an intervention when compared to drinkers receiving no intervention (Wilk et al, 1997).*
- *Brief advice can reduce weekly drinking by between 13% and 34%, resulting in 2.9 to 8.7 fewer mean drinks per week with a significant effect on recommended or safe alcohol use (Whitlock et al, 2004).*
- *Reductions in alcohol consumption are associated with a significant dose-dependent lowering of mean systolic and diastolic blood pressure (Miller et al, 2005).*
- *Brief advice on alcohol, combined with feedback on CDT levels, can reduce alcohol use and %CDT in primary care patients being treated for Type 2 diabetes and hypertension (Fleming et al, 2004).*
- *The SIP research completed in 2012 found that IBA was effective in primary care, Criminal Justice and A&E settings[80].*

All examples taken from Alcohol and its impact on the health of the nation, Don Lavoie, Alcohol Policy Team

Screening - The NICE guidance PH24 '*Alcohol-use disorders: preventing harmful drinking'* recommendation 9 is that universal alcohol screening is ideal but if not possible then should be undertaken with those at most risk by the following sectors: - *'Health and social care, criminal justice and community and voluntary sector professionals in both NHS and non-NHS settings who regularly come into contact with people who may be at risk of harm from the amount of alcohol they drink[81]'*.

Brief advice – PH24 recommendation 10 on brief interventions explains that BI should be undertaken following identification of harmful or hazardous drinking via alcohol screening.

The average person visits a GP five times per year[82], however research has found that an average GP list will see around 364 excessive drinkers per annum (on average one per day), and problem drinkers consult their GP twice as often[83] as their average patient. However the Omnibus Survey 2009[84] on alcohol use in the general population found that only 10% of males and 7% of females had discussed drinking with a health professional in the last year (most with their GP), although this did increase to 18% of males and 12% of females who drank more than the Department of Health weekly drinking limits (increasing or higher risk). Therefore conversely, this could mean around 82% of males and 88% of females who are drinking at higher or increasing risk levels have not discussed their drinking with a heath professional in the last year.

To apply the above findings to Sheffield:-

- Around 10% of those in Sheffield who are drinking at increasing or higher risk levels will be discussing their alcohol misuse with a health profession per annum.
- an average of one alcohol misusing patient per day visits the average GP practice
- those who misuse alcohol are twice as a likely to be visiting their GP to those who do not misuse alcohol
- 18% of people who drink at increasing and higher risk levels want to change their behaviour

Therefore General practice is an ideal opportunity to explore the increase in alcohol identification and screening, as it appears GPs have a number of face to face opportunities each year with those drinking at high levels with a view of could identifying more people who are drinking above recommended guidelines, provide brief advice and support or refer in to treatment if required.

Actions taken to identify people with alcohol health related conditions in Sheffield – alcohol screening

[78] Alcohol-use disorders: preventing harmful drinking Evidence Update March 2014 A summary of selected new evidence relevant to NICE Public Health Guidance 24. *'Alcohol-use disorders: preventing harmful drinking'* (2010)
Evidence Update 54 cites findings by Reinholdz H, Fornazar R, Bendtsen P et al. (2013) Comparison of systemic versus targeted screening for detection of risky drinking in primary care. Alcohol and Alcoholism 48: 172–9
[79] http://www.alcohollearningcentre.org.uk/Topics/Browse/HIC/IBA/
[80] http://www.sips.iop.kcl.ac.uk/index.php
[81] http://www.nice.org.uk/guidance/PH24/chapter/1-Recommendations
[82] http://www.england.nhs.uk/2013/09/17/mike-bewick/
[83] Cited in alcohol concern's *'The state of the nation – facts and figures on England and Alcohol'*.
[84] The last time this survey included such questions on alcohol.

In recent years such discussions have started to take place. Nationally general practice has started to screen for alcohol misuse in the general population with Direct Enhanced Service (DES) for alcohol and the NHS health check including alcohol screening as part of its criteria.

Alcohol DES – The alcohol DES's is managed by the Primary Care Team at NHSE. Launched nationally in 2008 it has been an ongoing offer to Sheffield GP practices since.

GP practices are commissioned to undertake an AUDIT with all new patients aged 16[85] plus per annum. All patients who undergo this process have their outcome recorded on the GP practice clinical database and claims for each AUDIT undertaken as part of this process and claimed by the practice. Where patients score high risk there are protocols for them to follow to ensure brief advice and treatment is offered. The slight change to the DES in 2014/15 has been where it is ascertained the individuals has a high AUDIT score and a mental health illness, then the practice should provide treatment for the alcohol misuse and then refer to mental health services. Therefore the impetuous for the practice with such patients is to provide treatment or refer to alcohol treatment services to address the alcohol misuse issue. It is hoped this will increase the number of individuals who are referred into specialist alcohol treatment.

In 2013/14 25,480 screenings were undertaken. In 2014/15 76 out of 87 practices or 87% have signed up to the alcohol DES in Sheffield and have a total practice population of 515,002[86]. This is higher than the 63 practices that were signed up in 2011/12. All the top 10 practices for the highest rate per 100,000 population for Hospital Admissions for Alcohol-Specific Conditions 2008/09 - 2010/11 are signed up to the DES which is encouraging.

Of the four GP consortiums in Sheffield Central has 78% of practices signed up to a DES (18/23), HASC has 88% (23/26), North has 91% (20/22) and West has 94% (15/16), see Table 22. Therefore the distribution is widespread.

Table 22 The number of practices signed up to the alcohol DES in 2014/15 by consortium.

	Signed up to the alcohol DES?		% signed up to a DES
	No	Yes	
Central	5	18	78%
HASC	3	23	88%
North	2	20	91%
West	1	15	94%
Total	**11**	**76**	87%

Of the 13% (11) practices not signed up to the DES in 2014/15, they were also not signed up for the DES in 2011/12. There is an argument that at least two of these practices should be signed up (Pitsmoor Surgery and East Bank Medical Centre) as they fell in the top 15 for rate per 100,000 populations for Hospital Admissions for Alcohol-Specific Conditions 2008/09 - 2010/11[87].

DACT commission a GP liaison nurse role within SHSC, to provide support to 26 practices in developing the practices use of the electronic screening tool and increasing referrals from GPs to alcohol treatment.

Receive up to date AUDIT scores (ideally by practice) and monitoring the subsequent referrals made into alcohol treatment.

Clear links are required between the Sheffield electronic screening tool, the DES and GP practices.

NHS Health check – is offered to 40 to 75 years olds (what is referred to as a health 'MOT') every five years and from 2013/14 alcohol screening (AUDIT) was added to the criteria, therefore a significant number of people who may not necessarily have been screened for alcohol misuse will now be screened. The potential number of people this applies to is measured and monitored in the PHOF which includes NHS health check indicators: - measuring the percentage of those eligible who are offered a check per year (indicator 2.22i) and of those offered the percentage who then took up the offer (indicator 2.22ii). In 2012/13:

- 6.1% of those eligible were offered a NHS health check in 2012/13, accounting for 9,360 individuals; this is less than the national average of 16.5%[88].
- 3,819 (40.8%) took up the offer compared with the national average of 49.1%.

This data was taken from the year prior to the alcohol screening being included in the health check. If the same number of people in Sheffield received a health check in 2013/2014 as they did in 2012/13, then a potential 3,000 people were screened for alcohol misuse as part of the NHS health check than would have been previously.

[85] http://www.hscic.gov.uk/gpes/alcohol
[86] Information provided by Sara Hartley, NHS England. Practice data as the 1st April 2014.
[87] Public Health Analysis Team, 2012. Practice Quilt.
[88] http://www.phoutcomes.info/

Interestingly, Sheffield is well below the national average for these indicators; nationally 16.5% of those eligible are offered and 49.1% then take up the offer. Therefore if the national average was achieved in locally a potential 25,000 people would be offered a health check in Sheffield and around 12,500 would take up the offer. PHE ambitious target is to get a 75% take up rate.

The Sheffield Alcohol Electronic Screening Tool

A new approach to alcohol screening has been introduced in Sheffield by one of the DACT commissioned services; SHSC-FT, who following a period of time of lower than expected referrals for specialist alcohol treatment started a project to increase the number of referrals received. Expected referral and treatment numbers were based on (1) the levels of those at risk of drinking at increasing and higher risk levels using national prevalence estimates, (2) the estimated proportion who would access alcohol treatment in a given 12 month period (RUSH model), (3) levels of hospital related admissions to hospital (4) low referrals into treatment from some services where one would expect a relatively high number of referrals e.g. children's social care who are known to have a higher than average level of alcohol misusing clients/ caseloads.

The theory therefore applied to the project was that referrals were low, not because the people were not there, but because services were not referring into treatment either because alcohol screening tools were not being used, screening was not part of protocol or the service's current approach to asking clients about alcohol mis/use did not identify the route of the problem and therefore remained hidden.

The Electronic screening tool was created, tested and is being currently introduced to specific services, likely to have a higher than average number of alcohol misusing clients on their caseloads, e.g. children's social care.

The tool was designed by alcohol treatment clinicians at SHSC and is based on the clinical evidence based AUDIT C (consumption) and AUDIT PC (primary care). The tool has seven questions on alcohol use. Those who score more than one are given a brief advice information sheet immediately following the screening (which is used as a basis of further conversation for those with a clinical position).

The prototype of the tool was piloted in Sheffield during July 2012 in eleven Sheffield pharmacies as part of the Health Living campaign. Around 180 people were screened during a two month period. The pilot gave valuable feedback on where the tool could be improved, on its ease use and in general the people screened had not felt too imposed on by having the screening completed in a pharmacy setting.

The tool has since become electronic and is internet based (www.alcoholscreeningsheffield.co.uk). Since its launch over 2,000 a mix of general and targeted screenings have been completed; by SHSC, social care, pharmacies and general practice surgeries. Screenings have even been completed at roadshows, including in the Oasis at Meadowhall during alcohol awareness week in November 2013.

The tool has therefore been used in a variety of settings (one on one through to crowded generic locations), it is proven a simple, evidence based and effective tool and the current outcomes are that over 2,000 screenings have been completed followed by 2,000 receiving a brief intervention (BI) following the screening and a number of referrals to treatment have been made, not just for those who were dependent drinkers (who were probably known prior to the screening taking place) but for those who would not necessarily have been identified as easily.

A total of 767 patients have been screened for alcohol misuse in one of 31 GP practices over the last two financial years. The latest financial year shows there has been a 139% increase in the number of patients screened compared to the previous year and five additional practices trained. Therefore in the practices trained two years ago there has been an increase in the use of the tool. 26 GP practices are supported in this process by the GP Liaison nurse.

A total of 541 patients were screened using the tool in 2013/14 and of these 119 people (22%) were referred for specialist alcohol treatment, this compares with 2012/13 when 226 people were screened and 60 were referred (27%).

Table 23 Use of the alcohol screening tool at GP practices

GP use of the screening tool	2012/13	2013/14	*% change*
Number of surgeries involved	26	31	*19%*
Number of staff trained on Screening Tool	85	140	*65%*
Number of people screened	226	541	*139%*
Number of referrals made by practice to SEAP	60	119	*98%*
Number who had an assessment following referral	0	63	
Number of SEAP assessments undertaken	0	0	
Number of comprensive assessments undertaken	0	0	

Of the 119 referred, 63 attended their appointment at SEAP and had a comprehensive assessment completed, this was 11% of the total screened and 53% of the total referred. The practices with the most referrals are the University Health Service, Gleadless Medical Centre, Manchester Road Surgery, Fox Hill Medical Centre, Firth Park and Mill Road Surgery (all of whom have a higher risk drinking prevalence rate between 15.5% and 13.0% of their practice population).

Table 24 Top 5 practices for use of the alcohol screening tool

	Rank				
Use of the screening tool by practice 2013/14	**1**	**2**	**3**	**4**	**5**
Number of people Screened (2013/14 only)	University Health Service (171)	Gleadless MC (92)	Manc. Road Surgery (40)	Foxhill MC (36)	Firth Park & Mill Road Surgery (18 each)
Number of referrals made by practice to SEAP (2013/14 only)	Foxhill MC (18)	Firth Park Surgery & Gleadless MC (12 each)		Mill Road Surgery (11)	Shiregreen MC (7)
Number who had an assessment following referral (2013/14 only)	Foxhill MC (9)	Firth Park Surgery & Mill Road Surgery (9 each)		Gleadless MC (7)	Dykes Hall MC & Shiregreen MC (5 each)

The top five practices for the total number of people screened in 2013/14 screened a total of 357 patients (67% of all those screened) showing that the tool was most used by the University Health Service, Gleadless Medical Centre (MC) and Manchester Road Surgery. This does not necessarily mean they have more patients with alcohol misuse compared with other practices, indeed only Gleadless MC are in the Top five referrers to SEAP, but it is more of an indicator on the more frequent use of the tool in the practice.

Of the 63 referred to SEAP, 60 referrals were made by five practices; these were Foxhill MC, Firth Park Surgery, Gleadless MC, Mill Road Surgery and Shiregreen MC. All five practices have a 'higher risk prevalence ratio' of between 12.5% and 13% of their practice population (citywide average was 12.8%) ranking them 22, 31, 45, 62 and 86 in the list of 88 practices which is across the spectrum[89]. These practices do however rank in the top end for the ratio per 100,000 for alcohol specific hospital admissions (2010 to 2012), ranking 53, 60, 63 and 77. The exception to this is Mill Road which is ranked 7th.

Again this does not mean the tool is more effectively used by these practices or they are more effective in referring to SEAP, what it may mean is that the use of the tool in these practices is more targeted and used on people they know will show dependency (Mill Road) and given the higher than average ranking for alcohol specific admissions screening is more likely to pick up a larger cohort of higher risk drinker. A targeted approach is not necessarily negative but the data potentially shows the tool is used differently by practices. Sometimes the tool can be a positive step to encouraging a client known by the clinician to have an alcohol problem, that they do have one (we know that only 18% drinking at increasing and higher risk levels want to change their behaviour[90]) and that it is time to seek additional support.

The use of the tool in these practices shows that the tool can be used in GP practices, it can be used either universally or targeted, it can be used as a persuasive instrument with those known to have a problem but it can also identify people who did not consider they had a problem.

However the screening tool is not without its opponents; worker buy-in varies within and across organisations and this is reflected in the take up of the tool within services, as the above shows not all GP practices currently use the tool and even where strategic buy-in of the tool has been achieved within the social care children and families' service, worker application of the tool is still not 100%. In some services it may be that the use of the tool should not be universal and should be targeted, based on a case by case basis. There are a number of reasons behind this, since the tool does have its limitations:-

[89] Public Health Analysis Team, 2012. Practice Quilt.

[90] *The Government's Alcohol Strategy*, March 2012, https://www.gov.uk/government/publications/alcohol-strategy

- There are other widely promoted and used evidence based clinical tools, which impacts on the level of take up and level of application.
- There is an obvious overlap with requirements of the DES for some practices and the tool does not put the outcome score onto the GP computer system e.g. SystmOne. This can be an issue because performance against the DES is measured using the data input into the AUDIT template on the computer system. Therefore to still get a DES payment and use the electronic screening tool you would have to ask the AUDIT questions, complete the template and then transfer the questions onto the internet tool and ask the two additional questions. Whilst this would be beneficial for those who are identified as dependent drinkers, referrals do not have to be made via the tool nor is there much incentive to record the outcome onto the tool if the DES AUDIT score reveals a lower risk drinker.
- Personal barometers (comparisons to how much they themselves drink) and individual approaches within workforces can result in a mixed approach to the use of the screening tool screening and individuals can and do change the interpretation of 'targeted' approach. Therefore some people will remain hidden whilst mainly those dependant drinkers will be identified as they would have been without screening taking place. Although this issue is not unique to the electronic Sheffield tool and is applicable to other tools available.
- Services take a long time to adopt a new tool as best practice and this tool is no different.
- The actual number of referrals to SHSC-FT has increased but further work is required to understand the numbers made following the use of the screening tool.

How has the project been addressing these limitations?

1. Training and launch - Role out via a comprehensive and effective training session prior to launching the tool has been implemented, with learning outcomes as follows:-
    a. Understand their clients, their expected referral rates and referrals rate prior to and after the tool has been launched (creating a benchmark),
    b. Understanding how early identification (both in terms of working with a client and or a client's drinking career) can reduce the time to work with a client. Identifying the issue means it can be addressed rather than remain hidden and remain a factor in being on the caseload, compared to a four minute screening period with the client.
    c. Understanding and being aware of cases in the media where children have been harmed as a result of undisclosed or unaddressed alcohol misuse of a parent.
2. GP liaison nurse funded by DACT/ LA has been working closely with over 30 GP practices to promote the use of the tool, although further work is required, to support those already trained and to address the concerns of those who had received the training but who still fail to refer.

IBA by children's social services[91]

The SHSC electronic alcohol screening tool (the Tool) has been used by Children's Social care for about a year. All workers have been in meetings or training on the screening tool and some teams started to use it in February 2013. The Tool is now embedded in the Assessment Process and all adults that are part of the assessment should be screened. Children's social care team managers also discuss use of the Tool in case supervision with social workers. Currently about 30% of assessments (as of March 2014) include the use of the Tool and around 100 referrals to SHSC have been made.

Use of the tool in child protection conferences – Since November 2013 the use of the tool in child protection conferences has increased and practice has changed. If the Tool has not been used prior to CP conference and the Chair feels it should have been then it becomes part of the Action Plan following CP conference. Currently (March 2014) 97 children subject to CP plan have parents who misuse alcohol.

Overall the tool has a number of benefits:-

- A significant increase in referrals into the adult alcohol service from children's services (13 referrals to both drug and alcohol services, in 2011/12 to 75, solely to alcohol services, November 2013/14).
- better and earlier identification of children who live with alcohol misuse so appropriate support can be offered to them
- A more accurate prediction and better understanding of alcohol misuse within the client group accessing different services, e.g. 59% of those parents screened to date by children's social care reached the score threshold and therefore require further assessment.

- **Further work is ongoing in children's social care to increase the use of the tool in assessment cases from 30%.**
- **To continue to work with GP practices to increase the number of practices trained on the tool and to increase the usage of the tool in practices where it is considered underused.**

[91] Information provided by Mandy Craig, Safeguarding Children Substance Misuse Service

- **Consider the tool in its current form and how it could be adapted to address the overlap with other tools and work to meet DES requirements.**

Identify new organisations to launch and rollout the tool e.g. Mandy Craig's paper recommended exploring the options in[92]:-

- Community Midwives to screen pregnant women.
- Health visitors to screen clients when undertaking their 6 to 8 week old baby home visit. Ideally use with both parents (if present) and the practice would support the 'Safe Sleep' message.
- Family Intervention Workers to use with families accessing a family support service.
- Housing Plus Workers to use with families accessing housing support.
- The Probation service
- Children's A&E (and adults) on parents and carers of vulnerable children
- Police Officers following a domestic abuse incident
- On parents whose child is accessing CAMHS (Child and Adolescent Mental Health Service)
- SHSC-FT to better monitor the number of referrals received via the electronic screening tool.

IBA undertaken by the Yorkshire Ambulance Service (YAS)[93]

YAS has an alcohol referral pathway running county-wide which allows clinicians to refer patients to specialist alcohol services across the region after assessment using the CAGE[94] tool and the delivery of IBA. This is a new initiative and not something that has been undertaken by YAS before. As a result of having this pathway in place, ambulance staff are likely to be delivering some form of alcohol brief advice to the patients that they are referring.

In the first quarter of 2013/14 YAS attended 10,178 calls where the use of alcohol was suspected. This equated to 5.9% of all calls, with associated costs including ambulance call out, A&E attendance, and possible admission.[95]

A research project is currently being scoped by Sheffield Hallam University[96] on the use of IBA within YAS as an evaluation of current practice.

YAS to be included in the consultation process to be undertaken for the new strategy on IBA and the work they undertake with alcohol misusers.

In summary – In Sheffield the number of people who are receiving IBA is increasing annually as it is becoming more widely available (in a number of difference settings and increased number of GP surgeries). IBA is a relatively inexpensive method of providing an effective (as per the evidence of the SIP research) alcohol interventions to reduce individual alcohol intake. The aim is to continue to increase year on year the number of people receiving IBA, with a view of increasing the number who are receiving brief advice and identifying those who require treatment but are hidden (they do not consider they have a problem). It can also be an effective method of increasing referrals into treatment. The commissioning of all such screening interventions in each sector needs to be coordinated and activity monitored.

- **The new alcohol treatment contract will continue to promote the use of an electronic screening tool, increasing the number of service which use the tool and with the ultimate aim of providing preventative brief interventions to those who require it, and referrals into treatment for those who score in the dependent levels.**
- **The commissioning of all such screening interventions in each sector needs to be coordinated and activity monitored.**

[92] Mandy Craig, 'Sheffield Alcohol Screening Tool - Early identification of alcohol misuse', November 2013
[93] Information provided by Ruth Crabtree, Clinical Excellence Manager, Yorkshire Ambulance Service
[94] CAGE is an internationally used assessment instrument for identifying alcoholics, with a total of four questions. Developed by Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Chapel Hill. CAGE is an internationally used assessment instrument for identifying alcoholics. http://www.patient.co.uk/doctor/cage-questionnaire
[95] Poster for the NICE shared learning awards 2014, Thomas Heywood, Yorkshire Ambulance Service.
[96] YAS IBA project being scoped by Brenden Wood B.Wood@shu.ac.uk and colleague Marelize.

Chapter 7 - Health Problems due to Alcohol Misuse

It is well documented in national strategies and research publications that excessive alcohol use (regular and long term drinking above the daily and weekly Department of Health guidelines) can result in individuals experiencing alcohol related health conditions. Such conditions are considered 'preventable' and in some cases can result in death.

Public Health England in their annual Local Alcohol Profiles for England (LAPE) (published in 29 April 2014) monitor the extent of alcohol related and specific illnesses and mortality by Local Authority and compare each to the England average[97]. The national indicators that monitor the health harms caused by alcohol are alcohol specific and related (broad and narrow) hospital admissions and mortality.

It is imperative for commissioners of community and secondary care alcohol treatment to understand the current extent of alcohol related and specific illnesses and mortality, since LAPE data can be used to:-

- better understand the use of health services by those with alcohol related problems,
- used for short term and long term commissioning for capacity planning purposes, ensuring enough capacity is available to meet the need of those at risk.
- used as benchmarks for monitoring the outcome of health related pilot projects and initiatives commissioned with the aims of reducing or curbing the increase nationally in alcohol related hospital admissions and mortality.
- Compare similar cities to Sheffield to understand where best practice may be happening elsewhere in the country and investigate further.

Alcohol Related Hospital Admissions

The state of the nation – facts and figures on England and alcohol[98] report cited the following:-

- The Department of Health estimated that 7 per cent of all hospital admissions are alcohol-related, (Department of Health, 2010).
- 1 in 16 admissions to hospital are alcohol related.
- Alcohol related conditions account for around 1 in 8 NHS bed days and one in eight NHS day cases.
- Just over 1 million (1,008,850) alcohol related admissions to hospital in 2012/13[99]

The LAPE data below shows the latest published data for Sheffield, using 2011/12 data.

Table 25 Alcohol hospital admissions

LAPE April 2014		SHEFFIELD			
	Indicator	Measure(a)	National Rank (b) Out of 326	Rank of 8 core cities	Regional Average
10	(10) Alcohol-specific hospital admission - males	495.07	207	1	521.67
11	(11) Alcohol-specific hospital admission - females	218.8	188	2	243.63
12	(12) Alcohol-related hospital admission (Broad) - males	1605.38	187	1	1752.53
13	(13) Alcohol-related hospital admission (Broad) - females	794.01	180	1	865.69
14	(14) Alcohol-related hospital admission (Narrow) - males	596.27	219	1	623.74
15	(15) Alcohol-related hospital admission (Narrow) - females	302.29	197	1	317.46
16	(16) Admission episodes for alcohol-related conditions (Broad)	2026.12	202	1	2139
17	(17) Admission episodes for alcohol-related conditions (Narrow)	706.09	257	3	687.87

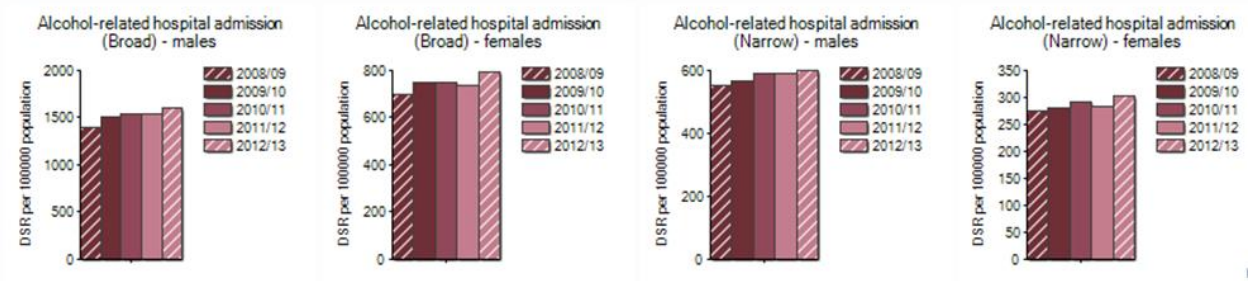
When a core city comparison is made Sheffield ranks first (the better) for six of the eight alcohol hospital indicators on the LAPE report. The exceptions are the indicators for 'alcohol specific hospital admission – females' (rank second) and admission episodes for alcohol related condition (narrow), ranked third.

[97] LAPE www.lape.org.uk
[98] The state of the nation – facts and figures on England and alcohol http://www.alcoholconcern.org.uk/assets/files/PressAndMedia/state.of.the.nation.pdf.
[99] Statistics on alcohol: England 2014

Sheffield is significantly better than the England average for Alcohol-related hospital admission (Broad) – males and significantly worse than the England average for Admission episodes for alcohol-related conditions (Narrow), for the other six Sheffield is 'Not significantly different to the England Average'.

All alcohol related admissions (Broad[100] and narrow[101]) have increased since 2008/09, as per the graphs produced by LAPE below.

Hospital Admission



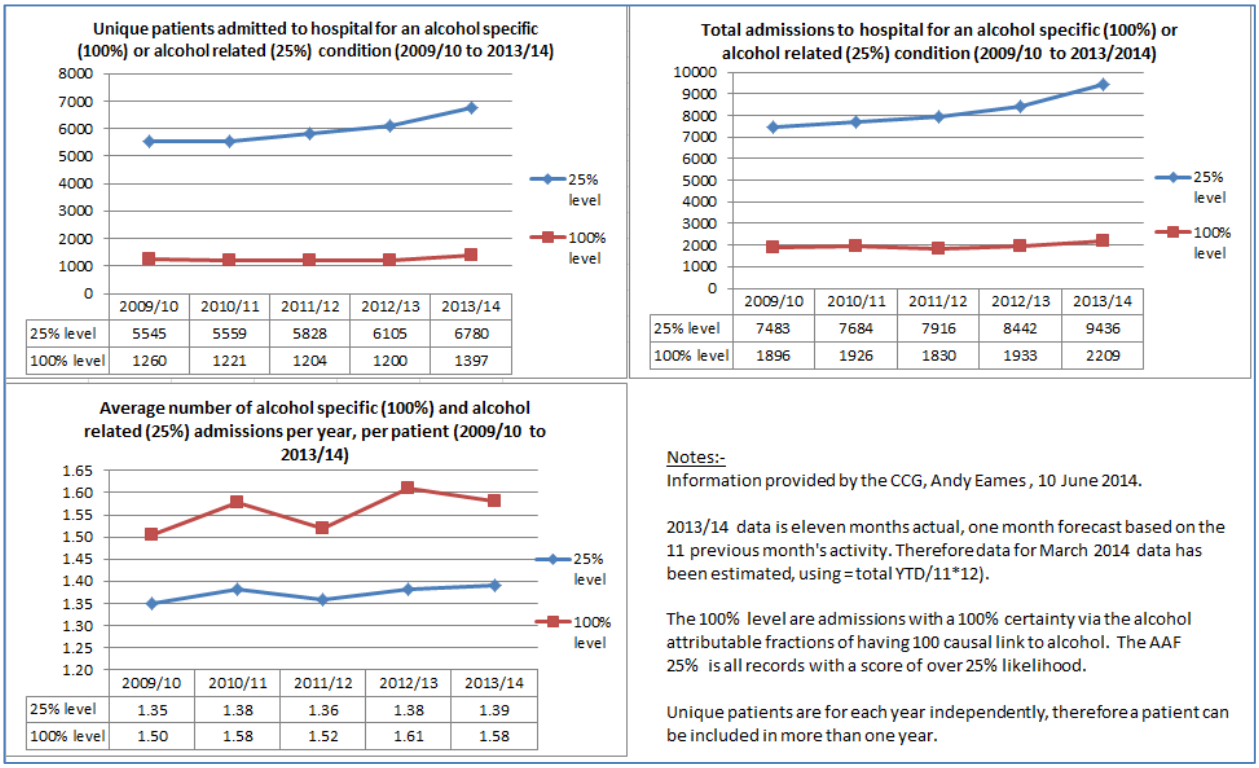
Information held by the CCG on hospital admissions for alcohol specific and related conditions

The CCG have provided information on the total number of alcohol specific (100%) and alcohol related conditions (25%) per year for the last five financial years, by number of individuals, number of episodes of hospital stay and average number of admissions per patient.

- The number of alcohol specific admissions (100%) increased in 2013/14 by 14.3% to 2,209 from 1,933 in 2012/13 and was for a total of 1,397 unique individuals, giving an average of 1.58 admissions per patient in the year.
- In the last three financial years the number of admissions has increased by an average of 5.0%; however 2013/14 experienced a greater increase than this (14.3%), which is the highest increase during the last five year period.
- The number of alcohol related admissions (25%) increased in 2013/14 by 11.8% to 9,436 from 8,442 in 2012/13 and was for a total of 6,780 unique individuals, giving an average of 1.39 admissions per patient in the year.
- In the last three financial years the number of admissions has increased by an average of 7.1%; however 2013/14 experienced a greater increase than this (11.8%), which is the highest increase during the last five year period.

[100] Broad – the LAPE definition is that a patient would be counted if either their primary or any secondary diagnosis (determined by ICD 10 codes) was an alcohol attributable condition. For full details see http://www.lape.org.uk/index.html for the PHE User guide: Local Alcohol Profiles for England 2014, page 36.

[101] Narrow –the LAPE definition is that a patient would be counted either their primary diagnosis (determined by ICD 10 codes) was an alcohol attributable condition OR if any of the secondary conditions was due to an AFF external cause. For full details see http://www.lape.org.uk/index.html for the PHE User guide: Local Alcohol Profiles for England 2014, page 37.



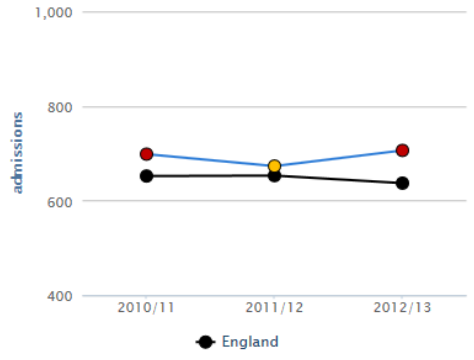
Costs associated with these hospital admissions were requested of the CCG but unavailable at the time of writing.

Performance measurements –
The health harms associated with alcohol misuse are incorporated in the national Public Health Outcomes framework (PHOF) www.phof.org.uk and these have become targets for the Health and Wellbeing board.

The PHOF indicator – 2.18 Alcohol related admissions to hospital is also the LAPE 17 indicator which is named slightly differently - 'admission episodes for alcohol related conditions narrow'. The national target therefore measures the total number of primary alcohol attributable diagnoses or the secondary diagnosis listed as an external factor (e.g. assault or road traffic accident) on the AFFs and includes both males and females.

Current PHOF performance (latest data published in May 2014) shows Sheffield is *'statistically below the England average'* and in the last year the rate has increased from 673 per 100,000 DSR in 2012/12 to 706 per 100,000 DSR in 2012/13, which is the highest rate it has been in the last three years.

2.18 - Alcohol related admissions to hospital Sheffield — Directly standardised rate - admissions



Period	Sig	Value	Lower CI	Upper CI	Yorkshire and the Humber	England
2010/11	●	698	675	722	684	652
2011/12	●	673	650	696	692	653
2012/13	●	706	683	730	688	637

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

The PHOF shows activity for 2012/13; however the local data from the CCG provides a more recent set of data, for 2013/14. Whilst the two are not directly comparable as they are calculated slightly differently (showing the number of 25% AFF hospital admissions) the CCG trend data does provide come indication on how Sheffield will fare on the PHOF when the next results are published. Given that the CCG data shows an increase from the previous year it is therefore likely that Sheffield will remain 'worse than England Average' on the PHOF 2.18 indicator when the annual update to this indicator (2013/14 activity) are published in 2015.

Any initiatives that are currently in progress or that will start during 2014/15; therefore will not impact on the PHOF

indicator until at least 2016, when activity for 2014/15 will be published, therefore local CCG measures of this indicator are imperative to understand the impact of any new initiatives.

Greater likelihood of health related illness

In addition to hospital related admissions a NICE briefing also provides information on the likelihood of health related harms due to alcohol misuse. The table below (published in 2012) shows that those who drink 3 units of alcohol per day are estimated to be 3 times more likely to be susceptible to liver disease, 2.5 times more likely to get mouth cancer, 1.8 times more likely to have throat cancer etc. These likelihoods increased when the daily amount of alcohol units was doubled to six units per day; 7 times more likely to have liver disease, 5 times more likely to have mouth cancer, 3 times more likely to have throat cancer.

Condition	Increased risk associated with drinking	
	3 units of alcohol per day (1.5 pints of beer, 250 ml of wine)	6 units of alcohol per day (3 pints of beer, 500ml of wine)
Liver disease	3 times	7 times
Mouth cancer	2.5 times	5 times
Throat cancer	1.8 times	3 times
Breast cancer	1.3 times	2 times
Hypertension (high blood pressure)	1.7 times	3 times
Ischaemic (blocked artery) stroke	No change	2 times
Haemorrhagic (burst blood vessel) stroke	1.8 times	3 times
Pancreatitis (inflamed pancreas)	1.3 times	2 times

http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map

Gap - It is unknown locally the number of people who will have discussed alcohol use their general practitioner, someone else at the surgery, another doctor or any other medical professional (see section on identification and brief advice).

Mortality/ Alcohol related deaths

Ill health caused by alcohol misuse can unfortunately for some individuals end in death.

1.4% of all deaths in England and Wales during 2012 were alcohol misuse related.

In 2012 there were an estimated 8,367 alcohol related deaths in the UK[102], 5,792 alcohol related male deaths (15.9 per 100,000 rate) 2,894 alcohol related female deaths (rate of 7.8 per 100,000 per annum), the total was less by 381 deaths in 2011[103].

66% of all alcohol related deaths are male (rate of 15.9 per 100,000 age standardised rate) with a peak rate of 42.5 per 100,000 for the 60-65 year olds group[104].

LAPE data estimates that there were 130 deaths wholly due to alcohol misuse in 2012/13, of which 100 were males (18.25 per 100,000 direct standardised population rate (DSR)) and 30 were females (5.7 per 100,000 DSR).

The same methodology cannot be used to work out the number of people who die from an alcohol related condition, as AAFs are used, and therefore the ratios applied do not refer to one person[105] The estimated male ratio for alcohol related mortality is 64.14 per 100,000 DSR and is much higher than the female ratio of 24.6 per 100,000 DSR).

[102] National statistics definition is those which are directly due to alcohol misuse.
[103] *Alcohol-related deaths in the United Kingdom, registered in 2012*, Office of National Statistics: Statistical bulletin, 19 February 2014
[104] *Alcohol-related deaths in the United Kingdom, registered in 2012*, Office of National Statistics: Statistical bulletin, 19 February 2014
[105] e.g. 64.14 does not mean 64.14 males per 100,000 it means the total ratio of the AFFs per 100,000.

The table 26 below shows all eight indicators on LAPE for mortality:-

Table 26 LAPE 2014 Mortality indicator rates for Sheffield compared to regional average, and national and core city rank.

LAPE April 2014	SHEFFIELD			
Indicator	**Measure(a)**	**National Rank (b) Out of 326**	**Rank of 8 core cities**	**Regional Average**
(1) Months of life lost - males	12.07	213	1	12.26
(2) Months of life lost - females	4.75	133	1	5.72
(3) Alcohol-specific mortality - males	18.25	263	1	15.8
(4) Alcohol-specific mortality - females	5.69	156	1	7.49
(5) Mortality from chronic liver disease - males	15.61	200	1	15.81
(6) Mortality from chronic liver disease - females	7.46	159	2	8.76
(7) Alcohol-related mortality - males	64.14	197	1	66.95
(8) Alcohol-related mortality - females	24.6	99	1	28.07

When core cities comparisons[106] are made, Sheffield ranks first (the better) for seven of the mortality eight indicators, *'mortality from chronic liver disease females*' being the exception, Sheffield ranks 2/8 core cities and 159 out 326 Local Authorities. For all mortality indicators (1-8) Sheffield remains *'not statistically different to the national average'* with the exception of *'alcohol specific mortality – males'* which is *'worse than the national average'*.

Alcohol specific mortality – males

Between the two LAPE publications of 2012 and 2014 Sheffield has moved down the ranking for Alcohol specific mortality – males from 219 to 263 out of 326. This is 44 places lower and the greatest change experienced of the core cities (see Table 27). This is despite being ranked first in the core city list.

Table 27 Alcohol specific mortality – Males (LAPE 2014), the ranking within the 8 Core cities and movement in ranking since 2012.

(3) Alcohol-specific mortality - males	Indicator	Ranking out of 326		Change in ranking
		2014	2012	
SHEFFIELD	18.3	263	219	-44
Leeds	18.3	264	278	14
Newcastle	20.1	281	314	33
Birmingham	21.8	296	303	7
Bristol	22.5	303	286	-17
Nottingham	26.3	315	273	-42
Liverpool	29.1	321	318	-3
Manchester	33.6	325	323	-2
LAPE 2012 and LAPE 2014				

Although rankings can get worse, the core city comparison shows that rankings can improve. Newcastle has improved its ranking by 33 (despite still having a worse rate than Sheffield) thus showing that ranking improvements can be made.

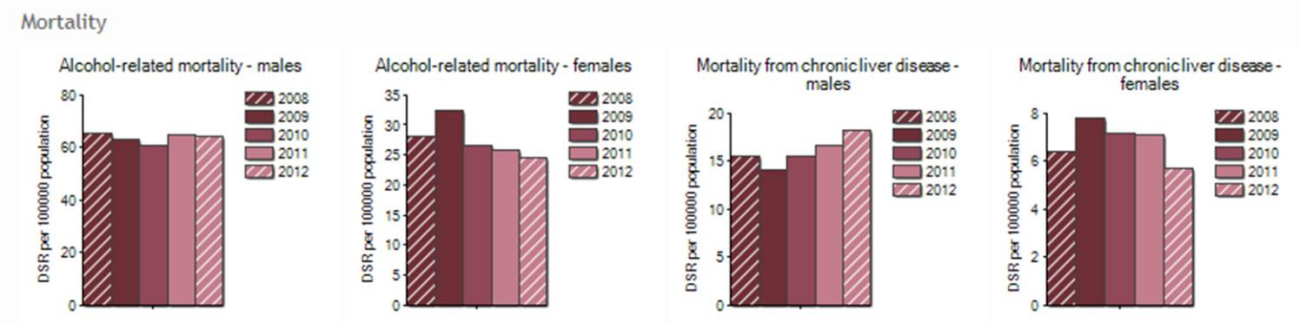
Discuss with Newcastle what changes/ projects (if any) have been undertaken which may have influenced their ranking for Alcohol specific mortality – males.

Trends in alcohol mortality

Only mortality from chronic liver disease has annually increased since 2009, alcohol related mortality males has remained the same whilst both female alcohol related mortality and chronic liver disease mortality are reducing.

[106] The seven core cities Sheffield compares indicators to are: Bristol, Birmingham, Manchester, Liverpool, Newcastle on Tyne, Nottingham and Leeds.

Graph 3



Who are the most vulnerable?
Links between deprivation and social economic status are both found to impact on alcohol related mortality.

Deprivation and alcohol mortality – Research undertaken by Breakwell et al (2007)[107] found an associated between deprived areas and higher incident rates of alcohol related mortality, for both males and females, although the difference was more significant for males than females. Published in 2007 using data from 2004 the report looked at the difference in rate of alcohol mortality between the top twenty derived areas and the top twenty least deprived areas and found there a fivefold increase for males and a threefold increase between the least and most deprived areas for alcohol related death rates[108].

Social economic status and alcohol related mortality – Research by Siegler et al. (2011)[109] found that those in routine jobs (the lowest classification) compared with higher managers and professionals (the highest classification) on average had a higher mortality rate; e.g. men had an estimated 3.5 times higher rate and women 5.7 times higher rate. Further observations found rate differences widened the lower the age group. The research suggested that *'alcohol-related mortality rates increased more rapidly and peaked at younger ages in the Routine class (Class 7) whereas for higher managers and professionals (Class 1) the rates increased steadily with age'*[110]. Levels of alcohol consumption, lifestyle, drinking at an earlier age, price of alcohol are all potential discussion point in this difference.

Sheffield on the Public Health England Longer Lives mortality rankings[111] is given the 'socio economic decile' of 4, which is 'more deprived', (there are five rankings, with Sheffield falling in the second most deprived). Sheffield on the Longer lives profile ranks 101/150 LA for mortality deaths from cancer, of which alcohol is listed as a common cause and 62/149 LAs for mortality from liver disease (18 per 100,000 populations), with alcohol listed as the first common cause.

Therefore given that Sheffield ranks high in the deprivation scale to other local authorities, it seems appropriate to recommend a focus on alcohol and deprivation.

In summary – Despite Sheffield comparing well to its peers, alcohol related mortality in Sheffield remains a strategic priority of the Health and Wellbeing Board, the Alcohol Planning and Commissioning Group, Sheffield Teaching Hospital and the Clinical Commissioning Group (CCG).

Alcoholic Liver disease
National statistics shows that Alcoholic Liver disease remains the most frequent cause of alcohol related registered deaths in 2012, accounting for over 63% (4,425)[112] of alcohol related deaths, with the 55 to 59 age group the highest number of deaths for this disease. This is a long term condition following long term alcohol misuse and there has been an 18% increase in the number of such deaths since 2002 when there were 3,629 deaths.

- In Sheffield the LAPE rate of mortality from chronic liver disease is as follows:-

107

[108] C. Breakwell, A. Baker, C. Griffiths, Office for National Statistics; G. Jackson, General Register Office for Scotland; G. Fegan & D. Marshall, *Trends and geographical variations in alcohol-related deaths in the United Kingdom, 1991–2004* as published in National Statistics *Health Statistics Quarterly, Spring 2007, Number 33.* 'Males rose from a rate of 6.2 deaths per 100,000 (least deprived twentieth) to 31.9 deaths per 100,000 (most deprived twentieth) and females were more than three times higher than for those living in the least deprived areas, rising from 3.7 deaths per 100,000 in the least deprived twentieth to 11.3 deaths per 100,000 in the most deprived twentieth'.

[109] V. Siegler, A. Al-Hamad, B. Johnson, C. Wells (Office for National Statistics) and N. Sheron Southampton University *'Social inequalities in alcohol-related adult mortality by National Statistics Socio-economic Classification, England and Wales, 2001–03'* Health Statistics Quarterly 50, Summer 2011.

[110] The report looked at all deaths in 2001 to 2003 and their occupation, to find the distribution of social economic occupation of those who died from an alcohol related illness. A second data set was calculated using 2001 census data to find the population by social economic occupation. The two were then applied together to create rates for each socio economic group.

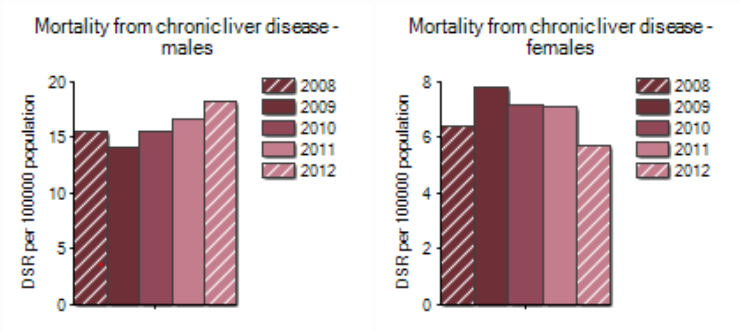
[111] http://longerlives.phe.org.uk/area-details#are/E08000019/par/E92000001

[112] The statistics on Alcohol: England 2014

- males is 15.61 per 100,000 DSR, rank 200/326
- females ratio of 7.46 per 100,000 DSR, rank 159/326

- Sheffield compares well to the other seven core cities for this rate, however the trends for Sheffield, see graph 4 below, show that the rate for males has increased between 2009 and 2012 although the female rate has decreased.

Graph 4



Applying the LAPE rates to the Sheffield population, would mean that around 85 males and 40 females will die of chronic liver disease per annum.

The PHOF also includes an indicator on liver disease and mortality; 4.06i *Under 75 (years) mortality from Liver Disease* which is 18.3 per 100,000 populations for all persons for Sheffield in 2012/13. However there is a subset to this indicator that recognises that a significant proportion of liver disease deaths are preventable, '*influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions'* and therefore the indicators measuring the preventable liver disease conditions are more appropriate to monitor for health harms caused by alcohol misuse. See footnote for the full list of ICD codes used to measure this indicator[113].

Current PHOF performance is as follows: - (activity shown form 2010 to 2012), where Sheffield 'is statistically is similar to the England average' for each measure (denoted by the orange circles on each of the bar graphs).

Indicator	Period	Sheffield		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
4.06ii - Under 75 mortality rate from liver disease considered preventable (Persons)	2010 - 12	202	15.8	16.4	15.8	38.2		9.0
4.06ii - Under 75 mortality rate from liver disease considered preventable (Male)	2010 - 12	144	22.7	21.4	21.1	54.9		10.8
4.06ii - Under 75 mortality rate from liver disease considered preventable (Female)	2010 - 12	58	9.0	11.5	10.6	21.4		6.3

http://www.phoutcomes.info/

- Under 75 (years) mortality from Liver Disease considered preventable – total = 15.8 per 100,000 populations, with account of 202 individuals.

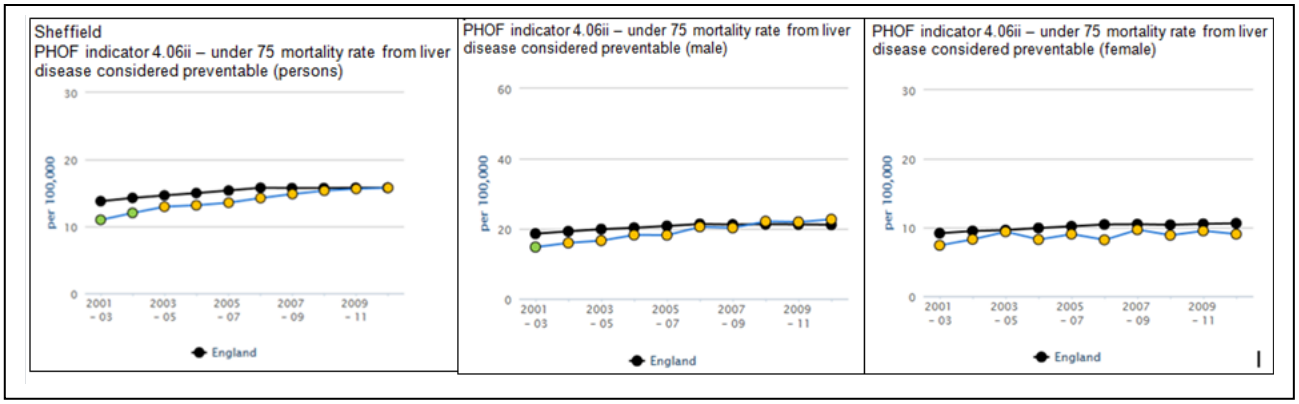
- 'Under 75 (years) mortality from Liver Disease considered preventable – males = 22.7 per 100,000 populations with a count of 144 individuals.

- 'Under 75 (years) mortality from Liver Disease considered preventable – females = 9.0 per 100,000 populations with a count of 58 individuals.

(Note not all counts are due to alcohol, therefore not directly comparable with the LAPE data.

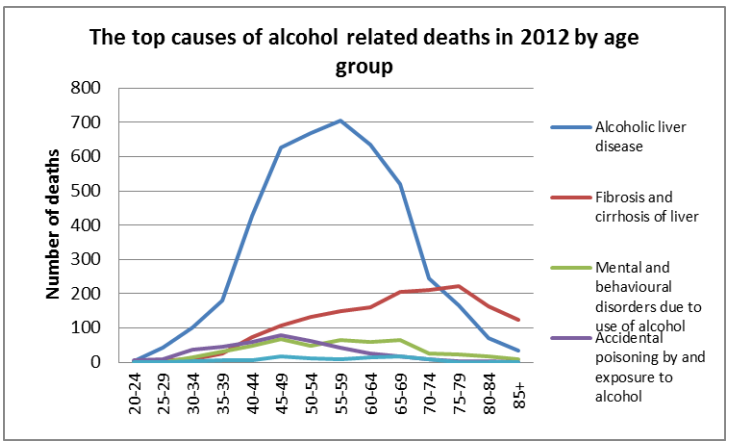
[113] B17.1 – Acute Hepatitis C, B18.2 – Chronic viral hepatitis C, C22 – Malignant neoplasm of liver and intrahepatic bile ducts, K70 – Alcoholic liver disease, k73 Chronic hepatitis, not elsewhere classified, K74 – Fibrosis and cirrhosis of liver.

Trends in the Under 75 (years) mortality from Liver Disease considered preventable.



The Sheffield rate has increased from a rate of 11.0 in 2001-03 to 15.8 (by) +4.8 in 2010-12, which is a greater rate of increase than experienced by England (+2.0) and Yorkshire (+1.9), meaning that Sheffield rate has travelled towards the England rate during this 10 year reported period, with the main influence being the male rate which has increased by +7.9 compared to the England increase of 2.5.

A small proportion of alcohol related deaths, 6%[114] of deaths nationally were due to alcohol poisoning (drinking alcohol in excess over a short period of time), and the highest age group for these deaths was age 45 to 49 years. There have been examples in the media recently of alcohol poisoning due to drinking games, e.g. Neknominate in early 2014 and the impact social media has on drinking habits.



[114] Alcohol-related deaths in the United Kingdom, registered in 2012, 19 February 2014 http://www.ons.gov.uk/ons/rel/subnational-health4/alcohol-related-deaths-in-the-united-kingdom/2012/sty-alcohol-releated-deaths.html

Hospital initiatives to address the health harms caused by alcohol misuse in Sheffield

There are national best practice recommendations for addressing alcohol misuse and reducing the harms caused by alcohol misuse. The most widely known are the seven best practice high impact changes contained in the *'Signs for Improvement*[115]' report by the Department of Health in 2009.

1. Work in partnership – *prioritise alcohol, include in the JSNA, a clear vision of what change would look like, work together to the shared vision.*
2. Develop activities to control the impact of alcohol misuse in the community – *Make use of the law to curb alcohol related crime and manage the night time economy.*
3. Influence change through advocacy – *Have well known and key strategic leaders in all partner organisations to lead on the change.*
4. Improve the effectiveness and capacity of specialist treatment – *increase treatment opportunities for dependent drinkers, reduce waiting times, review care pathways and blockages to treatment.*
5. Appoint an alcohol Health worker / liaison nurse – *to work alongside the lead clinician for alcohol in the local trust, to assist with the management of people with alcohol problems, broker between the hospital and community care, educate health workers in hospital and deliver brief interventions*
6. IBA –*Targeting those who drink too much but who are not currently seeking help for their alcohol use. Increase the number and locations where alcohol screenings and brief interventions happen. E.g. primary care, A&E, specialist settings and the criminal justice system.*
7. Amplify national social marketing priorities – *commission local social marketing activity (e.g. leaflets, fact sheets, wall charts) building on local and national alcohol campaigns.*

The report explains that actions 1 to 3 set the scene (strategic direction and clear actions) whilst 4 to 7 are evidence based specific alcohol interventions.

More recent recommendation are found on the Public Health England Longer Lives website[116] which recommends the following actions to reduce the number of alcohol related deaths[117]

- Campaigns to raise awareness of the dangers of alcohol and the silent nature of liver disease.
- Consider the restriction of alcohol consumption in public places and enforcement of underage sales penalties.
- Support GPs in making early risk assessments for liver disease, e.g., the Southampton Traffic Light Test (STL).

Sheffield has responded to these actions, with greater partnership working, the night time economy changes, the alcohol strategy for Sheffield, the JSNA for Sheffield, the JSIA, a complete treatment system commissioned and available for those who require it, the appointment of an alcohol liaison nurse, IBA now introduced in new areas, and social marketing campaigns.

Expert groups to be held during the development of a new Alcohol Strategy for Sheffield, which will draw on information in this report, will help to establish future actions that will be taken in Sheffield to further address health harms caused by alcohol misuse in the city.

Building on the Department of Health's recommendations, specific health initiatives are being piloted, scoped and have been launched. These include-

Alcohol Related Accident and Emergency Initiatives[118] - over the last few years the following initiatives have been undertaken. The outcomes is starting to increase the level of data and knowledge on alcohol misusing patients accessing the service and increase clinical understanding of alcohol misuse and screening, however not all initiatives are ongoing and the long term impact of these initiatives is unknown.

- Clinical staff working in A&E attended training on alcohol misuse; to specifically engage patients in discussing their alcohol misuse and open opportunities to provide brief interventions. Alcohol specialists worked alongside nursing staff to support their training. – The outcome of this initiative was good and clinical awareness of alcohol misuse has increased.
- Rollout of a screening tool for patients 'Am I drinking too much? Produced and created by SHSC. The outcome of this initiative was mixed; the tool was not being used consistently and therefore stopped.

[115] Department of Health (July 2009) *Signs for improvement – commissioning interventions to reduce alcohol-related harm* Gateway reference 11753 http://www.skillsforhealth.org.uk/component/docman/doc_view/129-ad-commissioning-guidelines.html
[116] http://longerlives.phe.org.uk/health-intervention/cancer#are/E08000019/par/E92000001
[117] http://longerlives.phe.org.uk/health-intervention/liver#are/E08000019/par/E92000001
[118] All information provided by Bazz,

- A&E returns clinic introduced, where people identified with alcohol problems were invited to a second appointment with an alcohol specialist (SEAP) – The outcome was that patients did not attend their arranged appointments with the alcohol specialist and therefore the initiative ended.
- Alcohol audits – two audits were undertaken between 8pm and 4am on a Saturday and Sunday evening on two separate weekends. In total 114 attendances were alcohol related (the majority were on the Saturday night, an average of 76%). Outcomes – found that alcohol coding could be improved, low number of glass injuries, in less peak times alcohol attendances were low, difficult to identify the location of the incident (e.g. bar) given the area the person was picked up from may not have been where they had been drinking.
- Alcohol coding – all alcohol related A&E attendances should be flagged as 'alcohol' – outcome the audits found that only 9 of the 53 alcohol related incidents had been coded as alcohol, therefore further improvements are required in this area.
- Review of alcohol related admissions from A&E – 6 months admission data was reviewed, of the 735 attendances 147 were admitted (20%), 80 alcohol withdrawal, 10 falls, 10 mental health, 11 liver disease and 37 others. The outcome was that up to 12% (18 cases) *could* have been inappropriate, suggesting potential saving to be made however there remains issue with non-specialist alcohol staff in A&E and their confidence at discharging clients who need to 'dry out' rather than admitting them. **These 18 cases over the 6 month period would be enough to fund an alcohol nurse…if 36 cases could be avoided per capita based on an average of £2,000 per admission.**
- Frequent attenders – the use of coding means frequent attenders can be identified. The outcome of this was two potential approaches that could be taken using this data, focus on the average user or/and focus on the smaller population of high end frequent attenders with complex needs and high associated costs with a view of streamlining services to reduce duplication, in effect.

- **There is still a need to identify some big, real change initiatives to implement and keep long term in A&E.**

- **Alcohol coding is still not routine, although has improved.**
- **Targeting or universal alcohol screening has been tried in A&E but is not routine.**
- **Alcohols lead not present 24/7 in the service.**

The Alcohol Liaison Nurse (ALN)[119] – since 2011 the alcohol liaison nurse role has been commissioned annually by DACT and operated by SHSC. . The role works in Sheffield Teaching Hospitals and is based on the *Signs for Improvement*[120] recommendation '*to work alongside the lead clinician for alcohol in the local trust, to assist with the management of people with alcohol problems, broker between the hospital and community care, educate health workers in hospital and deliver brief interventions'.*

The ALN currently operates in both STH hospitals; the Northern General (NGH) and the Royal Hallamshire (RHH). At the NGH the ALN operates Monday to Friday in the following wards known to be 'hot spot for alcohol patients' – the two Medical assessment units (male and female), Huntsman 5 (non-surgical, mainly acute medical presentations with complexities), the Surgical Assessment Centre (e.g. patients with pancreatitis and injuries following falls) and Brearley 6 the gastroenterology/ hepatology ward. The service provided at the RHH is limited to the gastroenterology/ hepatology ward (P2).

There is one ALN who works four days a week at NGH and a SEAP worker who works 2 hours per day. Together they undertake assertive outreach on patients who have been admitted to the 'hotpot' wards, getting the names of patients with alcohol problems from the staff nurse on the ward. The assertive outreach approach is to take the SEAP service (triage assessment and brief interventions) to the patients; it is pro-active and involves talking to the patients about their alcohol misuse and opportunities for further alcohol treatment.

Most patients are often in the process of being 'detoxed' therefore the intervention is opportunistic, but timely. Patient reactions are generally welcoming and interested, although not all want a referral for specialist treatment (relapse prevention, inpatient detoxification, PSI or mutual aid). Those who re-present and are seeing the ALN for a second (+) time don't actively request the service. As a minimum, patients receive brief interventions and receive leaflets promoting the service.

[119] Meeting held with Mike Simms, Alcohol Liaison nurse at SHSC on 15 July 2014.
[120] Department of Health (July 2009) Signs for improvement – commissioning interventions to reduce alcohol-related harm Gateway reference 11753 http://www.skillsforhealth.org.uk/component/docman/doc_view/129-ad-commissioning-guidelines.html

Given that length of stay is limited, there are not too many opportunities for follow-ups with patients, although for those who are more complex and willing a comprehensive assessment can be offered and provided by the ALN. Where this is possible it removes the need to refer to SEAP for further assessment and can result in a direct referral to prescribing or PSI treatment.

The ALN does receive some referrals from other wards. This has been influenced in a couple of ways, the presence of the ALN role on wards other than the hotspot wards and the education services provided by the role. Additionally clinical guidelines 'Cessation of drinking for adults with alcohol use disorders' have been written by a host of alcohol specialists at STH, SHSC and a GP with a specialist interest in alcohol who agreed a referral process[121] to SEAP where alcohol misuse is identified in hospital patients.

Work at RHH is slightly different. Patients who are seen by the ALN receive the same service as at NGH however the service is limited to P2 (the gastroenterology department) and only present one day per week. The ALN has educated staff on how to screen patients and lots of visual promotional materials are available on the ward. Patients are usually chronically ill on P2 therefore their length of stay is generally longer than a week, so a weekly service does not generally mean many patients are not offered the ALN service.

In 2014/15 P2 ward will relocate to the NGH to create one specialist gastro/hepatology department in Sheffield. This will be advantageous for those who would have been on P2, as the service will be available daily and the ALN will no longer have to travel between sites, increasing the availability of the role at NGH. The disadvantage of this change for RHH is that the ALN presence will be removed unless there is an agreement made on what would be the most effective course of action for the ALN at RHH.

The ALN and SEAP worker also work at Fitzwilliam centre, this is useful as it keeps the skills of the workers high in specialist alcohol treatment, but also means that referrals to SEAP or for comprehensive assessment from the hospital can be booked to times when these workers are at Fitzwilliam centre, as a way of continuity of care. This is not always possible but is often welcomed by patients.

Initiatives tried:-

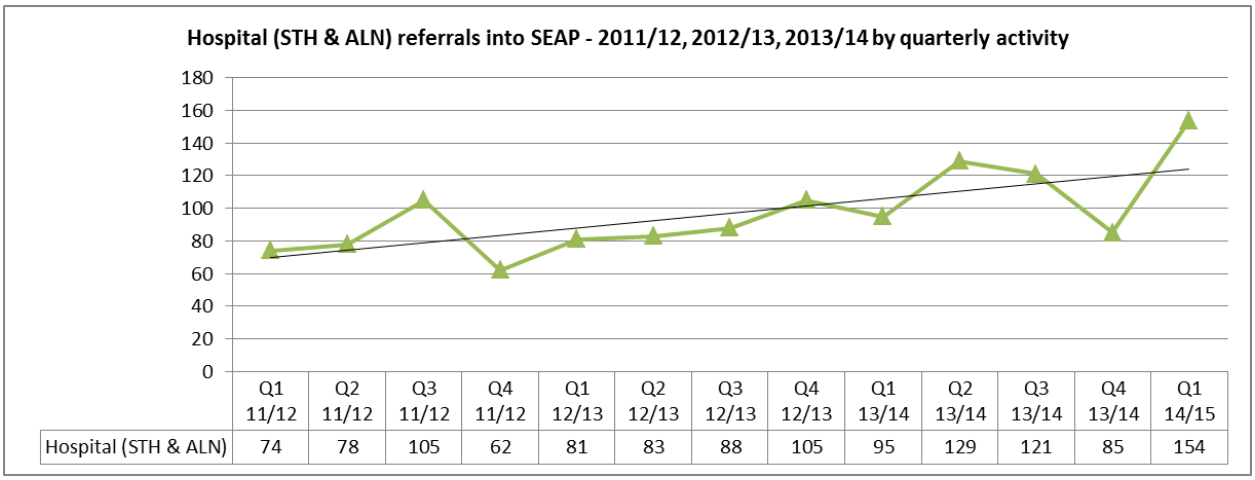
- To encourage 'hot spot' ward staff to promote the alcohol services and refer to SEAP.
- Accelerated discharge – for around 6 months patients who were detoxing and on Acamprosate were discharged part way through the course to the community, with the ALN visiting patients in their home. The project created a capacity issue for the ALN as this limited the time available to undertake the day to day operational ward rounds on the hotspot wards. Unfortunately, the initiative ceased due to the staffing and capacity issues. However, it is known that the initiative has had a positive impact in areas where capacity issues have not arisen.

The role of the ALN in A&E has changed over the years. Following attempts to roll out routine alcohol screening, actively encouraging referrals to a specific alcohol clinic and the introduction of the out of hours pathway (given that 70% of patients are alcohol related over a Friday and Saturday night) only the out of hours pathway remains in place, resulting in a small number of referrals. There is no formal referral process between A&E and the ALN specifically (since the 'Cessation of drinking for adults with alcohol use disorders' is mainly aimed at inpatients). The main role of the ALN in A&E remains an educational and training role of A&E staff, with occasional screening.

Over the last three years the role of the ALN has had a positive impact on referrals from the hospital to community alcohol treatment. Referrals from the hospital have increased from 319 referrals in 2011/12 to 430 in 2013/14, 35%. The average number of referrals per quarter in 2011/12 was 80, increasing to an average of 89 in 2012/13 and 108 in 2013/14, see graph 5 below, which shows the number of referrals by quarter for the last 13 quarters.

[121] Cessation of drinking for adults with alcohol use disorders: guidelines for professionals, June 2013

Graph 5 – Hospital referrals to SEAP over the last three financial years



	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15
Hospital (STH & ALN)	74	78	105	62	81	83	88	105	95	129	121	85	154

The activity increased in 2013/14 compared to the previous year however during this period a reduced alcohol liaison service operated for over a seven month period (between August 2013 and April 2014). The SEAP worker provided the service for two hours per day with no ALN presence for the first six weeks and for the last six month period (October and April) the ALN worked offsite at Fitzwilliam centre supervising the SEAP worker and present in the hospital once a week. Graph 5 shows that activity in the last six months of 2013/14 did not reduce compared to that of the activity in the first six months, however activity in Q4 was notably reduced (85) based to the level it had been a year previously compared to that of Q3 (121).

This suggests; firstly - despite the reduced workforce initially referrals continued as they had been, secondly - the role was sufficiently established to continue temporarily without an ALN present. Thirdly - it is likely that referrals would have been greater in 2013/14 had the ALN model operated as usual and fourthly, the process may work better if a nurse rather than an alcohol worker is employed in the task, from a professional kudos view point. This is based on the fact in Q1 2014/15 the model returned to have both the ALN and the SEAP worker both present and this quarter had the highest number of referrals from the hospital in the whole three year period (154).

Gap – despite the increase observed in the number referred from hospital to alcohol treatment there remains a gap between the numbers of people admitted to hospital with an alcohol condition (1,397 -alcohol specific patients in 2013/14 which does not include patient's admitted with non-specific conditions) and the number who take up the offer for a referral into alcohol treatment (430 in 2013/14[122]).

This shows there is a lot more work that can be done to continue to increase referrals. Activity observed in Q1 2014/15 suggests continuing with the current system referrals are likely to be over the 500 mark for the first time in 2014/15. There are however alternative systems in place nationally, which if implemented, may have greater impact (increase referrals faster).

How do ALN operate in other areas?

The ALN role is not unique to Sheffield but the operational model is. Other models are team based (the majority), operate on all hospital wards, have different clinical specialists undertaking the role, have different operating hours, have A&E presence and some deliver the service to those who are vulnerable, which includes alcohol misuse but also mental health and substance misuse, for example…

- Rotherham General Hospital has recently introduced a team of five alcohol specialists (hepatologist and nurses), headed for a hospital with half as many beds as Sheffield to serve the whole hospital.
- Chesterfield has a Rapid, Assessment, Intervention and Discharge (RAID) model, a team deliver an integrated 24/7 liaison psychiatry service for all ward areas including A&E. The team is multi-disciplinary, identifying, supporting, assessing and referring vulnerable patients (mental health, drug and/or alcohol misuse) for specialist support.

The hosting of the service differs by areas however the majority are by the same trust as the hospital in which they operate. In Sheffield this has been commissioned differently with a separate trust operating the ALN to the hospital in which they operate. This was mainly due to the initial issues with recruitment.

[122] Assuming that 430 were all unique individuals.

- It would be useful to understand the <u>funding arrangements of other models in other areas</u>, for example are they funded by the Acute Trust, the CCG / QIPP (Quality Innovation Partnership Programme) or LA?

<u>Gaps</u> –

- **Given that the role has operated for a number of years, it is worthwhile considering a review of the current model. Is the aim of the model to increase referrals into alcohol treatment in the community or is it to reduce length of bed stay, costs paid to the hospital and reduce further admissions. These issues are all inherently connected and future modelling needs to bear all these issues in mind.**
- **Given that general alcohol prevalence statistics suggest that at least 10% of the adult population drink at higher risk levels, then in a hospital of around 2,000 beds this would suggest around 200 potential patients with alcohol problems who could receive/ benefit from specialist alcohol interventions are in hospital at any one time. It is likely that the 200 is an under estimation because 1. We also know that patients who are drinking at higher levels are more likely to have health issues as a result of their drinking, 2. It does not factor in those drinking at increasing risk levels and 3. Binge drinking patients. Therefore one would expect if the current service expanded (bigger team, more wards and cover both hospitals) then the number of annual referrals to community treatment would increase.**
- **The ALN role does not cover 100% of either hospital and operates differently in NGH to RHH. What role should the ALN have at RHH given that the ward it operates on will relocate to NGH in autumn 2014 and should it differ to that of NGH?**
- **There are low referrals to SEAP from wards where the ALN is not present despite the guidelines on how to refer *'Cessation of drinking for adults with alcohol use disorders'*. Is it the role of the ALN to undertake this work or is it the role of each ward, and therefore should the referral pathway be promoted more widely?**
- **There is no formal referral process between A&E and the ALN. How can this change?**
- **If the ALN role was not present (performance from 2013/14 shows referrals reduced when the model changed for 6 months) then who would identify and refer into treatment routinely from the hospital and how could this be monitored?**

The Alcohol Strategy expert groups will consider these gaps and discuss possible actions to address them.

Chapter 8 - Alcohol Related Crime and Anti-Social Behaviour

Alcohol and crime is complex and this section addresses a number of different factors; the effects of alcohol consumption and the perpetration of crime, the effects of alcohol consumption by those who become victim for crime on the perpetrator, the location of where crime takes place, the times when crimes occur and the type of crimes committed.

Alcohol and Crime are part of the data recorded annually by Local Alcohol Profiles for England.

Sheffield LAPE[123] data shows the following rates of alcohol related crime

	SHEFFIELD		Leeds		Birmingham		Liverpool		Manchester		Newcastle		Nottingham		Bristol	
Indicator	Measure	National	Measure	National	Measure	National	Measure	National	Measure	National	Measure	National	Measure	National	Measure	National
(18) Alcohol-related recorded crime	5.37	200	6.52	251	7.08	269	6.48	248	8.97	301	5.18	187	9.74	309	8.08	290
(19) Alcohol-related violent crime	2.6	93	3.82	195	4.59	250	3.93	205	5.39	280	3.56	176	7.09	318	5.57	287
(20) Alcohol-related sexual offences	0.08	69	0.15	267	0.15	262	0.14	245	0.22	322	0.12	198	0.2	313	0.17	292

In Sheffield LAPE reports the rate of:-

- Alcohol recorded crime is 5.37 per 100,000 people (second of the eight core cities), national rank = 200/326.
- Alcohol-related violent crime is 2.6 per 100,000 people (first of the eight core cities), national rank = 93/326.
- Alcohol-recorded sexual offence is 0.08 per 100,000 people (first of the eight core cities) national rank = 69/326.

Local Sheffield information provided by South Yorkshire Police is discussed first for crimes and secondly for all incidents.

Alcohol related crime - A crime is where a person was then charged with an offence following a police incident; therefore these crimes are also included in the incident figures.

The number of crimes associated with alcohol misuse has reduced in the last three years, from 2,791 in 2011/12 to 2,238 in 2013/14, a reduction of 20%, 553 alcohol related crimes (see table 28).

Table 28 Alcohol related crimes and incidents.

	2011/12	2012/13	2013/14
Incidents	4482	5188	6368
Crimes	2791	2381	2238
% of incidents that are crimes	62%	46%	35%

This means that the proportion of incidents that become crimes has reduced over the last three years, with crimes accounting for 62% of the police incidents in 2011/12 compared with 35% in 2013/14. Central (851 a reduction of 22%), North East (430, a reduction of 15%) and East (282, a reduction of 36%) were the highest wards for alcohol related crimes.

Central (646), Burngreave (129), Firth Park (124), Walkley (107) and Southey (105) were the top five areas for alcohol related crimes in 2013/14.

Type of alcohol related crime committed

The details of 1,387 alcohol related crimes were available for 2013/14, of these the most crimes were for assault or common assault (939). The table 29 below shows that there are a number of crimes associated with weapon possession or physical wounding with or without intent, which together total 231 crimes (wounding without intent, 105, 65 for possession or intention to use a weapon in a public place and 61 were for wounding with intent to do grievous bodily harm). Public order offences (99) were forth in the list.

[123] http://www.lape.org.uk/

Table 29 Types of alcohol related crime

Crime	Volume
ASSAULT	702
COMMON ASSAULT	237
WOUNDING OR INFLICTING GRIEVOUS BODILY HARM WITHOUT INTENT	105
PUBLIC ORDER	99
POSSESSION OF / THREATEN WITH AN OFFENSIVE WEAPON (KNIFE, FIREARM)	65
WOUNDING WITH INTENT TO DO GRIEVOUS BODILY HARM	61
HARASSMENT	52
RACIALLY OR RELIGIOUSLY AGGRAVATED	39
CRUELTY TO AND OR NEGLECT OF CHILDREN	11
THREATS TO KILL	10
OTHER	6

Alcohol related Incidents - Not all incidents become crimes (as discussed above) and this section looks at all recorded police incidents recorded 'flagged' as alcohol related.

In 2013/14 there were 6,368 alcohol related incidents which was a change of 22.7% or an additional 1,180 more incidents on the previous year (for full details see Table 30). During 2013/14 there were a total of 202,910 incidents reported to the Police in Sheffield which was an increase of 1.9% (or 3,959 incidents) on the previous financial year (2012/13); therefore alcohol related incidents have increased more in the year proportionally than all police incidents.

Table 30 Alcohol related incidents

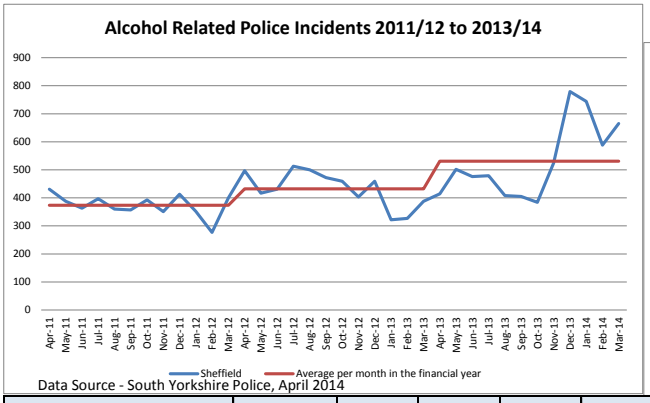
	2011/12	2012/13	2013/14	Change in the number of incidents between 2012/2013 and 2013/14
Total reported incidents in Sheffield	200,200	198,951	202,910	3,959
Total reported alcohol related incidents in Sheffield	4,482	5,188	6,368	1,180
Percentage change on the previous year		15.8%	22.7%	
% of alcohol related incidents	2%	3%	3%	
Data Source: South Yorkshire Police, April 2014				

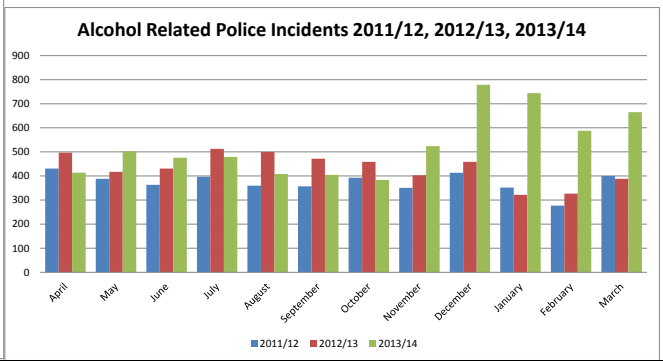
Graph 6 shows the trend in alcohol incidents experienced over the last three financial years, with activity showing a significant increase in the latest financial year between December 2013 and March 2014.

There was an average of 553 alcohol related incidents per month during 2013/14 compared to 432 in 2012/13 and 374 in 2011/12.

In the last three years, December is the only month which on all three occasion has been higher than the monthly average for the year; Table XXX shows the number of alcohol related incidents by month, with the top three highest months of the year highlighted in blue (the highest is in dark blue). The highest month is not the same in any of the three years these were as follows: - April 2011, July 2012 and December 2013, however in the three year period April, December and March have each been in the top three on two occasions.

Graph 6





Data Source - South Yorkshire Police, April 2014

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average per month
2011/12	431	388	363	397	360	357	393	351	413	352	277	400	374
2012/13	497	417	431	513	500	472	459	403	459	322	327	388	432
2013/14	414	502	476	479	408	405	384	524	779	744	588	665	531

Yellow shows the months where the activity is higher than the average per month for that financial year

Alcohol Related Incidents by Ward

The top three wards for the last three financial years for alcohol misuse related incidents are Central, North East and East wards (see table 30). All three have experienced an increase in incidents between 2012/13 and 2013/14, with Central experiencing the highest numbers and percentage, with a total of 2,101 incidents recorded in 2013/14 and an increase of 28% on the previous year. North East ward had 1,360 recorded alcohol related incidents in 2013/14 (18% increase) on the previous year and East had 1,061 in2013/14 (17% increase). South West was the only ward that remained statistically the same and there was no ward that had a reduction.

Table 30 Alcohol related incidents by ward

	Annual Total			Change between 2012/13 to 2013/14	
Area	Total 2011/12	Total 2012/13	Total 2013/14	Number of incidents difference	% change
Sheffield	4482	5188	6368	1180	22.7%
Central	1526	1641	2101	460	28.0%
North East	883	1146	1360	214	18.7%
East	721	908	1061	153	16.9%
South East	500	555	667	112	20.2%
South	336	429	622	193	45.0%
Northern	367	348	395	47	13.5%
South West	149	162	161	-1	-0.6%

Of the one hundred neighbourhoods in Sheffield, the top with the highest number of alcohol related incidents were Central, Burngreave, Darnall, Southey and Firth Park five (see table 31), with the top three remaining the highest ranked over the last three years. Of the top five in 2013/14 Southey experienced the greatest increase proportionally with an increase of 44% and has moved from being ranked 8 out of 28 to 4 out of 28 between 2012/13 and 2013/14.

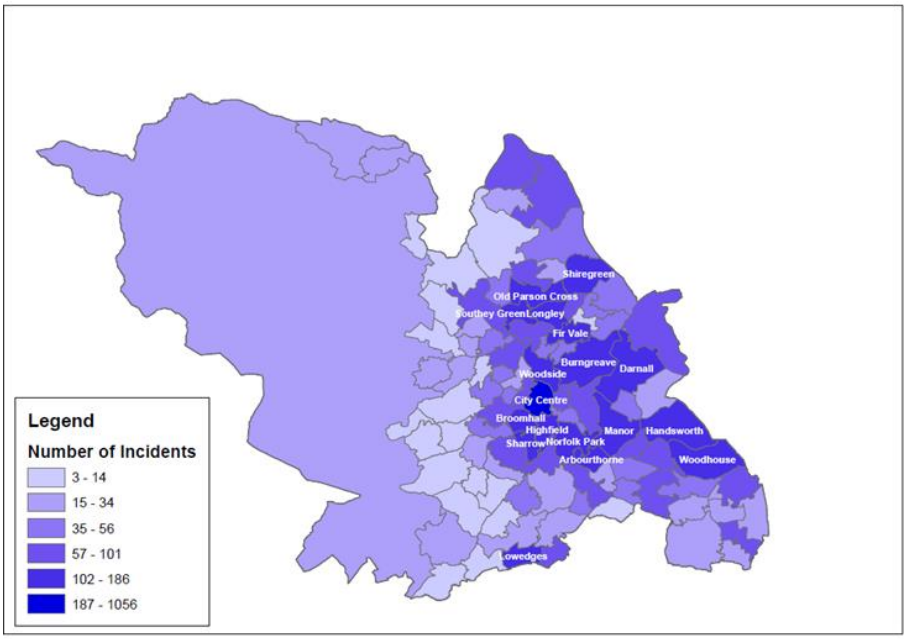
Table 31 - Alcohol related incidents by neighbourhood

	Annual Total			Change between 2012/13 to 2013/14		Rank		
Area	Total 2011/12	Total 2012/13	Total 2013/14	Number of incidents difference	% change	Rank in 2011/12	Rank in 2012/13	Rank in 2013/14
Central	1057	1202	1553	351	29.2%	1	1	1
Burngreave	296	459	528	69	15.0%	2	2	2
Darnall	231	258	366	108	41.9%	3	3	3
Southey	209	212	305	93	43.9%	4	8	4
Firth Park	197	256	303	47	18.4%	6	4	5
Manor Castle	182	230	252	22	9.6%	8	6	6
Woodhouse	186	202	252	50	24.8%	7	9	6
Arbourthorne	158	244	251	7	2.9%	10	5	8
Beauchief & Greenhill	117	135	246	111	82.2%	17	14	9
Shiregreen & Brightside	181	219	224	5	2.3%	9	7	10

Map of Sheffield by neighbourhood.

The map shows each neighbourhood in Sheffield, with the darker the colour, the more alcohol related incidents reported in 2013/14. Therefore the top five listed above are all in dark blue, showing clearly the city centre as the main area for alcohol related incidents, but also showing that alcohol related incidents are dispersed within communities with in the north and east and south of Sheffield.

Alcohol Related Incidents Recorded by South Yorkshire Police 2013-14



Alcohol related incidents (by type of Incident) in 2013/14

The most frequent type of alcohol related crime was for anti-social behavior, which accounted for 30% of all alcohol related crime in Sheffield, or a total of 1,941 incidents in 2013/14 (ASB incidents are listed as Nuisance, Personal and Environmental and are shown in blue on table 32).

Table 32 Alcohol related incidents by type of incident

		Result class						
	RESULT SUBCLASS	ANTI SOCIAL	CRIME	CRIME RELATED	PUBLIC SAFETY	TRANSPORT	Grand Total	% of total
1	NUISANCE	1463					1463	22.3%
2	DOMESTIC NON CRIME				1461		1461	22.3%
3	CONCERN/COLLAPSE/ILL/INJ				1351		1351	20.6%
4	VIOLENCE AGAINST PERSON		486	89			575	8.8%
5	SUSP CIRCS / INSECURE				481		481	7.3%
6	PERSONAL	438					438	6.7%
7	ROAD RELATED OFFENCE					201	201	3.1%
8	CRIMINAL DAMAGE/ARSON		94	6			100	1.5%
9	CIVIL DISPUTE				86		86	1.3%
10	THEFT/HANDLING		70	5			75	1.1%
11	ABANDONED CALL				55		55	0.8%
12	ENVIRONMENTAL	40					40	0.6%

However the second highest alcohol related incidents were domestic non-crime incidents (1,461 or 22%), the third for Concern for another (1,351 or 21%), forth was for violence against a person (575 or 9%) and the fifth for suspicious circumstances/ insecure (481 or 7%).

Alcohol related incidents – by day of the week

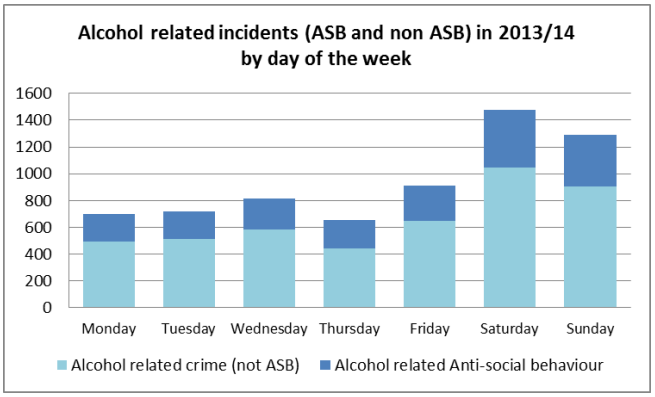
The day of the week is important to understand, as this connects with the night time economy, the pressures of A&E, bars and police time.

The majority of alcohol related incidents take place on Friday, Saturday and Sunday, with just under 6 out of 10 incidents (57%) taking place on these three days of the week, see table 33 and graph 7. Saturday is the day most likely for an alcohol related incident to happen, accounting for 23% (nearly one in four) incidents.

Table 33 Alcohol related incidents by day of the week

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Alcohol related crime (not ASB)	493	509	584	438	647	1043	904
Alcohol related Anti-social behaviour	205	208	233	213	262	434	386
% of alcohol related crime by day of the week	11%	11%	12%	10%	14%	23%	20%

Graph 7 Alcohol related incidents by day of the week

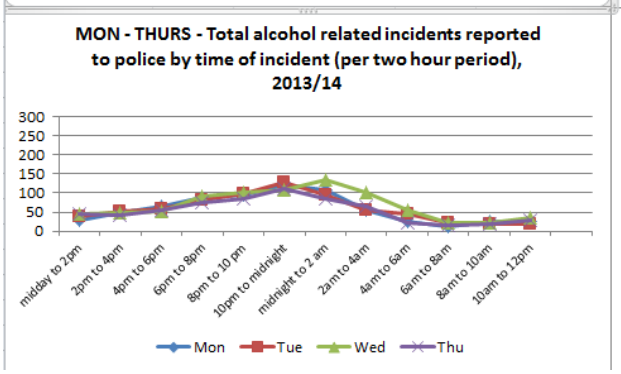


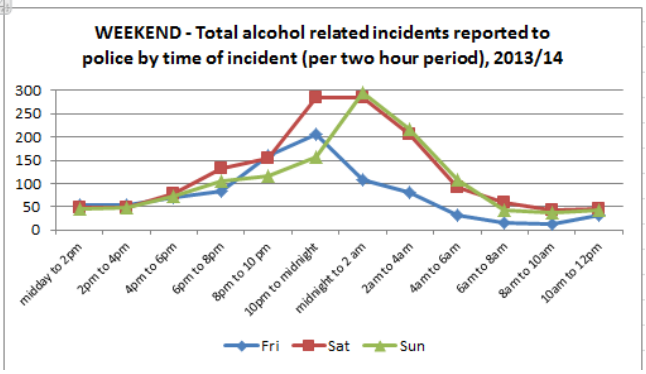
Time of day

The majority (46%) of alcohol related police incidents took place between 8pm and 2am. The majority of incidents on a Saturday (the most frequent day for incidents) took place between 10pm and 2am, whereas on a Sunday the majority takes place between midnight and 4am. On a Friday night the most frequent time period was 10pm to midnight (see graph 8). On weekdays (Monday to Thursday) 10pm to 2am was the most frequent time of day for alcohol related incidents; however note the graphs do show a difference in volume of incidents for this time period compared with the same time period at the weekend.

Graph 8

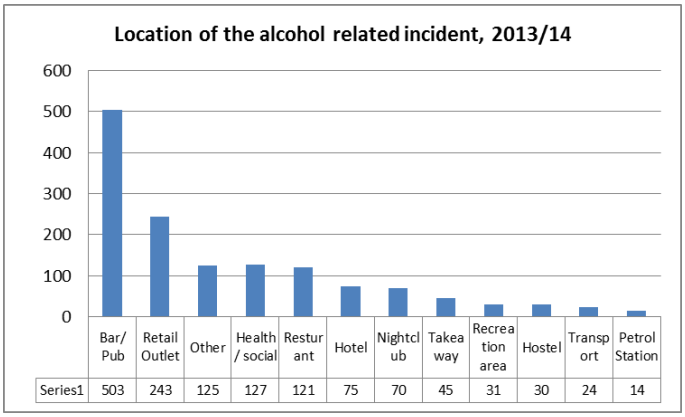
	Total and % per two hour period	
midday to 2pm	307	5%
2pm to 4pm	347	5%
4pm to 6pm	452	7%
6pm to 8pm	657	10%
8pm to 10 pm	813	12%
10pm to midnight	1111	17%
midnight to 2 am	1111	17%
2am to 4am	779	12%
4am to 6am	377	6%
6am to 8am	190	3%
8am to 10am	181	3%
10am to 12pm	234	4%





Location

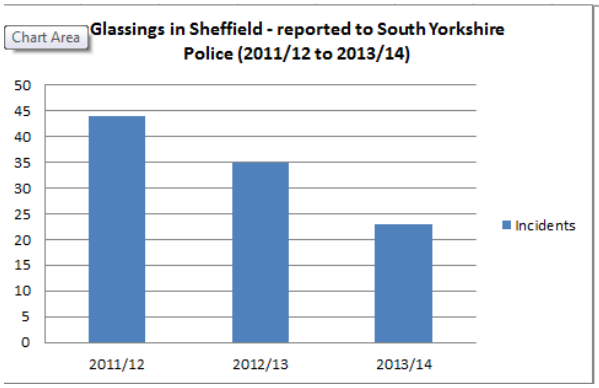
5,079 incidents took place at a recorded address (e.g. residential property), however the main 'type' of location for reported incidents outside of the home was a bar or club reporting 503 incidents, followed by retail outlets (Banks, shops, betting shops), 243 incidents and health / social reported 125 incidents (with the majority of these being the northern general hospital, with 89 incidents, see graph XX.



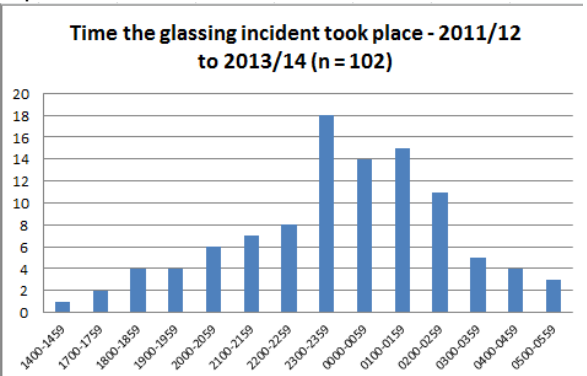
One of the requirements of the Best Bar None scheme is to encourage bars and pubs to report alcohol related incidents to the police, therefore the fact bars and clubs is the highest category is unsurprising, particularly given these are the main public areas where people consume alcohol. To put in further context 179 bars/pubs reported the total of 503 alcohol related incidents, which is an average of 2.8 incidents per bar/pub, however 129 had less than this, with either two or one incident reported.

One of the alcohol related crime incidents that has been closely monitored in the last three years is the number of glassing related incidents (where a person is a victim of being hit by a glass/bottle) that take place in the night time economy. Poly-carbonated glasses were distributed widely to bars and nightclubs in Sheffield city centre during 2010/11 and a second distribution exercise was undertaken in 2012/13. Glassing related incidents have reduced from 44 in 2011/12 to 23 in 2013/14, see graph 9.

Graph 9



Graph 10



The majority of incidents take place on Friday, Saturday and Sunday evenings (83%) between the hours of 10pm and 3am (66%), with one in five (18%) taking place between 11pm and midnight. The victim is generally young (58% aged 18 to 29 years old) although one in five were aged 40 to 49 years old and just over half are male victims (57%).

Criminal Justice routes into alcohol treatment

Alcohol Treatment Requirements (ATRs)

ATRs are for individuals with severe alcohol misuse issues/dependency, and a high risk of re-offending as a result of their alcohol use. ATRs are a disposal option for the courts which allocates community sentences with a requirement for alcohol treatment. DACT commissioned the treatment allowing access to appropriate and needs based sentencing. The Probation Officer identifies through assessment of their client a suitable alcohol misuse level, as well as a re-offending risk score through OASYS. This takes place whilst the individual is waiting to appear in court - they are referred to the Tier 2 alcohol provider (SEAP) who in reach into probation and court. They are assessed for suitability for an ATR and if deemed appropriate this will be recommended in the offender manager's pre-sentence report. The magistrate may then choose to allocate an ATR. Provided by the PSI team, turnaround is within five working days, the ATR provider is responsible for tracking the individual through their treatment sentence and ensuring they are compliant with their appointments.

In Sheffield there has been no local research undertaken to understand the benefits to those individuals who complete an ATR, however a report by Cheshire probation service[124] found it had a positive impact. They found that the average AUDIT score halved from 30 to 14, 69% reported a reduction in frequency of drinking, including a reduction from 86% to 24% drinking four or more times a week. Three quarters (77%) stated the amount consumed reduced and those drinking ten or more drinks on a typical drinking day dropped from 66% to 7%. 85% rated their health as either healthy or very healthy, with 67% happier with their lives, however during the duration of their ATR psychological health issues arose with just under half experiencing experienced anxiety or depression (49%) and stress (46%).

The ATR activity and completions target are set by probation annually. In Sheffield the targets set over the last three years would have meant a total of 510 ATRs to start and half were to be completed. There has been a significant under performance against this target with 285 PSI treatment packages starting and 158 completions (55% completion rate), see table 34. In the last year 95 started (48% of the annual 200 target) and 55 completed an ATR.

Table 34 – ATR activity 2011/12 to 2013/14

Alcohol treatment Requirements	2011/12		2012/13		2013/14	
Number of commencements target	110		200		200	
Number of commencements	79	*72%*	111	*56%*	95	*48%*
Number of successful completions target	56		104		104	
Number of successful completions	43	*77%*	60	*58%*	55	*53%*

The ongoing issues with ATR have been discussed widely in DACT quarterly performance review meetings with the provider, the provider has met regularly with the probation and the Criminal Justice Alcohol Group (attended by DACT, the provider and probation) has been a forum to raise and address issues.

[124] *Evaluation of the use of Alcohol Treatment Requirements and Alcohol Activity Requirements for offenders in Cheshire, 2009/10*, Liverpool John Moore University, Centre for Public Health http://www.cph.org.uk/wp-content/uploads/2012/08/evaluation-of-the-use-of-alcohol-treatment-requirements-and-alcohol-activity-requirements-for-offenders-in-cheshire.pdf

The issues appear to be as follows:-

- The need to increase the number of individuals receiving an ATR as part of their community sentence, this includes training of magistrate staff which has not taken place in 2013/14. Previous experience of such training has resulted in more ATRs being given.
- Of the 45% who failed to complete treatment the proportion who failed to engage with treatment and the proportion who failed due to an unrelated treatment reason (re-offended and returned to prison) is not known and this will be reported for the first time in 2014/15.

Fixed Penalty Notice (FPN)

The FPN seeks to provide a pathway for those committing minor alcohol related crime and nuisance offences with an opportunity to address their drinking and subsequent behavior. A FPN are issued to individuals who commit a minor alcohol specific offence or alcohol related (Public Order Act Section 5), i.e. drunken disorderly. When a FPN is received the individual can choose between paying a fine for their offence of £80 and the alternative of attending one session (previously two) of alcohol treatment (assessment, a brief intervention (BI), education and information on alcohol). The session must be arranged and attended within 28 days of the notice being issued, and the alcohol provider and ticketing office communicate about completions or non-compliance.

FPN offers an opportunity for health professionals to engage and educate a cohort of people who have misused alcohol, who may not necessarily interact and engage with treatment services. The aim is that these individuals become more aware of their drinking and change their drinking habits to reduce the short term health impacts of drinking to excess (risk of hospitalisation, accident, injury, commit or become a victim of crime) and for some reduce the long term health impacts of drinking to excess.

In the last three years a total of 733 FPNW have resulted in the individual taking up the offer of alcohol support (brief interventions), which is potential alcohol education engagement with 733 who may not necessarily have received such intervention without this enforcement. In the last financial year 257 individuals elected to book an appointment, with 87% (224 individuals) subsequently attending and receiving a BI within the required period, see table 35.

Table 35 shows the FPNW activity between 2011/12 and 2013/14.

Fixed Penalty Waiver	2011/12		2012/13		2013/14	
Number of FPN Waiver sessions selected	237		239		257	
Completions	197	*83%*	215	*90%*	224	*87%*

There is a gap in information as:-

- The number that requires alcohol treatment and subsequently starts alcohol treatment as a result of this intervention is unknown.
- The number of repeat offenders is unknown, although if an individual has received three, then they are charged rather than offered the disposal.

FPNW are continuing in 2014/15 and will be included in the alcohol treatment contract.

Conditional Bail

Alcohol conditional bail was implemented during 2013 following the Fixed Penalty Notice Waiver scheme.
The criteria for alcohol conditional bail is offences which are alcohol related but more serious than those for which a fixed penalty notice is applicable, for example, drink driving and assault (not domestic abuse or sexual assault). On being bailed from the custody suite, the offender is advised they will be booked an appointment to attend the commissioned alcohol treatment provider for an assessment. This assessment will ascertain whether their offending behaviour is intrinsically linked with an alcohol misuse issue – if it is, and the individual is assessed as needing further interventions, the assessor will make this recommendation to the court and when the case is heard the individual can be given sentence requirements such as attending alcohol treatment interventions to prevent further offending. The scheme allows alcohol related to be identified and support the process by which alcohol misusing offenders can be given the opportunity to address the root cause of certain offending behaviour.

Chapter 9 - The Night time economy, the safe sale of alcohol and a safe drinking environment

The National Alcohol Strategy explains the challenge faced nationally that drills down to local areas, with Sheffield no different to any other major city. How to create a safe drinking environment, build a robust and entertaining night time economy that draws people and businesses into the city thus boosting the local economy whilst addressing the minority that misuse alcohol in the same environment.

Initiatives such as Purple Flag, Best Bar None and the update to the Licensing Act (2003) applied locally work to create a safe drinking environment including the safe sale of alcohol, partnership work in the city-centre between major agencies – the police, safer neighbourhood officers, the city council, trading standards, safeguarding, DACT and health services work together to manage and reduce the levels of alcohol related crime, health issues and harm caused by the effects of alcohol misuse.

In 2011Sheffield was the first city in Yorkshire to be awarded Purple Flag status. This is a national status given to *'town centres that meet or surpass the standards of excellence in managing the evening and night-time economy'*[125]. The assessment cited joint working between agencies including Sheffield DACT, for example working on alcohol interventions and BBN scheme, as an example of best practice from the assessment, with the panel commending Sheffield for its *'co-ordinated efforts…through partnership, and the development of a vision and its implementation through planning, policy, strategy and action is commendable'*[126]. Purple Flag status is time limited, lasting a few years; therefore Sheffield is in the process of applying for a renewal of their status in 2014.

Best Bar None (BBN)[127] - Sheffield's BBN scheme is now in its sixth year (awards to be announced on 5 February 2015) and currently has 59 accredited premises across the city centre, Ecclesall Road and Sharrowvale Road. The scheme has been instrumental in raising awareness of safe licensing practice across the city.

Despite a number of premises closing down or removing themselves from the scheme for various reasons, a number of new premises joined and 2014 had the most number of applicant and accredited premises, meaning the scheme is still competitive, relevant and allows for learning for those running new premises within the night time economy of Sheffield.

New assessors were trained in the summer of 2013 which increased the pool of assessors available to the scheme. In 2013 there was also an app created for Sheffield BBN which is free to down load and directs the user to their nearest BBN accredited premises, promoting the use of safe premises within Sheffield for both residents and visitors. Sheffield's scheme was nominated for the most innovative scheme at the 2011 National Conference and was a runner up in this category.

Sheffield DACT is intending to run the scheme again for a sixth year in 2015/16 and will continue to use the contacts with BBN accredited premises to send out relevant drug and alcohol alerts, as well as domestic abuse and related information, into the night time economy to keep customers safe through licensed premises awareness.

Impact of the changes to the Licensing Act (2003)[128]

In April 2012 the 'Police Reform and Social Responsibility Act 2011' came into effect and this contained significant changes to licensing law that had been in place since the 2003 Licensing Act;

- **Temporary Event Notices –** there are now two kinds of TEN – 'standard' (submitted no less than 10 working days before the event) and 'late' (submitted no later than 5 working days before the event). Also in addition to local police, Environmental Health Departments may also object to TENs applications and can object along with them and the Licensing Authority.
- **Licensing Authority as a Responsible Authority -** The Licensing Authority (SCC in Sheffield's case) becomes a 'Responsible Authority' allowing them to comment on applications for new premises or variations to existing licences, regardless of any lack of other opposition of an application.
- **Persistent sale of alcohol to children –** The repercussions of a failed test purchase process have changed. Previously a premises licence holder was punished with a 3 month licence suspension and/or a fine up to £1k if there were three failed test purchases within a 3 month period or an option of 48 hour voluntary closure. The majority of premises chose voluntary closure in order to avoid appearing in Magistrates Court. The current rule is two failed test purchases in any three month period and the penalty can now be from £10k-£20k. The voluntary closure period can now also last from a minimum of 2 days to a maximum of 14 days.

[125] https://www.atcm.org/programmes/purple_flag/WelcometoPurpleFlag
[126] https://www.sheffield.gov.uk/out--about/city-centre/purple-Flag.html
[127] In discussion with Helen Phillips-Jackson, Sheffield DACT
[128] In discussion with Julie Hague, Safeguarding SCC and Tracey Ford Sheffield DACT

- **Health Bodies as Responsible Authorities –** this has been actioned so that Health Bodies are notified about new premises applications and can make representations against them. Any objection must be in line with current licensing objectives (prevention of crime and disorder, prevention of public nuisance, public safety and protection of children from harm). This has fallen to the Local Authority after the NHS reform and move of Public Health from NHS to LA settings.

These changes have been implemented across Sheffield, though data recording needs to be made and collated in order for public health to constructively input to licensing applications.

Sheffield has an established and effective approach to working with licensed premises to address and promote responsible drinking to protect the general public, including young adults and children. South Yorkshire Police, Trading Standards and Children's Safeguarding services provide training for bar, restaurant and retail staff working in licensed premises.

Training covers the following:- The law in relation to underage/proxy sales, possible consequences for the business, Impact of irresponsible adult drinking (safe and suitable family environment as per licensing act), impact underage drinking has on child/young people's behaviour, physical development, personal safety and health, impact irresponsible/illegal drinking can have on community, consequences (for business and public safety) selling illicit or counterfeit alcohol, false ID – what we are doing in Sheffield/how to respond if you are a licensee and CYP use it to try to buy alcohol.

In the last three years (2011 to 2013) 597 members of staff have been trained[129] and nearly 350 premised have been visited, see table 36 for full details. Central has the highest number of individuals, who have been trained, which is not surprising given it covers the city centre with the north SNA second with 152 people trained. In addition to this around 65 people have been trained in retail outlets, e.g. Tesco's and the Co-op.

Harm Reduction services have also provided overdose prevention training to door staff.

Table 36 – The total licenced premises and number of individuals trained by South Yorkshire Police, Trading Standards and Children's Safeguarding services between 2011 and 2013.

		2011	2012	2013	Total trained in the last 3 years
	Premises visited	77	108	162	347
	Total people trained	105	251	241	597
Total trained divided into SNA	Central	20	83	79	182
	North	35	68	49	152
	South West	25	34	48	107
	South East	15	42	31	88
	East	10	24	34	68
Information provided by Sheffield Safeguarding Children Board					

One of the challenges faced is the regular turnover of staff in licenced premises; therefore keeping premises aware and up to date with training is paramount. The training is delivered directly by safeguarding, police and trading standards, this face to face training also works as a way of brokering positive relations between premises and the Local Authority, so if and when issues arise there is a trust already established.

Training is offered to all new licenced premised, it is made a condition of some licensed contracts, offered to those providing and promoting events, and can be an action as part of a plan or warning following a complaint on a premise (e.g. sales of alcohol to those who are underage).

Safeguarding provide support for risk assessments which owners can undertake on their premises to promote responsible drinking. There is also a Children's charter that has been created by the partners in Sheffield, which is a poster that promotes six key messages that challenge irresponsible behaviour and promote social awareness. Messages include don't buy for those under age and don't leave drinks unattended for others to drink (those younger). The poster is displayed in licensed premises citywide, mainly voluntarily although as a Best Bar None criteria it is activity encouraged for those premises in the city centre and on Ecclesall Road who enter the scheme. It is also uses as a condition of some licensing premises or action plan (where applicable).

For those premises where complaints are made regarding irresponsible drinking, (this can come from a member of the public, a member of staff, or a partnership organisation) there are a number of steps taken to address the

[129] Information supplied by Julie Hague, Safeguarding Children's Service

situation with the premises. Advice and training are provided, if things don't change then an action plan or warning can be given, and where irresponsible practice (e.g. licenced conditions are breached) legal action can be taken.

Response to major events - There is a policy written by the Police which is applied for all major events, e.g. Tramways, Fright Night, Mosborough Music Festival). There is a pack provided to the event organisers, with training offered and includes the Safeguarding children and young people events guidance, including risk assessment which is something unique to Sheffield. Conditions of the alcohol licence are made for many high profile events which includes attending the training. The licence condition therefore means that the safeguarding children board has the opportunity to influence how the event operates, so that systems are in place to respond to irresponsible or illegal drinking (under 18's and adults who drink irresponsibly), and to respond to young unaccompanied people who arrive in drink at events and need to be responded to because they are either ill or behaving in a way that makes them vulnerable, through drink or drugs.

The risk assessments that event managers do proactively puts in place systems to promote safe, sensible drinking and a safe environment for children and young people at events.

Premises in the locality of the event are notified to raise awareness of proxy sales, issues with excessive drinking and young people pre-loading and ASB providing advice on how to deal with such situations. At such large events and other smaller community DACT commissioned alcohol treatment providers are often present, promoting safe drinking and advertising treatment options available where required.

There are initiatives and processes in place to address the sale of illegal alcohol and the sale of alcohol to those who are underage.

Illegal alcohol can be very dangerous when consumed as it contains ingredients often used to make industrial alcohol and not suitable for human consumption. Indeed there was a national news story where the contents of the illegal alcohol in a factory where illegal alcohol was being produced caused a large fire. Often illegal alcohol is often difficult to track / identify as off licence owners are reluctant to identify suppliers who are effectively keeping their identity unknown. There are particular concerns that the lure of illegal alcohol will be greatest to those must vulnerable for example, the street drinking population and students of which there is a large population in Sheffield who will be seeking cheap alcohol due to budgetary constraints.

Trading Standards in Sheffield discover illegal alcohol during test visits to off licence premises; they have found a growing number of outlets selling such products since 2012/13. During 2012/13 DACT provided Trading Standards with a one off payment to further the work into both identifying and seizing, and raising awareness of the risks of illegal alcohol among both the consumer public and those running off licences. This was done through increased inspections, awareness materials produced and disseminated throughout Sheffield warning of the dangers of using illegal alcohol.

In early 2014 DACT was notified of a death which had been attributed to illegal alcohol. Work is on-going to address its presence both in off licence premises and being sold outside of retail facilities.

Underage drinking is being tackled in a current pilot scheme 'fake IDs' to identify those who are underage entering adult venues using fake identification documents (ID), the aim is to work with these individuals to educate them on the risk associated with alcohol use, the risks of being in adult only venues and the potential consequences of their actions putting businesses at risk of losing their alcohol license. There were over 300 ID's seized in 2013[130]. Up to 2012 we piloted a number of educational workshops as part of a restorative justice system. They took place on Saturday mornings and made children and young people aware of the risks to themselves (legal consequences and personal risk of going in clubs/drinking alcohol) and made them aware that they were putting licensees/local businesses at risk by acting illegally. The pilot ran for just over a year and about 60 young people attended the workshops.

The workshops were reformed in 2013 to make better use of agency resources and instead of the workshops the system is now that we refer young people, if suspected of using false ID, to information on the safeguarding children service website (https://www.safeguardingsheffieldchildren.org.uk/welcome/information-children-families-public/information-children-young-people/false-id.html) and they are then required to contact the police to retrieve their documentation. The information on the safeguarding website comprises text and a short film that was made by a group of young advisor partners, who thought the film would be the best format to illustrate key risks and issues of trying to use false ID to get into an adult venue. In addition to this, an awareness campaign was launched via Sheffield Futures aimed at discouraging young people from trying to use false ID. The campaign materials were

[130] Information provided by Julie Hague, Licensing Project Manager, Sheffield Safeguarding Children Board

designed in consultation with a group of young advisors (to make sure it was relevant to its target audience and youth proofed) and use social media networks via schools/youth organisations to distribute the attached flyer.

Test Purchases are undertaken in outlets where there is suspected underage sales, such action is taken following any complaint on a licensed premise, a request by the premise which may come as a quality assurance process (again the safe sale of alcohol, including age appropriate sales is a Best bar None criteria) or a new premises, or where there has been a failure in the past. Premises that fail have three months to improve prior a retest (including the offer of training); a second failure results in a police closure order, over a limited period. A third failure in 12 months results in a license review.

The partnership of the Police, Trading Standards, Safeguarding and DACT are all members of the Substance Misuse steering groups. These are meetings held in a number of wards in Sheffield where alcohol has been identified as a priority for the area.

The DACT Communities and Development Officer is a key link into the Safer Neighbourhood Areas in Sheffield. The specific task is to lead on and address all issues regarding drugs and alcohol use, which includes being a key to linking communities, partners and treatment services together.

There are seven Safer Neighbourhood Areas (SNAs), each has a Safer Neighbourhood Team and is co-ordinated in partnership with South Yorkshire Police and Police Community Support Officers (PCSO's). It is an established network of partnership working and six of the seven SNAs have a Substance Misuse Group (SMG). These are Northern / North East, East, South East, South / South West, Central (covering Hillsborough and Walkley wards) and the City Centre.

SMGs are meetings held specifically to address alcohol (and drug) issues in the local communities. They are chaired by the DACT Communities and Development Officer with partners in attendance, including SNA officers, safeguarding, trading standards, the police and treatment providers (adult and young people).

Alcohol related issues addressed can include street drinking, underage drinking, anti-social behaviour and the illegal sale of alcohol. Often SNAs have one or a number of these issues to address at any one time. Specific actions are agreed at each meeting. Sometimes issues arise simultaneously in a number of areas or will be addressed in one community and then arise in another, so actions taken on one area can be and are often applied in other areas. It is also at SMGs that ideas for project initiatives arise, are discussed, pilots started and sometimes launched.

There is a gap in that the Broomhill ward is not part of the Central Substance Misuse Group, and is not covered by any of the other Substance Misuse Groups, which is a potential issue given that it is known for its high level of binge drinking, given the student population.

In Sheffield there are three Designated Public Place Orders (DPPO) in place, https://www.sheffield.gov.uk/business-economy/licensing/general-licensing/alcohol/designated-public-place-orders-DPPOs.html. DPPOs can be put in place where there are known issues with street drinking or alcohol related anti-social behaviour. A thorough consultation process including the public, determines the need and geographic area for the order with requests signed off by the licencing committee. Becoming a DPPO area means that individuals cannot drink alcohol in public areas, anyone found drinking alcohol in such areas can be given a Penalty Notice for Disorder (PND) £50 or be arrested and face prosecution.

The DPPOs in Sheffield are located in the City Centre which covers the whole areas of the inner city ring road, Woodhouse (since 2011 and agreed to extend until 2015) and Shiregreen (since 2011).

The SNA Inspectors have told the DACT that the DPPOs have been a significant tool in reducing anti-social behaviour and crime and disorder in the areas they have been introduced. In the city centre it helped to change attitudes, particularly in the night-time economy. There have been some recent issues, with reduction in officers, but also the relevant groups being more effective at getting round the legislation. However, work is on-going to help manage this.

The introduction on the DPPO in Woodhouse allowed Police and partners to change an entire culture of street drinking that had been prevalent in the village for many years. Police targeted those involved and handed out warning leaflets as well as offering support. A SEAP clinic was created in the village making access to support easier for those who needed it. Now there are very few incidents of street drinking in the village and the local community know it is not tolerated. Local businesses have seen an increase in takings and a local survey highlighted that the community was in support of the DPPO.

The key to the success of the DPPO in Woodhouse has been the partnership approach and providing support as opposed to law enforcement alone.

Street drinking – Similar to other cities, there is a known street drinking issue in Sheffield. 2014 has been a busy year for issues involving street drinkers in the city centre. No exact figures can be obtained, as the nature of incidents results in different recording headings being assigned to incidents on Police recording systems.

In addition with the issues taking place within the city centre it is difficult to separate problematic street drinking related incidents from those regarding the general night time economy which in itself is a separate matter. However all agencies, members of the business and residential community within the city centre have all agreed that 2014 has seen an increase in street drinking related disorder, particularly around the Devonshire Green area.

Recent joint patrols, between Drugs Staff, SYP and intelligence from a monthly Rough Sleeper Information Sharing Group (Partnership meeting chaired by Sheffield Housing and attended by all agencies working with most vulnerable in Sheffield) we know that what is commonly referred to as 'street drinking' population has become more homogenised into a wider more complex group of street populations, including drug users, rough sleepers and beggars.

There are a number of initiatives undertaken to address street drinking, which are continually reviewed and enhanced. There is a city centre 'sweep' of known squats and streets to identify and work with street drinkers. This is undertaken weekly by the Police and the street drinking service (SHSC), with both providing advice and support to address individual needs. A second initiative is located at the Archer Project, a project run and located in Sheffield Cathedral http://archerproject.org.uk/. The aim is to combat and reduce the level of anti-social behaviour in the surrounding area. A third relatively new project is again led by the police and is responding to a recent increase in street begging, who are also often street drinkers. Given the project is in its early stages, it is just getting established and may in the future result in further partnership work with established street drinking services.

The main partnership meeting to discuss street drinkers is the Vulnerable Person's meeting, where an average of 18 – 20 individuals are on the list for discussion at any one time. The meeting has been ongoing for a number of years but was recently changed and is now chaired by the Housing Independence Service (HIS), a key stakeholder. It is a forum where vulnerable individuals are discussed on a case by case basis with the aim of collating intelligence from a number of services who may be interacting with the person, known drinking associates, to understand their current status and identify how further support can be provided, including housing solutions, treatment opportunities and recovery initiatives. Given the relative infancy of the group it would be useful to review its effectiveness and client outcomes after it has been established for a period of time.

Chapter 10 - Alcohol Misuse - Diversity and vulnerabilities

Gender & Age
In Sheffield 67% of the people receiving treatment for alcohol are male and 33% female. This compares to 64% males and 36% females nationally.

The age group with the highest proportion of individuals in treatment locally is 45 – 49 years, for both males and females, with 20% of people in treatment falling in to this group. This is made up of 12% of the total treatment population being males in this age group and 8% females.

39% of the people receiving treatment for alcohol are males aged between 45 and 64, females between these ages make up 20% of the treatment population. Data reported by the Health and Social Care Information Centre (HSCIC)[131] states that adults aged 45 – 64 were most likely to report drinking alcohol in the last week than other age groups, with men in that age group drinking more than women, 71% and 59% respectively. Those aged 16 – 24 were most likely to report drinking heavily (more than 12 units for men and 9 units for women) at least once in the last week (27%), 26% of men and 28% of women.

Ethnicity & Nationality
85% of the Sheffield treatment population are white British in comparison to 81% of the overall Sheffield population. This also compares to 86% of the whole of the alcohol treatment population in England.

2% of the treatment population are other White, similar to the proportion in Sheffield, and 3% nationally. Other Asian, Caribbean, and African each represent 1% of the treatment population in Sheffield. All other ethnicities each make up less than 1% of the Sheffield treatment population. This is similar to what is seen nationally.

Religion
Data on a person's religion is only collected locally. Out of the alcohol clients who were asked the question in 2013-14, 37% stated that they were Christian, 1.6% Muslim, and 56% stated they were of no religion. 2% did not want to answer the question.

Sexuality
A person's sexuality is also only collected locally. Out of the people that were asked the question; 83% said they were Heterosexual, 1.7% were gay males, and 15% did not want to answer the question. Numbers for bisexual and lesbians were not reported due to the low number of people stating that this was their sexual orientation.

Disability
In 2013/14 26% of the Sheffield treatment population stated that they did have a disability.

Neighbourhood areas
Higher risk prevalence
Local PHE analyst teams have created local profiles for each of the 100 neighbourhoods using the higher risk prevalence data and binge drinking prevalence data[132]; see Appendix 2 for full data.

The data shows that the top five neighbourhoods with the greatest prevalence for higher risk drinkers in Sheffield were Endcliffe (15.2%), Crookesmoor (15.1%), City Centre (14.9), Highfield (14.6%) and Broomhill (14.5%).

Binge drinking prevalence
The six neighbourhoods in Sheffield with the highest prevalence of binge drinking were: - City Centre (41.1%), Crookesmoor (39.1%), Highfield (39.6%), Endcliffe (39.4%), Broomhill (37.5%) and Netherthorpe (37.5%).

The most seven wards[133] known for their levels of childhood poverty are Central, Arbourthorne, Burngreave, Darnall, Firth Park, Manor and South Green.

Burngreave is ranked in the top twenty wards with the highest prevalence rate for higher drinkers but does not fall in the top ten.

[131] Statistics on Alcohol, England 2014, Health and Social Care Information Centre, Published May 2014.
[132] Each profile gives a snapshot overview of key Health and Well Being indicators in a chosen Neighbourhood, with comparisons to Sheffield. This profile may be used for non-commercial purposes provided the source is acknowledged: Source: Sheffield Neighbourhood Health & Well-Being Profiles 2012, Public Health Intelligence Team, SCC. v1.1: 15th May 2013 https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/JSNA/health-and-wellbeing-across-sheffield/neighbourhoods-health-and-wellbeing-profiles.html
[133] The wards with higher than average child poverty levels are: Arbourthorne, Burngreave, Central, Darnall, Firth Park, Manor Castle, Southey, Walkley., The most up to date specific levels can be found at http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm

Burngreave and Darnall are in the top 11-20 neighbourhoods with the highest prevalence for top twenty for binge drinking.

	Alcohol: High Risk Drinkers (Age 16+), 2011				Alcohol: Binge Drinkers (Age 16+), 2011				Alcohol: Admissions for Alcohol-Specific Conditions (All Ages), 2011				Alcohol: Admissions for Alcohol-Attributable Conditions (All Ages), 2011			
	Numbe	% of adults (age 16+	LL 95% C	UL 95% C	Numbe	% of adults (age 16+	LL 95% C	UL 95% C	Numbe	DASR per 100,000	LL 95% C	UL 95% C	Numbe	DASR per 100,000	LL 95% C	UL 95% C
Arbourthorne	545	12.9	4.7	32.2	1500	30.2	25.8	34.9	155	830.3	703.9	972.8	444	2244.0	2036.4	2466.7
Burngreave	452	13.1	4.8	32.6	1303	32.2	27.6	37.3	91	627.4	501.5	774.7	319	2166.0	1922.6	2424.8
Darnall	726	13.0	4.8	32.4	2104	32.1	27.5	37.2	122	572.8	472.4	687.8	442	1900.9	1719.2	2095.9
Firth Park	160	13.0	4.8	32.4	457	31.5	27.0	36.5	12	210.0	108.0	367.5	83	1531.9	1213.9	1905.4
Manor	825	12.9	4.7	32.3	2322	30.9	26.5	35.8	240	852.0	746.6	967.9	724	2498.7	2317.0	2690.7
Southey Green	496	12.8	4.7	32.1	1361	30.0	25.7	34.7	157	912.8	774.8	1068.2	418	2347.5	2124.8	2587.0

Arbourthorne, Manor and Southey Green are in the top 11-20 neighbourhoods with the highest rate of alcohol admissions to hospital for specific conditions.

Manor is in the top ten of neighbourhoods with the highest rate of alcohol attributable admissions to hospital whilst Arbourthorne, Burngreave and Southey Green are in the top 11-20 neighbourhoods.

Only Firth Park is not ranked in the top 20 for any of the four factors.

Treatment area information is provided at high postcode level and therefore is not directly comparable to the neighbourhoods data. This is information taken directly from clients in treatment and is therefore protected by information governance arrangements. Details are found in table 37

Table 37 Clients in alcohol treatment on the 31st March 2014 and their postcode of residence

First part of the postcode	Activity	Percent of the total	First part of the postcode	Activity	Percent of the total
S5	60	16%	S3	20	5%
S2	49	13%	S10	18	5%
S6	39	10%	S11	17	4%
S8	38	10%	S20	16	4%
S13	31	8%	S9	13	3%
S35	21	5%	S36	12	3%
S12	20	5%	Other	32	8%
NATMS data - March 2014					
All clients in treatment on the 31st March 2014					

The data shows that those who reside in an S5 postcode (Longley, Shiregreen, Southey Green, Sheffield Lane Top, Firth Park) contributed to the highest number of people in treatment, followed by S2 (Manor, Manor Park, Arbourthorne, Wybourne, Norfolk park, High field, Lowfield) and S6 (Hillsborough, Malin Bridge, Birley Carr, Wisewood, Wadsley, Wadsley Bridge, Loxley).

Consideration should be given to specific areas in Sheffield, as there are some links between those areas of higher than average childhood poverty and those accessing treatment with some of these areas also in the top 20 for prevalence and hospital admissions. However the areas with the highest prevalence of drinking; are more affluent and have a lower number accessing treatment.

Domestic Abuse

South Yorkshire Police record an intoxication flag (under the influence of drugs / alcohol) for both domestic abuse crimes and incidents. The flag is recorded against all suspected / accused persons and for some complainants. In 2012/13 36.7% of all suspected / accused persons were recorded as under the influence of drink/drugs and this reduced to 32.4% in 2013/14. Out of the complainants who did have an intoxication status recorded, 27.2% were recorded as intoxicated in 2012/13. This percentage also reduced in 2013/14 when 24.7% were recorded as intoxicated.

Alcohol and drugs as an aggravating factor are recorded for all domestic abuse crimes but not for incidents. There was an 11.1% increase in the number of domestic related crimes in 2013/14 when compared to 2012/13. However, domestic related crimes that were alcohol aggravated reduced by 4.7% between the two years, with 759 recorded for

2012/13 and 723 in 2013/14.

It should be noted that for both crimes and incidents the intoxication status is not determined by testing but subjective judgement, most often made by the complainant.

Pregnancy

The UK health departments recommend that women should avoid drinking alcohol before and during pregnancy. Recommendations on drinking during pregnancy have tightened since the 2005 survey, when the guidelines were that drinking up to one or two units of alcohol no more than once or twice a week was regarded as safe.
The Infant Feeding Survey (2013)[134], found that in England during 2010 women were less likely to drink during pregnancy (41%) than five years previously in 2005 (55%). Of those who drank before their pregnancy (80% of the total), 48% gave up drinking altogether, 47% drank less and 2% remained drinking as before with the main reason (86%) for their change in drinking habits was the harm it may cause to the baby.

In 2010, two in five mothers (40%) drank alcohol during pregnancy, which is a lower proportion than in 2005 (54%). Mothers aged 35 or over (52%); mothers from managerial and professional occupations (51%) and mothers from a White ethnic background (46%) were more likely to drink during pregnancy.

Adjunctive Drug misuse

53% of people in alcohol treatment in Sheffield reported on NDTMS state that they do not use other substances. However, the same data also tells us that 38% of people missing data in the 2nd and 3rd drug field. The most common drug used by people in alcohol treatment is Cannabis, 6% of the treatment population reported use of cannabis as well as their alcohol use. 1% of people also reported Heroin use. Use of any other drug was reported by fewer than 10 people.

Roughly 10% of people in drug treatment in Sheffield reported also having a problem with alcohol in 2013/14. Screening for alcohol use takes place for all clients entering drug treatment.

[134] The Infant Breastfeeding Survey 2010, http://www.hscic.gov.uk/catalogue/PUB08694

Chapter 11 - Alcohol Misuse – Children and Young People

Alcohol misuse does not just affect those of legal drinking age; there are two perspectives in which alcohol can affect young people negatively:-

1. It is well known that young people ages 17 and under drink alcohol and that some drink beyond above the Department of Health healthy drinking guidelines for adults.
2. Young people can be affected in a number of ways by an adult's alcohol misuse problem.

The Silent Voices report by the Children's commissioner writes that children living with alcohol misusing parents are slower to be identified than those living with a drug misusing parent. However we do now the following:-

- around 20% of all child protection conferences had alcohol misuse as a compounding factor in 2013/14[135]
- 18% of all pregnant mothers referred to and discussed at the Substance misuse Multi Agency Pregnancy Liaison and Assessment Group (MAPLAG) in 2013/14 were known to be alcohol misuse parents
- 41% of those in community based alcohol treatment were parents and living with a child[136].

The latest *'Smoking, drinking and drug use among young people in England in 2012*[137]*'* (July 2013) provides some prevalence data to understand the extent to which young people drink alcohol and how they are affected by alcohol misuse. Taken from a survey of over 7,500 pupils (young people) aged between 11 and 15 years in the school environment, the findings were as follows:-

- 10% of 11 to 15 year olds drank alcohol in the last week compared to 12% in 2011 and 25% in 2003, showing that the proportion of young people drinking weekly is continuing to reduce over time.
- 25% of 15 year olds surveyed had consumed alcohol in the last week compared with 1% of 11 year olds.
- 6% said they drank weekly compared to 20% in 2001; however age was a factor here also, with 15% of 15 year olds said they drank weekly and 0.5% of pupils said they drank daily.
- Of those who had drank in the last week; the average units drank per week for 14 year olds was 8.5 units, 8 units for 15 year olds and 5 units for 11 to 13 year olds. However 33% of 14 year olds and 27% of 15 years olds had drunk more than 15 units in a week.
- In the last four weeks, 10% said they had been drunk; 7% once or twice and 3% on four or more occasions and 1% had attended hospital as a result of their drinking (7.5 of the 7,500 surveyed).
- 59% who said they had drunk in the last week reported binge drinking, drinking more than 4 units on one occasion.
- 44% reported buying alcohol and of these 37% has purchased it from a retail outlet (others were friends and relatives).
- 78% drank at home or at someone else's home, 47% drank at friend's parties and 18% said somewhere outside.
- 9% of 15 year olds reported drinking alcohol in a bar or club in the last four weeks.
- Those who perceived their parents would not like their drinking alcohol were less likely to have consumed alcohol in the last week (2%) compared with the 49% who perceived their parents does not mind how much they drink.
- Parents, teachers, TV, Newspapers and magazines and the internet were considered the 'most useful' sources of information about safe drinking.
- 59% said they had received a lesson at school on alcohol in the last year.

The data shows that some children as young as 11 drink alcohol, that one in three 14 years olds and nearly one third of 15 year olds in the last year have drunk to excess (over 15 units per week), just over one in 20 11 to 15 year olds having been drunk at least once, and one in thirty on four or more occasions. Over half those who admitted to drinking in the past week had also had an episode of binge drinking and a small fraction (0.001%) of those surveyed had attended hospital due to alcohol misuse.

The health consequences of young people drinking to excess are monitored by LAPE which shows that ratio of hospital related admissions for under 18 year olds and the numbers of under 18s attending community based alcohol support (commissioned by Sheffield City Council). This data is likely to show only a fraction (the high end health needs of young people who misuse alcohol) as it does not show the number of young people who were affected by

[135] Sheffield Safeguarding Children report, DACT Provider Monitoring framework Q4 2013/14.
[136] JSNA Alcohol and drugs JSNA Support pack; key data to support planning for effective drugs prevention, treatment and recovery: Sheffield. Public Health England (2013).
[137] Smoking, drinking and drug use among young people in England in 2012, Health and Social Care Information Centre, July 2013 http://www.hscic.gov.uk/catalogue/PUB11334

alcohol misuse (who may have been sick and not attended hospital), who may have visited their GP or sought other medical assistance (e.g. A&E).

Overall hospital admissions data and young people treatment data shows a reducing number of young people presenting for alcohol specific treatment.

Hospital admissions

In Sheffield the ratio of hospital admissions for alcohol misuse (LAPE 2014, see table below) was 18.56 per 100,000 under 18 years census population and is *'better than the England average'* of 42.7. When the 18.56 rate is applied to the under 18 population in Sheffield (122,685) an estimated 22 young people in Sheffield have an alcohol specific hospital admission per year.

LAPE April 2014		SHEFFIELD			
Indicator		**Measure(a)**	**National Rank (b) Out of 326**	**Rank of 8 core cities**	**Regional Average**
9	(9) Alcohol-specific hospital admission – under 18s	18.56	23	1	44.14

The 18.56 rate for Sheffield is lower than the 28 per 100,000 rate for under 18 years olds for the period 2008-2010/11 (LAPE 2012) and Sheffield has improved from 54 to 23 out of 326.

Young People (YP) Numbers in treatment

Between 2012/13 and 2011/12 there was a 22%[138],[139] reduction in the total number of YP people treated for alcohol misuse, which was a greater reduction than the 4.2% decreased observed for the total YP in treatment for substance misuse per se.

CRI is the current young people's substance misuse treatment service in Sheffield (known as The Corner), and is commissioned by Sheffield City Council. The activity numbers are low (the alcohol in treatment numbers are less than 10 for each financial year) and therefore the percentages are not reliably comparable (and therefore not provided) to that nationally, however it is noted that the service has experienced a similar reducing trend in activity[140][141] (where alcohol treatment numbers have reduced greater than total YP substance misuse treatment figures).

The proportion of YP people in treatment for alcohol misuse in Sheffield has changed from 8%[142] to 3%[143] of the total YP substance misuse treatment population between 2012/13 and 2011/12.

Conjunctive alcohol and cannabis misuse

Public Health England[144] writes that *'very few young people (under 18) develop dependency, those who use drugs and/or alcohol problematically are likely to be vulnerable, experiencing a range of problems, of which substance misuse is one'*.

In Sheffield there were fewer young people in treatment for conjunctive alcohol and cannabis misuse in 2012/13 (23 young people, of which 15 of these were aged 15 years or above) compared with the 41 YP in 2011/12.

What do we know about young people in specialist alcohol misuse treatment?

Information for Sheffield is unreliable given the low numbers; therefore national data has been used[145]. The majority of referrals come via Children and family services and Youth Offending teams (YOT), the majority then receive harm reduction advice and motivational interviewing with a very small fraction receiving specialist pharmacological treatment. Most individuals receive multiple interventions and received treatment for a period of less than 12 weeks (56%) and 86% completed treatment.

[138] Public Health England YP Needs Assessment data 2012-13 – National, www.ndtms.net
[139] Public Health England YP Needs Assessment data 2011-12 – National, www.ndtms.net
[140] Public Health England YP Needs Assessment data 2012-13 Treatment map and client profiles–, www.ndtms.net
[141] Public Health England YP Needs Assessment data 2011-12 Treatment map and client profiles–, www.ndtms.net
[142] Public Health England YP Needs Assessment data 2012-13 Treatment map and client profiles–, www.ndtms.net
[143] Public Health England YP Needs Assessment data 2012-13 Treatment map and client profiles–, www.ndtms.net
[144] Public Health England Needs assessment 201213 - risk harm profile data 2012/2013, www.ndtms.net
[145] Young people treatment map summary – 2012-13 www.ndtms.net

Vulnerable young adults – children living in homes with an alcohol misusing parent

A report by Alcohol Concern[146] reports that young people and children can be affected by their parent's alcohol misuse, stating that the more problematic the alcohol misuse in the household, e.g. both parents affected, then the greater likelihood of the negative effects on the children.

Estimating the number of children affected is difficult given that there are varying degrees of alcohol misuse and consumption (binge, increasing, higher and dependant) and each drinking status may not necessarily mean all those living in such a household with a certain level of alcohol consumption are affected to the same degree (Silent Voices, 2012). The same report however does cite findings by Manning et al (2009) which found that 30% of children under 16 years live with an adult binge drinker, 22% with a hazardous drinker and 2.5% with a harmful drinker. Applied to Sheffield (0-16 population is 106,929 (Census 2011) there are an estimated 2,673 living with a higher risk drinker.

How children living with an alcohol misusing parent can be affected

Alcohol Concern writes that parental alcohol misuse can create *less stable and less supportive homes* meaning some children are vulnerable to neglect, abuse, poor educational attainment, low self-esteem, offending behaviour, self-harm, domestic abuse, slower development, caring responsibilities, behavioural problems, alcohol and substance misuse. This list is not exhaustive and young people can be affected by one or a multiple number of these factors, e.g. neglect and poor education attainment.

How does Sheffield support young people who are affected by parental alcohol misuse?

There are a couple of initiatives happening in Sheffield to identify alcohol misusing families and the impact on family life.

MAPLAG is unique to Sheffield, providing case conferencing on each case, with the aim of creating a support package to best assist the parent and baby, including referral into structured alcohol treatment.

The government's 'Troubled Families' initiative[147] reports there are a number of families with multiple complex issues, which often includes alcohol misuse[148]; the initiative is to provide a partnership, co-ordinated and intense approach to working with up to 120,000 families nationally. It was found that such families more frequently used a number of different public sector services and often had a multitude of different organisations working with them. Together this was found to be both expensive to the services and the interaction often confusing for the family.

In Sheffield the initiative has been locally named as 'Building Successful families' with substance misuse (including alcohol misuse) as one of the ten vulnerability factors.

Triple P are recognised parenting programmes for parents with the aim of building better relationships, parenting skills and individual confidence over a period of 8 weeks. Led by Sheffield City Council, in 2013/14 a number of staff in adult alcohol treatment services were trained to deliver the course, and so far two courses have been completed in substance misusing treatment services. There is current work ongoing to evaluate the safeguarding outcomes and whether these have since improved following course attendance and engagement.

Nationally the Silent Voices report[149] has identified that there is no clear picture of the number and range of services available to children (and families) affected by parental alcohol misuse. Locally however, there are services for Young Carers and there is also the What About Me (WAM) project which is a support service for children whose parents misuse drugs and / or alcohol.

[146] *Swept under the carpet: children affected by parental alcohol misuse*, Alcohol Concern, October 2010 http://www.alcoholconcern.org.uk/publications/policy-reports/under-the-carpet

[147] https://www.gov.uk/government/policies/helping-troubled-families-turn-their-lives-around#issue

[148] Listening to Troubled Families, Louise Casey CB, Department for Communities and Local Government July 2012 https://www.gov.uk/government/publications/listening-to-troubled-families

[149] Silent Voices: supporting children and young people affected by alcohol misuse (2012) http://www.childrenscommissioner.gov.uk/content/publications/content_619

Chapter 12 - National Changes Ahead / Recent changes / future direction

This section is to raise awareness to national developments made over the last 12 months and where planned changes lie ahead. Not all changes will happen; indeed some are just here to be noted. The consultation for the needs assessment asked contributors to add to the list; therefore it is not exhaustive and was relevant at the time of publication.

1. The introduction of local alcohol action areas, (LAAA) - The government in February 2014 announced that 20 Local Authorities across England and Wales were to have special alcohol action areas with the aims of tackling the harmful effects of irresponsible drinking, particularly alcohol-related crime and disorder, and health harms.

These are areas in which local agencies, including licensing authorities, health bodies and the police will come together with businesses and other organisations to address problems being caused by alcohol in their area.
Work in the local alcohol action areas will be focused on the key aims of reducing alcohol-related crime and disorder, and reducing the negative health impacts caused by alcohol. Underpinning both of these will be the goal of promoting diverse and vibrant night-time economies.
Sheffield is not one of the 20 LAAA, the nearest LA to Sheffield is Doncaster which has a specific focus on health with Greater Manchester and Liverpool two of the Core cities Sheffield compares itself to also being part of the project.
https://www.gov.uk/government/publications/local-alcohol-action-areas

2. The government proposal for introducing Minimum unit pricing for alcohol has been delayed until more robust evidence is available that it will be effective.

3. Alcohol education tools-

The National Pharmaceutical Association (NPA) produced a series of scratch cards to support public health campaigns in community pharmacies. There are four different scratch card types to support awareness on the following topics, one of which is for alcohol screening. "Rethink your drink" scratch cards are designed to identify high risk drinkers and provide education around alcohol units and safe consumption guidelines for males and females. The scratch cards have been used in doctor's surgeries, pharmacies, dentists, job centres, gyms, pubs and community centres.

- During alcohol awareness week in 2013 Hampshire distributed 120,000 to local communities.
- Safer Havant Partnership distributed 3,000 scratch cards to local residents as part of their Know Your Limits campaign. http://www.saferhavant.co.uk/drugs__alcohol.aspx
- In London, a four-month scratch card campaign in 240 pharmacies resulted in 23,800 scratch cards being returned. There is no information to indicate if the people who completed the cards were targeted or not indications are that it was targeted as 40% of customers were classed as higher risk drinkers. Similar outcomes were found in a scheme ran in Devon, in 14 Healthy Living Pharmacies. http://www.pharmacy-life.co.uk/846/the-alcohol-lottery-scratch-card-success.

The use of the cards shows it is another way of educating people about alcohol units, misuse and the harms it can cause; it can identify higher risk drinkers, provide some brief advice (on the card or in a one to one with the health professional), it can be done on a large scale over a short period of time and is a further opportunity to refer into treatment.

Alcohol powder – although not available currently in the UK alcohol powder is available in a number of countries including Germany, Japan, the Netherlands and the recent launch of the American version 'Palcohol' raised the profile of this substance in the UK in early 2014. Powdered alcohol can turn a non-alcohol beverage into an alcoholic drink[150]. There are concerns for future health implications since it opens up the opportunity for consumption of alcohol in areas where alcohol use is not permitted, e.g. football terraces; depending on the price it may reduce the price of alcohol, and may open a potential new alcohol market e.g. young people.

Public Health England business plan 2014/15[151] - explains that they will introduce a small number of big ambitions that will target areas to reduce gaps in life expectancy and years of healthy life. The areas of focus have not yet been determined however alcohol misuse is one factor under consideration.

Social media and the internet

Smartphone drinks tracker app - The Department of Health has announced a new smartphone app and enhanced online drinks checker are now available to help people see the impact alcohol can have on their health, waist and wallet. The new tools are part of a nationwide Change4life campaign to raise awareness of the health impacts of drinking over the lower risk guidelines on a regular basis. The campaign also offers handy hints and tips on how

[150] http://www.theguardian.com/lifeandstyle/shortcuts/2014/apr/21/palcohol-powder-alcohol-vodka-rum-cocktail-snorting
[151] https://www.gov.uk/government/publications/phe-business-plan-2014-to-2015

people can cut down – such as having alcohol free days, not drinking at home before they go out, swapping to low alcohol or alcohol free drinks and simply using smaller glasses.
http://www.dh.gov.uk/health/2012/10/smartphone-drinks-tracker/

Interactive drink diaries – drink diaries are used in the treatment of alcohol misuse, the internet and mobile phone apps now provide alternatives to tracking drinking habits than paper diaries.
http://www.nhs.uk/Livewell/alcohol/Pages/Alcoholtracker.aspx

Guidance for doctors: alcohol, drugs and the workplace - Doctors can now access new BMA guidance to help them better understand and support patients and employers in tackling alcohol and illicit drug use. Alcohol, drugs and the workplace - the role of medical professionals recognises the prevalence of alcohol and drug misuse among people who work, and the impact on employers in terms of absenteeism and behavioural issues
http://bma.org.uk/practical-support-at-work/occupational-health/alcohol-drugs-and-the-workplace

Alcohol pledges for the alcohol industry – new pledges introduced - Ministers met industry representatives at the Home Office yesterday (7 July) to agree a series of pledges. These include:
• Producers calling time on super-strength products in large cans;
• Retailers committing to the responsible display and promotion of alcohol in shops and supermarkets; and
• Pubs and bars making sure they stock house wines below 12.5% ABV and promote lower-alcohol products to customers.
https://www.gov.uk/government/news/alcohol-industry-takes-action-to-tackle-irresponsible-drinking
The list of all pledges and signatories can be found at https://responsibilitydeal.dh.gov.uk/pledges/

Recommendations to the government
The government is lobbied by a number of different alcohol groups. The two most recent of these published are listed below. They raise again similar themes that have been discussed throughout the document and are cited here for information to show current thinking:-

The All Party Parliamentary Group on Alcohol Misuse[152] published their Alcohol misuse manifesto (August 2014) which raises the following ten measures it would like the government to commit to.
1. Make reducing alcohol harms the responsibility of a single government minister with clear accountability
2. Introduce a minimum unit price for alcoholic drinks
3. Introduce public health as a fifth licensing objective, enabling local authorities to make licensing decisions based on local population health need and the density of existing outlets
4. Strengthen regulation of alcohol marketing to protect children and young people
5. Increase funding for treatment and raise access levels from 6% to 15% of problem drinkers
6. Commissioners should prioritise the delivery of Identification and Brief Advice. Identification and Brief Advice should be delivered in a wide range of different settings including health care, involving GPs routinely asking questions, and in-workplace programmes
7. Include a health warning on all alcohol labels and deliver a government-funded national public awareness campaign on alcohol-related health issues
8. For all social workers, midwives and healthcare professionals, introduce mandatory training on parental substance misuse, foetal alcohol syndrome disorder and alcohol-related domestic violence
9. Reduce the blood alcohol limit for driving in England and Wales to 50mg/100ml, starting with drivers under the age of 21
10. Introduce the widespread use of sobriety orders to break the cycle of alcohol and crime, antisocial behaviour and domestic violence

The Centre for Social Justice raised in their *'Ambitious recovery report'* (August 2014)[153] that they would like the government to consider introducing a tax to each unit of alcohol by 1p sold outside of pubs over the next five years, which would be used to spend on alcohol treatment.

[152] http://www.alcoholconcern.org.uk/publications/other-publications/appg-alcohol-misuse-manifesto
[153] http://www.centreforsocialjustice.org.uk/UserStorage/pdf/Pdf%20reports/CSJJ2073_Addiction_15.08.14_2.pdf

Appendix 1 – LAPE 2014 for Sheffield compared to core cities

http://www.lape.org.uk/LAProfile.aspx?reg=X25003AF

	SHEFFIELD		Leeds		Birmingham		Liverpool		Manchester		Newcastle		Nottingham		Bristol	
Indicator	Measure	National	Measure	National	Measure	National	Measure	National	Measure	National	Measure	National	Measure	National	Measure	National
(1) Months of life lost - males	12.07	213	13.3	258	13.66	264	19.02	323	20.32	325	13.91	271	14.86	287	14.97	289
(2) Months of life lost - females	4.75	133	5.77	230	5.97	248	8.51	318	8.65	319	6.15	263	6.11	261	5.41	199
(3) Alcohol-specific mortality - males	18.25	263	18.28	264	21.78	296	29.12	321	33.57	325	20.08	281	26.25	315	22.5	303
(4) Alcohol-specific mortality - females	5.69	156	8.37	257	7.51	238	13.19	315	12.89	314	9.08	268	8.21	254	6	170
(5) Mortality from chronic liver disease - males	15.61	200	18.11	232	21.58	284	31.06	323	36.2	325	21.38	283	27.86	320	20.21	266
(6) Mortality from chronic liver disease - females	7.46	159	9.26	236	9.31	239	16.36	320	14.87	313	8.52	210	9.95	248	6.75	125
(7) Alcohol-related mortality - males	64.14	197	70.3	248	74.43	275	98.62	324	108.23	326	69.38	242	80.85	300	78.62	293
(8) Alcohol-related mortality - females	24.6	99	26.27	146	31.76	251	44.47	325	37.78	307	30.96	236	33.43	277	27.53	177
(9) Alcohol-specific hospital admission - under 18s	18.56	23	47.04	205	30.49	104	86.41	313	68.54	280	45.63	197	32.08	113	39.97	163
(10) Alcohol-specific hospital admission - males	495.07	207	611.89	260	621.68	265	1097.57	325	1095.45	324	803.93	309	708.98	289	711.51	290
(11) Alcohol-specific hospital admission - females	218.8	188	279.33	258	215.63	183	510.03	324	425.63	318	324.82	290	323.94	288	309.37	279
(12) Alcohol-related hospital admission (Broad) - males	1605.38	187	1851.94	263	1936.92	275	2487.73	322	2624.22	324	2289.24	312	1846.55	257	1965.53	280
(13) Alcohol-related hospital admission (Broad) - females	794.01	180	904.47	245	931.29	259	1246.93	320	1270.52	322	1106.31	306	947.89	270	968.24	280
(14) Alcohol-related hospital admission (Narrow) - males	596.27	219	693.82	285	660.81	260	896.34	323	887.21	321	756.76	303	757.94	304	673.1	270
(15) Alcohol-related hospital admission (Narrow) - females	302.29	197	346.57	266	298.61	184	437.37	317	413.49	309	367.22	288	371.29	290	333.35	245
(16) Admission episodes for alcohol-related conditions (Broad)	2026.12	202	2053.64	209	2314.08	263	2934.89	316	3137.29	324	2916.65	314	2478.26	286	2480.59	287
(17) Admission episodes for alcohol-related conditions (Narrow)	706.09	257	683.35	242	690.97	252	809.62	298	852.19	310	827.93	303	877.68	316	721.44	267
(18) Alcohol-related recorded crime	5.37	200	6.52	251	7.08	269	6.48	248	8.97	301	5.18	187	9.74	309	8.08	290
(19) Alcohol-related violent crime	2.6	93	3.82	195	4.59	250	3.93	205	5.39	280	3.56	176	7.09	318	5.57	287
(20) Alcohol-related sexual offences	0.08	69	0.15	267	0.15	262	0.14	245	0.22	322	0.12	198	0.2	313	0.17	292
(21) Abstainers synthetic estimate	17.32	54	16.73	64	25.28	11	15.85	89	20.47	31	16.76	62	19.85	35	16.01	85
(22) Lower Risk drinking (% of drinkers only) synthetic estimate	73.22	138	73.24	133	75.22	10	74.44	29	73.55	118	72.54	223	73.8	84	72.24	269
(23) Increasing Risk drinking (% of drinkers only) synthetic estimate	19.54	79	19.66	95	18.55	13	18.53	12	19.21	44	19.89	119	18.98	28	20.3	163
(24) Higher Risk drinking (% of drinkers only) synthetic estimate	7.24	293	7.09	275	6.23	26	7.03	268	7.24	294	7.57	311	7.22	290	7.47	305
(25) Binge drinking (synthetic estimate)	26.9	308	25.6	297	16.5	60	22.6	252	29	318	33.7	326	23.9	276	26.3	306
(26) Employees in bars	1.68	126	1.62	113	1.6	109	1.91	161	1.62	111	2.61	257	1.23	50	1.55	103

Sheffield compared well to the other seven core cities, with the least number of 'red' indicators and three green indicators. The nearest city to Sheffield for LAPE data is Leeds which has 9 red indicators. Only Birmingham has more green indicators, with four.

Sheffield has three indicators that are green which means 'better than the England Average' statistically. These are alcohol specific admission to hospital for under 18s, Alcohol related hospital admissions (broad) which means either the primary or a secondary reason was alcohol attributable and the % of Sheffield employees that work in bars.

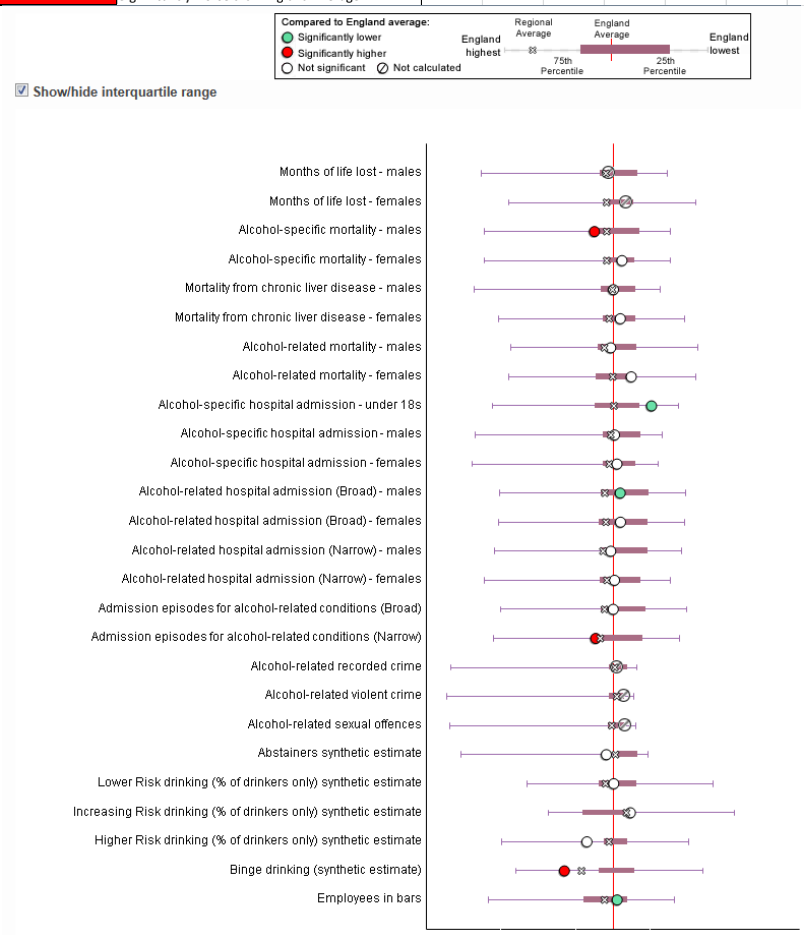
Three indicators are red which means they are statistically worse than the England Average. The three indicators are; Alcohol specific mortality - males, admission episodes for alcohol related conditions (narrow) which means the primary reason at admission was for an alcohol attributable condition or a secondary reason was a external e.g. assault and synthetic estimates for binge drinking (the data has not been recalculated therefore it remains the same).

Sheffield is the only core city to fall in the top 100 ranking for alcohol related admissions to hosptial for under 18s, alcohol related mortality females, alcohol related violent crime and alcohol related sexual offences

Sheffield activity has increased between 2011/12 and 2012/13 for mortality for chronic liver diseases (male), and all four alcohol related hospital admissions (broad and narrow, male and females).

Sheffield actiivty has less less for mortality from chronic liver disease females, alcohol related mortality male and females, alcoholic specific hosptial admissions under 18, alcohol related recorded crime and alcohol related violent crime.

Key	
	Significantly better than England Average
	Not significantly different to the England Average
	Significantly worse than England Average



LAPE indicator definitions

There has been a change in the reporting metrics since the 2012 LAPE data. Therefore the above dats CANNOT BE DIRECTLY COMPARED to the 2012 data and caution must be taken if choosing to do so	
Alcohol-specific	Alcohol-specific outcomes include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because all cases (100%) are caused by alcohol.
Alcohol-related	Alcohol-related conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls. The attributable fractions for alcohol-related outcomes used here range from between 0 and less than 1.0. For example, the alcohol-attributable fraction for mortality from pneumonia among men aged 75 and over is 0.10 because the latest epidemiological data suggest that 10% of pneumonia cases among this population are due to alcohol. Outcomes where alcohol has a protective effect (i.e. the fraction is less than 0) are not included when the alcohol-attributable fractions are applied to mortality and hospital episode statistics data.
Indicator value	The actual indicator value for the Local Authority as calculated in the definitions below.
Ranks	The rank of the local indicator value among all 326 Local Authorities in England. A rank of 1 is the lowest value Local Authority in England and a rank of 326 is the highest except for indicators 21 & 22 were the ranking is reversed (1 is the highest value and 326 the lowest).
Suppression	Where values in 'Trend Charts' and 'Data' are blank, data have been suppressed to prevent disclosure unless otherwise stated. For mortality data counts below 3 have been suppressed and for HES data, counts below 6 have been suppressed (HES counts of 0 do not require suppression). Further suppression has been applied to the datasets in LAPE to prevent disclosure through subtraction.
1,2	**Months of life lost- males/females** An estimate of the increase in life expectancy at birth that would be expected if all alcohol-related deaths among males/females aged less than 75 years were prevented. Knowledge and Intelligence Team (North West) from 2010-2012 England and Wales life expectancy tables for males and females (from Office for National Statistics), alcohol-related deaths from the Public Health Mortality File 2010-2012 for males/females aged less than 75 years and the Office for National Statistics mid-year population estimates for 2010-2012.
3,4	**Alcohol-specific mortality- males/females** Deaths from alcohol-specific conditions, all ages, males/females, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from the Public Health Mortality File for 2010-2012 and Office for National Statistics mid-year population estimates for 2010-2012.
5,6	**Mortality from chronic liver disease- males/females** Deaths from chronic liver disease including cirrhosis (International Classification of Diseases, version 10: K70, K73-K74), all ages, males/females, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from the Public Health Mortality File for 2010-2012 and Office for National Statistics mid-year population estimates for 2010-2012.
7,8	**Alcohol-related mortality - males/females** Deaths from alcohol-related conditions, all ages, males/females, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from the Office for National Statistics Public Health Mortality File for 2012 and mid-year population estimates for 2012.
9	**Alcohol-specific hospital admission - under 18s** Persons admitted to hospital due to alcohol-specific conditions, under 18 year olds, crude rate per 100,000 population. Knowledge and Intelligence Team (North West) from hospital episode statistics 2010/11 to 2012/13. Office for National Statistics mid-year population estimates 2010, 2011 and 2012. Does not include attendance at Accident and Emergency departments.
10, 11	**Alcohol-specific hospital admission - males/females** Persons admitted to hospital due to alcohol-specific conditions, all ages, males/females, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from hospital episode statistics 2012/13. Office for National Statistics mid-year population estimates 2012. Does not include attendance at Accident and Emergency departments.
12, 13, 14, 15	**Alcohol-related hospital admission - males/females** Persons admitted to hospital due to alcohol-related conditions (broad measure [primary diagnosis or any secondary diagnosis] and narrow measure [primary diagnosis or any secondary diagnosis with an external cause]), all ages, males/females, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from hospital episode statistics 2012/13. Office for National Statistics mid-year population estimates 2012. Does not include attendance at Accident and Emergency departments.
16, 17	**Admission episodes for alcohol-related conditions** Admission episodes for alcohol-related conditions (broad measure [primary diagnosis or any secondary diagnosis] and narrow measure [primary diagnosis or any secondary diagnosis with an external cause]), all ages, directly age-standardised rate per 100,000 population (standardised to the European standard population). Knowledge and Intelligence Team (North West) from hospital episode statistics 2012/13. Office for National Statistics mid-year population estimates 2012. Does not include attendance at Accident and Emergency departments.
18, 19, 20	**Alcohol-attributable recorded crimes** Alcohol-related recorded crimes (based on the Home Office's former 'key offence' categories), all ages, persons, crude rate per 1,000 population. Knowledge and Intelligence Team (North West) from Office for National Statistics recorded crime statistics 2012/13. Office for National Statistics 2011 mid-year populations. Attributable fractions for alcohol for each crime category were applied where available, based on survey data on arrestees who tested positive for alcohol by the UK Prime Minister's Strategy Unit.
21	**Abstainers synthetic estimate** Abstainers: Mid 2009 synthetic estimate of the percentage of abstainers in the population aged 16 years and over who report abstaining from drinking. Estimates
22	**Lower Risk drinking (% of drinkers only) synthetic estimate** Lower risk drinking (as a percentage of drinkers): Mid 2009 synthetic estimate of the percentage of drinkers in the population aged 16 years and over who report
23	**Increasing Risk drinking (% of drinkers only) synthetic estimate** Increasing risk drinking (as a percentage of drinkers): Mid 2009 synthetic estimate of the percentage of drinkers in the population aged 16 years and over who report
24	**Higher Risk drinking (% of drinkers only) synthetic estimate** Higher risk drinking (as a percentage of drinkers): Mid 2009 synthetic estimate of the percentage of drinkers in the population aged 16 years and over who report
25	**Binge drinking (synthetic estimate)** Synthetic estimate of the percentage of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, eight or
26	**Employees in bars - % of all employees** The number of those in employment in the beverage serving activities industry sector (Standard Industrial Classification 2007: 563), as a percentage of all in employment. Business Register and Employment Survey September 2012, Office for National Statistics from Nomis: www.nomisweb.co.uk.

Appendix 2 - Alcohol Neighbourhood profiles data, 2011 Published by PHE analyst team

	Alcohol: High Risk Drinkers (Age 16+), 2011				Alcohol: Binge Drinkers (Age 16+), 2011			
	Numbe	% of adults (age 16+	LL 95% C	UL 95% C	Numbe	% of adults (age 16+	LL 95% C	UL 95% C
Abbeyfield	301	13.1	4.8	32.7	868	32.3	27.6	37.4
Acres Hill	281	12.2	4.5	30.5	735	26.9	23.0	31.2
Arbourthorne	545	12.9	4.7	32.2	1500	30.2	25.8	34.9
Base Green	363	12.4	4.6	31.0	926	26.7	22.9	31.0
Batemoor / Jordanthorpe	370	12.7	4.6	31.6	988	28.6	24.5	33.1
Beauchief	195	12.1	4.4	30.2	480	25.0	21.4	28.9
Beighton	511	12.7	4.7	31.8	1353	28.5	24.4	33.1
Bents Green	229	12.6	4.6	31.4	565	26.2	22.4	30.4
Birley	674	12.6	4.6	31.5	1804	28.6	24.5	33.1
Bradway	338	12.3	4.5	30.7	823	25.2	21.6	29.2
Brightside	428	13.1	4.8	32.7	1216	31.8	27.3	36.9
Brincliffe	502	12.7	4.7	31.8	1399	30.2	25.9	35.0
Broomhall	712	14.1	5.2	35.3	2209	37.4	32.0	43.3
Broomhill	923	14.5	5.3	36.4	2825	37.5	32.1	43.5
Burncross	353	12.3	4.5	30.8	882	26.0	22.2	30.1
Burngreave	452	13.1	4.8	32.6	1303	32.2	27.6	37.3
Chapeltown	901	12.6	4.6	31.5	2328	27.6	23.6	31.9
Charnock	315	12.3	4.5	30.6	786	25.8	22.1	29.9
City Centre	1178	14.9	5.4	37.1	3831	41.1	35.2	47.6
Colley	386	12.6	4.6	31.6	1011	28.1	24.0	32.5
Crookes	1050	13.4	4.9	33.5	3132	33.9	29.1	39.3
Crookesmoor	331	15.1	5.5	37.7	1018	39.1	33.4	45.3
Crosspool	622	12.5	4.6	31.1	1582	26.8	22.9	31.0
Darnall	726	13.0	4.8	32.4	2104	32.1	27.5	37.2
Deepcar	527	12.6	4.6	31.6	1374	27.9	23.9	32.4
Dore	621	12.1	4.4	30.2	1500	24.5	21.0	28.4
Ecclesall	295	12.6	4.6	31.5	723	26.1	22.3	30.2
Ecclesfield	416	12.2	4.5	30.6	1062	26.3	22.5	30.5
Endcliffe	995	15.2	5.6	38.0	3065	39.4	33.7	45.6
Fir Vale	759	13.1	4.8	32.7	2248	33.2	28.4	38.5
Firshill	169	12.3	4.5	30.7	445	27.2	23.3	31.6
Firth Park	160	13.0	4.8	32.4	457	31.5	27.0	36.5
Flower	256	12.7	4.7	31.8	704	29.6	25.4	34.4
Fox Hill	490	12.6	4.6	31.6	1319	28.9	24.8	33.5
Fulwood	554	12.6	4.6	31.4	1386	26.6	22.8	30.8
Gleadless	395	12.2	4.5	30.4	976	25.3	21.7	29.3
Gleadless Valley	552	12.6	4.6	31.4	1504	29.0	24.8	33.6
Granville	358	12.9	4.7	32.3	1045	32.3	27.6	37.4
Greenhill	570	12.3	4.5	30.8	1431	26.1	22.4	30.3
Grenoside	394	12.2	4.5	30.6	964	25.2	21.6	29.2
Greystones	673	12.9	4.7	32.2	1876	30.7	26.2	35.5
Hackenthorpe	528	12.6	4.6	31.5	1403	28.3	24.2	32.8
Halfway	360	12.5	4.6	31.2	964	28.4	24.4	33.0
Handsworth	883	12.4	4.6	31.1	2290	27.3	23.3	31.6
Heeley	740	12.8	4.7	32.1	2096	31.1	26.7	36.1
Hemsworth	342	12.6	4.6	31.5	922	28.8	24.7	33.4
High Green	878	12.7	4.6	31.6	2314	28.3	24.2	32.8
Highfield	1032	14.6	5.4	36.5	3292	39.6	33.9	45.9
Hillsborough	667	12.8	4.7	31.9	1877	30.8	26.3	35.6
Hollins End	563	12.5	4.6	31.1	1453	27.2	23.3	31.5
Housteads	351	12.7	4.7	31.8	971	30.0	25.7	34.8
Langsett	438	12.5	4.6	31.2	1213	29.5	25.2	34.2
Lodge Moor	209	11.9	4.4	29.8	506	24.2	20.8	28.1
Longley	540	12.7	4.7	31.7	1419	28.2	24.2	32.7
Lowedges	541	12.5	4.6	31.3	1479	29.0	24.8	33.6
Loxley	166	12.4	4.6	31.0	412	25.9	22.2	30.0
Manor	825	12.9	4.7	32.3	2322	30.9	26.5	35.8
Meersbrook	769	12.5	4.6	31.3	2004	27.7	23.7	32.0

	Alcohol: High Risk Drinkers (Age 16+), 2011				Alcohol: Binge Drinkers (Age 16+), 2011			
	Numbe	% of adults (age 16+	LL 95% C	UL 95% C	Numbe	% of adults (age 16+	LL 95% C	UL 95% C
Meersbrook	769	12.5	4.6	31.3	2004	27.7	23.7	32.0
Middlewood	455	13.0	4.8	32.5	1294	31.7	27.1	36.7
Millhouses	388	12.8	4.7	31.9	996	27.8	23.8	32.2
Mosborough	487	12.6	4.6	31.5	1282	28.3	24.2	32.7
Nether Edge	1174	13.1	4.8	32.8	3403	32.5	27.8	37.7
Netherthorpe	629	14.2	5.2	35.5	1954	37.5	32.1	43.4
New Parson Cross	470	12.8	4.7	32.0	1265	29.3	25.1	33.9
Norfolk Park	644	12.8	4.7	32.0	1827	30.9	26.5	35.8
Norton	293	12.2	4.5	30.6	716	25.1	21.5	29.1
Old Parson Cross	780	12.9	4.7	32.1	2144	30.0	25.7	34.8
Oughtibridge	333	12.6	4.6	31.6	864	27.8	23.8	32.2
Owlthorpe	412	12.6	4.6	31.6	1041	27.0	23.1	31.3
Park Hill	197	13.9	5.1	34.7	566	33.8	29.0	39.2
Ranmoor	422	12.6	4.6	31.4	1118	28.3	24.2	32.8
Richmond	349	12.6	4.6	31.4	912	27.8	23.8	32.2
Rural Area	272	12.6	4.6	31.5	672	26.3	22.5	30.5
Sharrow	1065	13.5	5.0	33.8	3265	35.7	30.5	41.3
Shirecliffe	389	12.6	4.6	31.4	1049	28.7	24.5	33.2
Shiregreen	978	12.9	4.7	32.3	2719	30.5	26.1	35.3
Sothall	485	13.3	4.9	33.1	1310	30.6	26.2	35.5
Southey Green	496	12.8	4.7	32.1	1361	30.0	25.7	34.7
Stannington	449	12.5	4.6	31.1	1120	26.2	22.4	30.4
Stocksbridge	663	12.5	4.6	31.2	1713	27.2	23.3	31.6
Stubbin / Brushes	442	12.9	4.7	32.2	1243	30.7	26.3	35.6
Tinsley	390	13.0	4.8	32.4	1136	32.2	27.6	37.3
Totley	346	12.3	4.5	30.7	868	25.9	22.2	30.0
Upperthorpe	342	13.1	4.8	32.7	975	31.9	27.3	36.9
Wadsley	509	12.7	4.7	31.7	1354	28.6	24.5	33.1
Walkley	482	12.9	4.7	32.1	1398	32.0	27.4	37.1
Walkley Bank	285	12.6	4.6	31.5	755	28.4	24.3	32.9
Waterthorpe	370	12.4	4.5	30.9	919	25.8	22.1	29.9
Westfield	349	13.0	4.8	32.4	963	30.6	26.2	35.4
Wharncliffe Side	128	12.7	4.7	31.8	329	27.8	23.8	32.2
Whirlow / Abbeydale	258	12.5	4.6	31.2	628	25.6	21.9	29.7
Wincobank	442	12.9	4.7	32.1	1181	29.2	25.0	33.9
Wisewood	317	12.4	4.5	30.9	832	27.4	23.5	31.8
Woodhouse	925	12.5	4.6	31.2	2418	27.5	23.6	31.9
Woodland View	525	12.1	4.4	30.3	1342	26.1	22.3	30.2
Woodseats	741	12.7	4.6	31.6	2053	29.9	25.6	34.6
Woodside	435	13.3	4.9	33.2	1324	34.9	29.9	40.4
Woodthorpe	472	12.6	4.6	31.5	1284	29.0	24.8	33.6
Worrall	132	12.4	4.5	30.9	337	26.6	22.8	30.9
Wybourn	583	13.0	4.8	32.6	1662	31.7	27.2	36.8

	Best 10
	Worst 10
	Worst 11-20