By:	Linda Smith Public Health Specialist, KCC Jess Mookerjee, Public Health Consultant, KCC
To:	Swale Health and Wellbeing Board
Date:	17 September 2014
Subject:	Alcohol Strategy for Kent 2014-2016
Classification:	Unrestricted

Summary

Although the majority of people drink alcohol responsibly, there are still a proportion of people for whom alcohol misuse is a problem. Liver disease is on the increase and alcohol misuse can also lead to violence and family disruption. In Kent it is estimated that alcohol harm accounts for approximately £108m of Health commissioning resource each year.[1]

The National Alcohol Strategy makes key recommendations on enforcement and disorder that are echoed in the Kent Strategy. The Kent Strategy for 2014-16 goes further by pledging action to improve the current prevention and treatment arrangements in Kent.

Currently there is evidence that not enough people are being referred for Alcohol Treatment and that too few people are aware of the harm that alcohol misuse is causing them. There are also a number of vulnerable groups, whose needs must be addressed.

This Alcohol Strategy has six pledges for action to reduce alcohol-related harm and seven evidence-based steps that we will take to reduce harm from alcohol consumption. Each local Health and wellbeing Board is asked to consider developing local action plans for implementation of the Kent strategy.

Recommendations

The Swale Health and Wellbeing Board is asked to:

1. note this report and consider key actions from the strategy to be taken
2. develop a Local Alcohol Action Plan to implement the Kent Alcohol Strategy
3. consider creating a multi-partner Task and Finish Group to address the six pledge areas of the Kent Alcohol Strategy

[1] Data Extracted from NHIS Alcohol Impact Model

1. Purpose

1.1 To inform the Swale Health and Wellbeing Board about the Kent Alcohol Strategy 2014-2016 that was approved by Kent Adult Social Care and Health Cabinet Committee earlier this year. Appendix 1

2. Background

2.1 Although the majority of people in Swale and the UK consume alcohol responsibly, excessive consumption of alcohol is a growing problem in Kent and across the country and contributes to health issues such as liver disease and obesity. Alcohol also contributes to crime and disorder, is linked to domestic violence, mental distress and family disruption.

2.2 Liver disease is almost wholly attributed to alcohol misuse and is the fifth largest cause of death in England. Liver disease is the only chronic condition that is increasing rapidly in the UK, with a five-fold increase in the development of cirrhosis in 35-55 year olds over the last 10 years. The average age of death from liver disease is 59 years, compared to 82-84 years for heart and lung disease or stroke.

3. Local Needs

Local Authority (LA) and Clinical Commissioning Group (CCG) level information on a number of indicators is available through Local Alcohol Profile (LAPE). Some key points from LAPE (2013) are:

a) Both male and female alcohol specific admissions have decreased from 2006-2008 trends

b) Predicted trends are for admissions to increase

c) Emergency admissions <18 years is declining. Only one indicator: males by Local Authority shows an slight increase (not by CCG area)

d) Liver disease emergency admissions, top three LA wards: West Downs, Sheerness, East, Kemsley (all ages, 2009-20014)

e) Alcohol specific emergency admissions, top three LA wards: Sheerness East, Leysdown & Warden, Sheerness West (all ages, 2009-20014)

f) Liver disease mortality, top three LA wards: Leysdown & Warden, Sheerness East, Abbey (all ages, 2009-20014)

g) 11 indicators are better than the South East average

Further information relating to alcohol profiles is available both at ward and CCG level (please see appendix 2 for an example selection).

4. Kent Alcohol Strategy 2014-2016

The National Alcohol Strategy focuses on the importance of preventing and reducing the impact of alcohol on crime and disorder across the UK.

The New Kent Alcohol Strategy builds on the previous Alcohol Strategy for Kent 2010-2013.

4.1 The Key aims of the Alcohol Strategy for Kent 2014-2016 are to:

a) Reduce alcohol-related specific deaths
b) Continue to reduce alcohol-related disorder and violence year on year
c) Raise awareness of alcohol-related harm in the population
d) Increase pro-active identification and brief advice at primary care
e) Increase numbers referred into treatment providers as appropriate

4.2 The new strategy will strengthen many of the positive actions of the 2010-13 strategy: namely in the area of trading standards and local alcohol partnerships. The Kent Community Action Partnerships (KCAP) were identified nationally as best practice and showed how local action between police, trading standards, industry and the community could have good results in tackling under-age sales, town centre disruption and irresponsible licence holding. The new 2014-16 strategy will expand on this by enabling more KCAP sites across Kent.

4.3 The 2014-16 Kent Alcohol Strategy goes further than the previous strategy in a number of areas, notably the health prevention and treatment pathways. Currently there is capacity in the existing Alcohol Treatment Services which is not being utilised fully.

The development of an Integrated Care Pathway for alcohol and the introduction of a Locally Enhanced Service for Primary Care and pharmacy will help to provide the preventative element and increase earlier access to specialist treatment services.

4.4 A section has been developed for each key area (pledge element) which explores current action, the planned activity for the future and how we will know it has been successful (Table 1).

Table 1

Alcohol Strategy Pledge area	**Priority Actions to Address**
Prevention and Identification	Identification and Brief Advice (IBA) in Primary Care and pharmacies, Training, Social Marketing and targeted promotion. The development of an integrated care pathway for alcohol, increasing access/earlier access into specialist treatment provider services. Proactive case-finding for IBA screening in Primary Care especially those with mental health conditions and vulnerable populations

Treatment	Improve liaison at A&E, Pro-active care into and away from hospital, Creating a liaison team and after-care packages, better signposting. Better joint working and pathways into primary care.
Enforcement and responsibility	Tackling night-time economy, reduction of violence, use of crime & community partnerships, spot checks on traders, working with industry.
Local Action	Continue good practice using KCAP model and expand into areas where there is no KCAP. Improve data and needs assessment. Widen the partnerships. Support local schemes like street pastors and Alcohol Zones.
Vulnerable groups and inequalities	Prioritise dual diagnosis by improving the links between mental health workers and substance misuse treatment providers, domestic violence awareness campaigns and working with perpetrators. Work with the military covenant groups to increase awareness in ex-military/ veteran population.
Children and Young People	Continue with RisKit, lead a Kent-wide campaign, co-ordinate hidden harm strategy linked to KIASS, systematic screening in A&E.

4.5 The development of the Alcohol Strategy for Kent 2014-16 commenced in 2013, and took account of good practice being developed, and therefore many of the actions identified within the strategy are already underway.

- An improved 'in reach' system from the community treatment provider into the A&E in Maidstone and Tunbridge Wells Hospitals and the Queen Mother Queen Elizabeth in Margate.
- Agreement has been reached with many Kent Clinical Commissioning Groups (CCGs) to provide improved access to 'Identification & Brief Advice', where GPs are incentivised to pro-actively screen patients for alcohol misuse and then provide advice and/ or referral to treatment providers.
- Pharmacies will also be incentivised to pro-actively screen patients for alcohol misuse and then provide advice and/ or referral to treatment providers.

5 Implementation

5.1 A strategy implementation group will monitor progress on Kent Alcohol Strategy. This group will meet on a quarterly basis to monitor progress and will review the strategy on an annual basis. The implementation group will include a range of partners.

5.2 Each Health and Wellbeing Board should consider developing a detailed local action plan with a timeline and agreed responsibilities to ensure that actions developed will be focussed on achieving the outcomes within the Kent strategy.

5.3 Each locality will be provided with the widest range of alcohol profiles at Ward and CCG level as available. This will enable each area to target areas for action and provide information to monitor progress against aims and inform commissioning intentions.

6. Conclusion

Whilst much progress has been made in some areas, notably the reduction of admissions in those under 18 years, there is much work to be done to address the actual and predicted trend in hospital admissions across all ages.

By using the clear action 'road-map' of the Kent Alcohol Strategy 'Six Pledges' and 'Seven High Impact steps' and building upon the work to date and willingness to tackle alcohol related harm in our communities, it is anticipated that Kent will make good progress against the aims of the Kent Alcohol Strategy provided that:

- The importance of addressing and implementing the Kent Alcohol Strategy should be (and be seen to be) of high priority amongst organisations
- There should be a willingness to extend data capture and share data
- There should be support for workforce training
- Organisations should work together to avoid duplication and work flexibly to facilitate an integrated and comprehensive approach to tackling alcohol harm in Kent

7 Recommendations:

Members of the Swale Health and Wellbeing Board are asked to:

1. note this report and consider key actions from the strategy to be taken
2. develop a Local Alcohol Action Plan to implement the Kent Alcohol Strategy
3. consider creating a multi-partner Task and Finish Group to address the six pledge areas of the Kent Alcohol Strategy

8. Background Documents

Appendix 1 Kent Alcohol Strategy
Appendix 2 Local alcohol data profiles

9. Contact details

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Appendix 1 Kent Alcohol Strategy 2014-2016

Kent Alcohol Strategy 2014_16.pdf

Appendix 2 Local alcohol data profiles

Table 1 Summary of LAPE profile Indicators, 2013 (Source: NWPHO, KMPHO)

	Indicators	Swale	South East region
Mortality	Months of life lost - males	10.32	9.89
	Months of life lost - females	5.58	4.72
	Alcohol-specific mortality - males	10.40	11.78
	Alcohol-specific mortality - females	5.57	5.35
	Mortality from chronic liver disease - males	13.10	12.94
	Mortality from chronic liver disease - females	8.09	6.92
	Alcohol-related mortality - males	70.16	58.49
	Alcohol-related mortality - females	30.52	25.95
Admissions	Alcohol-specific hospital admission - under 18s	24.68	37.30
	Alcohol-specific hospital admission - males	301.51	375.53
	Alcohol-specific hospital admission - females	166.44	188.37
	Alcohol-related hospital admission (Broad) - males	1509.85	1409.59
	Alcohol-related hospital admission (Broad) - females	746.81	705.48
	Alcohol-related hospital admission (Narrow) - males	517.19	495.95
	Alcohol-related hospital admission (Narrow) - females	262.43	267.25
	Admission episodes for alcohol-related conditions (Broad)	1713.29	1615.65
	Admission episodes for alcohol-related conditions (Narrow)	501.91	513.12
Crime	Alcohol-related recorded crimes	5.65	4.90
	Alcohol-related violent crimes	4.14	3.60
	Alcohol-related sexual offences	0.11	0.11
Other	Abstainers synthetic estimate	14.32	14.73
	Lower Risk drinking (% of drinkers only) synthetic estimate	73.70	72.71
	Increasing Risk drinking (% of drinkers only) synthetic estimate	19.66	20.54
	Higher Risk drinking (% of drinkers only) synthetic estimate	6.63	6.75
	Binge drinking (synthetic estimate)	16.50	18.10
	Employees in bars - % of all employees	1.53	1.59

	Best locally
	Better performance than regional average
	Worse performance than regional average
	Worst locally

Tables 2 LAPE locality profile with definitions

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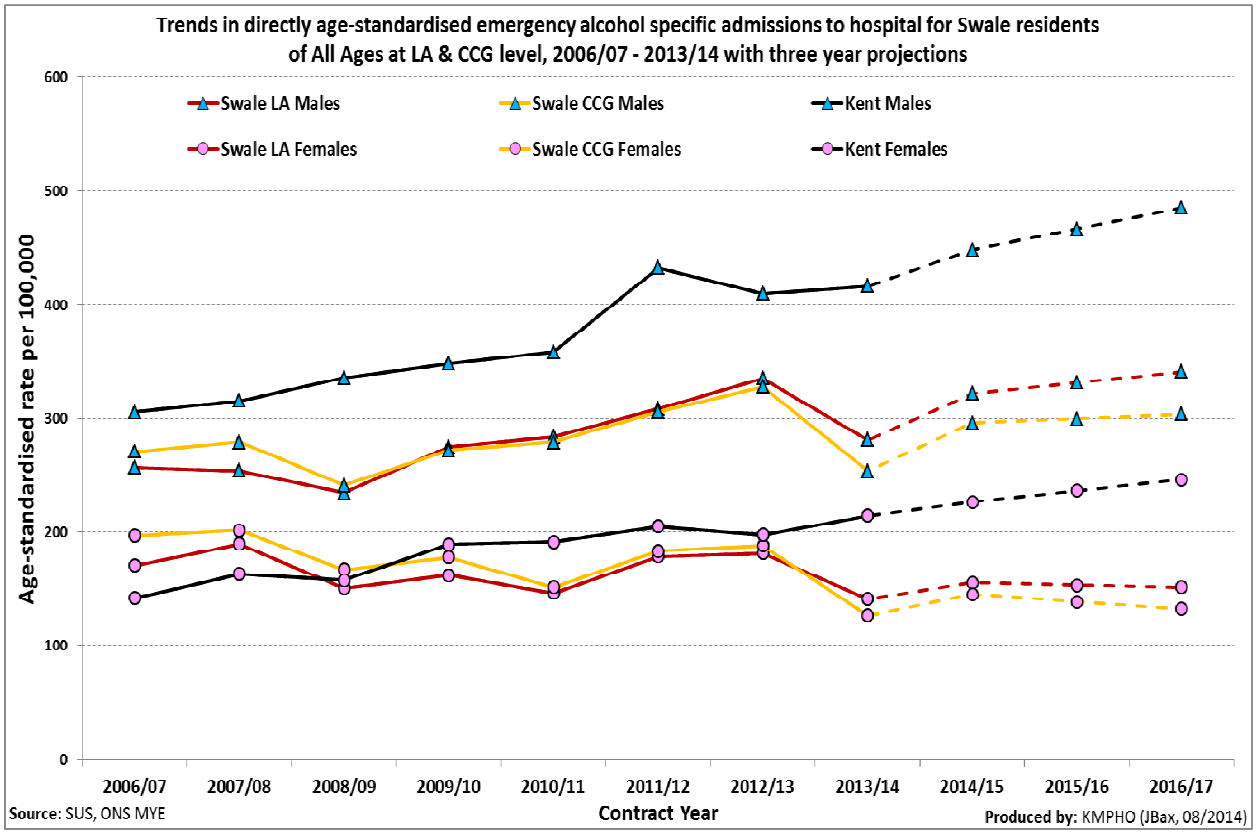
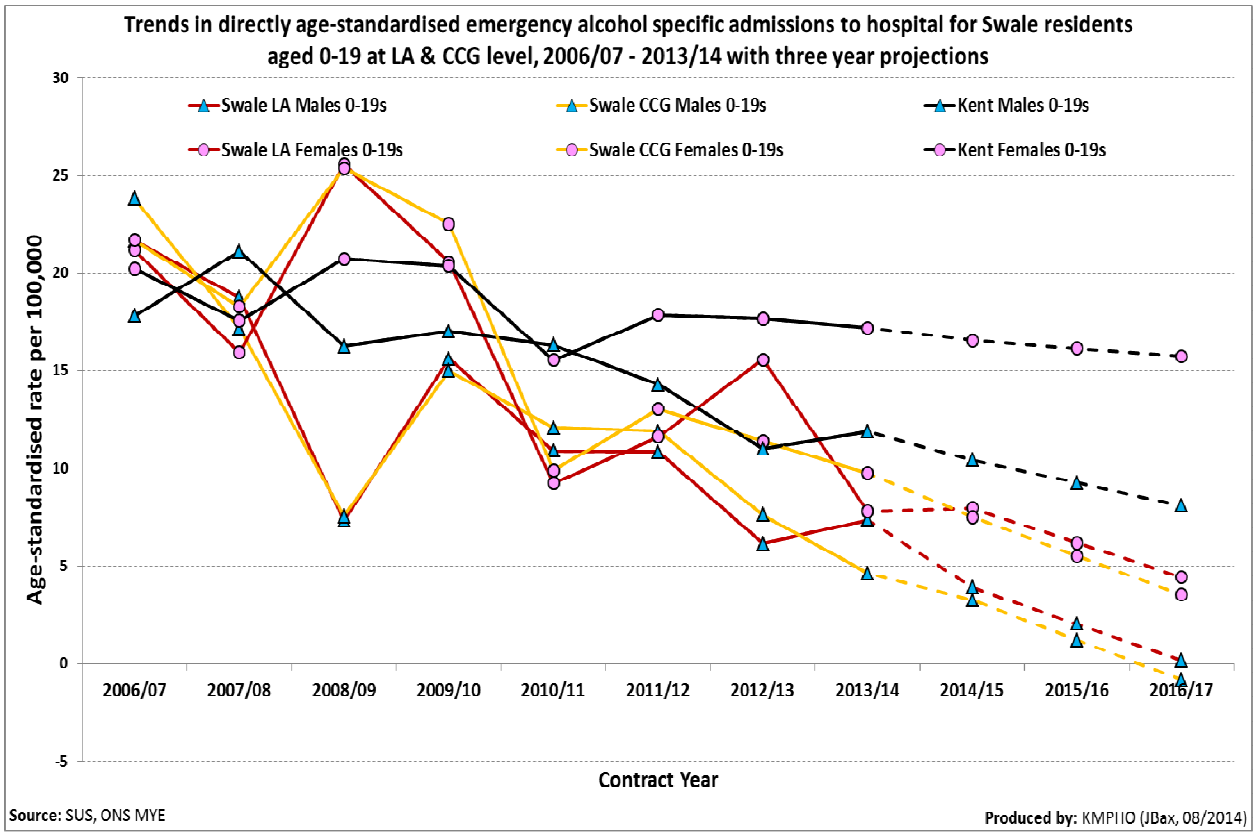
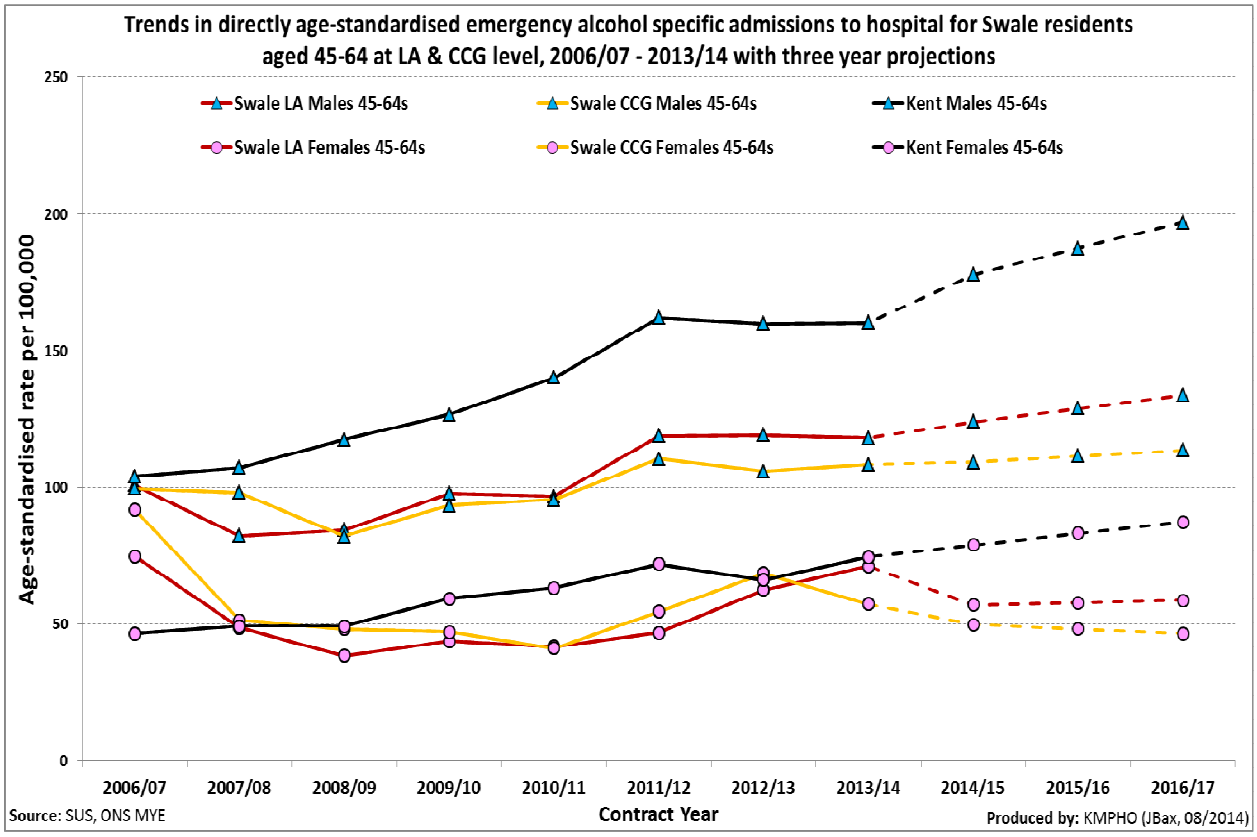
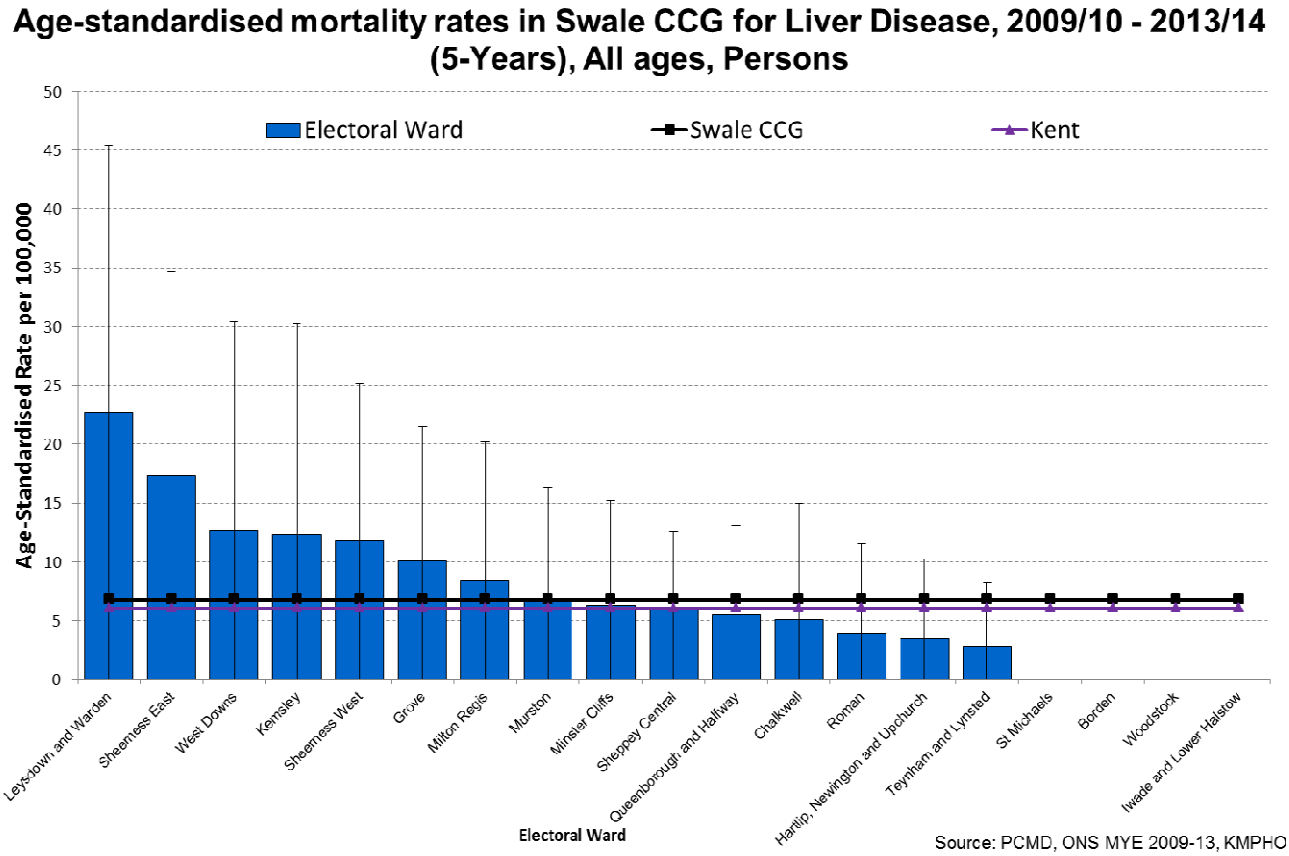
SwaleLAPEProfile201

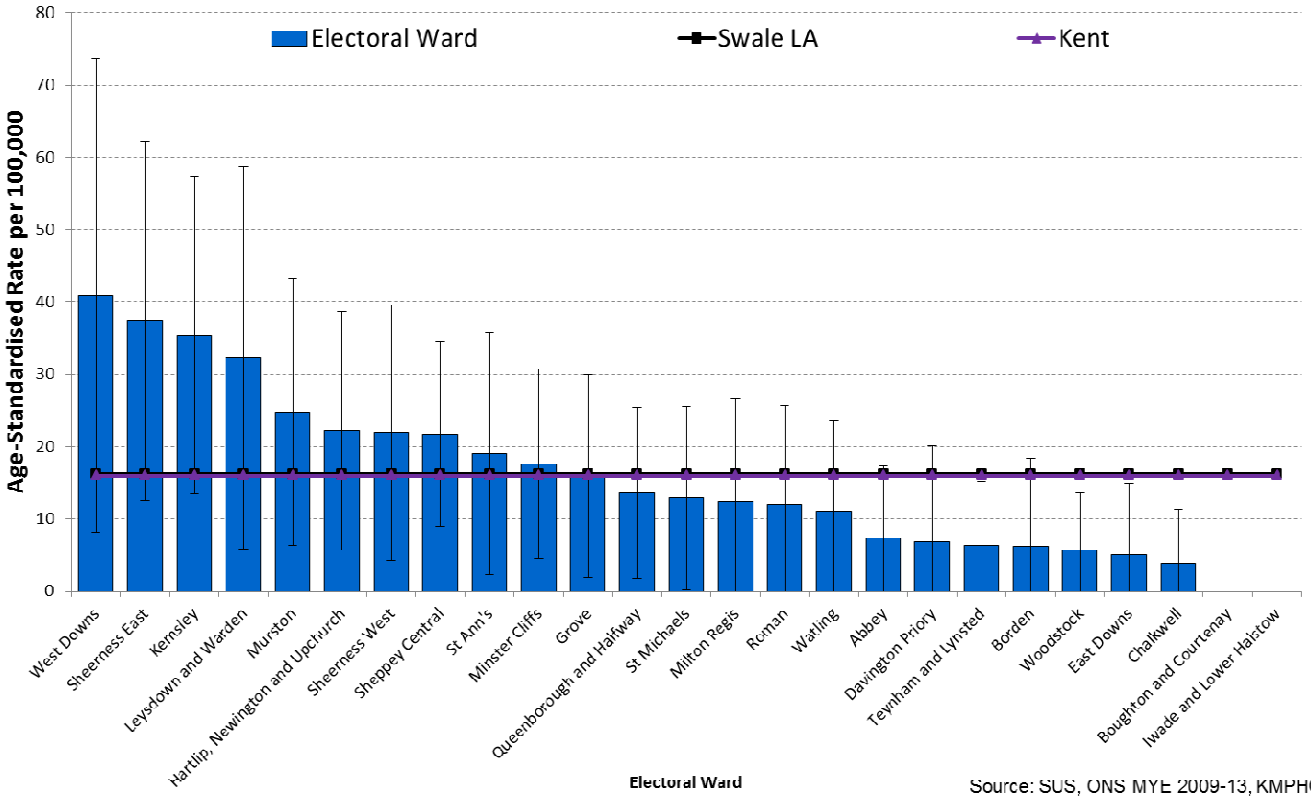

Trends in directly age-standardised emergency alcohol specific admissions to hospital for Swale residents of All Ages at LA & CCG level, 2006/07 - 2013/14 with three year projections
Swale LA Males
Swale CCG Males
Kent Males
Swale LA Females
Swale CCG Females
Kent Females
Age-standardised rate per 100,000
600
500
400
300
200
100
0
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
Contract Year
Source: SUS, ONS MYE
Produced by: KMPHO (JBax, 08/2014)


Trends in directly age-standardised emergency alcohol specific admissions to hospital for Swale residents aged 0-19 at LA & CCG level, 2006/07 - 2013/14 with three year projections
Swale LA Males 0-19s
Swale CCG Males 0-19s
Kent Males 0-19s
Swale LA Females 0-19s
Swale CCG Females 0-19s
Kent Females 0-19s
Age-standardised rate per 100,000
30
25
20
15
10
5
0
-5
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
Contract Year
Source: SUS, ONS MYE
Produced by: KMPHO (JBax, 08/2014)


Trends in directly age-standardised emergency alcohol specific admissions to hospital for Swale residents aged 45-64 at LA & CCG level, 2006/07 - 2013/14 with three year projections
Swale LA Males 45-64s
Swale CCG Males 45-64s
Kent Males 45-64s
Swale LA Females 45-64s
Swale CCG Females 45-64s
Kent Females 45-64s
Age-standardised rate per 100,000
250
200
150
100
50
0
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
Contract Year
Source: SUS, ONS MYE
Produced by: KMPHO (JBax, 08/2014)

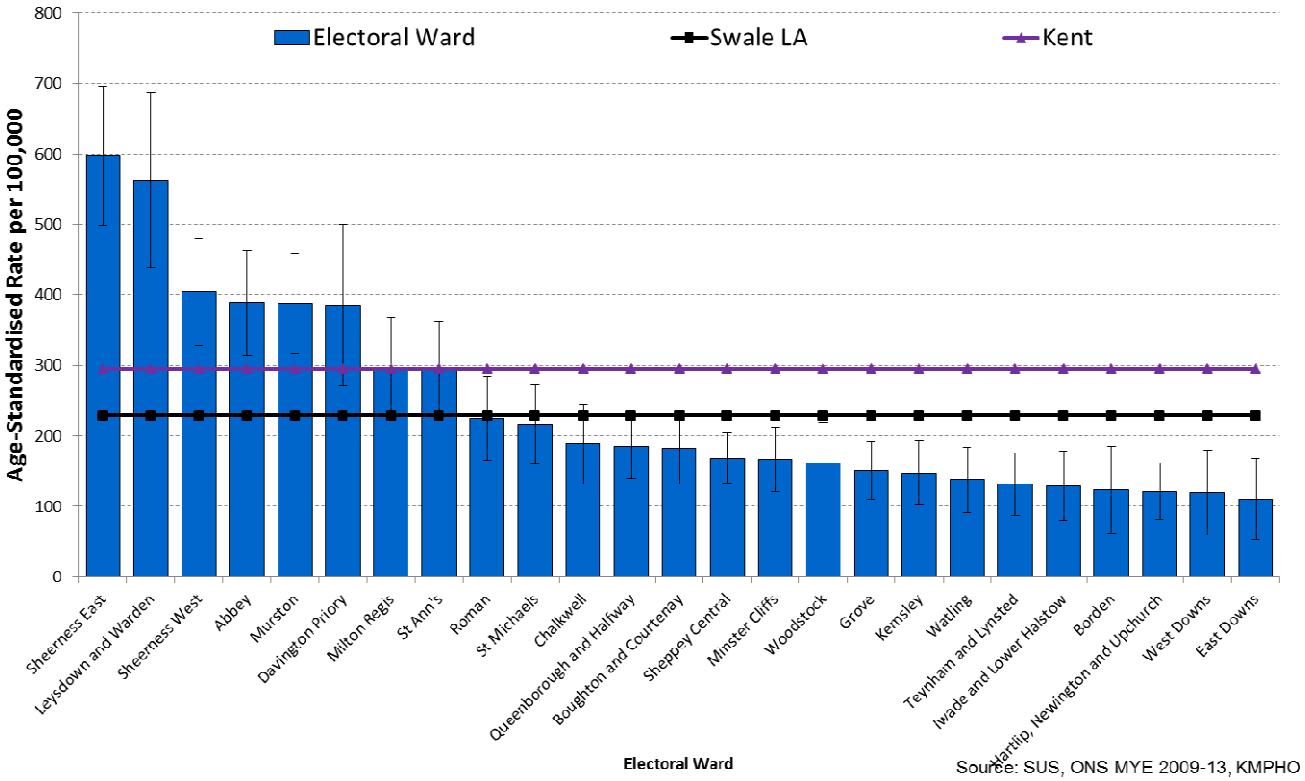

Age-standardised mortality rates in Swale CCG for Liver Disease, 2009/10 - 2013/14 (5-Years), All ages, Persons
Electoral Ward
Swale CCG
Kent
Age-Standardised Rate per 100,000
50
45
40
35
30
25
20
15
10
5
0
Leysdown and Warden
Sheerness East
West Downs
Kemsley
Sheerness West
Grove
Milton Regis
Murston
Minster Cliffs
Sheppey Central
Queenborough and Halfway
Chalkwell
Roman
Hartlip, Newington and Upchurch
Teynham and Lynsted
St Michaels
Borden
Woodstock
Iwade and Lower Halstow
Electoral Ward
Source: PCMD, ONS MYE 2009-13, KMPHO

Age-standardised emergency admission rates in Swale LA for Liver Disease (Primary Diagnosis= K70), 2009/10 - 2013/14 (5-Years), All ages, Persons



Source: SUS, ONS MYE 2009-13, KMPHO

Age-standardised emergency admission rates in Swale LA for Alcohol-specific conditions, 2009/10 - 2013/14 (5-Years), All ages, Persons



Source: SUS, ONS MYE 2009-13, KMPHO