Tuesday, 09 July 2013

Meeting of the Health and Wellbeing Board

Wednesday, 17 July 2013

3.00 pm

Meadfoot Room, Town Hall, Castle Circus, Torquay, TQ1 3DR

Members of the Board

Caroline Taylor, Torbay Council
Debbie Stark, Torbay Council
Sam Barrell, South Devon and Torbay Clinical Commissioning Group
Richard Williams, Torbay Council
Steve Moore, NHS England
Pat Harris, Healthwatch Torbay
Councillor Lewis
Councillor Scouler
Councillor Pritchard
Councillor Davies
Councillor Morey

For information relating to this meeting or to request a copy in another format or language please contact:

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01803 207064
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HEALTH AND WELLBEING BOARD
AGENDA

1. Apologies

To receive any apologies for absence, including notifications of any changes to the membership of the Committee.

2. Minutes (Pages 1 - 6)

To confirm as a correct record the Minutes of the Health and Wellbeing Board held on 23 May 2013.

3. Declaration of interest

3(a) To receive declarations of non pecuniary interests in respect of items on this agenda

For reference: Having declared their non pecuniary interest Members may remain in the meeting and speak and, vote on the matter in question. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

3(b) To receive declarations of disclosable pecuniary interests in respect of items on this agenda

For reference: Where a Member has a disclosable pecuniary interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Governance Support or Legal Services prior to the meeting.)

4. Urgent items

To consider any other items that the Chairman/woman decides are urgent.

5. Update Report - Adult Social Services (Pages 7 - 9)

To receive an update on the current position of Adult Social Services.

6. Update Report - Clinical Commissioning Group (Pages 10 - 11)

To receive an update on the current position of the Clinical Commissioning Group.

7. Update Report - Public Health (To Follow)

To receive an update on the current position of Public Health.

8.	**Update Report - Healthwatch** To receive an update on the current position of Healthwatch.	(Pages 12 - 14)
9.	**Update Report - Children's Services** To receive an update on the current position of Children's Services.	(To Follow)
10.	**The Preventative Community Project (Community HUB)** To consider a report that provides a brief overview of the Preventative Community Project/Community HUB.	(Pages 15 - 28)
11.	**Adult Learning Disability Services (including Winterborne View Action Plan)** To consider a report on the above.	(To Follow)
12.	**Joint Health and Wellbeing Strategy Priority 8 - Reduce Alcohol Consumption** To discuss how the Health and Wellbeing Board can broaden and lengthen the whole community approach to the reduction of alcohol consumption.	(Pages 29 - 80)
13.	**Information Pack** To note the contents of the information pack which is published as a separate document to the main agenda reports pack.	Circulated Seperately

Minutes of the Health and Wellbeing Board

23 May 2013

-: Present :-

Sam Barrell, Nigel Denning, Kevin Dixon, Councillor Chris Lewis, Steve Moore, Councillor Mike Morey, Councillor Christine Scouler, Debbie Stark and Caroline Taylor

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1. Election of Chairman/woman

Councillor Lewis was elected Chairman for the 2013/2014 Municipal Year.

(Councillor Lewis in the Chair)

2. Apologies

An apology for absence was received from Councillor Pritchard.

3. Appointment of Vice-Chairman/woman

Debbie Stark was appointed as Vice-Chairman for the 2013/2014 Municipal Year.

4. Minutes

The Minutes of the meeting of the Shadow Health and Wellbeing Board were confirmed as a correct record and signed by the Chairman.

5. Declarations of interest

Councillor Scouler declared a non-pecuniary interest as she was a Governor of Torbay Hospital.

6. Operation of the Torbay Health and Wellbeing Board

The Board noted the report on the Operation of the Torbay Health and Wellbeing Board.

7. Update Report - Adult Social Services

Members noted the report and were advised that partners would shortly be asked to engage in a review of accommodation based support, taking into account Torbay's Local Plan.

8. Update Report - Clinical Commissioning Group

The Board noted the update from the Clinical Commissioning Group.

9. Update Report - Public Health

Members noted the update report and were informed that Plymouth City Council and Torbay Council had entered into interim shared arrangements for the post of Director of Public Health.

The Board was also advised that the alcohol strategy was due to be refreshed with discussions had regarding whether or not the Alcohol Strategy should become an action plan within the Health and Wellbeing Board Strategy in order to avoid duplication within strategies.

10. Update Report - Healthwatch

Members noted the update report on Healthwatch and welcomed the news that Torbay was recognised as being 'ahead of the field' in terms of the development of Healthwatch.

11. Update Report - Children's Services

Members were informed that a recent unannounced Ofsted inspection had found the local authority arrangements for the protection of children to be adequate which was considered a significant milestone in the journey of improvement. Members were advised that responsibility for the continued improvements in child protection services from a partnership perspective sat with the Health and Wellbeing Board.

Resolved:

(i) that the Ofsted Inspection report be noted;

(ii) that a Partnership Executive be established as a sub-group of the Board, to ensure continued improvements in child protection services and to act on the areas for improvement identified within the Ofsted report;

(iii) that the membership of the Partnership Executive consist of:

- Director of Children's Services
- Executive Head – Safeguarding and Wellbeing (Torbay Council)
- Representative of Devon and Cornwall Police
- Director of Nursing and Professional Practice – Torbay and South Devon Health and Care NHS Trust
- Head of Quality Governance – Southern Devon and Torbay Clinical Commissioning Group
- Headteacher representative – nominated by Torbay Association of Secondary Heads

(iv) that the protocol arrangements with the Local Safeguarding Children's Board, as recommended in the accompanying report, be agreed;

(v) that the Chairman of the Health and Wellbeing Board together with the Chairman of the existing Children's Improvement Board formally respond to the Department for Education detailing these arrangements.

12. Torbay Safeguarding Children Board

The Board considered a brief overview of the role of the Torbay Safeguarding Children Board and considered the inter-relationship between both Boards. Members recognised the importance for both the Health and Wellbeing Board and the Torbay Safeguarding Children Board to develop an effective joint protocol to support their working relationship in the interests of safeguarding children.

Resolved:

(i) That the Director of Children's Services develop a draft protocol to support the working relation between the Health and Wellbeing Board and the Torbay Safeguarding Children Board in the interests of safeguarding children; and

(ii) the draft protocol be agreed by the Chairmen of the Health and Wellbeing Board and Torbay Safeguarding Children Board prior to formal ratification by the respective boards.

13. Performance Framework

The Board considered a report which sought to establish a performance framework for the Joint Health and Wellbeing Strategy. Members were advised that the Shadow Health and Wellbeing Board had agreed that at each meeting an update would be provided on each of the three outcomes identified within the Joint Health and Wellbeing Strategy. In drafting the outcome reports it became obvious that a wider discussion to determine the indicators to be used to measure the success of the Health and Wellbeing Strategy was required.

Resolved:

That the Partnership Commissioning Board (or Joint Commissioning Management Group, as appropriate) review the performance framework for the Joint Health and Wellbeing Strategy.

14. Integrated Health Initiative

The Board considered a report which outlined the commitment from Government to integrate health and social care by 2018 and inviting expressions of interest to become 'pioneers' in this area. The 'pioneers' will work across the whole local health, public health and social care systems as well as other local authority departments and the voluntary and community sector.

The Board was of the view that successful 'pioneers' would have an opportunity to transform health and social care, with the opportunity going beyond the traditional adult services. Whilst there was no tangible funding the members were of the view that there were other benefits to be gained from the examination of the whole health and social care system.

Resolved:

(i) that the health and care system leaders in Torbay prepare an expression of interest to become health and social care integration pioneers;

(ii) that, if successful, further consideration be given to how the Health and Wellbeing Board can work effectively with any other governance arrangements to support the pioneer work.

15. Development of Mapping and Consultation Work in Torbay Organisational Audit

Members considered a report that provided an update on work that had been undertaken on mapping the statutory, voluntary, community and public sector organisations within Torbay. Members were informed that it was important to have a clear picture of the variety and nature of the organisations in the Bay in order to adopt an efficient single resource that would be used for consultation and communication.

Resolved:

(i) that available information relating to contacts and links for all relevant organisations in Torbay be cross-referenced to ensure accuracy;

(ii) that, once completed, the Torbay Health and Wellbeing Board adopt a single resource which will be used as the focus for consultation and communication with health and social care organisations in Torbay; and

(iii) that the Torbay Health and Wellbeing Board support the upkeep and maintenance of the resource.

16. Joint Health and Wellbeing Strategy - Priority 15 Improve Care for People Living with Dementia and their Carers

As part of its agreed approach, the Board gave consideration to one of its priorities within the Joint Health and Wellbeing Strategy, namely Priority 15: Improve Care for People living with Dementia and their Carers. Representatives from the Clinical Commissioning Group, Devon Partnership NHS Trust and Torbay Southern Devon Health and Care NHS Trust gave details of the work that was currently underway in Torbay in relation to this Priority together with that which was planned.

Members of the Board then discussed how the Health and Wellbeing Board could "broaden and lengthen" the whole-community approach to dementia. In particular, members were asked to pay particular attention to whether the actions within the

Joint Health and Wellbeing Strategy were the right ones, what needed to change locally to meet the outcomes required by the Board, and what could the Board do to promote integrated working to support this priority.

In addition to the representatives of the NHS organisations listed above, a representative of the Alzheimer's Society also contributed to the discussion. Members of the Board had been asked prior to the meeting to consider how their organisation was helping to create a dementia friendly society in Torbay together with any feedback received from clients, patients or the general public about how those living with dementia and their carers are treated within the wider community.

The current diagnosis gap in Torbay is 47% with an ambition of reaching 55% by 2014. This gap in diagnosis is not unusual for population makeup of the area and is typical of other seaside resorts. The performance within Torbay could be tested out through comparison with other local authority areas and across GP practices.

Whilst age is the biggest risk factor associated with dementia, there is more that can be done around prevention with some of the contributory factors also being the same contributory factors to heart disease and stroke. Future public health campaigns should highlight dementia alongside the healthy living message.

Training would continue within community settings such as care homes and domiciliary services, as well as in the wider primary care environment (including practice nurses, community nurses, pharmacists and receptionists – all of whom may be seeing patients on a more regular basis than doctors and may therefore be more able to identify changes in behaviour).

Ensuring that people can live well with dementia would help to address the stigma associated with the condition as well as helping to allay the fears of seeking a diagnosis. Raising awareness of dementia within the wider community would increase the number of people who are aware of symptoms and associated changes in behaviour in order that concerns could be raised and referrals made.

In terms of raising awareness, it was noted that there were a series of opportunities throughout the year (including the inaugural meeting of Healthwatch Torbay, the Devon Interfaith Festival and the Peninsula Public Health Network) which could be used to promote healthy lifestyles and preventable diseases. The increased use of social media would also be explored.

For Torbay to be a truly dementia friendly community, consideration would need to be given to what the area would look like in, say, 10 years time and whether, as a resort, Torbay would be able to promote itself as a dementia friendly area. There was likely to be work to be done around the physical and environmental attributes of the area as well as the behaviours, values and attitudes of the community as a whole. It was suggested that there was a role for Healthwatch Torbay in testing out the current levels of dementia-friendliness within Torbay.

Consideration was also given to the Dementia Friendly Schools Programme which was being run in Plymouth and whether this could be implemented within the schools in Torbay.

17. Information Pack

The information pack was noted.

Chairman/woman

Title:	Update Report - Adult Services		
Wards Affected:	All		
To:	Health and Wellbeing Board	**On:**	17 July 2013

Contact: Caroline Taylor, Director of Adult Social Services
Telephone: 01803 207116
Email: caroline.taylor@torbay.gov.uk

1. Achievements since last meeting

1.1 The beginning of the financial year end has indicated that the commissioning of adults services from TSDHCT has been progressing in line with the ASA. This continues to be a positive achievement given the demand pressures on the services for adults.

1.2 Dialogue with care homes as providers of services continues to take place and a further development of the fees model in conjunction with the CCG will take place over the summer and autumn period before council sets fees for further years.

1.3 The process of acquisition of TSDHCT continues with a members working group considering the detail of the business case. A summary and recommendations of the final business case following formal evaluation in June is going to council on 18th July 2013, followed by NHS processes for final decision and determination. The council remains committed to the model of integration of health and social care.

1.4 Supporting people services continue to provide preventative services and a consideration with partners will be how to manage the expected reductions in public expenditure and still manage support and prevention for vulnerable groups.

1.5 The pioneer bid to government to help support the transformation of health and social care for local people was submitted on time. This will be assessed and any announcement will be made in September.

1.6 Government set out its funding intentions in June for CSR. The 10% cut to 2015/16 local government funding by the Chancellor in his Spending Round announcement last week brought few surprises to most of us. This means overall funding for local government will fall by £2.1 billion in 2015/16.

1.7 There was some slightly better news in the announcements, there will be a £3.8 billion pooled budget for health and adult social care and a continuation

of the existing transfer of funds from the NHS to Adult Social Care, known as section 256 monies. There is also an additional £200m to support the transformation process.

1.8 Adult social care services will need to develop its approach to Dilnot and self-funders which will drive new organisational demands and new processes for assessments will be required. Some of the new monies in the government announcements it is understood are for the costs of Dilnot year 1.

2. Challenges for the next three months

2.1 The need to focus on delivery whilst the acquisition process goes through its determination is a continued risk to our local system. This is mitigated through good local working relations across the health and care system and an emphasis on the focus on 'Mrs Smith' with shared vision and values.

2.2 The action plan to improve our mental health services through AMPA has been submitted to CQC and a short and long term set of improvements are underway.

2.3 The work of the health and well being board, the CCG and the pioneer bid will need to be pulled together into a single programme of work reported to the HWBB for Torbay, and to the governance of Devon County Council in order to manage our resources efficiently and effectively.

2.4 Development of holistic review of accommodation based care and support, including care homes, Dom care, supported living, extra care housing for long term view of market for providers including mental health as well as physical fragility is part of a market position statement required by January 2014, and capacity will need to be prioritized for this.

2.5 Understanding the financial announcements by government and having an early discussion with CCG as to what this may mean regarding our future financial commissioning intentions and the 'single pot' approach articulated in the acquisition process.

3. Action required by partners

3.1 Support to develop work for pioneer of health and care system as per Norman Lamb pilot within a single work programme for local government, CCG and providers reporting to HWBB and DCC Governance.

3.2 Engaging with care homes jointly with CCG regarding fees for future years.

3.3 Continued engagement of role of voluntary and community sector for joined up role of health and care in financially sustainable way.

3.4 Engaging with CCG regarding future financial model and use of 256 and transformational monies.

DRAFT

3.5 Reviewing supporting people arrangements via service user and providers consultation in view of reducing resources in local government.

DRAFT

Title:	Update Report –South Devon and Torbay Clinical Commissioning Group (CCG)		
Wards Affected:	All		
To:	Torbay Health and Wellbeing Board	**On:**	17 July 2013
Contact:	Dr Sam Barrell, chief clinical officer		
Telephone:	01803 652 451		
Email:	Laura.jenkins@nhs.net (PA)		

1. Achievements since last meeting

1.1 We have seen positive developments in forging closer working links with our partners and providers, as well as with the public. As part of our Meet the CCG series, we held a successful open meeting in Torquay in June with some 80 attendees from the community and public. They joined round-table discussions before an open plenary session with questions to our CCG from the floor.

1.2 Our ambitious project to connect clinicians with e-Prescribing has been given the go-ahead, with confirmation of funding from HM Treasury of £3.1million. This means the South Acute Programme is now pressing ahead to develop a range of systems aimed at enabling clinicians, no matter where they work, to have an up-to-date picture of the medication a patient is taking. We see significant gains in this for patient safety and quality of care.

1.3 The Joined Up Health and Care Cabinet has established a new programme board and is recruiting a project lead to drive our whole-system integration programme.

1.4 A redesign of mental health and learning disability services has begun well, with valuable feedback from our early engagement with people with lived experience of mental health problems. This work will continue over the coming months.

2. Challenges for the next three months

2.1 We are awaiting the outcome of the acquisition process under which South Devon Healthcare NHS Foundation Trust has bid to acquire Torbay and Southern Devon Health and Care NHS Trust. The principles underlying the bid – of streamlined, integrated care – will need to be taken forward regardless of the formal decision.

2.2 The five locality commissioning groups within our wider CCG will be carrying out an engagement within their local areas about future community services. This engagement will be on a wide scale and will need considerable resources to make sure that as many people as possible can have their say.

2.3 With nationwide pressures on emergency services and urgent care, the CCG is working with all providers to make sure plans and systems are in place to maintain the highest quality of care for patients. This is particularly important as we head into our winter planning phase.

3. Action required by partners

3.1 To note this report.

healthwatch Torbay

Healthwatch Torbay is the independent health & social care regulator and consumer champion for Torbay. Using real patient feedback to make recommendations; We can really make a difference.

Internal Report - July 2013

Contents:

1. Internal Developments
2. News, Events & Community Projects
3. Public and Patient Engagement

1. Internal Developments

Healthwatch Torbay, in Paignton Library & Information Centre on Great Western Road

Feedback Systems

Healthwatch Torbay are up and running as the new champion for local people and independent regulator for health and social care services in the Bay. We are already receiving plenty of feedback from service users and have established specific systems to gather feedback, including:

- Online submission forms via our website, www.healthwatchtorbay.org.uk;
- Our Freephone number (08000 520 029) and email address (info@healthwatchtorbay.org.uk);
- Our purpose-built walk-in centre at Paignton Library & Information Centre;
- Through social media via our Facebook and Twitter accounts;
- Visiting providers and both hosting and attending community events where we can directly interact with users;
- Through the design, production and distribution of 5000 promotional leaflets with a separate written submission form that can be posted in privacy for free (see design on the right).

A cross section of the design of our new Healthwatch Torbay leaflet

New Information System

To ensure all the feedback we capture is utilised in the correct way, we are currently in the process of implementing a brand new information database system that will allow us to quickly and easily collate and analyse all the user feedback we receive. We will then be able to produce particularly extensive reports and recommendations at a much faster rate. The system also allows us to signpost users to the correct services and deal with enquiries very efficiently.

Staffing

As well as a Manager and a Coordinator, we have employed a Youth Coordinator to specifically engage with young people in Torbay and gather feedback (e.g. young carers); a Community Engagement Worker to liaise directly with consumers and feedback providers; and an Information and Communications Officer to promote Healthwatch Torbay locally and ensure communications systems (including website, information, responses, etc.) are regularly maintained. We also have a part-time Communications Officer to gather personal case studies and news items.

Board of Directors

To mark National Volunteers' Week we recently thanked all our fantastic volunteers and launched a search for a new voluntary **Board of Directors**. An interim Board of Directors was set up to oversee the launch of the organisation, which is now in the position to elect a new a voluntary Chair of the Board - as Lay Leader for three years - and also voluntary Board Members - Lay Members required to work together as a team to influence decision makers to bring about positive changes. The new Board will be officially launched at our inaugural Annual General Meeting on Wednesday 18th September from 6.30pm – 8.30pm at Paignton Library.

2. News, Events & Community Projects

Kevin Dixon, Pat Harris, Katy Heard, Cllr Christine Scouler and Mandy Seymour at our official opening

Official Opening

Special Guests poured into Paignton Library & Information Centre recently for the official opening of new offices for both Healthwatch Torbay and Torbay Carers Services.Torbay MP Adrian Sanders joined dignitaries and guests from Torbay Council, Torbay and Southern Devon Health and Care NHS Trust, South Devon and Torbay Clinical Commissioning Group, Paignton Hospital League of Friends, South Western Ambulance Service NHS Foundation Trust and others at the special lunchtime launch, with the opening plaque officially unveiled by Councillor Christine Scouler, Executive Lead for Adult Social Care and Older People at Torbay Council. Speeches from Mandy Seymour, Chief Executive of Torbay and Southern Devon Health and Care NHS Trust (TSDHCT) and Healthwatch Torbay Acting Chairman Kevin Dixon congratulated both organisations on their new headquarters, thanking everyone for attending.

Torbay Hospital PLACE Assessments

Healthwatch Torbay volunteers took part in a special assessment designed to assess Torbay Hospital across a range of environmental aspects against common guidelines. The Patient-led assessments of the care environment (PLACE) provide an annual snapshot that gives hospitals a clear picture of how their environment is seen by those using it, and how they can improve it. Three of our volunteers - Anita Forrest, Kevin Dixon, and Sam Ebden – undertook training to participate in the PLACE assessments.

National Carers Week

For National Carers Week, Healthwatch Torbay were involved in a variety of events, including hosting a Cream Tea for Carers event at the Livermead Cliff Hotel, Torquay, attended by over 50 local carers. Our Youth Coordinator Bekki also trained young adult carers to be peer evaluators, to be able to gather feedback and experiences from other young adult carers. This included a creative activity event for young people at Parkfield Youth Centre to gather feedback about the young carers service.

Healthwatch Torbay hosts the 'Cream Tea for Carers 'event at the Livermead Cliff Hotel, Torquay

NHS England Conference

Healthwatch Torbay Manager Pat Harris attended the NHS England Conference in London on 25th June to provide a joint presentation with the South Devon & Torbay Clinical Commissioning Group on Healthwatch Torbay and our collaborative working with partners. During the conference, the collaboration between South Devon and Torbay CCG and Healthwatch Torbay was described as the **"jewel in the crown of partnership working in the South West"** by the Local Government Association's senior Healthwatch adviser, Trish Stokoe. Healthwatch Torbay was put forward for working closely with the Health and Wellbeing Board, Director of Public Health at Torbay Council and the CCG throughout transition, authorisation and the establishment of the new organisations. The collaboration also included support for current Healthwatch Torbay youth work initiatives, including setting up Torbay Youth Power and training a team of Young Inspectors. The youth project has been cited by NHS England as an example of national good practice and is expected to be highlighted in a keynote speech at the Association of Directors of Children's Services national conference.

South Devon College Partnership

Our Youth Coordinator has been working at developing a successful partnership with South Devon College and was even recently invited to be a guest judge at the prestigious Worldskills UK Health & Social Care Competition held at the College. Healthwatch Torbay and South Devon College have been working closely together for a while on a variety of different initiatives, including: students designing promotional materials for the launch of Torbay Youth Power (TYP); setting up creative consultation activities for health & social care professionals and over 150 students; giving presentations; and hosting quizzes and Q & A sessions at the College.

Quality Account Responses

To date we have provided responses and recommendations to six separate Quality Accounts for local NHS Trusts and other organisations, including: South Devon Healthcare NHS Foundation Trust; Torbay and Southern Devon Health & Care NHS Trust; Devon Partnership NHS Trust; Rowcroft Hospice Quality Account; and the Adult Social Care Local Account.

Community Events

We have attended a variety of events including: the first ever National Healthwatch Conference in Birmingham; information sessions at Pembroke Surgery (Paignton) and Brixham Community Centre; the Active for Life event at Torquay Town Hall; and we have also chaired a CCG Open Forum meeting Q&A session at the English Riviera Conference Centre in Torquay.

Surveys and Reports

- We are preparing a report on the Melville Hill/Warren Road are of Torquay to outline recommendations for improvement, after a survey we commissioned discovered people, on average, die 8 years younger in that area.
- We are preparing a similar survey and report on the cost of wasted medication in Torbay.
- We are also revisiting the recommendations that were put forward to the Torbay and Southern Devon Health & Care NHS Trust domiciliary report to see if the actions were taken forward.

Forthcoming Events

- We have created a communications plan incorporating our own forthcoming events which includes three separate public community engagement events in Brixham, Paignton and Torquay town centre in September.
- We are currently working with the Herald Express on a patient-led double page spread on how changes to the NHS will affect the public, and also to produce a regular Healthwatch Torbay monthly column.
- We are also hoping to be part of an exciting bid – with the CCG – to become one of only ten national 'Pioneer Sites for Integration'.

Further information on any of the above can be found on our website: www.healthwatchtorbay.org.uk

3. Public and Patient Engagement

Introduction

As we are yet to implement our new information system; thorough statistical analysis and tracking of enquiries, feedback, experiences or concerns is limited. However, below is a breakdown of the **issues** and **concerns** received from 2nd April to 11th June (10 week period) and the action taken.

NB. Date range does not apply to 'Current Issues & Trends' section

Number of Concerns

- **21** individual issues/concerns have been received either via events, telephone, online or from our drop-in-centre at Paignton Library and Information Centre.
- **10** people raised concerns around **2** separate issues at external meetings.

Breakdown of Responses

- **6** have been logged with no further action at this moment of time, people have been informed of this when placing the issue
- **8** have been given the information they required either when they phoned or when they dropped into the centre or - in the worst case - have been phoned back the same day with the information required
- **4** have been forwarded to PALs for further investigation with the client's approval
- **3** have been received through the web site, but **2** were anonymous. The named person was contacted immediately to confirm we had received his concern. He didn't want us to do anything just to log his concern.
- The concerns raised by the **10** people at external meetings have been logged with no further action at the moment but we will monitor any developing pattern.

Further Action

- As a result of all the logged information we have made **1** formal request for information on 29th May with the expected reply no later than 28th June. Acknowledgement of receipt of this letter has already been received.

Current Specific Issues (for June 2013 ONLY)

- Of the **14** concerns raised in June via events, telephone, online or from our drop-in-centre: **7** involved Doctor First Appointment; **4** were experiences with Torbay Hospital (**1** positive experience); **1** involved Mental Health (accessing Counselling Services); **1** was Community Based (accessing a support group) and **1** was Housing-related. A response was required in 5 cases.
- **5** were signposted – **2** to SEAP, **2** to PALs, and **1** to Disability Information Service. The rest were logged.

Any Other Comments

- Our new social media development is showing signs of patient involvement. As of 30th June 2013, Healthwatch Torbay had **280** followers on Twitter and **22** likes on Facebook. We have had interaction with a number of different people and organisations, and have even received patient feedback on specific health-related issues on 4 separate occasions.
- We are currently in the process of distributing the majority of our **5000** leaflets to Care Homes, Doctors & Dental Practices, waiting rooms and other available outlets. The leaflets have a separate written submission form that can be posted in privacy for free.

Title:	The Preventative Community Project (Community HUB)		
Wards Affected:	Hele & Watcombe Wards Torquay		
To:	Health and Wellbeing Board	**On:**	17/07/2013
Contact:	Mrs Christine Timmon		
Telephone:	07825 027629		
Email:	ctimmon@nhs.net		

1. Purpose

1.1 To provide Torbay Health and Wellbeing Board with a brief overview of the Preventative Community Project/Community Hub.

2. Recommendation

2.1 To note the activities being undertaken by the Preventative Community Project/Community Hub pilot in the Hele and Watcombe community.

3. Supporting Information

3.1.1 Background**:** The PCP original vision was based on the idea of a community preventative multi-agency team. This developed from joint work on more collaborative working and integration between Children Services, Community Safety and Public Health. Also linked with work that Hazel Stuteley undertook in Falmouth and concepts from “The Tipping Point: How Little Things Can Make a Big Difference” by Malcolm Gladwell.

3.1.2 There has been recognition in findings from Marmot, Allen and Field that childhood is an important time not only for the healthy development of the child but the opportunity to intervene to prevent long term adverse consequences. With the planned increase in health visiting numbers in Torbay to 54.5 WTE in line with the *Call to Action, Health Visitor Implementation Plan, 2010 – 2015*. An opportunity has arisen to develop a preventative community model in partnership with Children Services that helps increase community capacity and social capital to ensure sustainable support from the community.

3.1.3 Project Aims:

- To lay the foundation for a new way of collaborative working across statutory agencies, voluntary groups and a defined community in Torbay.
- To incorporate evidence which demonstrates improved outcomes for

children and young people following increased resources in Early Years.
- To develop and build upon existing preventative services in partnership with the community in order to identify at an early stage, when an individual, family or population require additional help, support and interventions.
- To work with current community capacity models and social capital in order to reduce reliance on public services and increase community resilience.
- To pilot and review the development of a 0 to 19 SCPHN team in Torbay, evaluating the project including an option appraisal, to inform the future development of the SCPHN service.

4. Relationship to Joint Strategic Needs Assessment - Priorities

4.1 The Preventative Community Project /Community Hub (PCP) are piloting a 0 to 19 Specialist Community Public Health Nursing Service (health visiting and school nursing) in partnership with other statutory organisations and the voluntary sector with Hele and Watcombe communities.

4.2 The PCP have a focus on reducing inequalities in health and wider social inequalities by working in partnership with other statutory agencies, the voluntary sector and the community to help reduce early disadvantage and reduce poorer outcomes from pregnancy and birth and during childhood. The PCP considers the wider determinant of health offering support with poverty, life style choices and housing support.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 This project was the topic of the first Health and Wellbeing Board forum in 2012 and fits with our outcome that children have the best start in life.

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

6.1 This issue remains a priority to meet the needs of our population.

Appendices

Appendix 1: Project Objectives.
Appendix 2: Revised project plan
Appendix 3: An interim report on progress to date including main actions & developments.

The Preventative Community Project /Community Hub

A revised delivery model:

The revised delivery model is a staged approach to delivering the original vision.

Stage one the six month pilot from 18/2/13 to 31/8/13

The 0 to 19 health team consist of Health Visitors, School Nurses, Public Health Staff Nurses, Community Nursery Nurses, Health Visitor Assistant, Student SCPHN and Life Style Workers.

Other practitioners that work in the Hele & Watcombe area have linked with the health team these have included, Midwives, Police Officers, PCSO's, Street wardens, Sanctuary Housing staff and Action for Children, Children Centres staff. Two workshops have been run on the 21st January and the 12th February to facilitate joined up working including a session facilitated by Helen Thorn on information sharing across agencies.

There are other professionals and agencies that work in Hele and Watcombe that will also be involved in the project.

The 0 to 19 health team remain GP and school attached with an additional responsibility for the geographical areas of Hele & Watcombe.

The health team is based on two sites Barton Health Centre and Union House 4th floor this is an interim arrangement while additional space at Barton Health Centre or a more suitable site can be located. All clinical work will be undertaken at Barton Health Centre or other community venues in Hele and Watcombe. Other professionals and partner agencies are not collocated with the Health team.

A health visitor coordinator has been identified, Donna Harding who will link with the local community and partner agencies that work in the Hele and Watcombe area. The coordinator will attend the Hele and Watcombe tasking group that currently runs monthly at the Hele Angels centre and link with both the Hele and Watcombe Community Partnerships and the wider voluntary sector.

The coordinator role is supported by a Senior Lifestyles worker Trudi May helping the team make links with Hele and Watcombe communities.

The coordinator will bring the information back to the health teams weekly meeting to discuss and consider actions to address health issue's identified by the local community.

A joined up approach to issues identified by the local community will be addressed across agencies in partnership with the community. This will be taken to the project's steering group who consist of a lead for each partner agency and the two Community Partnership's for further discussion and planning

If a family is highlighted as requiring an early intervention then the coordinator will liaise with the named practitioner for that family. Level 1 support will be coordinated by the named practitioner and a referral will be made to the Safeguarding HUB if the threshold criteria reach level 2 or 3 as described in the Child's Journey.

Stage Two

A positive evaluation and option appraisal may result in this service model being rolled out across the Specialist Community Public Health Nursing Teams in Torbay.

The 16 Community Partnerships' in Torbay would be aligned to a 0 to 19 Specialist Community Public Health Nursing Teams. A best fit model would be developed for each team with Community Partnership's, GP practices and local schools.

Each team would have a different level of resource dependant on need positively discriminating towards deprived areas. The Health Visitor caseloads will be weighted according to the Sarah Cowley Model. Ref 1

An option for the delivery of Stage two could consist of a step approach choosing an additional Community Partnership, instead of a complete roll out across the Trust. This would fit with the Health Visitor 2015 proposed increase in Health Visitors; the proposed increase is staged at several points in the year up to 2015. Currently the majority of new Health Visitors are recruited following completion of the SCPHN training in September and February of each year.

Stage Three

The Specialist Community Public Health Nursing 0 to 19 team would deliver a service to a defined geographical area. Each team would already have an identified Community Partnership Area they have been responsible for and begun working with local partners and community groups. The SCPHN 0 to19 team would have gained knowledge obtained from stage 2 that would inform the formation of new geographical caseloads.

References

- Cowley S and Bidmead C, *Controversial Questions (Part One): What is the Right Size for a Health Visiting Caseload?*, Community Practitioner, 2009; 82 (6): 18-22

Objectives and outcome measures for the Preventative Community Project (Community HUB)

1. **To pilot a preventative (early intervention) community team in the geographical areas of Hele and Watcombe Torbay.**
   a. **Integrating and amalgamating Health Visitors, School Nurses, Midwives and Lifestyle Workers into the local community and community services (piloting the delivery of health services from community venues, such as the Acorn Centre and the Watcombe Community Centre,)**
   b. **Agreeing the focus, functions and common systems of the Community Hub team.**
   c. **Develop the staff and pilot new ways of working, to accommodate the needs of the pilot service and service user.**
   d. **The team will develop a "record log" to capture a variety of change aspects during the pilot, such as change in ways of working, issues and risk identified/encountered and attempting to capture the community spirit. This should be completed periodically (weekly) and owned / governed by the team coordinator and presented to the steering group.**

2. **To pilot a service model to deliver a community capacity building approach, in partnership with the Hele and Watcombe communities and other agencies to;**
   a. **Improve the health outcomes to children and young people**
   b. **Identify the needs of the community in relation to current gaps in service delivery and identify a system / process/ service to address that need (e.g. School Nurses could identify girls in the local community who did not have their HPV vaccine and there for run a local catch up campaign to eliminate this gap)**
   c. **Build on community strengths, capacity and relationships. To further develop opportunities for volunteers in the service provision.**
   d. **Investigate the potential to reduce the duplication in service delivery (e.g. the Health Visitors working with early years education at the 2 year review and the HV 2.5 review) to deliver a lean, integrated services with partners.**
   e. **Use closer relationships with partners to identify early when families need support providing support at level 1 under the Child's Journey - therefore building on an early intervention, prevention strategy. Capturing good practice in case studies across agencies.**

f. **The identification of adult and young carers and sign posting to appropriate support networks.**

3. **To build on existing relationships with the community and community groups e.g. Hele Angel and the Chairs of both the Hele and Watcombe Community Partnerships other community groups and individuals.**
   a. **To research the current Community Partnership leads and other community leaders**
   b. **Develop a way of working with these groups over the lifetime of the pilot**
   c. **To work in partnership with the community groups to identify health need within the community, so inform service delivery.**

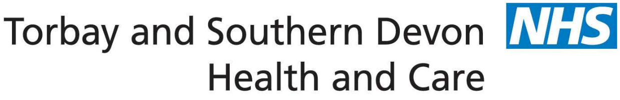
4. **To pilot and review the development of a 0 to 19 team in health, through integrated working with Health visitors and School Nurses in the pilot Hub.**
   a. **Perform a team (HV, SN, Midwives and partner's) S.W.O.T analysis prior to pilot initiation based on this objective (this will aid with the final pilot report and also provide a comparator for the final team (HV, SN, Midwives & partner's) S.W.O.T analysis.**
   b. **Pilot the removal of boundaries between Health visiting and School Nursing.**
   c. **Identify and pilot new opportunities to deliver Public Health Agendas together.**
   d. **Develop a communication strategy for the community to build closer relationships and help with the development of an awareness of all services provision with the Hele and Watcombe areas.**
   e. **To pilot the Band 5's Public health Staff Nurse working across both Health Visiting and School Nursing.**
   f. **Perform a final S.W.O.T analysis (HV, SN, Midwives & all partner's) including outcomes achieved) from this objective and compare with the initial S.W.O.T analysis created at the start of the pilot.**
   g. **Deliver a report / option appraisal in the 0 – 19 initiative.**

5. **To deliver a final project appraisal report, evaluating the pilot and making recommendations for the potential Bay wide roll out of the model. This report will include an Option Appraisal, to inform the future development of the service.**

<u>Christine Timmon</u>
Acting Professional Lead for Health Visiting & School Nurse
19/03/13

Preventative Community Project/Community Hub Action Plan: Lead C Timmon (CT)

	1. To pilot a preventative (early intervention) community team in the geographical areas of Hele and Watcombe Torbay.		
	Action	Completion date	Responsible lead
1.1	Integrating and amalgamating Health Visitors, School Nurses, Midwives and Lifestyle Workers into the local community and community services (piloting the delivery of health services from community venues, such as the Acorn Centre and the Watcombe Community Centre,)	31.3.13 On going	CT/coordinator
1.2	Agreeing the focus, functions and common systems of the Community Hub team with the multi-agency team.	31.3.13	CT
1.3	Develop the staff and pilot new ways of working, to accommodate the needs of the pilot service and service user.	31.3.13	CT/coordinator/T/L
1.4	Develop a "record log" to capture a variety of change aspects during the pilot, such as change in ways of working, issues and risk identified/encountered and attempting to capture the community spirit. This should be completed periodically (weekly) and owned / governed by the team coordinator and presented to the steering group.	30.6.13	CT/coordinator
	2. To pilot a service model to deliver a community capacity building approach, in partnership with the Hele and Watcombe communities and other agencies to; Improve the health outcomes to children and young people		
	Action	Completion date	Responsible lead
2.2	Identify the needs of the community in relation to current gaps in service delivery and identify a system / process/ service to address that need.	31.3.13	CT/coordinator/T/L
2.3	Build on community strengths, capacity and relationships. To further develop opportunities for volunteers in the service provision.	31.3.13	CT/coordinator
2.4	Investigate the potential to reduce the duplication in service delivery (e.g. the amalgamation of the 2 year early years review with the 2.5 healthy child HV review) to deliver an integrated services with early year providers.	31.3.13	CT/Early Years Manager
2.5	Use closer relationships with partners to identify early when	31.3.13	CT/coordin



	families need support providing support at level 1 under the Child's Journey - therefore building on an early intervention, prevention strategy. Capturing good practice in case studies across agencies.		ator
2.6	The identification of adult and young carers and sign posting to appropriate support networks.	28/6/13	CT/James Drummond
3. To build on existing relationships with the community and community groups e.g. Hele Angel and the Chairs of both the Hele and Watcombe Community Partnerships other community groups and individuals.			
	Action	Completion date	Responsible lead
3.1	To identify the current Community Partnership leads and other community leaders through engagement sessions in community centres, kick start sessions.	30.6.13	CT/co-ordinator
3.2	Develop a way of working with these groups over the lifetime of the pilot To work in partnership with the community groups to identify health need within the community, so inform service delivery.	30.6.13	CT/co-ordinator/ steering group
4. To pilot and review the development of a 0 to 19 team in health, through integrated working with Health visitors and School Nurses in the pilot Hub.			
	Action	Completion date	Responsible lead
4.1	Complete a team multi-agency S.W.O.T analysis prior to pilot initiation based on this objective (this will aid with the final pilot report and also provide a comparator for the final multi-agency team S.W.O.T analysis.	30.9.13	CT
4.2	Pilot the removal of boundaries between Health visiting and School Nursing.	30.9.13	CT
4.3	Identify and pilot new opportunities to deliver the Public Health Agendas together.	30.9.13	CT/steering group
4.4	Develop a communication strategy for the community to build closer relationships and help with the development of an awareness of all services provision with the Hele and Watcombe areas.	30.9.13	CT
5. To pilot the Band 5's Public Health Staff Nurse working across both Health Visiting and			

	School Nursing.		
	Action	Completi on date	Responsible lead
5.1	The evaluation of the role and made recommendations for future team structures.	30.9.13	CT
5.2	To deliver a final project appraisal report, evaluating the pilot and making recommendations for the potential Bay wide roll out of the model. This report will include an Option Appraisal, to inform the future development of the service.	31.3.14	CT

Children's Partnership Improvement Plan

An Interim report on the Preventative Community Project/Community Hub.

Background

- The PCP original vision was based on the idea of a community preventative multi-agency team. This developed from joint work on more collaborative working and integration between Children Services, Community Safety and Public Health. Also linked with work that Hazel Stuteley undertook in Falmouth and concepts from "The Tipping Point: How Little Things Can Make a Big Difference" by Malcolm Gladwell.
- There has been recognition in findings from Marmot, Allen and Field that childhood is an important time not only for the healthy development of the child but the opportunity to intervene to prevent long term adverse consequences. With the increase in health visiting numbers in Torbay to 54.5 WTE an opportunity has arisen to develop a preventative community model that helps increase community capacity and social capital to ensure sustainable support from the community.

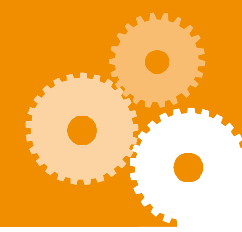
Project Aims:

- To lay the foundation for a new way of collaborative working across statutory agencies, voluntary groups and a defined community in Torbay.
- To incorporate evidence which demonstrates improved outcomes for children and young people following increased resources in Early Years.
- To develop and build upon existing preventative services in partnership with the community in order to identify at an early stage, when an individual, family or population require additional help, support and interventions.
- To work with current community capacity models and social capital in order to reduce reliance on public services and increase community resilience.

  Appendix 1: Project Objectives.

Activities completed since 18/2/2103

- The wider PCP/Community Hub team came together in January 2013 at an away day to begin building working relationships by exploring individual roles and looking at how the team could work together.
- A SWOT analysis was completed prior to the project commencing to get a base line on agencies working together.



- A session was facilitated on information sharing across agencies.
- A project co-ordinator has been identified from the SCPHN team who is working with a senior life styles worker. They have been attending the Hele Angels tasking group and linking with both Community Partnership Boards and other voluntary sector providers. Building foundations and forging working relationships with partner agencies and identifying resources available across agencies and the voluntary sector.
- The 0-19 Public Health Nursing Team (HV and SN) meet on a monthly basis. Staff are enthusiastic about developing new services to meet the community's needs
- The steering group membership has been reviewed. Additional representatives have been invited to join the group from Barton Surgery, Barton Primary School, and Early Years *(Appendix 2)*
- A directory of local services for Hele & Watcombe entitled "What's on" is now available to all staff following a scoping exercise. All health staff are sign-posting families to a broader range of local services. In future this leaflet will be available at clinics and Children Centres.
  (*Appendix 3)*
- A questionnaire distributed by Hele's Angels contained a section called Helping with Health. The results of the questionnaire were used to ascertain what healthy life style areas the local community want to focus: 196 questionnaires were returned *(A*ppendix 4)
- A flyer was displayed in key locations inviting families with children aged 0 to 19 to contact the co-ordinator or life styles worker by text or e-mail who responded by sending out 3 simple questions to ascertain local views on health (*Appendix 5)*
- The health team and partner agencies have undertaken a fact finding and information gathering exercise with residents in Watcombe using an aide memoire and question sheet with similar health questions to the Hele's Angels questionnaire (*Appendix 6 & 7)*
- The SCPHN team discussed the findings from both the questionnaire & fact finding activity and have a plan of activities to meet some of the expressed health needs (*Appendix 8).*
- Health promotion topics have been displayed in several sites in the community. These topics were chosen in response to the findings from the questionnaire sent out in H & W. In June & July this included promoting sun safety & Bay Walks. In August, the health promotion topic will be the importance of adequate fluids for school children and water safety; September – weaning; October - mental health including services for women with postnatal depression.
- The PHSN has undertaken training in order to provide baby massage to babies where the mother has postnatal depression or other attachment disorders to aid bonding and improve communication between mother and baby.
- The SCPHN team are working in partnership with the Torbay Tots at the Windmill centre, a new family workshop project led by local volunteers. This has involved accompanying vulnerable families to facilitate their attendance.
- The PCP co-ordinator is working in partnership with Action for Children community impact team at the Watcombe Community Centre to re-launch a

Stay and Play group.

- A contact list of professionals working in H & W, including a brief statement of role has been produced and circulated. This includes the central point of contact for the SCPHN team/project.
- Newsletter circulated this month. (*Appendix 9)*
- Hidden carers training session delivered on the 27.6.13 to the PCP team to raise awareness across agencies.

Key achievements so far: (outcomes)

- The SCPHN team has the staffing resourced identified for 2015 by the Call to Action Health Visiting Implementation Plan. The increased capacity was partly achieved by appointing 3 Public Health Staff Nurses.
- Health visitors and school nurses who work in H & W have come together to create a 0 to 19 SCPHN team in Hele and Watcombe delivering a seamless service to families.
- The project co-ordinator is the central contact point for the project.
- The partner agencies are finding health more accessible as this project has led to an inclusive approach to meeting needs. A health representative was previously missing from Hele's Angels tasking group
- A Housing Officer has identified that the SCPHN team has assessment skills, encompassing the wider determinants of health, enabling more relevant and timely interventions and signposting to address a broad range of needs.
- Improved inter-professional relationships have resulted in early interventions with positive outcomes for families e.g.: A vulnerable family for safety reasons needed to move to temporary accommodation. The parent had concerns around the safety of her residence. As a result of the newly formed relationship, the HV was able to call the housing officer and within 24 hours a home visit was organised with a rent officer to discuss her options. Comment by client to SCPHN "*Thank you so much for everything. You are the nicest person I ever had to help me and you are so caring and helpful about everything and I'm glad I've got you by my side helping"*
- The project manager responded to the request from Barton Academy to participate in a school project to reduce the absent rate. A school nurse and PHSN are working as part of a team supporting families who have children absent from school due to their health.
- A PHSN is working in partnership with the Bladder & Bowel service and Barton Academy, with identified children, at Tier 1 within the Partnership area.
- The co-ordinator is continuing to network with partner agencies; voluntary and community service providers in Hele & Watcombe. This month a referral was received from Sanctuary Housing for a vulnerable family prior to moving into the area which resulted in a HV contacting the family, carrying out a home visit in the first couple of days of the families move and linking with several statutory and voluntary services in the Community to provide support - This will be written up as a case study demonstrating good multi-agency practice and positive outcomes.
- Watcombe School have linked with the school nurse who is organising a health

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promotion day on the 11/7/13 to include the wider PCP team. Topic includes SN- head lice/worms. HV sun safety, nutrition, hand washing and dental health. The lifestyles team smoking cessation. The PCSOs relationship building by doing finger printing. The fire safety officer covering carbon monoxide poisoning and home safety. Hele's Angels bringing the virtually safe project.

Milestones

Milestones	Original Date	Actual Date
Start date for the project	2012	18/2/2013
Project Plan reviewed		18/2/2013
Increased capacity in the SCPHN team		18/3/2013

Risks

Description	Recommendations	Owner
The 0 – 19 SCPHN team are on 2 sites resulting in problems with team dynamics & functioning. Negative aspects over shadow positive outcomes of project.	Identify one base for the team	Torbay & Southern Devon Health & care NHS Trust.
The co-ordinator requesting a base move from September 2013	Identity a new co-ordinator	CT
Managing expectations of the project from different organisations and individuals.	Revisit the objectives and share with partner agencies	
The project manager left in December 2012 prior to the start of the project. Reduced capacity to develop and run the project.	Appoint a project manager to help with the 2nd stage of the project. Extend the duration of stage 1 for an additional 6 months.	All agencies
Lack of public awareness of the Community Hub and its potential benefit to the community	Administrative support required to increase capacity to deliver project. Link with communication plan	All agencies

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Description	Recommendations	Owner
Partner agencies have disengaged from project.	Review steering group membership & launch	CT all services

Next Steps.

Action	Name	Date
Collect case studies to show how the project is working at the family level	ChristineTimmon	25/12/13
Identify a single base for the team	Lyn Ware & estates	30/09/13
Identify a new coordinator	Christine Timmon	25/08/13
Replace health staff that are leaving	Christine Timmon	20/09/13
Team Building - Away day for the Barton SCPHN team.	Lyn Ware & C Timmon	30/9/13
Review the steering group membership and terms of reference	C Timmon & Coordinator	30/09/13
Engage with additional agencies and the voluntary section	coordinator	30/9/13
Increase the duration of stage one by 6 months	Leads Health & CS	30/9/13

Appendices

To Add

Appendix 8 - Childhood nutrition in the first year – 2. (SN) Bladder & bowel clinic prior to B & B service drop in for toilet training- 3. SALT Baby project in September 4. Mellow parenting course 5. Stakeholder's day re IAPT day to talk about access to psychological services – beauty therapy in school body image and self-esteem for this age group. 6. Boys and football 7.Ages & stages join with the 2.5 HCP review at squirrels. 8. Link with breaking free launch

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Outcome 2
A healthy life with a reduced gap in life expectancy

Life expectancy in Torbay is in line with national estimates. However, there is noticeable variation between where people live. For example, males in Tormohun having a life expectancy of 74.5 years compared to those living in Churston with Galmpton having a life expectancy of 82.4 years.

High levels of deprivation, low educational attainment, unhealthy lifestyle factors (high smoking, poor diet, low physical activity hazardous and harmful drinking) and access to quality primary care are all interrelated determinants of early death and lower life expectancy. In particular, smoking contributes to half of the life expectancy gap. Life expectancy is also significantly lower in certain groups such as those with severe mental illness, learning disabilities or problematic drug users.

We will work in partnership to prevent people becoming ill in the first place by supporting our residents to address the key lifestyle risk factors of smoking, physical inactivity and alcohol misuse, which are more common in the deprived areas of the bay. We will also encourage early diagnosis and management of the major killer diseases such as cardiovascular disease and cancer as reducing deaths from these diseases. We will develop specific programmes to address inequalities in health behaviours amongst young women in Torbay. We will provide an effective public protection and safeguarding system so that children and vulnerable adults are protected, feel safe and supported in their families and communities.

To achieve a reduction in the life expectancy gap, our actions will range from universal to targeted to meet the different levels of need, as appropriate – what Marmot terms 'proportionate universalism'.

Priority 8
Reduce alcohol consumption

- Continue to include alcohol screening in the NHS Healthchecks programme as this programme (focused on identifying and supporting those at high risk of cardiovascular disease, including hypertension) expands

- Extend the range of Identification and Brief Advice opportunities available through non-medical settings for people with alcohol problems e.g. safeguarding and early intervention services

- Improve pathway between hospital and community treatment services for people with alcohol related problems

- Promote and support peer-led recovery opportunities in the community

This paper provides a brief overview of alcohol consumption in Torbay.

Most people who have alcohol-related health problems aren't dependent on alcohol. They're simply people who have regularly drunk more than the recommended levels for some years. Alcohol's hidden health harms usually only emerge after a number of years. And by then, serious health problems can have developed.
Liver problems, reduced fertility, high blood pressure, increased risk of various cancers and heart attack are some of the numerous harmful effects of regularly drinking more than the recommended levels.

Understanding and quantifying patterns of alcohol consumption in the population is challenging.

What do we know?

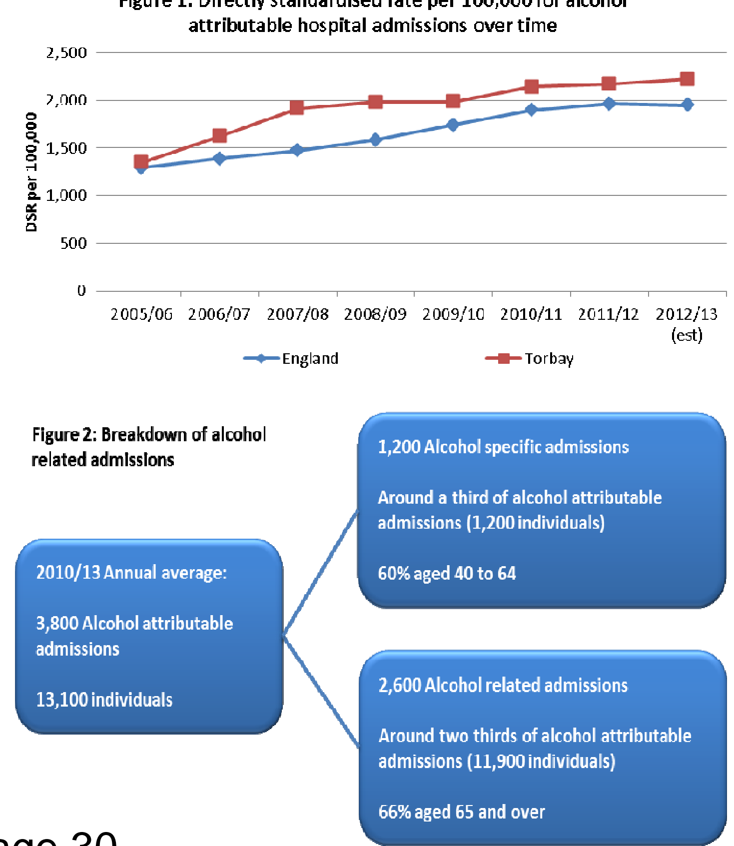
- Modelled estimates suggest a **lower proportion** of **Torbay's** over 16 population **binge drink** (18.0%) compared to the England average (20.1%) (2007/08 data from the 2012/13 JSNA). Binge drinking is defined as consuming eight or more units in a single session for men and six or more for women.
- Information recorded through A&E attendances, does not facilitate alcohol specific analysis of attendances.
- One measure of alcohol consumption is the measure of alcohol attributable hospital admissions.

Alcohol attributable hospital admissions in Torbay

The rate of alcohol attributable hospital admissions in Torbay is significantly higher than the national average. Rates have been increasing, both in Torbay and across England.

There are two types of alcohol attributable admission; ***specific*** and ***related***. *Specific* conditions are those considered wholly attributable to alcohol, whist *related* are conditions where alcohol could be considered a risk factor for that disease.

On average, there are some 3,800 hospital admissions that could be due to alcohol per year. Of which around two thirds are due to alcohol related admissions.



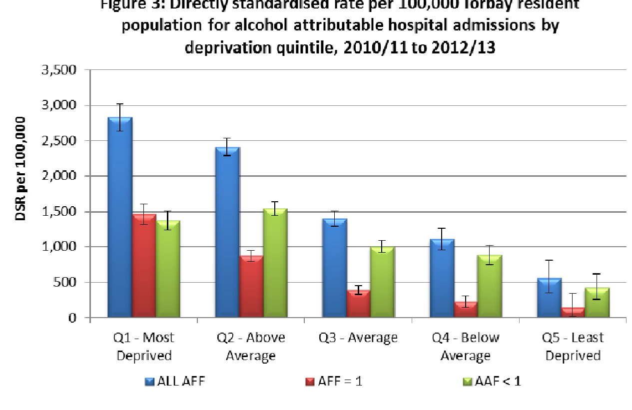


Figure 3: Directly standardised rate per 100,000 Torbay resident population for alcohol attributable hospital admissions by deprivation quintile, 2010/11 to 2012/13

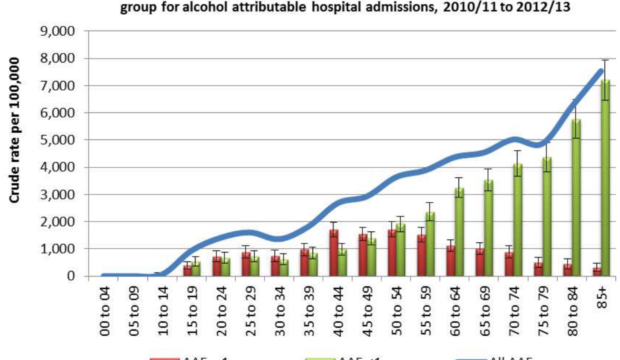


Figure 4 - Crude rate per 100,000 resident population in Torbay by quinary age group for alcohol attributable hospital admissions, 2010/11 to 2012/13

Rates of alcohol attributable admissions are highest in the more deprived neighbourhoods, especially for alcohol specific admissions (AAF =1). However, there is less variation between communities for alcohol related admissions (AAF <1).

There are clear differences in the epidemiology of who is being admitted. There is a clear relationship with age, as we would expect given the relationship between age and burden of disease.

For alcohol specific conditions (AAF =1), the peak is within the 40 to 54 age groups. This is in contrast to the alcohol related (AAF <1) admissions which increase with age.

With an aging population, and after adjusting for age, we might expect the rate of alcohol related admissions to continue to increase under current methodology.

Mental and behavioural disorders due to use of alcohol (ICD10 F10) account for over 80% of alcohol specific admissions; equivalent to an age standardised rate of some 715 per 100,000.

Hypertensive disease represents the largest disease burden within the alcohol related admissions. With a gap between those managed in primary care, and the estimated prevalence, we may expect more people to enter hospital with hypertensive diseases, which may inadvertently increase the overall rate of alcohol attributable admissions.

Table 1: Top three diseases by specific and related alcohol admission, 2010/13 annual average.

Alcohol specific admission (AAF = 1)	**Count**	**Rate (DSR)**
Overall AAF = 1	1,200	846
Mental and behavioural disorders due to use of alcohol	1,000	715
Ethanol poisoning	100	72
Alcoholic liver disease	75	48
Alcohol related admission (AAF > 1)	**Count**	**Rate (DSR)**
Overall AAF > 1	2,600	1,324
Hypertensive diseases	1,100	510
Cardiac arrhythmias	700	256
Epilepsy and Status epilepticus	300	229

The gap in hypertension prevalence and those managed in primary care by locality within the CCG is shown in figure 5.

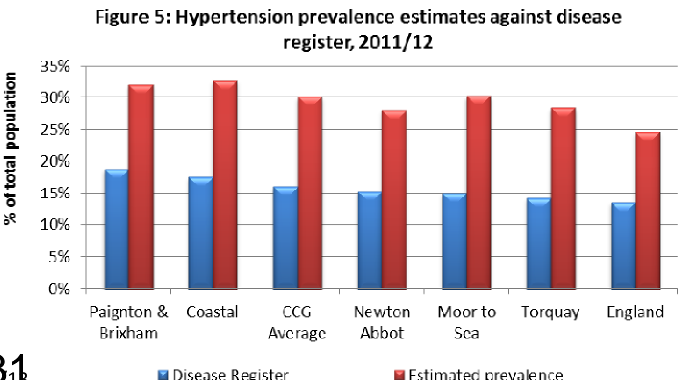


Figure 5: Hypertension prevalence estimates against disease register, 2011/12

The Government's Alcohol Strategy

Cm 8336

HM Government

The Government's Alcohol Strategy

Presented to Parliament
by the Secretary of State for the Home Department
by Command of Her Majesty

March 2012

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The Government's Alcohol Strategy

PM Foreword

Binge drinking isn't some fringe issue, it accounts for half of all alcohol consumed in this country. The crime and violence it causes drains resources in our hospitals, generates mayhem on our streets and spreads fear in our communities.

My message is simple. We can't go on like this. We have to tackle the scourge of violence caused by binge drinking. And we have to do it now.

This strategy sets out how we will attack it from every angle. More powers to stop serving alcohol to people who are already drunk. More powers for local areas to restrict opening and closing times, control the density of licensed premises and charge a late night levy to support policing. More powers for hospitals not just to tackle the drunks turning up in A&E – but also the problem clubs that send them there night after night. And a real effort to get to grips with the root cause of the problem. And that means coming down hard on cheap alcohol.

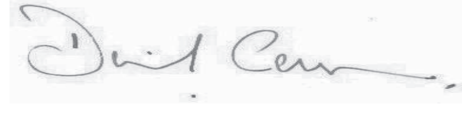
When beer is cheaper than water, it's just too easy for people to get drunk on cheap alcohol at home before they even set foot in the pub. So we are going to introduce a new minimum unit price. For the first time it will be illegal for shops to sell alcohol for less than this set price per unit. We are consulting on the actual price, but if it is 40p that could mean 50,000 fewer crimes each year and 900 fewer alcohol-related deaths a year by the end of the decade.

This isn't about stopping responsible drinking, adding burdens on business or some new kind of stealth tax - it's about fast, immediate action where universal change is needed.

And let's be clear. This will not hurt pubs. A pint is around two units. If the minimum price is 40p a unit, it won't affect the price of a pint in a pub. In fact, pubs may benefit by making the cheap alternatives in supermarkets more expensive.

We are working in partnership with business on all the proposals in the strategy, and I am pleased that the drinks industry are playing their part in promoting responsible drinking - including by giving consumers a wider choice of lower strength products and smaller servings to take one billion units out of the market by 2015.

Of course, I know the proposals in this strategy won't be universally popular. But the responsibility of being in government isn't always about doing the popular thing. It's about doing the right thing. Binge drinking is a serious problem. And I make no excuses for clamping down on it.



1. Introduction – a new approach

1.1 Fifty years ago, the United Kingdom had one of the lowest drinking levels in Europe but it is now one of the few European countries whose consumption has increased over that period. Over the last decade we have seen a culture grow where it has become acceptable to be excessively drunk in public and cause nuisance and harm to ourselves and others.

1.2 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. The majority of people who drink do so in an entirely responsible way, 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.

1.3 A combination of irresponsibility, ignorance and poor habits – whether by individuals, parents or businesses – led to almost 1 million alcohol-related violent crimes[1] and 1.2 million alcohol-related hospital admissions in 2010/11 alone. The levels of binge drinking among 15-16 year olds in the UK compare poorly with many other European countries[2] and alcohol is one of the three biggest lifestyle risk factors for disease and death in the United Kingdom after smoking and obesity. It has become acceptable to use alcohol for stress relief, putting many people at real risk of chronic diseases. Society is paying the costs – alcohol-related harm is now estimated to cost society £21 billion annually.

1.4 The problem has developed for the following reasons:

- Cheap alcohol is too readily available and industry needs and commercial advantages have too frequently been prioritised over community concerns. This has led to a change in behaviour, with increasing numbers of people drinking excessively at home, including many who do so before they go on a night out, termed 'pre-loading'. In a recent study, around two-thirds of 17-30 year olds arrested in a city in England claimed to have 'pre-loaded'[3] before a night out, and a further study found 'pre-loaders' two-and-a-half times more likely to be involved in violence than other drinkers[4].
- Previous governments have failed to tackle the problem. The vibrant café culture, much promised by the previous Government's Licensing Act, failed to

[1] Chaplin, R., Flatley, J. and Smith, K. (2011) Crime in England and Wales 2010/11. Home Office Statistical Bulletin 10/11. London: Home Office. Supplementary Table 7.11- http://www.homeoffice.gov.uk/science-research/research-statistics/crime/crime-statistics/bcs-supplementary-tabs/.

[2] Hibell, B. (et al) The 2007 ESPAD report. Substance use among students in 35 European countries.

[3] Barton, A. and Husk, K. (forthcoming) Controlling pre-loaders: alcohol related violence in an English night time economy. Drugs and Alcohol Today.

[4] Hughes, K., Anderson, Z., Morleo, M. and Bellis, M.A. (2008) 'Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes', Addiction, 103 (1), pp 60-5.

materialise. Too many places continue to cater for, and therefore remain blighted by, those who drink to get drunk, regardless of the consequences for themselves or others.

- There has not been enough challenge to the individuals that drink and cause harm to others, and of businesses that tolerate and even encourage this behaviour.

  The result is a situation where responsible citizens and businesses are paying the price for irresponsible citizens and businesses.

1.5 This strategy signals a radical change in the approach and seeks to turn the tide against irresponsible drinking. Such change will not be achieved overnight. It will require long-term and sustained action by local agencies, industry, communities and the Government. We will:

- Take firm and fast action where immediate and universal change is needed. Chapter 2 sets out how we will end the availability of cheap alcohol and irresponsible promotions. We will introduce a minimum unit price for alcohol and will consult on the introduction of a ban on multi-buy promotions in the off-trade.
- Ensure that local areas are able to tackle local problems, reduce alcohol-fuelled violent crime on our streets, and tackle health inequalities. Chapter 3 sets out the extensive range of tools and powers we are giving to local agencies to challenge those people that continue to behave in an unacceptable way and make it easier to take action against and, if necessary, close down, problem premises. It asks local areas to make decisions for themselves, working effectively in partnership and giving communities the information they need to hold local services to account. We will give stronger powers to control the density of licensed premises and make health a licensing objective for this purpose. We will give areas the powers to restrict alcohol sales if late opening is causing problems through extended powers to make Early Morning Restriction Orders; introduce a new late night levy so that those businesses that trade into the late night contribute towards the cost of policing; and end the notion that drinking is an unqualified right by piloting sobriety schemes for those people whose offending is linked to excessive alcohol consumption. We will also support hospitals to tackle unacceptable drunken behaviour at A&E.
- Secure industry's support in changing individual drinking behaviour. Chapter 4 recognises the crucial role that the industry can play in changing the drinking culture, from one of excess to one of responsibility; and from one where alcohol is linked to bad behaviour to one where it is linked to positive "socialising". It sets out how we will build on the Responsibility Deal to drive greater industry responsibility and action to prevent alcohol misuse, including giving consumers a wider choice of lower strength products in both the on-trade and off-trade, taking one billion units out of the market by 2015. We promise to support and free up businesses that are acting responsibly but, through the Responsibility Deal, extend a challenge to all of industry to make more progress, more quickly on the responsible production, sale and promotion of alcohol.
- Support individuals to make informed choices about healthier and responsible drinking, so it is no longer considered acceptable to drink excessively. Chapter 5

sets out how we will ensure that everyone understands the risks around excessive alcohol consumption to help them make the right choices for themselves and their families, including through asking Dame Sally Davies, the Chief Medical Officer, to oversee a review of the alcohol guidelines for adults. It provides details on the support system that should be available for those that need particular help in changing their behaviour, including an alcohol check within the NHS Health Check for adults.

1.6 Our ambition is clear – we will radically reshape the approach to alcohol and reduce the number of people drinking to excess. The outcomes we want to see are:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
- A reduction in the amount of alcohol-fuelled violent crime;
- A reduction in the number of adults drinking above the NHS guidelines[5];
- A reduction in the number of people "binge drinking"[6];
- A reduction in the number of alcohol-related deaths; and
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed.

1.7 Further information on trends in alcohol use and harm and effective practice is available at the Alcohol Learning Centre (http://www.alcohollearningcentre.org.uk).

1.8 The taxation aspects of this strategy will apply UK-wide. The provisions on crime and policing, alcohol licensing and pricing set out in this strategy are only intended to apply to England and Wales. We will work closely with the devolved administrations in Scotland and Northern Ireland to ensure a co-ordinated approach to those issues that is in line with the devolution settlement.

[5] No more regularly than 3 to 4 units per day for men and no more regularly than 2 to 3 units per day for women.
[6] Measured by those who self-report drinking on their heaviest drinking day in the previous week more than 8 units per day for men and more than 6 units per day for women.

2. Turning the tide

2.1 Over the last decade, we have witnessed a dramatic change in people's attitude to, and the harms caused by, alcohol consumption. We estimate that in a community of 100,000 people, each year:

- 2,000 people will be admitted to hospital with an alcohol-related condition;
- 1,000 people will be a victim of alcohol-related violent crime;
- Over 400 11-15 year olds will be drinking weekly;
- Over 13,000 people will binge-drink;
- Over 21,500 people will be regularly drinking above the lower-risk levels;
- Over 3,000 will be showing some signs of alcohol dependence; and
- Over 500 will be moderately or severely dependent on alcohol.

2.2 These statistics highlight the urgent and unquestionable need for all of those who drink alcohol – no matter who they are or what they do – to take responsibility for their drinking behaviour and establish a less risky approach to drinking as the norm. Such change will require collective action by individuals, communities, local agencies and industry. The following chapters set out how the Government will support, enable and challenge them to achieve this.

2.3 Wherever possible, action to tackle alcohol-related harm, crime and disorder should be taken at the local level by those who understand the problems that their community is facing. However, at times, action is needed to achieve universal and radical change across the country and tackle the underlying issues. This chapter sets out how the Government will lead the way and turn the tide against irresponsible sales and promotion of alcohol.

Reducing the availability of cheap alcohol

2.4 In 2010, £42.1 billion was spent on alcohol in England and Wales alone[7]. Alcohol has been so heavily discounted that it is now possible to buy a can of lager for as little as 20p or a two litre bottle of cider for £1.69. There is strong and consistent evidence that an increase in the price of alcohol reduces the demand for alcohol which in turn can lead to a reduction in harm, including for those who regularly drink heavily and young drinkers under 18.[8][9] We can no longer afford to ignore this.

2.5 The Government's Review of Alcohol Taxation in November 2010, recognised that the majority of drinkers consume alcohol in a responsible manner. However, the harms associated with problem consumption of alcohol remain a concern. The Government has already taken action to tackle the availability of heavily discounted alcohol by:

- Raising alcohol duty by 2% above retail inflation (RPI) each year to 2014-15;
- Introducing a 'minimum juice' rule for cider, so that high strength white ciders can no longer qualify for the lower rates of duty that apply to cider; and

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[7] Clancy, G. (2011). Consumer Trends Quarter 1 2011, No. 60. Office for National Statistics. http://www.ons.gov.uk/ons/rel/consumer-trends/consumer-trends/q1-2011/index.html.

[8] Booth, A., Meier, P., Stockwell, T., Sutton, A., Wilkinson, A., Wong, R. (2008) Independent review of the effects of alcohol pricing and promotion. Department of Health.

[9] The likely impacts of increasing alcohol price: a summary review of the evidence base (2011). Home Office.

- Introducing a new higher rate of duty for high strength beer over 7.5% Alcohol By Volume (ABV) and a new lower rate of duty for beer at 2.8% ABV and below to align duty more closely to alcohol strength.

2.6 The UK would support any future changes to the EU rules to allow duty on wine to rise in line with alcoholic strength. The UK will also seek a full impact assessment, including the health aspects, of the EU Commission's proposal on the Reform of the Common Organisation of the Market in Wine due in 2013.

2.7 These are significant steps forward but, as there is such a strong link between price and consumption, we need to go further still to end the irresponsible promotion and discounting of alcohol. This is why we will take an ambitious approach to tackling the issue of excessive alcohol consumption.

2.8 We will introduce a minimum unit price (MUP) for alcohol meaning that, for the first time ever in England and Wales, alcohol will not be allowed to be sold below a certain defined price. We will consult on the level in the coming months with a view to introducing legislation as soon as possible.

2.9 We will also consult on a ban on multi-buy promotions in the off-trade (shops) meaning that multiple bottles or cans could not be sold cheaper than the multiple of one bottle or can. This would put an end to any alcohol promotion or sale that offers customers a discount for buying multiple products in stores and therefore those that encourage and incentivise customers to buy larger quantities than they want.

2.10 We do not currently intend to apply this ban to the on-trade (pubs, bars, restaurants etc.) as this is already a more controlled and regulated drinking environment. We will launch a review of current commitments within the Mandatory Code for Alcohol to ensure they are sufficiently targeting problems such as irresponsible promotions in pubs and clubs. We will also consult on applying the Mandatory Code to all sectors involved in the sale of alcohol, where relevant.

2.11 Given our intention to introduce MUP, we do not currently intend to implement a ban on the below cost sale of alcohol (defined as Duty+VAT). The introduction of MUP is likely to provide a net benefit to many retailers without a specific tax on any surplus profits. Rather than introducing a new levy or tax on surplus profits, we intend to work with industry to use any additional revenue to provide better value to customers in other areas (ending the situation where loss-leading on alcohol means that moderate drinkers effectively subsidise heavy drinkers through the cost of their weekly shop).

Alcohol Advertising

2.12 There is known to be a link between advertising and people's alcohol consumption, particularly those under the age of 18.[10] Some countries have introduced a complete ban on alcohol advertising (Norway) or a ban on TV advertising with other controls (France) to tackle this. So far we have not seen evidence demonstrating that a ban is

[10] Booth, A., Meier, P., Stockwell, T., Sutton, A., Wilkinson, A., Wong, R. (2008) Independent review of the effects of alcohol pricing and promotion. Department of Health.

a proportionate response but we are determined to minimise the harmful effects of alcohol advertising.

2.13 Alcohol advertising in the UK is already subject to controls that seek to prevent advertisers targeting and appealing to young people. The controls cover broadcast, print and online advertising and are a mix of co-regulation (with Ofcom) and self-regulation, administered by the Advertising Standards Authority (ASA) and the Portman Group. The Portman Code covers marketing such as sponsorship, promotion and product packaging. We will work with the Portman Group to ensure that where unacceptable marketing does occur, it results in the removal of offending brands from retailers.

2.14 The existing controls have the ability to address the problems associated with advertising alcohol but the system depends on people being aware of the controls and how they can complain. We will work with industry and other relevant bodies to help raise public awareness of the controls and encourage public feedback.

2.15 There are specific rules to prevent adverts being shown in a context which will have 'a particular appeal' to people aged under 18[11]. While these rules restrict the targeting of young people, they still allow potentially large numbers of under-18s to see alcohol advertising. We will work with the ASA and Ofcom to examine ways to ensure that adverts promoting alcohol are not shown during programmes of high appeal to young people.

2.16 Due to the proliferation of media channels in recent years, the opportunities to interact with alcohol marketing have increased. It is important that this increased capacity allows advertisers more precisely to minimise young people's interaction with alcohol marketing. The ASA recently extended its remit further into new media marketing. We will work with the ASA to ensure the full and vigorous application of ASA powers to online and social media and work with industry to develop a scheme to verify people's actual ages, which will apply to alcohol company websites and associated social media.

2.17 As part of the Bailey Review, a range of media regulators, including the ASA and Ofcom, recently set up a single, user-friendly website, called ParentPort, to make it easier for parents to make complaints, get information on regulation, and leave comments if they feel a programme, advertisement, product or service is inappropriate or unsuitable for their children. We will look for opportunities to create links through to ParentPort from high traffic sites to ensure that people can easily report any alcohol adverts they think are unsuitable. We will also work with the ASA and other relevant bodies to look at the rules and incentives that might inhibit the promotion of lower strength alcohol products and the encouragement of responsible drinking behaviours.

[11] For broadcast adverts the restriction is triggered when the Broadcasters' Audience Research Board (BARB) [11] audience index for those aged 10-15 is 120 or more (i.e. more than 20% above their share in the population). Similarly for non-broadcast advertising there is a specific rule that no medium can be used to advertise alcoholic drinks if more than 25% of its audience are under 18.

Responding to emerging issues

2.18 The Government has a responsibility to identify and tackle new and emerging threats or issues, whether they are crime-related such as the increase in alcohol duty fraud; health-related such as the rising incidence of liver disease in young adults; or both such as the growing availability of counterfeit alcohol.

2.19 Alcohol duty fraud costs the Government up to £1.2 billion per year and organised crime groups are responsible for much of this cost. In 2010, HMRC introduced a renewed strategy to tackle all forms of alcohol duty fraud. Despite this, beer duty fraud in particular remains a significant problem. In 2012, Government announced its intention to consult on alcohol anti-fraud measures, including the introduction of fiscal marks for beer, supply chain legislation, and a licensing scheme for wholesale alcohol dealers.

2.20 In the UK, There has been a 25% increase in liver disease between 2001 and 2009. Alcohol-related liver disease accounts for over a third (37%) of all liver disease deaths[12]. It is predicted that the cost to the NHS of managing this could be around £1 billion per year by 2015. While liver disease is not caused solely by excessive drinking, alcohol is the major contributor. The recently published liver disease strategy sets out: the reasons why liver disease is an increasing concern for the country; the vital need to prevent this disease better; and what the NHS and local areas will need to do to tackle it.

We will take national action to:
- Tackle the availability of cheap alcohol through the introduction of a minimum unit price for alcohol and consult on a ban on multi-buy promotions in the off-trade.
- Launch a review of current commitments within the Mandatory Code for Alcohol to ensure they are sufficiently targeting problems such as irresponsible promotions in pubs and clubs.
- Consult on alcohol anti-fraud measures, including the introduction of fiscal marks for beer, supply chain legislation, and a licensing scheme for wholesale alcohol dealers.
- Work with the Portman Group to ensure that where unacceptable marketing does occur, it results in the removal of offending brands from retailers.
- Work with the ASA and Ofcom to examine ways to ensure that adverts promoting alcohol are not shown during programmes of high appeal to young people.
- Work with the ASA to ensure the full and vigorous application of ASA powers to online and social media and work with industry to develop a scheme to verify people's actual ages which will apply to alcohol company websites and associated social media.
- Work with the ASA and other relevant bodies to look at the rules and incentives that might inhibit the promotion of lower strength alcohol products.

[12] Deaths from liver disease Implications for end of life care in England (2012). NHS National End of Life Care Programme.

3. Taking the right action locally

3.1 Local communities, services and businesses are best placed to tackle alcohol-related issues in their area and enforce the behaviour and develop the cultures that they want. Over the last year, we have taken significant steps to enable local agencies to take the right action locally. We have set out a new approach to crime, policing and health, reforming the delivery landscape so that:

- From April 2013, upper tier and unitary local authorities will receive a ring-fenced public health grant, including funding for alcohol services. Local authorities will be supported by Public Health England. They will be free to design services to meet local needs, working in partnership where this makes sense for them. This can maximise the scope for early interventions and can better meet the needs of specific groups.
- Health and Wellbeing Boards will bring together councils, the NHS and local communities to understand local needs and priorities through the Joint Strategic Needs Assessment (JSNA) and develop a joint Health and Wellbeing Strategy, which will set out how they will work together to meet these needs. The boards will be able to promote integration of health and social care services with health-related services like criminal justice services, education or housing. This will help join up services around individuals' needs and improve health and wellbeing outcomes for the local population.
- From November 2012, directly elected Police and Crime Commissioners (PCCs) will ensure the public's priorities drive local police force activity and hold chief constables to account on action taken locally. As well as their core policing role, PCCs will have a remit to cut crime and anti-social behaviour and will have commissioning powers and funding to enable them to do this with partners. They will need to work collaboratively with other local leaders – including establishing strong links with Health and Wellbeing Boards, Clinical Commissioning Groups and local authorities – to develop common causes with partners on a range of crime and health issues and achieve the most effective community safety and criminal justice outcomes for communities.

3.2 These local structures will provide mechanisms to ensure that the needs of all populations, and all issues, are considered, from the health of the population through to community safety and the needs of offenders or those dependent on alcohol. Local areas should ensure commissioning for drugs and alcohol services has the right representation, accountability and engagement to deliver on these broad aims.

Changing behaviour at the local level

3.3 Over the last few years, town centres have become increasingly focused on the night time economy and, as a result, we have seen a growth in licensed premises. Areas such as Durham, and schemes such as Best Bar None, Purple Flag, Community Alcohol Partnerships, Pubwatch and Business Improvement Districts across the country have shown that a thriving and growing night time economy can operate where excessive drinking is tackled consistently and robustly by business, the police and local authorities working together.

3.4 It is up to local communities to set the standards and behaviours that they want to see in their surrounding area. This is why we have radically reformed our approach to policing with the introduction of directly elected PCCs, and to licensing through the Police Reform and Social Responsibility Act 2011. This gives power back to local agencies for local alcohol issues and more control over the opening and closing hours of local businesses to stop crime and disorder from stretching into the early hours of the morning.

3.5 We are giving local areas powers to take firm action to address the harms from alcohol and, if necessary, close down problem premises. From 25 April 2012, licensing authorities and local health bodies will formally become 'responsible authorities' under the Licensing Act 2003, ensuring that they are automatically notified of an application or review, and can more easily instigate a review of a licence themselves. At the same time, new powers will make it easier to refuse, revoke or impose conditions on a licence by reducing the evidential threshold from 'necessary' to 'appropriate', thereby making it easier to challenge irresponsible businesses.

3.6 Individuals and local communities will also have more power to input into decisions locally. The vicinity test on licensing will be removed, meaning that anyone – no matter where they live – will be able to input into a decision to grant or revoke an alcohol licence, not just those that that live in the immediate vicinity. From October 2012, extended powers to make Early Morning Restriction Orders (EMROs) will enable local areas to restrict alcohol sales late at night if they are causing problems.

3.7 There is evidence of a link between the number of venues selling alcohol in one area and levels of harm, whether this is crime, damage to health, or harm to young people[13]. We therefore believe local communities should be able to limit the density of premises where this is contributing to the major types of harm. Cumulative Impact Policies (CIPs) can do this to tackle certain issues, but we want to go further and will amend the statutory guidance on the Licensing Act 2003 to make clear that CIPs apply to both the on-trade and the off-trade and that licensing authorities can reflect the needs of their local area by using measures such as fixed closing times, staggered closing times and zoning where they consider them to be appropriate. We will also strengthen local powers and the public's ability to control the density of premises by making it easier to introduce CIPs by reducing the burden of evidence on licensing authorities when making their decision.

3.8 We want to go further and ensure local action on alcohol is even more open and transparent to the public. Police.uk provides communities across England and Wales with street-level crime and anti-social behaviour information, including those occurring on or near a number of key public spaces, hospitals, nightclubs and supermarkets. From May 2012, this will include information on what happens after crimes are recorded occurring in those places, for example information on the action

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[13] Popova, S., Giesbrecht, N., Bekmuradov, D. and Patra, J. (2009) Hours and days of sale and density of alcohol outputs: Impacts on alcohol consumption and damage: A systematic review. Alcohol & Alcoholism. Vol. 44, No. 5, pp500-516

taken by the police or the sentence imposed by the court. Locally, some areas may publish even more detailed information, such as details of those individuals subject to Drinking Banning Orders (DBOs).

3.8 As part of our reforms to encourage greater community involvement in local alcohol licensing decisions, from April 2012, we will require licensing authorities to publish locally key information about new licensing applications, including details of the address of the relevant premises and guidance on how to make representations to the licensing authority. We will pilot how to provide further information on crime occurring on or near local alcohol hotspots as well as trialling publication of further licensing data online. This could include, for example, work with local authorities to encourage publication of licence conditions for premises online so that the public know what they are and can report when conditions are being broken or information on irresponsible licensed premises whose failure to tackle drunken behaviour results in hospital admissions.

Challenge and enforcement

3.9 Communities should not have to tolerate alcohol-related crime and disorder. Almost a quarter (24%) of the public think that drunk or rowdy behaviour is a problem in their local area[14]. Individuals should not expect to be able to ignore their responsibilities when drunk. We will ensure local agencies and the police have the powers to make those who cause harm face the consequences of their actions.

3.10 Local services already have access to a wide range of tools and powers to challenge those that cause harm to themselves and others. We expect the police and local authorities to take quick and firm action to tackle and punish those premises and individuals that are acting irresponsibly and to protect the most vulnerable in our communities. Proactive visible policing is vital to managing the night time economy – nipping bad behaviour in the bud and setting the tone locally. In many areas the police play a preventative role – focusing targeted effort to reduce problems to prevent the need for greater action later on. The need for an increased police presence on the streets at night to manage the problems from alcohol can put pressure on local resources. From October 2012, a new late night levy will empower local areas to make those businesses that sell alcohol late into the night contribute towards the cost of policing and wider local authority action. This will help enable visible and proactive policing at targeted locations where there are local needs.

3.11 We are also making sure local areas have strong powers to protect the vulnerable. We are doubling the maximum fine for persistently selling alcohol to a person under 18 to £20,000 and making it easier to close down premises found to be persistently selling alcohol to young people. The police also have powers to seize alcohol from young people under the age of 18 and can prosecute a further offence of persistently possessing alcohol in a public place. We are working with the Sentencing Council

[14] Chaplin, R., Flatley, J. and Smith, K. (2011) *Crime in England and Wales 2010/11*. Home Office Statistical Bulletin 10/11. London: Home Office.

and others in the criminal justice system to encourage greater use of existing powers to prosecute and sentence those that have committed the persistent sales offence.

3.12Where we identify that tools and powers are being used insufficiently, we will work with the police and others to change this. For example, it is an offence, under the Licensing Act 2003, to knowingly serve alcohol to a drunk but there were only three convictions for this offence in 2010. This could send a powerful message locally and we will work with the police to tackle the issue of serving alcohol to drunks including exploring how greater use can be made of existing powers and how test purchasing can support this.

3.13 Where local communities think tools are not targeted or effective enough, we will give the police and local partners faster and more flexible powers to tackle local problems. We know, for example, that increasing numbers of licensing teams are now made up of Police Community Support Officers (PCSOs) and support staff and will therefore explore the benefit of an additional discretionary power for PCSOs to enter licensed premises (Section 179 of the Licensing Act 2003) to support the enforcement of licensing locally. We will also tackle problem drinking through our reforms to anti-social behaviour tools and powers.

Rights and responsibilities

3.14 A&E departments can be a particular flashpoint for those who have drunk to excess, causing fear and distress to others awaiting and administering treatment. We should not tolerate any violence or disorder in hospitals and will make a range of measures available to tackle this unacceptable behaviour.

3.15We will support NHS Trusts and Foundation Trusts to work with their local police to ensure that appropriate action is taken, including through hospital security staff being empowered through the Community Safety Accreditation Scheme. Under this scheme, accredited staff can be given powers to issue Penalty Notices for Disorder (£80 fines) to those individuals whose drunken behaviour is likely to cause harassment, alarm or distress. They can also take action against the consumption of alcohol in a designated public place. Some hospitals have found it effective to place police officers in A&Es. We would encourage forces to look at this model and consider using late night levy funding to support such a role according to local needs.

3.16Those who seek treatment in A&E departments must respect their surroundings or lose their right to the same service standards as others. The NHS Constitution sets a maximum waiting time for A&E departments of four hours but recognises that abusive or violent behaviour would be reasonable grounds to refuse access to NHS services, meaning staff can refuse to treat drunks who are abusive in A&E. We will go even further to tackle violence against hospital staff. We are developing new injunctions as part of our reforms to anti-social behaviour tools and powers and we will explore giving NHS Protect (the body that leads work to identify and tackle crime across the health service) the power to apply for these injunctions. This would give the NHS the ability to deal with individuals who persistently cause a problem in hospitals, for example those who are regularly drunk and abuse staff.

3.17 We are also giving local areas new powers to take firm action against irresponsible premises which fail to tackle drunken behaviour. From 25 April 2012, licensing authorities and local health bodies will formally become 'responsible authorities' under the Licensing Act 2003. For the first time, local health bodies will be able to instigate a review of a licence. This means that a hospital that is regularly dealing with patients at A&E as a result of alcohol-related violence at a particular pub will now be able to instigate a review of the licence at those premises. If things do not improve, we would expect the premises to lose their licence.

3.18 It is vital that licensing authorities are able to take health-related harms into consideration in decisions on Cumulative Impact Policies (CIPs). This is a current gap and could make an important contribution to local wellbeing, including in deprived communities that are suffering health inequalities. We will therefore launch a consultation on a new health-related objective for alcohol licensing related specifically to cumulative impact. This will enable health bodies to input into decisions on applications for new licences, so that local health harms, including those seen in A&E departments, are a key factor in deciding whether a new licence is granted.

3.19 We will also end the notion that drinking is an unqualified right without any associated sense of responsibility. We will run innovative trials of enforced sobriety schemes making use of existing powers as part of Conditional Cautions and community sentence orders, for people convicted of alcohol-related crimes. The Conditional Caution scheme will focus on lower level offences such as drunk and disorderly, criminal damage and public disorder. The pilot areas for the conditional caution scheme will be Westminster, St. Helens, Hull, Plymouth and Cardiff. Later this year, we also intend to pilot compulsory sobriety measures for community orders which will focus on more serious offences such as common assault and actual bodily harm. We are also introducing new powers on sobriety in the Legal Aid, Sentencing and Punishment of Offenders Bill.

3.20 Through the trials, we intend to test both the use of breathalysers and specialist electronic tags which monitor alcohol levels to determine what forms of monitoring are most suitable in terms of effectiveness, enforceability and cost. We have already commenced testing this innovative tagging equipment as this will be the first time that it has been trialled for these purposes in this country.

Working across boundaries

3.21 None of this can be achieved by one agency or service alone. The factors contributing to harmful alcohol use are complex and vary significantly from place to place. Effective partnership work to reduce and prevent alcohol-related harm will contribute to a range of other local priorities including improving wellbeing, especially that of young people; reducing crime and disorder; reoffending; improving health; and also supporting the local economy. The Alcohol Learning Centre[15] summarises advice on effective local partnerships. In her recent report, Baroness Newlove[16] set out how the Government is investing £1million to help local agencies, businesses

[15] http://www.alcohollearningcentre.org.uk

and, crucially, local people in ten areas to come together and tackle problem drinking head on. The fund is being provided by the Department for Communities and Local Government and the work will be led by Baroness Newlove.

3.22Good information sharing is critical if local partners are to understand the scale and range of the problems locally, identify vulnerable groups who are likely to be at higher risk of alcohol-related harm and identify priorities for action. The Coalition Programme for Government included a commitment to require hospitals to share non-confidential information with the police, so they know where gun and knife crime is happening. The implementation of this commitment focuses on all types of violent assault – many of which are alcohol-related. To deliver this commitment, we have promoted the College of Emergency Medicine guidance which is based on the 'Cardiff model'. This sets out the importance of sharing non-personal data with the police, particularly core information on the date, location and type of assault. It highlights the important role of senior clinical, police and local authority leadership in promoting active use of the intelligence to target policing and tackle problem premises.

3.23 In Cardiff, this approach has shown a sustained reduction of violence-related attendances of up to 40%[17]. We will encourage all hospitals to share non-confidential information on alcohol-related injuries with the police.

Evidence based action on health harms

3.24 Local Authorities and Clinical Commissioning Groups will need to work together to meet local needs as identified in the Joint Strategic Needs Assessment. Funding through the Public Health Grant will allow local authorities to commission Identification and Brief Advice, which is proven to be effective in reducing the drinking of people at risk of ill health, and specialised treatment for those with greater needs. Alcohol liaison nurses within A&E have been shown to reduce re-presentations and may in future be co-funded by Clinical Commissioning Groups alongside Local Authorities.

3.25 Local areas should work in partnership to support as much integration across clinical pathways as possible, maximising the scope for early interventions and secondary prevention. Working in partnership will allow the needs of specific groups, such as offenders, to be adequately addressed.

3.26 The *Liberating the NHS* White Paper and the NHS Future Forum's recent report made clear that the NHS will continue to have a responsibility to take every opportunity to prevent poor health and promote healthy living, including healthier choices on alcohol, by making the most of healthcare professionals' contact with individual patients. The NHS Future Forum working group on the NHS Constitution will consider this as part of its work on strengthening the Constitution.

[17] Florence, C., Shepherd, J. Brennan, I. and Simon, T. (2011) :'Effectiveness of anonymised information sharing and use in health service, police, and local government partnership for preventing violence related injury: experimental study and time series analysis. British Medical Journal 2011

ACTIONS: We will ensure that local areas are able to tackle local problems and will:
- Give local agencies powers to reduce alcohol harm through the changes to public health, new Police and Crime Commissioners, and by rebalancing the Licensing Act.
- Give local communities the tools to restrict alcohol sales late at night, if they are causing problems, through extended powers to introduce Early Morning Restriction Orders.
- Give local communities the power to introduce a new late night levy to ensure those businesses that sell alcohol into the late night contribute towards the cost of policing.
- Work with 5 areas to pilot sobriety schemes, removing the right to drink for those who have shown they cannot drink responsibly.
- Strengthen local powers to control the density of premises licensed to sell alcohol, including a new health-related objective for alcohol licensing for this purpose.
- Work with Baroness Newlove, investing £1m to help local agencies, businesses and local people come together and tackle problem drinking head on.
- Pilot how to provide further information on crime occurring on or near local alcohol hotspots as well as trialling publication of further licensing data online.
- Develop new injunctions as part of our reforms to anti-social behaviour tools and powers and explore giving NHS Protect the power to apply for these injunctions.
- Encourage all hospitals to share non-confidential information on alcohol-related injuries with the police and other local agencies.

4. Shared responsibility with industry

4.1 The alcohol industry and wider retail and hospitality industries play a key role in our economy. Of the 200,000 premises licensed to sell alcohol, most make a positive and valuable contribution to their local communities and to the economy with wider tourist, cultural and export benefits. Well-run and responsible community pubs form an important component of the social fabric of our communities and such supervision of drinking can help prevent crime and disorder.

4.2 However, too much of the industry still supports and encourages irresponsible behaviour through poor product location, under age sales, excessively cheap drinks and encouragement of excessive drinking. We have already set out in Chapter Two the action that the Government will take to put an end to irresponsible practices. The Government is clear though that this responsibility is shared with industry and wants industry to go significantly further on action to tackle the harms of excessive alcohol consumption.

Industry's responsibility to change behaviour

4.3 We are clear that it is not just the responsibility of Government or local agencies to tackle the issue of alcohol-related harm. It is the ethical responsibility of the entire industry – alcohol retailers, alcohol producers and both the on-trade and off-trade – to promote, market, advertise and sell their products in a responsible way. This is recognised by the major alcohol producers, who have established the Portman Group as a self-regulator. We are working with the industry in collaboration with Non-Governmental Organisations (NGOs) through the Responsibility Deal, which does not cover pricing issues or other measures that only Government can take.

4.4The alcohol industry has a direct and powerful connection and influence on consumer behaviours. We know that:

- people consume more when prices are lower;
- marketing and advertising affect drinking behaviour; and
- store layout and product location affect the type and volume of sales.

4.5Through the Responsibility Deal, the alcohol industry has adopted a core commitment to "foster a culture of responsible drinking, which will help people to drink within guidelines". We have a way to go to achieve that culture, as 22% of people say they drink regularly above the guidelines. Industry have already taken action by making pledges in a range of areas:

- Product labelling on unit content, NHS guidelines and drinking when pregnant to cover 80% of products by December 2013;
- Unit messaging in the on-trade and off-trade;
- Combating under age sales through Challenge 21 and 25;
- Funding Drinkaware;
- Actions on advertising, including not putting adverts near schools; and
- Supporting Community Alcohol Partnerships (CAPs) and other local schemes.

4.6 Some individual companies have demonstrated particular leadership, by making additional individual pledges including:

- Heineken in reducing the number of units in popular products;
- ASDA in not stacking alcohol at the front of their stores;
- Diageo in supporting training provided by the National Organisation for Fetal Alcohol Syndrome for 10,000 midwives to advise a million women over the next three years about the dangers of drinking during pregnancy; and
- Support of local schemes such as Best Bar None and Community Alcohol Partnerships (CAPs).

4.7 The Responsibility Deal has made good progress though industry, NGOs and the Government have consistently accepted that we need to make more progress, more quickly. We will therefore continue to work with producers, retailers and NGOs to help reshape how people drink and how they think about alcohol in support of the core commitment.

4.8 We welcome the new pledge from industry to give consumers a wider choice of lower strength products in both the on-trade and the off-trade to take one billion units out of the market by 2015. This will bring significant benefits for public health, reduce crime and demonstrates the positive contribution that industry can make.

4.9 The Responsibility Deal Alcohol Network, which includes industry and NGOs, will seek to make further progress in the following areas:
- Giving consumers better information on their consumption by extending the Responsibility Deal agreement on labels to include calorie content;
- Incentivising smaller servings by providing single / small measures as the default and only providing large measures when specifically requested;
- Providing clearer information about unit content, subject to any revised drinking guidelines; and
- Changing the ease of availability of alcohol through responsible product placement, for example ensuring that alcohol sold in shops is not sold alongside any product that appeals to children.

4.10 Subsequently, we would expect to see progress on:
- Delivery of evidence-based, effective education and prevention programmes intended to reduce drinking by young people;
- Better training for bar staff to reduce sales to people who are drunk;
- Workplace alcohol education and prevention programmes;
- A major extension of schemes such as CAPs, Best Bar None, Purple Flags and Business Improvement Districts including a new focus on health and wellbeing;
- A long-term commitment (through to 2020) to an increased scope and funding for Drinkaware, including how it can best direct interventions to the target groups. There is a strategic review this year of Drinkaware and the Government will participate to seek to maximise its effectiveness and accountability; and
- Harnessing the power of industry's own advertising to link positive and responsible behaviour to decisions on the consumption of alcohol. We will work with the Portman Group to ensure their Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks is robust, and that it actively encourages advertising which builds more positive associations (for example, between alcohol and

positive socialising) instead of negative ones (for example, between alcohol and wild, disinhibited behaviour).

Supporting growth and responsible businesses

4.11 We are committed to freeing up responsible industries and supporting positive growth. It is estimated that the alcohol industry contributes around £29 billion to the UK's economy. In total, it is estimated that, over 1.8 million jobs in the UK economy are supported by the alcohol industry[18].

4.12 We know that growth and responsibility can exist well together. The Government strongly endorses and welcomes self-regulating and pro-active initiatives, driven by the licensed trade in partnership with the police and local authorities. In particular, licensed premises receiving Best Bar None accreditation; town and city centres achieving Purple Flag status; and Business Improvement Districts are good examples of what can be achieved through a determination to make a difference.

4.13 As well as sending out clear messages that crime and disorder will not be tolerated in pubs, clubs and wider locations, these and other improvement schemes have been proven to increase footfall and stimulate business. For example, over the three year period of taking part in a Best Bar None scheme in Durham, licensees have reported an estimated 75% cumulative increase in trade; a 50% increase in town centre footfall and an expected 87% reduction in violent crime.

Cutting red tape

4.14 We see no merit in making responsible businesses jump through unnecessary hoops, but equally we need to maintain the integrity of the licensing system to protect society from those irresponsible businesses that exploit loopholes to gain business at any cost, regardless of the risks to the individual and to society. We therefore intend to seek views on giving licensing authorities greater freedom to take decisions that reflect the needs of their local community, including:

- Allowing them to introduce simpler, locally-determined processes for issuing a Temporary Event Notice (TEN); and increasing the current limit for TENs that can be used at single premises from 12 to 15 or 18, to enable occasional sales of alcohol at community events;
- Reducing the burden of licensing on certain types of businesses that provide minimal alcohol sales and are not impacting on crime and disorder, for example by removing the need for some premises to hold a personal licence; and
- Giving local areas more flexibility over the licensing of late-night refreshments at premises where alcohol is not sold, enabling them to determine locally where such a licence is necessary.

[18] The economic outlook for the UK drinks sector and the impact of the changes to excise duty and VAT announced in the 2008 Budget and Pre-Budget Report, Oxford Economics (February 2009).

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

- Challenge the industry to meet a new set of commitments to drive down alcohol misuse.
- Continue work through the Responsibility Deal to support the alcohol industry to market, advertise and sell their products in a responsible way and deliver the core commitment to "foster a culture of responsible drinking, which will help people to drink within guidelines".
- Cut red tape for responsible businesses by giving licensing authorities greater freedom to take decisions that reflect the needs of their local community.
- Continue work with industry on areas such as calorie labelling, not serving people when drunk and a renewed commitment to Drinkaware.

5. Supporting individuals to change

5.1 There is no 'one size fits all' solution to tackle excessive alcohol consumption and we have already set out the wide range of action that Government, local agencies and the industry should take to achieve this in the preceding chapters. Ultimately, individuals need to take control of and change their behaviours – though some may need help to do so. We know that:

- 83% of those who regularly drink above the guidelines do not think their drinking is putting their long term health at risk[19];
- Whereas most smokers wish to quit, only 18% of people who drink above the lower-risk guidelines say they actually wish to change their behaviour; and
- External and environmental factors can hugely influence – positively and negatively – the amounts that individuals or groups of the population drink and the ways they drink.

5.2 This chapter sets out how we can support individuals to change by:

- Ensuring everyone is aware of the risks of excessive alcohol consumption and can make informed choices about responsible drinking; and
- Recognising that some people will need support to change their behaviour and ensuring that this is available, particularly for the most vulnerable in our communities.

Understanding the risks

5.3 Drinking patterns change as individuals move through life, in response to changing social groups, partners, family, or work pressures. Life events such as becoming a parent, divorce, bereavement, or a health scare may influence drinking patterns and can affect people in different ways.

5.4 Drinking too much too soon is a significant risk to young people's health and development. Most children under 16 (55%) have never drunk alcohol[20]. However, despite declining rates of drinking in the last decade, the UK compares poorly with other European countries for drinking by 15-16 year old students in regular European surveys and we cannot be complacent[21]. The Chief Medical Officer for England's 2009 guidance that young people under 15 should not drink alcohol at all is based on the fact that young people who start drinking alcohol at an early age drink more frequently and more than those who start drinking later; as a result, they are more likely to develop alcohol problems in adolescence and adulthood. We will ensure that young people know the risks associated with alcohol by making it a key feature of a new £2.6 million youth marketing programme aimed to drive further reductions in regular smoking, drinking, drug use and risky sexual behaviour during the teenage years.

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[19] Social marketing data, Department of Health (unpublished).
[20] Fuller, E. (2011) Smoking, drinking and drug use among young people in England in 2010, Information Centre for Health and Social Care.

[21] Hibell, B. (et al) The 2007 ESPAD report. Substance use among students in 35 European countries.

5.5 We will support those that have the greatest influence on young people to promote healthy drinking. Parenting style is a key influence on whether a child will drink responsibly in adolescence and adulthood but only 17% of parents have a planned conversation with their child about the harm alcohol can cause[22]. As Baroness Newlove set out in her recent report, parents need to take proper account of the impact of how they behave on their children's attitudes to alcohol as they grow up and become adults themselves. We will ensure that guidance is available for parents through a range of public and community organisations including; NHS Choices, Directgov, Family Lives and NetMums, Mumsnet, Dad Talk, and Contact a Family.

5.6The Government is investing £448 million to turn around the lives of the 120,000 most troubled families in the country. Working with local authorities, we will support them into education and employment and tackle their criminal and anti-social behaviour. A significant number of these families will have other problems including alcohol dependence, mental illness, domestic abuse, poor parenting and long-term benefit dependence. These families are not beyond help and their lives can be turned around with co-ordinated and intensive support.

5.7 Good schools play a vital role as promoters of health and wellbeing in the local community. They understand the connections between pupils' physical and mental health, their safety, and their educational achievement, and are well placed to provide good pastoral care and early intervention for problems which may arise from, or lead to, alcohol misuse. The Government's review of Personal, Social, Health and Economic (PSHE) education is focused on improving the quality of PSHE in all schools and its core outcomes. This will include exploring how schools can better decide for themselves what pupils need to know, in consultation with parents and others locally. Schools and out-of-school services will also be able to access information about effective alcohol prevention programmes through the Centre for the Analysis of Youth Transitions (CAYT).

5.8 Supportive relationships, strong ambitions and good opportunities are key protective factors against early drinking and young people's misuse of alcohol. These are the key elements of the vision set out in Positive for Youth, which brings together all Government youth policy into a single plan. Assessment of local need through the Joint Strategic Needs Assessment and integrated commissioning and cross-sector partnership will be critical in ensuring young people get early help and advice from practitioners and services they trust, such as youth organisations. Young people's involvement will be key in shaping effective local support.

5.9 Up to one-third of alcohol-related A&E attendances are for under 18 year olds and local areas vary significantly in how they approach the care of young people in this situation[23]. Health services have a responsibility to ensure this 'treatable moment' is used to advise young people about their drinking. The Department of Health will also work with practitioners, the Royal Colleges and the Association of Directors of Children's Services to develop a model that ensures young people who attend A&E

[22] Williams, B., Davies, L. and Wright V. (2010) Children, Young People and Alcohol. Department for Children, Schools and Families.
[23] Data from East Midlands Public Health Observatory (unpublished).

due to alcohol receive proper follow-up and care, including their parents being informed, where appropriate. A recent report has highlighted the opportunities for sexual health services to help tackle alcohol misuse, given the strong links between drinking and poor sexual health in the young[24]. The Department of Health is piloting interventions which provide alcohol advice in sexual health clinics.

5.10 More people under the age of 25 report getting very drunk than any other adult age group[25] and around 50% of students drink more than the lower-risk guidelines[26]. Under 25s also have the highest risk of being a victim of violent crime[27]. There have been some good examples of how to make appropriate information easily accessible for young adults such as Drinkaware's "Why let good times go bad?" campaign and we expect to see more campaigns such as this in the future.

5.11 We expect universities to play a key role in helping students to understand and act on the risks of excessive alcohol consumption and ensure that an environment of subsidised bars does not unduly promote drinking. Drinkaware is also funding research in Welsh universities based on the use of 'social norms' - perceptions that a peer group drinks more than is the reality can be countered with information on real (lower) drinking levels. We want to do all we can to ensure that we are not bringing up a generation who believe that you can't have fun without alcohol.

5.12 Around a third of adult men (25-64) and a fifth of women in the same age group say they drink at levels above the lower-risk guidelines. Moreover, 8% of men and 4% of women in this age group admit to drinking at levels more than twice the lower-risk guidelines[28]. Many in this age group are parents, whose excessive parental drinking will be a risk to their children. It has become acceptable to develop a habit of routinely using alcohol for stress relief, putting many people at risk of chronic diseases, such as liver disease; diabetes; cardiovascular disease; and cancers of the breast and gastrointestinal tract. The latest estimate is that up to 70,000 people could die avoidably over the next twenty years if the wrong actions are taken.

5.13 We are already taking significant steps to address this. In February 2012, we launched a fully-integrated Change4Life[29] campaign to communicate the health harms of drinking above the lower-risk guidelines and provide a range of tips and tools to encourage people to drink responsibly. The campaign was based on the insights around how people use alcohol to unwind, and that what starts off at one glass can all too easily become more. The television adverts are backed up by posters for offices and public places, and leaflets for NHS staff to use with patients.

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[24] Alcohol and sex: a cocktail for poor sexual health, Royal College of Physicians and British Association for Sexual Health and HIV, December 2011.
[25] Matthews, S. and Richardson, A. (2005) Findings from the 2003 Offending, Crime and Justice Survey: alcohol-related crime and disorder. Home Office Research Findings 261. Home Office: London.
[26] Gill, J. S. (2002) Reported levels of alcohol consumption and binge drinking within the UK undergraduate student population over the last 25 years. Alcohol and Alcoholism.
[27] Chaplin, R., Flatley, J. and Smith, K. (2011) *Crime in England and Wales 2010/11*. Home Office Statistical Bulletin 10/11. London: Home Office.
[28] Office of National Statistics (2011). Smoking and drinking among adults, 2009. A report on the General Lifestyle Survey.
29 http://www.nhs.uk/Change4Life/Pages/change-for-life.aspx

Our intention is to extend this social marketing campaign, if the evidence shows the campaign improves health outcomes and is good value for money.

5.14 To support this further, we will ask Dame Sally Davies, the UK Government's Chief Medical Officer, to oversee a review of the alcohol guidelines for adults. This will also take account of available science on how we can best communicate the risks from alcohol, improving the public's understanding of both personal risks and societal harms. This will include whether separate advice is desirable for the maximum amount of alcohol to be drunk in one occasion and for people over 65. This could complement the existing guidelines for young people and women who are pregnant or trying to conceive.

5.15 Fetal alcohol spectrum disorders (FASD) result from mothers drinking alcohol during pregnancy. They are lifelong conditions that can have a severe impact on individuals and their families - leading to a wide range of difficulties including low IQ, memory disorders, attention disorders, speech and language disorders, visual and hearing defects, epilepsy and heart defects. They are caused entirely by drinking during pregnancy, and so are completely preventable. We do not have good information about the incidence of FASD, so it is likely that significant numbers of children are not diagnosed. FASD can be caused by mothers drinking even before they know they are pregnant; so preventing them is strongly linked to reducing the levels of heavy drinking in the population as a whole, and especially among women. We will also continue to raise awareness of the need for women who are pregnant or trying to conceive to avoid alcohol, including by increasing the awareness of health professionals.

5.16 There are real opportunities, often under-exploited, for health services to identify those at risk and provide advice and support to those that need it, whether via regular contact with NHS staff, or in particular settings such as A&E, through well evidenced brief interventions. Identification and Brief Advice (IBA) is a simple intervention aimed at individuals who are at risk through drinking above the guidelines, but not typically seeking help for an alcohol problem. IBA has been proven to reduce drinking, leading to improved health and reduced calls on hospital services. At least one in eight at-risk drinkers reduce their drinking as a result of IBA. The National Institute for Health and Clinical Excellence (NICE) recommends that NHS health professionals routinely carry out alcohol screening as an integral part of their practice, focusing on groups at increased risk.

5.17 The Department of Health will include alcohol identification and any subsequent brief advice needed within the NHS Health Check for adults from age 40 to 75 for the first time from April 2013. It will also look at the data from the recently published Screening and Intervention Programme for Sensible Drinking (SIPS) research to see if it can support further action by GPs via the Quality and Outcomes Framework.

5.18 We also encourage Local Authorities, newly responsible for public health, to examine the strong case for further local investment in IBA by primary care staff, using the evidence set out in reports from the SIPS research.

5.19 Alcohol Liaison Nurses offer a vital NHS contribution to secondary prevention, improving the future health of patients, including those who enter hospital with severe alcohol problems and multiple health problems. We encourage all hospitals to employ Alcohol Liaison Nurses to provide:

- Medical management of patients with alcohol problems in the hospital;
- Liaison with community alcohol and other specialist services;
- Education and support for other healthcare workers in the hospital; and
- Delivery of IBA within the hospital with a focus on key groups, including pregnant women.

5.20 Alcohol is known to be a driver in some cases of domestic violence. Ending violence against women and girls, including domestic violence, is a priority for this Government. Last year the Government published the Call to End Violence Against Women and Girls which set out how we will achieve this. A detailed range of supporting actions was updated this month[30] including ensuring that front-line practitioners are equipped so that they can respond appropriately to perpetrators and victims. Understanding how the use of drugs and alcohol can potentially increase the frequency and severity of violence is key to this. We expect all areas to implement the recent NICE guidance and a quality standard on the management of harmful drinking and alcohol dependence[31].

Treatment and recovery

5.21 It is vital that we provide effective treatment and recovery. The Government's Drug Strategy sets out how we are raising the ambition to support full recovery for those suffering from addiction, including alcohol. Increasing effective treatment for dependent drinkers will offer the most immediate opportunity to reduce alcohol-related admissions and to reduce NHS costs. Treating alcohol dependence, where successful, has also been shown to prevent future illnesses.

5.22 Around 31,000 (33%) of adults in alcohol treatment are parents with childcare responsibilities. A further 20% are parents whose child lives elsewhere[32]. Local treatment services and children's and family services are increasingly working together – as part of a wider team around the family – to identify and respond to alcohol-related problems. Evidence shows that Family Intervention Projects (FIPs) are effective in tackling these families' entrenched problems including a 34% reduction in drug and alcohol problems, 58% reduction in anti-social behaviour and over 50% reduction in truancy[33].

5.23 Recovery goes beyond medical or mental health issues to include dealing with the wider factors that reinforce dependence, such as childcare, housing needs, employability and involvement in crime. The Government's Drug Strategy sets out how we are working with eight pilot areas developing approaches to paying for

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[30] Home Office (2012) Call to end violence against women and girls. Taking Action - the next chapter
[31] www.guidance.nice.org.uk/
[32] Data from National Alcohol Treatment Monitoring System, National Treatment Agency (unpublished).
[33] Monitoring and Evaluation of Family Intervention Projects and Services to March 2011.

outcomes for recovery from drug or alcohol dependency. They all plan to commission services from April 2012.

Mental Health

5.24 There is a clear association between having a mental illness and increasing risk of alcohol dependence – if you drink too much, you put your mental health at risk. If you have a mental health problem, you are more likely to drink at levels that put your health at risk. For children, emotional and mental health problems are associated with the misuse of alcohol. Promoting good mental health in children and adults can help prevent alcohol misuse. Parenting programmes and prevention programmes for children can both help, particularly when problems are identified early.

5.25 We will publish the implementation framework for No Health Without Mental Health, the Government's mental health strategy, soon. It will set out what local organisations can do, and what Government and national organisations are doing to support them in the promotion of good mental health and wellbeing, as well as in the treatment of mental illness, including dual diagnosis (co-existing mental health and drug and alcohol problems).

Offenders

5.26 Alcohol contributes to too many crimes. Almost a million (44% of the total) violent crimes are alcohol-related[34]. There is a high prevalence among the offender population of drinking at higher risk levels, both among adults and young offenders. We need to ensure that entry into the criminal justice system punishes offenders but also provides an opportunity to provide support to overcome alcohol problems and prevent further offending.

5.27 Areas are advised to identify and address problems as early as possible by identifying treatable stages throughout the criminal justice pathway. To support local areas we will produce a cost-benefit analysis to make the case for local investment in alcohol interventions and treatment services for offenders. We will use the learning from evaluations of the eight pilot areas (those developing approaches to paying for outcomes for recovery from drug or alcohol dependency) to inform a potential Payment by Results approach to alcohol treatment for offenders.

5.28 Prisons are important places for rehabilitation and tackling dependency and we will develop, by July 2012, an alcohol interventions pathway and outcome framework in four prisons, to inform the commissioning of a range of effective interventions in all types of prison. From April 2013 the NHS Commissioning Board (NHSCB) will be responsible for commissioning health services and facilities for those in prisons and other places of prescribed detention. This will support the work at a national and local level to prevent and reduce alcohol related ill health and reoffending in the prison population.

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[34] Chaplin, R., Flatley, J. and Smith, K. (2011) *Crime in England and Wales 2010/11*. Home Office Statistical Bulletin 10/11. London: Home Office. Supplementary Tables 7 http://www.homeoffice.gov.uk/science-research/research-statistics/crime/crime-statistics/bcs-supplementary-tabs/.

5.29 We will increase the flexibility of the Alcohol Treatment Requirement imposed by the court as part of a community sentence so areas can tailor treatment to target more serious alcohol-related offending problems. We have consulted on reforms on anti-social behaviour, including a new civil order which could require individuals to undertake positive activities to address underlying issues that may be driving their behaviour, for example by accessing alcohol treatment.

5.30 Many areas are providing an integrated approach to drug and alcohol arrest referrals, for example joint drug and alcohol workers in the police custody suite assessing the needs of offenders and signposting them to appropriate treatment services. Areas can currently, on the basis of local priorities, use the Drug Interventions Programme funding from the Home Office for both drug and alcohol arrest referral.

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

- Review the alcohol guidelines for adults so that people can make responsible and informed choices about their drinking.
- Integrate alcohol into the wider Change4Life brand for the first time and commit to an on-going social marketing campaign to communicate the health harms of drinking above the lower-risk guidelines.
- Include an alcohol check within the NHS Health Check for adults from April 2013.
- Support parents to have a real impact on their children's behaviour through our social marketing for young people.
- Invest £448 million to turn around the lives of the 120,000 most troubled families in the country, a significant number of which will have alcohol-related problems
- Develop a model pathway to reduce under 18 year olds' alcohol related A&E attendances.
- Develop an alcohol interventions pathway and outcome framework in four prisons, to inform the commissioning of a range of effective interventions in all types of prison.
- Increase the flexibility of the Alcohol Treatment Requirement imposed by the court as part of a community sentence.
- Produce a cost-benefit analysis to make the case for local investment in alcohol interventions and treatment services for offenders
- Work with pilot areas to develop approaches to paying for outcomes for recovery from drug or alcohol dependency.

Next Steps

This strategy sets out a clear commitment to address the harms of alcohol and encourage responsible behaviour. Individuals, communities, local agencies, local premises and national industries all have a role to play. Over the coming months we will launch consultations and take action forward on areas highlighted in the strategy. To keep up to date of these see http://www.homeoffice.gov.uk/about-us/consultations/.

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TORBAY ALCOHOL HARM REDUCTION STRATEGY 2011 – 2013

WORKING IN PARTNERSHIP

FOREWARD

Working together as Torbay Strategic Partnership we have revised the Bay's multi agency alcohol strategy. This strategy sets out the direction of how all the agencies are going to deal with this issue including the police, the council, health service and the voluntary and community sectors. It provides an agreed framework within which services and plans will be developed to ensure Torbay is a healthier and safer place for everyone.

The impact of alcohol on Families is recognised as an underlying theme throughout the strategy. It crosses all of our priority areas and is influential on health education, young people, older people, crime, anti social behaviour, domestic abuse and treatment services.

This strategy builds on the success of Safer Nights Torbay which was launched in December 2010 with partners involved Torbay Council, Torbay Care Trust, Devon and Cornwall Constabulary, Torbay Street Pastors, Westcountry Ambulance Trust, Torquay Business Improvement District, local taxi and black cab firms and South Devon College.

This strategy is supported by service specific plans which provide the more detailed and comprehensive actions which will lead to the successful achievement of the priority areas.

OUR PRINCIPLE PURPOSE

- Enable coherence and consistency of activity across the different stakeholders working in Torbay
- Deliver activity that is rooted in evidence and targeted at greatest need
- Improve the integration of our information and governance systems to support development and monitor progress.

OUR VISION:
To minimise the harm caused by alcohol to individuals, families and communities in Torbay, whilst creating an environment which supports responsible use of alcohol.
AND
To better influence and manage the positive enjoyment and negative abuse of alcohol across a community which also seeks to be a responsible tourist area.

AIMS:

- Stem the waste of public money spent as a result of irresponsible use of alcohol
- Increase the health and wealth of our community as a result of the responsible use of alcohol
- Give clear guidelines for parents and young people about the effects of alcohol and what is not safe or sensible
- Spell out clearly for everyone, including older people, the health risks of harmful drinking.
- Support and offer treatment for those at risk from their drinking behaviour.
- Support Torbay's tourist and night-time economy by means of partnership working
- Increase understanding of the effects of alcohol on domestic abuse.
- Support Torbay's tourist and night time economy by means of partnership working.
- Achieve measurable success against national comparative health targets

OUR PRIORITIES FOR THE NEXT THREE YEARS:
We will focus activity and effort on

- ***Engaging Communities*** *- in stopping alcohol from being a problem in the first place by sending out safe drinking messages and targeting binge-drinkers supported by a multi-media communications campaign.*
- ***Supporting Torbay's Night Time Economy*** *- whilst achieving a balance between a thriving economy and alcohol misuse, taking strong legal and enforcement action to stop under-age drinking, alcohol-related violence and irresponsible drink promotions in pubs and shops*
- ***Improving Services for People*** *–minimising the harm caused by alcohol to individuals and families.*

1.0 SECTION ONE – NEEDS ASSESSMENT

1.1 What We Know - Regionally

- An estimated three-quarters of a million (728, 530) or 23% of South West residents aged 16-64 are hazardous drinkers (24% national), and a further 118,780 (4%) are dependent drinkers. (8% national).
- Only 1 in 14 of the 'in-need' alcohol dependent population is currently accessing treatment each year.
- More than 500 people aged under 18 are admitted to hospital specifically due to alcohol each year in the South West, with boys and girls equally likely to be admitted.
- In 2004, around a third of admissions to hospital for acute intoxification in the South West were children aged under 16.
- There were 1,615 alcohol specific hospital admissions in people aged over 65 in the South West in 2004.
- There were more than 50,000 domestic violence incidents it the South West in 2005/06. It is estimated that in around 19,600 (40%) of these the perpetrator was under the influence of alcohol.
- Drink-driving is estimated to account for more than 168 serious injuries and around 50 road deaths in the South West each year.
- More than 6,500 people were sentenced for drink-driving or attempting to drive with excess alcohol by South West Magistrates Courts in 2004.
- There were an estimated 97,685 alcohol related ambulance journeys to Accident and Emergency departments in the South West in 2004/05.
- The estimated cost of alcohol related emergency ambulance journeys in the South West during 2004/05 was £23 million.

(Source: Calling Time, SWPHO, 2008)

- The number of alcohol-related deaths in the UK has increased since the early 1990s, rising from the lowest figure of 4,023 (6.7 per 100,000 population) in 1992 to the highest of 9,031 (13.6 per 100,000) in 2008. In 2009 the number of deaths fell to 8,664 (12.8 per 100,000).
- Regionally in the South West rates have also increased over the 10 year period between 1999 and 2009, deaths rates for females increased by 28% and males increased by 24%.

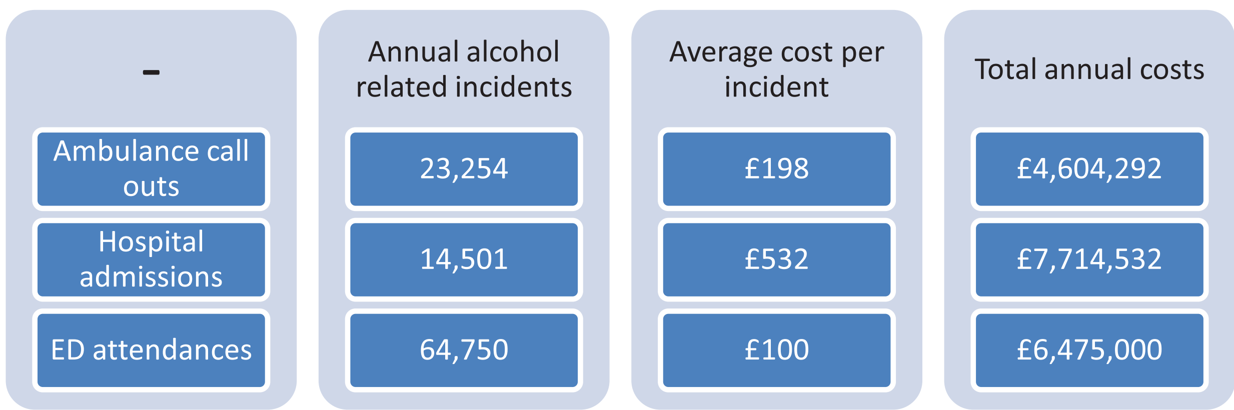
1.2 What We Know - The Cost Of Alcohol

Estimates have been made to the total cost of alcohol misuse in relation to the relevant statutory agencies which include:

- Costs to the health service is estimated to be in the region of £2.7billion a year, almost twice the equivalent figure in 2001.
- Costs of crime and antisocial behaviour linked to alcohol misuse is £7.3 billion, as annually, 1.2 million violent incidents – around half of all violent crimes; 40% of domestic violence cases and 6% of all road casualties – are linked to alcohol misuse
- The overall annual cost of productivity lost as a result of alcohol misuse is £6.4 billion per annum.
- Alcohol concern estimate that for every £1 invested in specialist alcohol treatments, £5 is saved on health, welfare and crime costs.

(Source: Alcohol Concern: Making Alcohol a health priority, 2011)

Table 1 Estimated cost of underage drinkers to primary health care services 2008/09



-	Annual alcohol related incidents	Average cost per incident	Total annual costs
Ambulance call outs	23,254	£198	£4,604,292
Hospital admissions	14,501	£532	£7,714,532
ED attendances	64,750	£100	£6,475,000

Source: Alcohol concern – Making sense of alcohol 2010

1.3 What We Know – Locally

Torbay has significantly higher rates than England and the South West for alcohol attributable hospital admissions. The indicator measures the number of persons admitted to hospital as a direct result of excessive alcohol consumption (e.g. alcoholic, cirrhosis, or acute alcohol intoxication).

Number of adults estimated to be binge drinking is not significantly different from the England average. (18.6% of adults estimated Torbay as modelled using Health Survey England 2007-2008 compared to 20.2% England Average).

A review of local hospital admissions data found that:

- Over a 3 year period (April 2007-March 2010) the value of alcohol related admissions to hospital was £8.8m.
- £1.04 million (12 % of total spend) was spent on acute alcohol related hospital admissions - *(£38,000 (3% of acute spend) was on conditions wholly attributable to alcohol.)*
- £7.76 million (88%) was spent on chronic conditions. (*10855 NHS number count) - *(£1.3 million (12% of chronic spend) was spent on chronic conditions wholly attributable to alcohol.)*

(Source: Torbay Alcohol related hospital admissions 2010, Doug Haines & Dr Louise Wilson)

1.4 Types of Drinking Behaviour

Type of Drinking Behaviour	Description	Prevalence	Trend	
Lower Risk Drinkers	Those who drink over the sensible drinking limits, either regularly or through less frequent sessions of heavy binge drinking, but have so far avoided significant alcohol related problems	7.6 million people	For women the binge drinking rate (twice over the recommended limit once a week) increased from 7% in 1998 to 16% in 2006, similarly in men the proportion rose from 20% to 24% over the same period	⇧ Torbay Equivalent *(2010 population)* 9,398 females 13,022 males
Increasing Risk Drinkers	Harmful drinkers are usually drinking at levels above those recommended for sensible drinking, typically at higher levels than most hazardous drinkers. Unlike hazardous drinkers, harmful drinkers show clear evidence of alcohol related harm	2.9 million people	Heavy drinking rose amongst men from 19% in 2005 to 24% in 2007 and from 8% to 15% for women over the same period	⇧ Torbay Equivalent *(2010 population)* 8,811 females 13,022 males
Higher Risk Drinkers	Those who are likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking. In severe cases, they may have withdrawal fits and may drink to escape or avoid these symptoms.	1.6 million people	There was a 24% increase in the number of moderate to severely dependent drinkers between 2000 and 2007	⇧

Source: Making alcohol a health priority, Opportunities for reduce alcohol harms and rising costs, Alcohol Concern 2011)

Levels of alcohol misuse is higher in men and those living within the more deprived wards of the Bay. This is an important factor in understanding the health inequalities that exist among communities and supports the 'first and most' approach being taken to tackle and reduce the inequalities gap. The Marmot review identified 'Reducing health inequalities as a matter of fairness and social justice.' The review made a recommendation to focus public health alcohol reduction interventions both population wide and target groups to reduce the social gradient.

The chart below show the various causes in the gap for life expectancy between the most deprived areas in Torbay (most deprived quintile) and the rest of Torbay. The number of years shown represents the number of years for that specific disease – for example , Digestive disease in males accounts for around 0.5 years and around 11.2% of all diseases.

The Inequalities Gap : Life Expectancy Years Gained

Male

Cause	Share
All circulatory diseases	15.7% = 0.7 years
All cancers	18% = 0.8 years
Respiratory diseases	9% = 0.4 years
Digestive	11.2% = 0.5 years
Mental and behavioural including suicide	15.7% = 0.7 years
Other	27% = 1.2 years

Infectious & parasitic diseases 2.2% = 0.1 years

Deaths under 28 days 1.1% = 0.05 years

Female

Cause	Share
All circulatory diseases	16.7% = 0.5 years
All cancers	23.3% = 0.7 years
Respiratory diseases	10.0% = 0.3 years
Digestive	13.3% = 0.4 years
Other	16.7% = 0.5 years
Death under 28 days	10% = 0.3 years

Mental & behavioural including suicide 6.7% = 0.2 years

Infectious & parasitic diseases 3.3% = 0.1 years

Figures based on the London Health Observatory Health Inequalities Intervention Tool

Chronic cirrhosis of the liver included in the ‘Digestive’ category is the biggest cause of the gap in life expectancy for men and contributes to a further 11%.

2.0 SECTION TWO - PROGRESS MADE OVER THE PAST THREE YEARS

A number of successful initiatives have been undertaken to impact on the way that alcohol misuse is perceived, addressed and treated.

Reducing Harm caused to the Individual Adults

Training & Screening

- £500k investment in community drug & alcohol services in line with implementing NICE guidance.
- Peer support groups to help people manage their own recovery during & after completing formal treatment
- Acces to medicated and non medicated detoxification programmes; residential rehabilitation placements as appropriate.
- Opportunistic screening training for staff in hospital settings; primary care; social care and criminal justice services to identify; advise & support or refer people with 'risky drinking' behaviours.
- 8 GPs completed Royal College of General Practitioners Training Certificate in Mgmt of Alcohol Problems in Primary Care.

Reducing Alcohol Related Crime and the Fear of Crime

Safer Nights Torbay

- Partnership approach to make harbourside a safer one has resulted in reduction in night time assaults and improved perceptions around drunk and rowdy behaviour.
- Taxi Marshalls operate over peak holiday periods
- 'The Safe Place' - street pastors vehicle operates 52 weekends between 9pm and 4am Torquay harbourside and Paignton Town
- Intelligence shared between agencies identifes patterns , trends and enables resources to be targeted at community prevention actvities (Access to treatment and support for offenders

Reducing Harm caused to the Individual – Young People

Education

- Age appropriate resources for use in schools
- Peer Education challenging 'social norms'
- Over 20,000 6th form students participated in Learn2Live road safety events
- Alcohol awareness events

Parenting

- Alcohol and sexual health risks covered in parent training
- Parent information and health promotion activities
- Children of parents who misuse drugs & alcohol identified, needs assessed which informs the treatment/support plan.

Targeted Approach

- Test puchasing in 2010 resulted in 0% of sales to <18yrs
- Referral process betwen A&E and Under 18yrs services.
- Looked After children screened and support for those at greater risk of developing problematic alcohol
- Transition process in place to ensure engagement in treatment

Improving Access and Effectiveness of Treatment Services

Treatment & Support

- Pathways implemented for A&E presentations & admissions to wards; Probation; Job Centre Plus; Drug misusers with concomitant alcohol problems
- Detox support across hospital and community to ensure continuity through transition.
- Preparation work with those who will benefit from residental rehabilitation placement including their aftercare.
- Targeted intensive support for problematic drinkers with concomitant complex needs.
- Recovery support systems developed including transitional support for peopel informla treatment into mutual support.

SECTION THREE – PRIORITIES

PRIOITY ONE : ENGAGING COMMUNITIES

Objective: Stopping alcohol from being a problem in the first place by providing clear safe drinking messages and targeting heavy drinkers supported by a multi-media communications campaign.

What we know

The report 'Swept under the carpet: Children affected by parental alcohol misuse,' published in October 2010 found that 8 out of 10 adults agreed that heavy drinking among parents is a serious problem for children in the UK. And 84% agreed that a parent who drinks heavily is as harmful to a child as a parent who take drugs.

Drinking habits have changed significantly. Alcohol is now 75% more affordable than in 1980 and alcohol consumption has more than doubled over the past 50 years.

Since its launch in 2005 *Know the Code* presented a recognisable graphic and clear message, but after 5 years it is now felt the message needs to be reinforced and the evidence is undeniable in supporting a clear prevention and communication strategy from stopping alcohol becoming a problem in the first place.

What We will do ...

Communication

- Safer Nights Torbay Social Marketing Campaign - communication plan with new graphics and resources which focus on the effects of alcohol on the body especially as a result of binge drinking and how to adopt safe drinking whilst enjoying nights out.
- Target 16-24 yrs frequenting harbouside and town centre areas; young people drinking within neighbourhoods, streets and licensed premises with materials ciruclated to local businesses (including pubs and clubs) and viral media.
- Use of national resources to target local advertising campaign which challenges drunken behaviour

Peer Surfers

- Trained peer educators within secondary schools challenging social norms around risk taking behaviours and binge drinking.

Locality Working

- Multi disciplinary teams from across organisations working at a neighbourhood level addressing the priority needs sepcific to those residents which will influence the make up of the team.

PRIORITY TWO: SUPPORTING TORBAY'S NIGHT TIME ECONOMY
Objective: Achieving a balance between a thriving economy and alcohol misuse taking strong legal and enforcement action to stop under-age drinking, alcohol-related violence and irresponsible drink promotions in pubs and shops

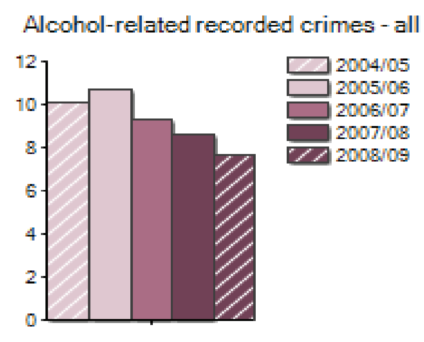
What we know
The alcohol and night time economy agenda is not exclusive to Torbay and is reflected throughout the country. Violent behaviour in public spaces which can be directly associated with the misuse of alcohol not only poses a strain on the resources of the police and the broader criminal justice system, but also has a direct impact on other statutory agencies like the NHS and local authorities.
There are a number of social and physical factors associated with the misuse of alcohol within the setting of the night time economy, which in isolation may not lead to violence, but when combined can aggravate situations, resulting in a higher likelihood of violent behaviour. These include:

- Low cost easily accessible supermarket supplied alcohol
- Large numbers of people within relatively small areas (both inside and external to licensed premises)
- Loud music
- Behaviour/attitude of staff
- Competition for limited transport
- Competition for access to food/refreshment

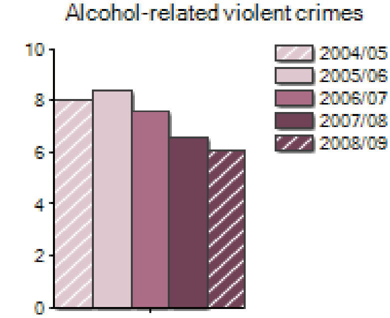
Across the UK, alcohol misuse is a major contributor to crime, disorder, violent and anti social behaviour, with an estimated cost of up to £7.3 billion. However, over 1 million people are employed in pubs, bars, nightclubs and restaurants in the UK and drinking at a responsible level is an enjoyable social pursuit for the vast majority of people.
(Safe, Sensible, Social 2007)

Within Torbay there have been noted reductions in Alcohol Related Crime and Fear of Crime

- Night time assaults have fallen by 42% (2005/06 @ 721 to 2009/10 @ 416) *(Source: Devon & Cornwall Constabulary)*
- Public Perception of drunk rowdy behaviour has reduced from 69% in 2003 to 36% in 2009. (NI41)
- In 2009, 69% of people who visited the Harbourside after 8pm reported feeling safe compared to 65% in 2008 *(Source: Place Survey)*



Torbay rate 7.6 per 1,000 is higher than regional at 6.7 per 1,000



Torbay rate 6.0 per 1,000 is higher than regional at 5.1 per 1,000

Torbay rate 0.1 per 1,000 is similar to regional at 0.1 per 1,000

What We Will Do ...

- Focus and capacity will continue to be directed at operationally managing the night time economy, whilst also raising awareness about health and community safety messages relating to the alcohol agenda. Key element will be to improve perceptions around drunk and rowdy behaviour, whilst recognising that Torbay's night time economy is an integral element of the local economy and tourism offer. Safer Nights Torbay partnership is working closely with local business and in consultation with the public to continue to create a safe night time environment and experience based on evidence of what works. This work includes:

Safer Nights Torbay

- Use ARID data to enhance intelligence and response to alcohol related assaults. To be used both within Joint Tasking and Licensing Intelligence meetings.
- Promote public safety by challenging attitudes to drunken, irresponsible behaivour
- Apply for Purple Flag (Torquay Town Centre) which will positively influence local perception, attract positive media and raise the quality of town centres at night making them cleaner, safer and offering a diverse choice.

Partnerships

- Taxi Marshalls operate over specific busy periods in agreed town centres regulating specific hotspots for alcohol related crime and disorder.
- Street Pastors and'Safe Place' vehicle to operate in Torquay and Paignton town centre 52 weekends a year between hours 9pm and 4am providing support and guidance for all vulnerable people.

Working with Licensees

- Ensure all applications are checked and representations made where appropriate to do so to meet the licensing objectives
- Encourage attendance at licensing forums for each of the towns
- Help with applications to give advice when requested and it is felt to be appropiate
- Develop template documents and policies for businesses
- Undertake both advice visits/inspections and to take enforcement action as appropriate
- Continue to undertake proxy buying (including undercover).
- Explore options for consideration as to impact of zero tolerance policy and local initiatives.

PRIORITY THREE: IMPROVING SERVICES FOR PEOPLE
Objective: M*inimising the harm caused by alcohol to individuals and families.*

WHAT WE KNOW – Minimise the harm caused by alcohol to Adults
Although older people tend to drink less alcohol than younger people still 1 in 6 older men and 1 in 15 older women are drinking enough to harm themselves.

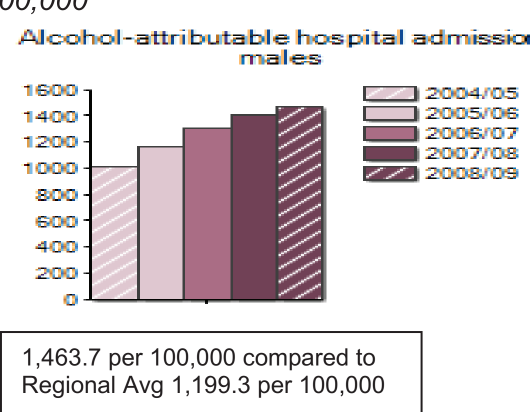
There is little evidence on the effects with older people however research by the North West Public Health Observatory has shown that elderly people have a significantly lower tolerance to alcohol due to natural changes associated with the ageing process. Therefore the impacts of alcohol misuse are more severe for older people. Accidents are a principal cause of death among older people, and alcohol can contribute to mortality and morbidity through its deteriorating effect on stability and judgement. Alcohol is also associated with mental illness, and can contribute to dementia (10% of elderly sufferers have alcohol related brain damage) as well as depression. Furthermore, older people consume more prescribed medicines, the effects of which alcohol can nullify or exacerbate. (*Alcohol – Some sobering Statistics, 2000).*

Local analysis of Acute Alcohol Attributable Hospital Admission 2008/09 shows high numbers of older age adults.

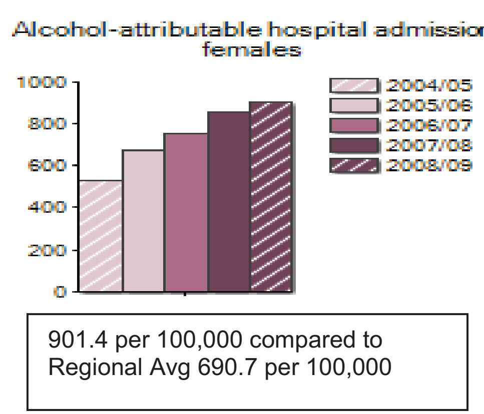
Age Group	*Count of NHS #*		*Sum of AF_Cost*	*Count of NHS #*		*Total Sum of AF_Cost*
	Female	*Male*	*Female*	*Male*	*Total*	*Total*
16 to 24	*315*	*230*	*£ 60,652*	*£ 66,947*	*545*	*£ 127,598*
25 to 34	*284*	*170*	*£ 47,837*	*£ 51,576*	*454*	*£ 99,413*
35 to 44	*323*	*193*	*£ 64,298*	*£ 65,724*	*516*	*£ 130,022*
45 to 54	*149*	*185*	*£ 37,784*	*£ 60,654*	*334*	*£ 98,438*
55 to 64	*171*	*153*	*£ 53,989*	*£ 85,088*	*324*	*£ 139,077*
65 to 74	*209*	*132*	*£ 26,319*	*£ 46,000*	*341*	*£ 72,319*
75+	*1,292*	*441*	*£ 177,032*	*£ 191,778*	*1,733*	*£ 368,809*
Total	***2,743***	***1,504***	***£ 467,912***	***£ 567,765***	***4,247***	***£ 1,035,677***

(Source: Torbay Alcohol related hospital admissions 2010, Doug Haines & Dr Louie Wilson)

Torbay alcohol-attributable hospital admission rates for males is higher than the regional average although lower than national rates. For females the rate is both higher than regional and national rates. Year on year increases can be seen from the diagrams below. Nationally the rates 1297.8 male and 732.1 females per 100,000



1,463.7 per 100,000 compared to Regional Avg 1,199.3 per 100,000



901.4 per 100,000 compared to Regional Avg 690.7 per 100,000

Source: Local Alcohol Profiles, North West Public Health Observatory

Alcohol is a significant factor among families with range of complex issues where there is domestic abuse; parental mental health or substance misuse and in some cases subsequent impact on safeguarding of children.

Domestic Abuse Incidents

-	Total DA incidents	Alcohol/ drugs involved	% Drugs/ Alcohol
2007/08	2929	1518	51.8%
2008/09	3205	1571	49.0%
2009/10	3032	1381	45.5%
2010/11*	2013	910	45.2%

What We Will Do ...

Training Programme	•Training programme with specific courses to enable staff to screen; signpost; offer brief intervention. •Multi Agency Sustance Misuse Screening Tool (MASST) - •Tailored course specficically developed for those working with older adults to screen and provide intervention. •Provide RCGP Training Certificate in Mgmt of Alcohol Problems in Primary Care to increase number of practices with GP accredited by 25%.
Screening and Earlier Intervention	•Roll out of routine questioning within adult community services (incl sexual health & carers) •Promotion of substance misuse screening tool and brief interventions training amongst services working with older adults to include Carers and criminal justice settings.
Working with Families	•Locality Tasking in Torquay and Paignton/Brixham to assist in better early identification of hazardous and harmful drinkers within families. Which will improve signposting and referral to appropriate services; improve initegration and joint working with partnership agencies including voluntary sector; inform local commisisoning arrangements for adults and children services in relation to parental alcohol misuse and alochol related domestic abuse.

WHAT WE KNOW – Minimise the harm caused by alcohol to young people

Whilst restricting access to alcohol for young people continues to be a key aim of partner agencies there has been a recognition of the need to focus also on 'safe and sensible drinking'. Young people should be helped to make informed choices about their alcohol consumption and the activities they engage in and supported if the choices they make were to impact negatively on their health and well being.

NICE Public health guidance make recommendations for School Based alcohol education and recommendations for screening and brief intervention for young people and adults. Effectiveness of this will need to be supported to national policy changes in pricing, availability and marketing.[1]

What We Will Do ...

Young people receive consistent messages	•Roll out social norms peer surfers project in secondary schools •Resource materials supporting Public Health campaigns and enjoy Safer Nights out in Torbay produced and circulalated •Universal and tageted health promtion event (incl Senior lifeskills in secondary schools)
Parents and carers receive consistent messages	•Review the Triple P parenting programme content •Tackle parent and proxy supply of alcohol to young people via test purchaisng
Effective Prevention and treatment programmes	•New Tier 3 service specification commissioned with clear performance standards; outcomes framework; information sharing and recording (with specific targeting of vulnerable groups) •Review of Tier 2 service and agree specification in light of funding envelope (with specific targeting of vulnerable groups •Practitioner training programme at universal, targeted and specialist levels. •Adequate number of places commissioned for young people to access medical assessments and prescribiing treatments
Children of parents who misuse drugs & alcohol are informed and well supported	•Needs of children are identified and assessed which informs treatment package of both parent and child
Informed Plan to reduce use of alcohol among children and young people	•Complete local survey on views and usage and effectiveness of PSHE drug education •Multi agency 'tasking' meetings to take whole community approach in response to neighboruhood issues on alcohol (incl test purchasing; anti social behaivour)

[1] NICE Guidance PH 7 and 24

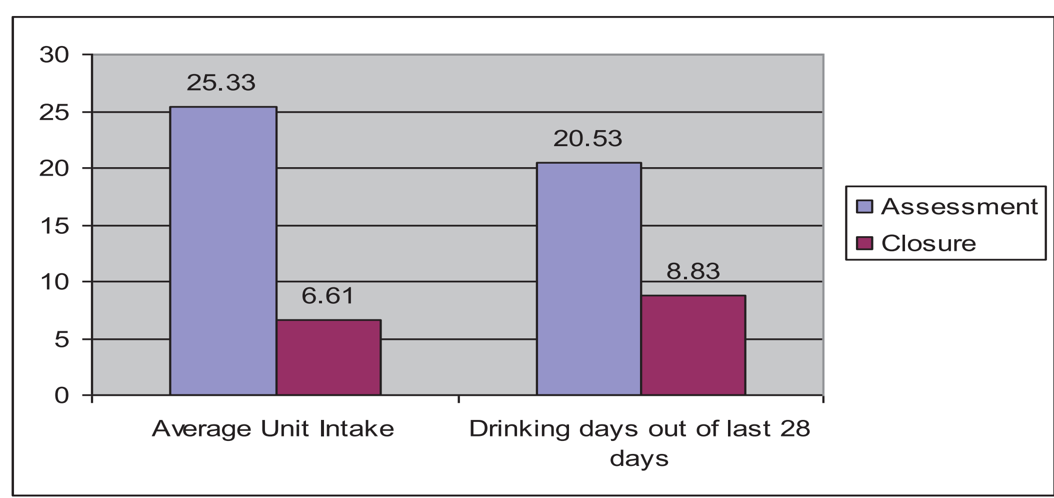
WHAT WE KNOW – Alcohol Treatment and Alcohol Related Hospital Admission.

The primary aim of alcohol treatment and interventions is to "achieve a reduction in alcohol-related harm and improvements in health and social functioning, normally including a reduction in alcohol consumption or changes in patterns of alcohol consumption that contribute to harm, or a significant risks of harm, to the service user or others." *(Models of Care for Alcohol (NTA, NHS).*

From identifying people early on it is crucial to engage and enable them into treatment services as quickly as possible. Current young people services are in contact with 100% in under 15 days. Adult services are averaging 65% of people being seen in under 3 weeks.

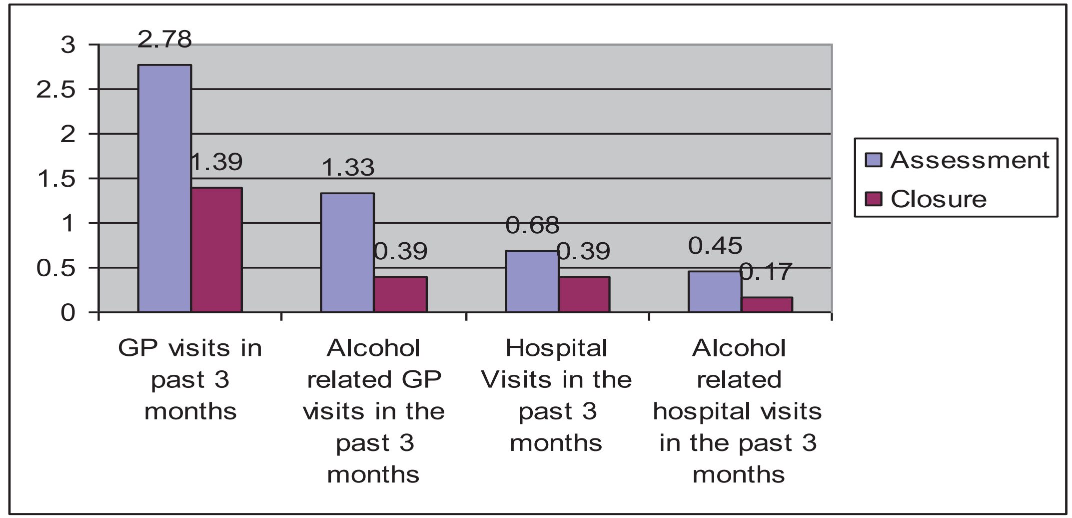
Screening of new and existing patients by GPs within primary care has identified a number of patients being referred for treatment.

People entering the Torbay Primary Care Alcohol Service have a range of need and complex issues, reporting at least 1 in 10 having some sort of housing need. In evaluating the effectiveness of the service a number of measures are reported on with identified numbers of people reducing their alcohol usage. Patient self reported data for a 28 day and 3 month period follows :



28 Day Period

- Average unit intake reduced by 70% against a target of 50% reduction.
- Drinking days reduced by 54% against a target of 50% reduction.



3 month period
Non-alcohol & alcohol related visits.

- GP visits reduced by 36% against a target of 50% reduction.
- Alcohol related GP visits reduced by 68% against a target of 50% reduction.
- Hospital visits reduced by 65% against a target of 50% reduction.
- Alcohol related hospital visits reduced by 83% against a target of 50%

What We Will Do ....

Optimise the capacity to meet demand for community alcohol treatment and models of delivery which will meet the needs of all who require an intervention, including those with high levels of complexity and those who find it difficult to engage in treatment

Pathway & Policy Design & Implementation	•Focus hospital alcohol team on pathway and policy design to suppor the implementation of screening and brief advice programmes wihtin A&E and wider hospital. •Develop a system to monitor the equity of serivce provision •Build on opportunities that emerge from the development of the Integrated Offender Management for drugs to include alcohol related issues.
Reduce Alcohol Related Admissions	•Engage service users & ex-service users in providing recovery programmes. •New group work programme 'Re`covery Captial' increasing indivudal responsiblity for devleoping personal recovery plans •Implement new intervention programem for non-prescribed drug users based on evidence based practice following a 6 x session plan.
Effectiveness of Treatment	•Use of National Alcohol Monitoring System (NAMS) to define activity and performance •Activity against local measures set including Changes in drinking behaviours; Changes in AUDIT scores; Changes in criminal activity; Changes in GP and hospital presentation; Changes in health and well-being •Performance and governance monitoring by Torbay Drug & Alcohol Action Team (DAAT)

SECTION FOUR – THE CHALLENGE

This strategy takes a joint multi agency approach to alcohol policy particularly around commissioning. Ever reducing resources pose the greatest challenge to organisations and the impact this has on ability to maintain levels of services.

Whilst progress is made to realise cost effectiveness and measures to address duplication there is the need and support to continue to create an effective environment within which organisations enable commissioners to work together to allocate resources on agreed priority areas equally supporting the areas where de commissioning needs to take place.

Whilst the actions identified in the previous sections are planned and are being progressed within existing budgets it will be crucial to secure resource commitment beyond the short term to realise the outcomes and impact and longer lasting behaviour change anticipated. As well as considering models of effective practice tested elsewhere and transferrable within the local context.

SECTION FIVE – THE FUTURE POSSIBILITIES ... IF ONLY!!!!!!

In working with Qi Results to develop this strategy a number of additional projects have been identified for further consideration and implementation over the next 2 years. This would take a connective approach to a joined up policy on addressing alcohol across the different partners including the new GP commissioners of healthcare.

A road traffic campaign – **Promote an intolerance equivalent to use of mobile phone and or wearing of seat belts**

"Zero Tolerance of drink-driving"

A restaurant campaign – **Encouraging a positive choice and rewarding responsible citizenship**

"Nominated Driver Eats Free"

A nightclub campaign - **Promoting voluntary checking at the end of the evening administered by Bouncers.**

"Breathe. Live"

A consumer Campaign - **Engaging consumers and retailers to consider the price of supermarket alcohol**

"The Cost of Cheap Booze"

Celebrity Endorsement - **Raising the aspirations of young people**

"Born in Torbay"

Focused Outreach - **activities that focus on youth groups and link alcohol and sexual health matters**

"Girls" "Boys"

Communication Strategy – pro active attracting national recognition

Engagement of the whole Community "Torbay ~ Your Bay