NORTH YORKSHIRE COUNTY COUNCIL

YOUNG PEOPLE OVERVIEW AND SCRUTINY COMMITTEE

30th January 2015

Final North Yorkshire Joint Alcohol Strategy 2014 - 2019

1.0 Purpose of Report

1.1 This report asks the Committee to note the information in the report and Final North Yorkshire Joint Alcohol Strategy.

2.0 Purpose

2.1 The North Yorkshire Alcohol Strategy 2014 – 2019 and a working draft of the Implementation Plan were agreed by HAS Leadership Team on 28th May 2014. The Strategy has also been agreed by the Integrated Commissioning Board on 11th September 2014 and by the North Yorkshire and York Chief Executives Group on 6th November 2014. The Strategy and draft Implementation Plan are being presented to CMB to gain approval and agreement for the County Council to be an official signatory of the Strategy and for use of the County Council logo in the Strategy document.

3.0 Background

3.1 Alcohol impacts the population. The Strategy describes the problem, builds the case for action and sets out our 5-year vision. It outlines what is needed at strategic level to counter the impacts, and describes how we would measure success.

3.2 The Strategy and Implementation Plan were developed by an Alcohol Strategy Steering Group made up of representatives from NYCC (Trading Standards and Public Health), Community Safety Partnerships, District Licencing authorities, NY Police, Probation services and the Office of the Police and Crime Commissioner. The Strategy was informed by an alcohol health needs assessment and extensive engagement which included a stakeholder event held in February 2014 and a further four week engagement exercise throughout May 2014. The portfolio holder for Public Health and Prevention attended the stakeholder event and has contributed to the development of the Strategy.

3.3 The Alcohol Strategy aims to galvanise partners (statutory and non-statutory organisations, the community and businesses) within North Yorkshire to collectively reduce the harms from alcohol. It has been developed to ensure that we continue to build on the on-going work across the county, informed by the latest data and information collected within the alcohol health needs assessment. It uses the best evidence, where available, of what works taking into account best value for money.

Alcohol Strategy vision and outcomes

3.4 The Strategy includes the vision statement:

> 'Working together to reduce the harm caused by alcohol to individuals, families, communities and businesses in North Yorkshire while ensuring that people are able to enjoy alcohol responsibly'.

3.5 In order to achieve that vision, it identifies three outcome areas:

- Establish responsible and sensible drinking as the norm
- Identify and support those who need help through recovery
- Reduce alcohol-related disorder

3.6 To enable the realisation of those outcomes, there are three underpinning themes or values:

- Working in partnership
- Reducing inequalities and protecting the vulnerable
- Ensuring effectiveness and value for money whilst encouraging innovation

3.7 The draft Strategy received high levels of support from the public and stakeholders. Overall, the majority (81%) of those who completed the survey agreed with the vision and strategic direction of the draft Strategy as well as the 3 priority outcomes identified (94%). The feedback from this engagement was used to shape the final Strategy document (Appendix 1).

3.8 The following is a summary of the responses received. The full engagement report is available Appendix 2.

4.0 Implementation Plan

4.1 An implementation plan for the Strategy has been produced (Appendix 3 draft implementation plan). This identifies key actions for each Directorate of NYCC as well as for our partners.

4.2 Included in the actions for which NYCC will have a lead role are:

- Supporting schools to deliver consistent and high quality personal, social, health and economic (PSHE) education around alcohol (and other risky behaviours) – CYPS
- Preventing under-age sales (including proxy sales), irresponsible drinks promotions and illegal imports of alcohol and ensure sanctions are fully applied to businesses that break the law – BES
- Developing clear pathways that specialists and non-specialists can use to identify people with alcohol misuse issues in order to offer brief advice or referral for specialist treatment and support depending on the level of risk identified, alongside a directory of local resources available to treat – HAS

4.3 We are also developing an outcomes framework (Appendix 4) to monitor progress against agreed indicators. The Public Health team have done work to establish the baseline for these indicators as well as the projected performance over the next 5 years if current trends continue. This will inform the proposed targets for monitoring progress.

4.4 It is proposed that the Strategy Implementation Plan will be monitored by the Drugs and Alcohol Partnership Advisory Group chaired by the Director of Public Health. This Group will also make recommendations for review of the Strategy is the need arises.

4.5 An annual report will be produced for partners highlighting progress against the Strategy outcomes and reviewing actions for the coming year for the 5-year duration of the Strategy.

5.0 Resource Implications

5.1 HAS Leadership Team has agreed to invest from the Public Health Grant towards implementing aspects of the North Yorkshire Alcohol Strategy mainly provision of identification and brief advice (IBA) interventions for people who do not need specialist treatment:

- 2014/15 £300,000
- 2015/16 £200,000
- 2016/17 £200,000

5.2 Additional investment to Trading Standards will support implementation of the Alcohol Strategy (as well as tobacco control):

- 2014/15 £105,171
- 2015/16 £107,275
- 2016/17 £109,420
- 2017/18 £111,609

6.0 Equalities Implications

6.1 The Public Health Team is leading on the development of an Equalities Impact Assessment with support from Shanna Carrell.

6.2 The Assessment is currently underway and is considered an on-going process.

6.3 To date the key findings indicate that the development of the alcohol strategy needs to seek to address the engagement of specific cohorts, and access. The premise of the proposed draft strategy is to assist harmful and hazardous alcohol users to address their alcohol issues, in line with current national policy. There will be a cohort of individuals who have particularly complex needs and may not have a recovery aspiration.

6.4 NYCC have awarded contracts for a North Yorkshire wide integrated substance misuse service including recovery and mentoring which will meet the needs for those with drug and dependent alcohol use.

5.0 Recommendations

5.1 Note the information in the report and North Yorkshire Joint Alcohol Strategy.

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Date: 14th January 2015
Background Documents: none
Annex: North Yorkshire Final Alcohol Strategy
North Yorkshire Action Plan

North Yorkshire Joint Alcohol Strategy 2014-2019

‘Working together to reduce the harm caused by alcohol to individuals, families, communities and businesses in North Yorkshire while ensuring that people are able to enjoy alcohol responsibly’

Health and Wellbeing Board
North Yorkshire

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Foreword

The vast majority of people who drink alcohol in North Yorkshire do so responsibly. Sensible drinking is a feature of many social gatherings across the county and those who drink within safe limits represent the typical picture of alcohol consumption.

Unfortunately, the stereotypes of alcohol misuse are still present in our communities. Alcohol misuse continues to be a common factor behind police calls to incidents of violence in our homes and communities. The health consequences of alcohol misuse add to the pressure on our emergency departments and health care services. Irresponsible drinking by a minority can mar the enjoyment of a night out for the many residents and visitors who come to our town centres.

The vision for this countywide alcohol strategy recognises that we need to promote responsible safe drinking as the norm for those who use alcohol while working together to reduce the harms of alcohol misuse.

Changing the drinking culture is a key outcome we are aiming to achieve. The availability of cheap alcohol and the social pressures to drink make it easy for people to engage in binge drinking and harmful drinking. Too many people who engage in this pattern of drinking are not aware of the damage it can cause to their health. This is an issue for all age groups. A middle aged woman who drinks two large glasses of wine at dinner is as much at risk from binge drinking as the stereotypical young man who has a heavy drinking session with his mates.

We also know that there are large numbers of people who are drinking at levels that cause harm to themselves and others. There are effective services and interventions to help people overcome alcohol dependency but a substantial proportion of those who could benefit are not aware that they have a problem or do not know what treatment is available. Screening for alcohol problems and offering brief advice in primary care is a very effective method of helping those with harmful levels of drinking. The strategy aims to make these interventions more readily available.

We can do more through coordinated action across agencies to tackle alcohol related crime and antisocial behaviour. The strategy will promote sharing of information on impacts from alcohol that can be used by licensing agencies to limit availability in areas where problems are known to exist and support local partnerships to manage their night time economy.

With such a large agenda, we need the collective focus and resources of all key partners to achieve the priority outcomes we have identified in the strategy. We need to target our efforts on areas and groups that have a disproportionate impact from alcohol misuse and we need to do so in efficient and innovative ways. These underpinning values will inform the delivery of the strategy.

We thank all those who have contributed to the development of this strategy which outlines our local response to the recognised public health and social challenge of alcohol misuse. We look forward to working with willing partner agencies and the public in order to realise the vision that we present here.

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The Humberside, Lincolnshire and North Yorkshire CRC Limited

Executive Summary

Purpose

This alcohol strategy aims to galvanise partners (statutory and non-statutory organisations, the community and businesses) within North Yorkshire to collectively reduce the harms from alcohol. It sets out the case for action and our five year vision. It has been developed to ensure that we continue to build on the ongoing work across the county, informed by the latest data and information collected within the Alcohol Health Needs Assessment, using the best evidence of what works where available, and taking into account best value.

Understanding the problem and building the case for action

The impacts from alcohol can be broadly categorised into the health, social and economic effects. In North Yorkshire, although around one in seven adults abstain from alcohol, around a quarter of all people who drink are estimated to be drinking at harmful or hazardous levels. Alcohol-related hospital admissions are increasing year on year, and nearly 200 people die in North Yorkshire every year as a result of alcohol. It is associated with crime, including domestic violence and sexual crime, and features in antisocial behaviour in particular, with over a quarter of incidents in some areas linked to alcohol. It costs society through public services responding to the impacts, as well as on businesses affected by absenteeism and lost productivity. It impacts unfairly on children and families of people who are dependent on alcohol.

Yet drinking responsibly within limits can be safe.

National guidance tells us how we need to tackle this problem by utilising both a population approach with greater awareness to encourage sensible drinking and use of licensing laws - through to evidence-based methods to identify people who are drinking at hazardous or harmful levels and providing the correct level of support. At the moment, we have variable prevention and treatment services across the county.

What do we need to do?

Using the evidence and guidance produced nationally we have set the local strategic direction for dealing with the harms from alcohol within North Yorkshire. We have adopted the vision statement:

‘Working together to reduce the harm caused by alcohol to individuals, families, communities and businesses in North Yorkshire while ensuring that people are able to enjoy alcohol responsibly’

In order to achieve that vision, we have identified three outcome areas:

- Establish responsible and sensible drinking as the norm within the safer drinking guidelines, for example through greater awareness in at risk groups; school education; increasing the capacity to prevent irresponsible and unlawful sales; and exploring the feasibility of working with businesses to promote sensible and safe drinking

- Identify and support those who need help into treatment through recovery for example through establishing clear pathways of support and referral, training professionals who regularly come into contact with people who are affected by alcohol in identification and brief advice; and ensuring specialist treatment services provide support where it is needed most
- Reduce alcohol-related crime and disorder through better application of the licensing laws; working with the North Yorkshire Community Safety Partnership and local partnerships to effectively manage the night time economy

We have also identified three underpinning themes or values to achieve those outcomes:

- Working in partnership
- Reducing inequalities and protecting the vulnerable
- Ensuring effectiveness and value for money whilst encouraging innovation

We are developing an implementation plan to complement this strategy and will set up the right governance structures to ensure success. We will measure success against a number of outcomes including alcohol related deaths, crime and disorder rates and admissions for alcohol and alcohol related illnesses.

1. Purpose

This alcohol strategy aims to galvanise partners (statutory and non-statutory organisations, the community and businesses) within North Yorkshire to collectively reduce the harms from alcohol. It sets out the case for action and our five year vision.

It has been developed to ensure that we continue to build on the ongoing work across the county, informed by the latest data and information collected within the Alcohol Health Needs Assessment, using the best evidence of what works where available, and taking into account best value.

This document is intended to provide the strategic overview and priorities surrounding the alcohol challenges for North Yorkshire so that all partners can align their plans to support and deliver the agreed outcomes.

We will develop an action plan to implement the strategy over the next three years, working with City of York Council where applicable. Implementation of the action plan will enable a coordinated partnership approach to achieving its outcomes.

2. Understanding the problem and building the case for action

2.1. What harm can alcohol do?

A definition of the different levels of alcohol consumption and their risks is shown in Appendix 1.

Health

Alcohol harms health through three mechanisms

- Acute intoxicating effects, occurring after a binge
- Chronic toxic effects, following prolonged periods of drinking at harmful levels
- Propensity for addiction leading to physical and psychological dependency

The immediate intoxicating effects of alcohol - reduced inhibitions, impaired judgement, slurred speech, and nausea/vomiting, for example - are often easily identifiable; however the longer-term health consequences of excessive drinking, despite their serious and potentially deadly nature, may remain undetected. Studies have shown that alcohol is linked to more than 60 different medical conditions including:

- Cancer - alcohol is one of the most well-established causes of cancer. The International Agency for Research into Cancer (IARC; part of the World Health Organisation) has classified alcohol as a Group 1 carcinogen since 1988[1]. A study published in 2011 found that alcohol is responsible for around 4% of UK cancers, about 12,500 cases per year[2]. The proportion of cases attributable to alcohol was highest for mouth and throat cancers (around 30%), but bowel cancers accounted for the greatest overall number of cases linked to alcohol (around 4,650 cases a year)
- Liver cirrhosis - the final stage of alcoholic liver disease
- High blood pressure and increased risk of stroke and heart disease
- Mental health issues - there is a link between drinking too much alcohol and a number of mental health problems. Persistent heavy drinking can also be associated with memory loss difficulties
- Pancreatitis and stomach problems

Social

Alcohol impacts wider than health, it impacts on families and communities

- Children of heavy drinkers are at risk of physical and emotional neglect, abuse, and stress and are more likely to have their own alcohol problems in later life
- Alcohol is associated with truancy
- Alcohol is a factor in up to 50% of cases of domestic violence
- Marriages are twice as likely to end in divorce if one or both partners has an alcohol problem
- Alcohol is associated with antisocial behaviour

- Increase vulnerability to violence, sexual crime or longer term vulnerability such as child neglect
- Binge drinking is associated with unsafe and unlawful sex
- Homelessness is associated with alcohol dependency
- Alcohol is a factor in road safety

Economic

Data submitted by the Department of Health to the Health Select Committee (Government's alcohol strategy, Third report of session 2012-13) estimates the costs of alcohol misuse as follows:

- NHS in England - £3.5 billion per year (at 2009/10 costs)
- Crime in England - £11 billion per year (at 2010/11 costs)
- Lost productivity in the UK - £7.3 billion per year (at 2009/10 costs)
- Cost of alcohol related Killed or Seriously Injured (KSI) road collisions per year in York and North Yorkshire is £7.4 million (at 2012 values)

The submission estimates that the total cost to society is approximately £21 billion per year. (This does not include the impact of alcohol misuse on families and communities.) It is estimated that 8-14 million working days are lost annually due to alcohol-related problems. With regard to safety, up to 25% of workplace accidents and around 60% of fatal accidents at work may be associated with alcohol.

2.2. What is the picture in North Yorkshire?

The North Yorkshire Alcohol Health Needs Assessment[3] was updated at the end of 2013. The key points identified from it and the Joint Strategic Intelligence Assessment are:

Risk of alcohol related harm

- Modelled estimates of alcohol consumption show between 7-8% of the North Yorkshire population who drink are classified as higher risk drinkers; 20-22% are classified as increasing risk drinkers; 71-74% are classified as lower risk drinkers
- Nationally around 4% of 16-64 year olds are classed as dependent
- Modelled binge drinking rates are between 23.2% and 28.1% with the highest estimated rates in Richmondshire. These are all higher than the England rate
- Modelled rates of abstainers as a percentage within the total population aged 16 years and over are between 12.8% to 14.8%
- Nationally, hazardous drinking rates are highest in the 45-64 year old age band, followed by the 25-44, 16-24 and 65+ age bands respectively
- Nationally, the proportion of men who drink hazardously is approximately 1.5 times higher than females, although the gap is less pronounced in the younger age bands
- Drinking in pregnancy can increase the risk of miscarriage and Foetal Alcohol Spectrum Disorders. National data indicates that 5% of pregnant women drank alcohol on two or more days prior to interview compared with 20% (women aged 16-49 years) who were not pregnant or unsure

Health outcomes

- The alcohol specific death rates for men in North Yorkshire are just under twice the rates of those of women. There is a difference when comparing rates to England. Male rates are approximately a third less than England; however the rate in women is similar to England. The highest rates for both men and women are in Scarborough. North Yorkshire is following the England trend of a steady increase in the rate for those dying from alcohol specific conditions in men, and a flattening of the rate after a slight increase for women
- Alcohol specific death rates for both men and women follow a gradient of inequality with those from more deprived backgrounds more likely to have a higher death rate
- Alcohol related admissions to hospital have continued to rise in line with national figures, with rates in women being about half those for men. Most districts are less than the England average but Craven has a statistically significant higher rate than England for female admissions.
- Locally, the hospital admission rate due to alcohol-specific conditions amongst under-18 year olds is in line with the national average. The rate has steadily fallen over the last few years
- The cost of ambulance attendances in North Yorkshire and York where alcohol was involved was nearly a quarter of a million pounds in just one quarter of this year

Crime and antisocial behaviour

- Alcohol related crime is not significantly high compared to other areas of England. There has been a marked fall in crime attributable to alcohol in England and North Yorkshire over the last five years. Scarborough has the highest rates of alcohol attributed crime (about double that of Ryedale)
- Rates of alcohol related antisocial behaviour vary between districts. Between April and August 2013 the proportion of antisocial behaviour linked to alcohol ranged from 13% in Ryedale to 27% in Scarborough
- 18-29% of police recorded antisocial behaviour is linked to alcohol and has a significant impact on peoples sense of wellbeing across North Yorkshire
- Between April and August 2013, the proportion of crime linked to alcohol varied from 9% in Ryedale to 16% in Richmondshire and Scarborough
- Custody data shows that across North Yorkshire Police, between 30% and 40% of all arrestees are drunk or have consumed alcohol
- Between April and August 2013, the proportion of violent and sexual crime linked to alcohol in each Command ranged from 26% in Hambleton to 40% in Richmondshire and Scarborough
- There are on average over four fatal collisions and 34 serious collisions in York and North Yorkshire per year involving alcohol (2008-12)
- Alcohol is a factor in an average of 9% of fatal road collisions, 8% of serious road collisions and 10% of

killed or Seriously Injured (KSI) young person (aged 14-24) road collisions

- During the winter drink drive campaign, 2013, 6% of the drivers stopped were arrested at the scene for drink or drug driving offences
- There have been an average of 46 complaints of underage sales per year for the last three years in North Yorkshire
- It is estimated that the total cost to detain Alcohol Related Detainees in North Yorkshire Police Custody between 1st June 2013 to 1st September 2013 is £158,400

Vulnerable groups

- In 2014 1% of children in year 6 and 24% of children in Years 8 and 10 in North Yorkshire said they had an alcohol drink in the last seven days (both lower than a previous survey in 2012)
- National estimates are that 30% of children live with a binge drinker, 22% live with a hazardous drinker and 6% live with a dependent drinker
- We have a large military presence in North Yorkshire with nearly 15,000 serving personnel. The King's cohort study[4] showed that alcohol misuse in the Army runs at a level twice that for the same group in the general population levelling out to that of the general population by age 35. Rates were higher in those returning from deployment
- Street drinking has been identified as a particular problem for some districts

2.3. What are the national drivers?

The **2012 National Alcohol Strategy**[5] states that the problem has developed for a number of reasons: a combination of irresponsibility, ignorance and poor habits - whether by individuals, parents or businesses. It describes how alcohol has become acceptable to use for stress relief, putting many people at real risk of chronic diseases. In addition, it states that cheap alcohol is too readily available and industry needs and commercial advantages have too frequently been prioritised over community concerns. This has led to 'pre-loading' before a night out.

The strategy has developed clear outcomes to 'radically reshape the approach to alcohol and reduce the number of people drinking to excess'. The outcomes expected 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
- A reduction in the number of people 'binge drinking'
- A reduction in the number of alcohol-related deaths
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed

The Government did consult on an evidence based minimum price for alcohol of 45p per unit but decided to opt for a far less stringent formula of banning sales of alcohol below the cost duty plus VAT.

The Government's **Drug strategy (2010) Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life**[6] sets out a fundamentally different approach to preventing drug use in our communities, and in supporting recovery from drug and alcohol dependence. The strategy has recovery at its heart and aims to:

- Put more responsibility on individuals to seek help and overcome dependency
- Place emphasis on providing a more holistic approach by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing
- Reduce demand
- Take an uncompromising approach to crack down on those involved in the drug supply both at home and abroad
- Put power and accountability in the hands of local communities to tackle drugs and the harms they cause

The **Police Reform and Social Responsibility Act 2011**[7] covers a number of areas, some of which are relevant to the alcohol agenda:

- Amends and supplements the Licensing Act 2003 with the intention of 'rebalancing' it in favour of local authorities, the police and local communities
- Replaces police authorities with directly elected Police and Crime Commissioners, with the aim of improving police accountability

The first North Yorkshire Police and Crime Commissioner was appointed in November 2012. The core functions of Police and Crime Commissioners are to secure the maintenance of an efficient and effective police force within their area and to hold the Chief Constable to account for the delivery of the police and crime plan.

As well as their core policing role, commissioners have a remit to cut crime and disorder and have commissioning powers and funding to enable them to do this. They hold a proportion of funding related to community safety/crime reduction. Commissioners are free to pool funding with local partners and have flexibility to decide how to use their resources to deliver against the priorities set out in the Police and Crime Plan.

The **Health and Social Care Act 2012** has meant that from April 2013, upper tier and unitary local authorities have received a ring-fenced public health grant, including funding for alcohol services. Local authorities are supported by Public Health England and are 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.

It has also meant that Health and Wellbeing Boards have been formed which 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 sets out how they will work together to meet these needs. The boards promote integration of health and social care services with health-related services like criminal justice services, education or housing. They help join up services around individuals' needs and improve health and wellbeing outcomes for the local population.

With the new responsibilities for Directors of Public Health (DsPH) under the 2012 changes to the **Licensing Act 2003** DsPH are now considered a Responsible Authority for the purposes of the Act working to common goals and the 'common good'. This gives them a responsibility to consider responding to licensing applications made to the local authority. However, there is no specific health or public health objective in the Act and responses must be based on the existing licensing objectives set out in the Act.

The Governments **Strategic Framework for Road Safety (2011)** provides clarity to local authorities, road safety professionals and other stakeholders of their roles and responsibilities to reduce casualties and improve safety for road users. It also sets out a wide range of measures to tackle careless and dangerous driving behaviour - from a new fixed penalty notice for careless driving, to tougher action against drink and drug drivers.

2.4. What are the local drivers?

The **North Yorkshire Police and Crime Plan**[8] sets out a vision that people in North Yorkshire will: 'Be safe; feel safe - protected by the most responsive service in England'. A clear deliverable within the plan states that the Police and Crime Commissioner will work in partnership to: 'Develop an evidence-based, area wide alcohol strategy working with our partners including health, which leads to improved provision on the ground in local communities and clear, measurable outcomes. The expected outcomes are: reduced levels of antisocial behaviour, violent crime and domestic violence across the force area.' The Police and Crime Plan is being refreshed.

The **North Yorkshire Joint Health and Wellbeing strategy**[9] (2012) sets out the priorities of the Health and Wellbeing Board. Alcohol contributes to all the stated priorities:

- Improve the health of everyone
- Ill health prevention
- Healthy and sustainable communities
- People with long-term conditions
- Children and young people
- Emotional health and wellbeing
- People living with deprivation
- Vulnerable groups

It specifically encourages positive lifestyle behaviour changes including a reduction in alcohol consumption.

The **2012 North Yorkshire Joint Strategic Needs Assessment**[10] (JSNA) identified some unmet need with regards to alcohol:

- There needs to be a systematic, coordinated approach to alcohol harm reduction and commissioning of alcohol services involving all partner agencies within an agreed substance misuse strategy

- Improve the quality of local data on alcohol consumption in North Yorkshire so as not to rely on modelled estimates
- Improve capacity and access to a Tier 1 programme to provide screening and brief interventions for example in Primary Care or A&E
- Continue to provide specialist treatment services for dependent drinkers whose health and social issues associated with their alcohol use have become severe whilst improving support for people earlier
- Include alcohol screening as part of the NHS Health Check programme as indicated in the Government's recently published Alcohol Strategy
- There is a need to improve the quality of PSHE including drugs and alcohol education lessons to ensure they are relevant and engage pupils in their learning. This should include consulting with pupils on how learning opportunities can best meet their needs
- In primary schools there is a need to increase the percentage of pupils who do not drink alcohol in Yr 6 (83%). There are gaps around support for primary schools at a Tier 2 level. There is a need to put in place targeted interventions for those pupils identified with higher levels of drugs, alcohol or smoking use; including vulnerable groups.
- The Children and Young People's Service is leading the re-tendering for a Young People's Tier 3 services for Risk Taking Behaviour which encompasses evidence based interventions and services around substance misuse (drugs and alcohol) and sexual health for young people. This forms part of the healthy child programme tender.
- A more coordinated approach to training is required so that staff are up to date on young people's drug/alcohol use, assessment and referral into treatment services

The updated **2014 North Yorkshire Joint Strategic Intelligence Assessment**[11] highlights how excessive alcohol intake may manifest itself in violent crime, criminal damage, hate crime and antisocial behaviour, particularly within the night time economy as well as increasing vulnerability in respect of child neglect, sexual crime, particularly for young people, and within domestic violence.

The **95 Alive York and North Yorkshire Road Safety Partnership** is a well-established multi agency partnership that works on a data led basis to address the key priority issues that will reduce casualties and make use of the roads safer in North Yorkshire and York. Coordination of programmes and campaigns to support and complement, for example, police Drink and Drug Driving enforcement operations adds value and impact and widens the deterrent effect of their policing. There is significant scope to further develop this work to incorporate other health campaigns and messages within this established high profile area.

The **DfE and ACPO drug advice for schools** - Advice for local authorities, headteachers, school staff and governing bodies (September 2012), highlighted a number of key points in the document:

- Pupils affected by their own or other's drug

misuse should have early access to support through the school and other local services

- Schools are strongly advised to have a written drugs policy to act as a central reference point for all school staff
- It is helpful for a senior member of staff to have responsibility for this policy and for liaising with the local police and support services

Where the document refers to drugs, this includes alcohol unless otherwise specified.

The Role of Schools - as part of the statutory duty on schools to promote pupils' wellbeing, schools have a clear role to play in preventing drug misuse as part of their pastoral responsibilities. To support this, the Government's Drug Strategy 2010 ensures that school staff have the information, advice and power to:

- Provide accurate information on drugs and alcohol through education and targeted information, including via the FRANK service
- Tackle problem behaviour in schools, with wider powers of search and confiscation
- Work with local voluntary organisations, health partners, the police and others to prevent drug or alcohol misuse

2.5. What does the evidence say we should be doing?

The National Institute for Health and Care Excellence (NICE) has produced five key evidence guidelines that relate to alcohol:

- Alcohol Use Disorders: Preventing harmful drinking (Public Health Guidance 24) (2010)[12]
- Alcohol Dependence and harmful alcohol use (Clinical Guideline 115) (2011)[13]
- Alcohol use disorders: diagnosis and clinical management of alcohol-related physical complications. (Clinical Guideline 100) (2010)[14]
- School-based interventions on alcohol (Public Health Guidance 7) (2007)[15]
- Behaviour change: individual approaches (Public Health Guidance 49) (2014)[16]

NICE describe two approaches.

- Population-level approaches are important because they can help reduce the aggregate level of alcohol consumed. They can help those who are not in regular contact with the relevant services; and those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking. They can also help prevent people from drinking harmful or hazardous amounts in the first place
- Individual-level interventions can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as they are most likely to change their behaviour if it is tackled early. In addition, an early intervention could prevent extensive damage

Prevention and education

NICE say that locally, licensing should:

- Be based on local data and, if necessary, limit the number of new licensed premises in a given area
- Work in partnership to identify and take action against premises that regularly sell alcohol to people who are underage, intoxicated or making illegal purchases for others
- Undertake test purchases to ensure compliance with the law on underage sales
- Ensure sanctions are fully applied to businesses that break the law on underage sales, sales to those who are intoxicated and proxy purchases

NICE suggested that national policy should:

- Consider revising legislation on licensing
- Consider a review of the current advertising codes to ensure children and young people's exposure to alcohol advertising is as low as possible
- Assess the potential costs and benefits of a complete alcohol advertising ban to protect children and young people from exposure to alcohol marketing

NICE also highlights the use of school based interventions to reduce alcohol:

- Ensure alcohol education is an integral part of the national science, PSHE and PSHE education curricula, in line with Department for Children, Schools and Families (DCSF) guidance
- Ensure alcohol education is tailored for different age groups and takes different learning needs into account (based, for example, on individual, social and environmental factors). It should aim to encourage children not to drink, delay the age at which young people start drinking and reduce the harm it can cause among those who do drink

Education programmes should:

- Increase knowledge of the potential damage alcohol use can cause - physically, mentally and socially (including the legal consequences)
- Provide the opportunity to explore attitudes to - and perceptions of - alcohol use
- Help develop decision-making, assertiveness, coping and verbal/non-verbal skills
- Help develop self-esteem
- Increase awareness of how the media, advertisements, role models and the views of parents, peers and society can influence alcohol consumption

Early identification and harm minimisation

NICE advises the provision of screening and brief interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers). Where screening everyone is not feasible the following applies.

NHS professionals should focus on people:

- With relevant physical conditions (such as hypertension and gastrointestinal or liver disorders)

- With relevant mental health problems (such as anxiety, depression or other mood disorders)
- Who have been assaulted
- At risk of self-harm
- Who regularly experience accidents or minor traumas
- Who regularly attend GUM clinics or repeatedly seek emergency contraception

Non-NHS professionals should focus on people:

- At risk of self-harm
- Who are vulnerable
- Involved in crime or other antisocial behaviour
- Who have been assaulted
- At risk of domestic abuse
- Whose children are involved with child safeguarding agencies
- With drug problems

In young people aged 16-17 yrs, the use of screening tools is validated. NICE advise a focus on key groups that may be at an increased risk of alcohol-related harm. These include those:

- Who have had an accident or a minor injury
- Who regularly attend genito-urinary medicine (GUM) clinics or repeatedly seek emergency contraception
- Involved in crime or other antisocial behaviour
- Who truant on a regular basis
- At risk of self-harm
- Who are looked-after children
- Involved with child safeguarding agencies

For adults who have not responded to brief structured advice on alcohol, offer an extended brief intervention (up to four sessions of 20-30 minutes each). Staff should be trained to provide alcohol screening and structured brief advice.

The cost effectiveness reviews and economic modelling for the Alcohol Use Disorders: Preventing harmful drinking NICE guideline suggests that screening plus brief intervention at the next GP consultation, the next registration with a new GP or the next A&E visit would be cost effective when compared to doing nothing.

Referral to specialist treatment should be made if one or more of the following has occurred. They:

- Show signs of moderate or severe alcohol dependence
- Have failed to benefit from structured brief advice and an extended brief intervention and wish to receive further help for an alcohol problem
- Show signs of severe alcohol-related impairment or have a related co-morbid condition

Treatment and rehabilitation

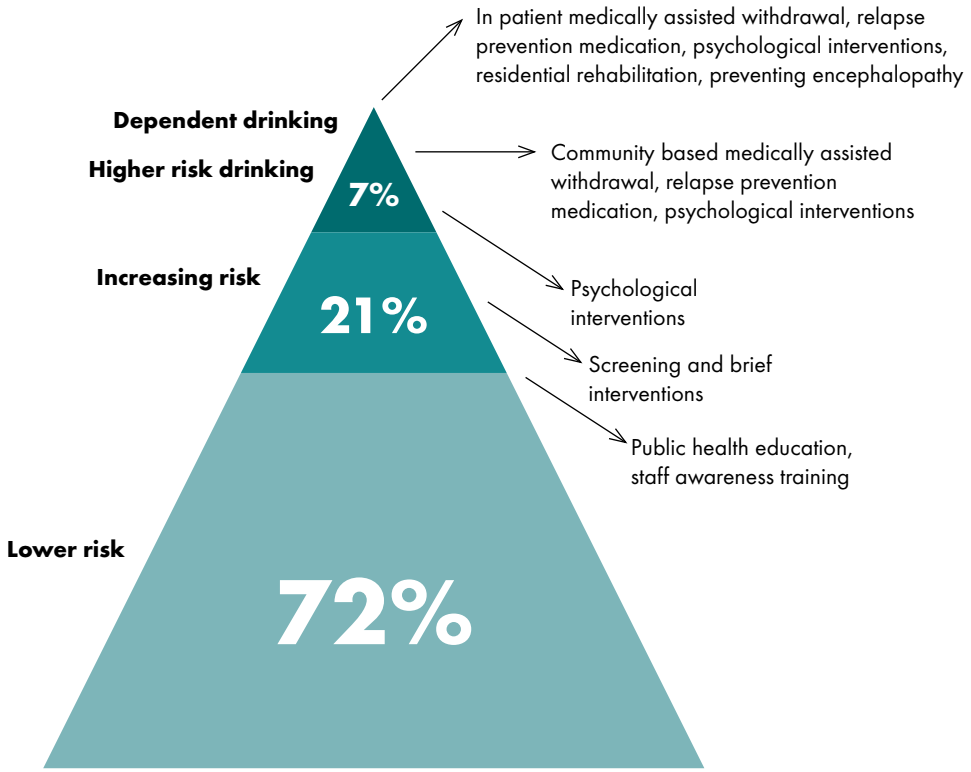
- For all people seeking help for alcohol misuse:
  - give information on the value and availability of community support networks and self-help groups
  - help them to participate in community support networks and self-help groups by encouraging them to go to meetings and arranging support so that they can attend
  - provide a psychological intervention focused specifically on alcohol-related cognitions, behaviour, problems and social networks
  - offer behavioural couples therapy to service users who have a regular partner and whose partner is willing to participate in treatment
- For high levels of consumption offer outpatient-based community assisted withdrawal programmes
- For very high levels of consumption and/or additional complications consider inpatient or residential assisted withdrawal
- After successful assisted withdrawal offer a community programme which consists of an appropriate drug regime and psychological interventions
- Encourage families and carers to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change

As well as the NICE evidence, the Alcohol Matrix[17] produced by Drug and Alcohol Findings summarises the treatment of alcohol-related problems among adults organised by specific interventions through how their impacts are affected by staff, management, and the nature of the organisation, and whole local area treatment systems. The different types of treatment interventions depending on levels of risk are summarised below.

Alcohol treatment has been shown to be highly cost effective. Comparing the use of resources six months before the start of the

UKATT treatment to the six months prior to the one year follow-up interview, the suggestion is that, for every £1 spent in treatment, the public sector saves £5 (UKATT Research Team[18]).

Figure 1: Levels of intervention for different types of alcohol risk (% relates to estimated proportion of risk levels in North Yorkshire)



The Department of Health produced Signs for Improvement[19] which sets out commissioning interventions to reduce the harm caused by alcohol in local communities. It identifies seven High Impact Changes that are calculated to be the most effective and practical actions used extensively across the NHS and local government:

- Work in partnership
- Develop activities to control the impact of alcohol misuse in the community
- Influence change through advocacy
- Improve the effectiveness and capacity of specialist treatment - ensure the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in the area
- Appoint Alcohol Health Worker(s) - commission an adequate number of Alcohol Health Workers or Alcohol Liaison Nurses to work across the acute hospitals
- Identification and Brief Advice - provide more help to encourage people to drink less, through Primary Care and A&E
- Amplify national social marketing priorities - commission local social marketing activity which builds on the evidence, strategy and tools provided by the national social marketing programme. Ensure this promotes the local available service response

The national framework for the commissioning of adult treatment for alcohol misusers categorises the interventions above into four tiers:

Tier 1	Generic services which work with a wide range of clients. As a minimum they should be able to screen and refer individuals to local specialist services.
Tier 2	Specialist but low threshold services which are easy to access.
Tier 3	Services provided solely for drug and alcohol misusers in structured programmes of care.
Tier 4	Structured services which are aimed at individuals with a high level of presenting need, including inpatient drug and alcohol detoxification and residential rehabilitation units.

Reducing offending and Night Time Economy

A recent Ministry of Justice review[20] of reducing reoffending provides an overview of key evidence relating to reducing the reoffending of adult offenders. It concludes that overall, there is currently insufficient evidence to determine the impact on reoffending of alcohol treatment for offenders, although treatment in some settings does show promise. There is, however, good evidence that alcohol-related interventions can help reduce hazardous drinking more generally.

A useful summary of the types of interventions to help reduce disorder in the Night Time Economy, groups the interventions into six areas:

- Pricing
- Licensing
  - outlet density and mix
  - monitoring and enforcement
  - licensing hours
- Premises design and operations
  - glassware management within premises
  - manager and staff training
  - accreditation and awards
  - environment within the premises (covering capacity, layout, seating, games, food, and general atmosphere)
- Public realm design
  - CCTV
  - street lighting
  - active frontages
  - public toilet provision
  - glassware management outside premises
  - general layout
- Service interventions
  - transport (covering buses, taxis and parking)
  - policing (covering targeted policing, street policing, third party policing, transport policing, antisocial

behaviour/drink banning orders and alcohol arrest referral schemes)
  - health care
  - noise and light pollution
  - public education campaigns
- Community mobilisation (e.g. third party policy, and ensuring residents are aware of licensing restrictions to report breaches)

2.6. What's currently happening to reduce harm from alcohol in North Yorkshire

Prevention

Reducing alcohol features in Young and Yorkshire. The plan for all children, young people and their families living in North Yorkshire 2014-17. Some specialist providers of treatment to young people provide targeted prevention. Some providers of treatment services across the districts offer some prevention advice but this is not consistent.

There are several national campaigns to raise awareness of alcohol issues (e.g. **know your limits, drinkaware, change4life, Think!**) and a local campaign (**reduce my risk**) from the North East produced by Balance, shown in the Tyne Tees area which covers parts of North Yorkshire.

Reducing crime and antisocial behaviour

Each district has a Community Safety Partnership (CSP) and part of their remit is to tackle alcohol related crime and disorder. Interventions fall into four main categories:

- Responsible drinking
- Responsible retailing
- Enforcement
- Environment

There are many actions being taken but reduced funding is always a threat, and there are different priorities across the county. A new Community Safety Partnership (CSP) model is proposed to start from April 2014. It amalgamates all the CSPs into one North Yorkshire CSP with delivery at North Yorkshire and local district level.

Identifying people at risk

There is a nationally commissioned Directly Enhanced Service (DES) in primary care which provides specific funding for GPs to deliver Identification and Brief Advice (IBA) to newly registered patients. Figures from October 2010 to September 2011 show that across North Yorkshire 12,282 newly registered patients were screened for alcohol misuse.

Yorkshire Ambulance Service have developed a pathway across Yorkshire for identifying and referring people with alcohol related harm to treatment services but this has short term funding only.

Treatment Services

Currently treatment services at the different tiers are provided by a variety of providers in each district and funded by various funding streams which may or may not be recurrent. They mainly cover Tiers 2 - 4. Access to services is not equitable across the county and is described in detail in the Alcohol Health Needs Assessment.

North Yorkshire County Council awarded three year (plus facility to extend for further two years) contracts for a new specialist drug and alcohol service for adults in May 2014. The new integrated service commenced on 1st October 2014 across North Yorkshire and comprises a Treatment aspect and a Recovery and Mentoring aspect.

Treatment provision delivered by GPs (shared care) in their practices under the local authority primary care contract and pharmacy-based supervised consumption and needle exchange services will continue to be commissioned separately.

The new specialist service is available to all adults who misuse illicit or illicitly obtained drugs, and harmful and dependent drinkers.

A key objective for the new service is to rebalance specialist service provision across the county in order to better respond to need - and principally to increase capacity to address the needs of, particularly, dependent drinkers, in line with NICE guidelines. Dependent drinkers would typically score 20+ on a validated alcohol assessment tool such as AUDIT.

For children and young people there is a Risky Behaviours Team which provides specialist support for alcohol and substance misuse. The Healthy Child Programme is due to be recommissioned in 2015.

The Department of Health is piloting mental health nurses and other mental health professionals to work with police stations and courts so that people with mental health conditions and substance misuse problems get the right treatment as quickly as possible with the aim to help reduce re-offending.

Liaison and Diversion services should ensure that individuals can access appropriate interventions, in order to reduce health inequalities, improve physical and mental health, tackle offending behaviours including substance misuse, reduce crime and re-offending and increase the efficiency and effectiveness of the criminal justice system. This will be rolled out nationally by 2017.

2.7. Modelling the scale of the unmet need

Using the latest numbers of people screened through the GP new patient Directly Enhanced service means that around 2.5% of the adult population are being screened by that route per year. Using the NICE Alcohol Commissioning and Benchmarking tool[22], that should result in approximately 1,843 people who have hazardous drinking patterns receiving brief interventions per year. However, the tool estimates that there are 120,000 people who have harmful or hazardous drinking patterns in North Yorkshire, meaning only 1.6% are potentially receiving brief advice through that route per year.

With the addition of NHS Health checks (all 40-74 year olds without existing cardiovascular disease screened every five years), that number of people receiving brief advice can be increased to 4746 per year at the current NHS Health Check uptake rate of 50% of invitations. That still means only 4% of harmful or hazardous drinkers taking up advice per year. It is not clear what the

ideal rate of alcohol screening should be but these numbers demonstrate the need to scale up screening and identification.

There were 1,042 service users engaged with treatment services due to alcohol in 2012/13. Nationally it is estimated that only 10% of people who may be eligible are engaged with services. If we assume (using the NICE Alcohol Commissioning and Benchmarking tool) that 2.6% of the adult population are dependent drinkers, then there would be a potential 12,850 people in North Yorkshire who are dependent (ie around 8% are engaged). It is recommended in the Signs for Improvement guidance that at least 15% of dependent drinkers need to be engaged with treatment services which would mean a realistic target would be 1,928 people engaging with treatment services ie a gap of around 900 - or nearly doubling current service provision.

2.8. What people have told us

Stakeholder event

A stakeholder event was held on 17th February 2014. 75 delegates attended the event to discuss the vision, outcomes and priorities for action. A full report from the event has been published[23].

Key themes identified from the event that the vision and outcomes should include were:

- Working together - the notion that to really make a difference, we all need to be taking responsibility
- To reduce the many different harms from alcohol
- To recognise that some groups or communities are affected more than others. Protecting children was a recurrent theme
- A culture shift is needed to denormalise risky drinking behaviour
- That there are some ways of working or values that we should collectively adhere to - for example to reduce inequalities, and ensure whatever we do is effective and cost effective, and encourage innovation

Actions needed to meet the vision and outcomes were placed on flipcharts with two axes - impact and feasibility. Key themes of actions that emerged were:

- Awareness raising of the harms from alcohol in the population, through technology, social media, libraries, schools, further education and universities
- Awareness raising of the harms, use of identification tools and brief interventions, and support available with professionals regularly coming into contact with people who drink at hazardous or harmful levels in different settings (e.g. police, GP, probation, community pharmacies, youth justice system, ambulance and A&E)
- Clear pathways for treatment once harmful or hazardous drinking is identified using a directory of local resources and a single point of access
- Effective use of police and local authority powers (e.g. section 27, exclusion zones, licensing conditions)
- Influencing local increases in cost of alcohol, reduced strength of alcohol and reduced cost of soft drinks

Big Issues from the Joint Strategic Needs Assessment (JSNA)

As part of the process to develop the JSNA in 2012, local residents were asked to identify the big issues affecting health and wellbeing locally. Typical issues around alcohol were its links with crime, antisocial behaviour, domestic violence and impact on people's health.

Comments received about alcohol were around the following themes:

- For both crime and antisocial behaviour, alcohol is seen as the key causation factor. It can also lead to other issues e.g. 'risky' sexual activities
- Chronic health problems due to excessive alcohol consumption - inability of A&E and other acute services to meet the demands of this type of patient
- Harm caused by drugs and alcohol i.e. crime, particularly theft and violent offences
- Reduced funding for preventative work linked to drugs and alcohol
- Alcohol linked to violent behaviour including domestic abuse
- Excess drinking across all age groups, including underage drinking

3. What do we need to do?

3.1. Our Vision

Working with our stakeholders, we have developed a shared vision:

"Working together to reduce the harms caused by alcohol to individuals, families, communities and businesses in North Yorkshire while ensuring that people are able to enjoy alcohol responsibly"

3.2. Outcome areas

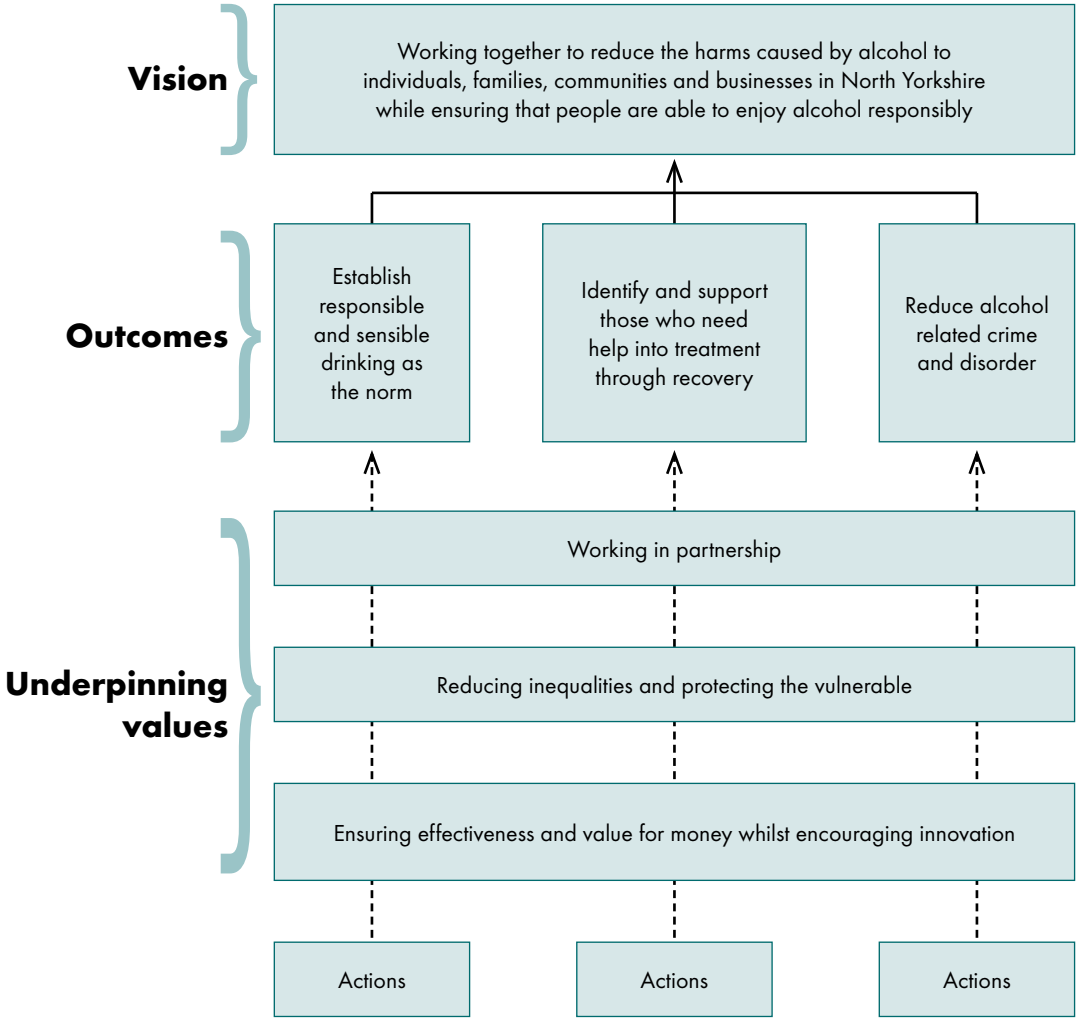
In order to achieve that vision, we have identified three outcome areas:

- Establish responsible and sensible drinking as the norm
- Identify and support those who need help into treatment through recovery
- Reduce alcohol-related crime and disorder

These areas will be used to develop the action plan.

3.2.1. Establish responsible and sensible drinking as the norm within the safer drinking guidelines

For too many, harmful or hazardous drinking has become normal. We need to shift that culture so that low risk drinking becomes the norm. This is right across a person's life course, starting with pregnancy and foetal development, to influencing aspirations in childhood through to teenage



years, to young adulthood and leaving home, to the stresses of work and middle age and then retirement and risk of isolation in old age. Education and awareness raising is part of the solution, but this needs to be targeted as different people respond differently to how information is given. Availability of alcohol also impacts on what society sees as the norm.

We will:

- Support schools to deliver consistent and high quality personal, social, health and economic (PSHE) education around alcohol (and other risky behaviours)
- Increase awareness of the harms of alcohol, support available, identification tools, and benefits of sensible drinking across the whole population but specifically with:
  - parents and children (through the recommissioning of the Healthy Child Programme)
  - women of child bearing age and young mothers
  - further education establishments including colleges and universities
  - middle aged males
  - other population groups as needs are identified
- Increase the capacity to prevent underage sales (including proxy sales), sales to those who are intoxicated, non-compliance with any other alcohol licence condition, irresponsible drinks promotions and illegal imports of alcohol and ensure sanctions are fully applied to businesses that break the law
- Work with businesses to encourage sensible drinking including the introduction of a mandatory licensing condition and possible development of Cumulative Impact Zones (CIZ)
- Ensure that there is a systematic process to include 'health' as part of the consideration on licensing applications and renewals

3.2.2. Identify and support those who need help into treatment through recovery

There is clear evidence that some people are more at risk of dependent and harmful drinking than others, that we are not identifying them consistently, and services are not offered at the scale needed for the size of the problem. We therefore need a systematic process to ensure that people in the general population, as well as those who are more at risk are identified early, effective advice and support is given, and that there are clear pathways to treatment that has the magnitude to cope with the demand.

We will:

- Develop a clear pathway that specialists and non-specialists can use from identification to support and referral, depending on the level of risk identified, alongside a directory of local resources available. This needs to link to the community navigator model being developed across the county with single point of access

- Develop the awareness, skills and capacity of professionals (e.g. police custody, ambulance, emergency departments, primary care, probation) who come regularly into contact with people who are suffering the consequences of alcohol* to identify harmful and hazardous alcohol use, offer brief advice, and refer to specialist treatment appropriately
- Support the development of specialist services in settings where professionals come regularly into contact with people who are suffering the consequences of alcohol* and an increased need is identified (e.g. A&E, custody, probation, street drinking)
- Increase awareness and the use of simple identification tools and effective advice and signposting in the wider public health workforce (e.g. housing agencies, social care, community pharmacies)
- Ensure that specialist services have the capacity to deal with the expected need
- Increase the uptake and ensure the effectiveness of the GP led NHS Health Checks for the population aged 40-74 years in identifying people who are at risk of harm from alcohol, and providing appropriate support
- Pilot and evaluate innovative programmes like police Alcohol Referral Schemes and street triage
- Ensure antenatal screening, support and interventions are effective
- Work with Public Health England in the local implementation of the Liaison and Diversion programme

3.2.3. Reduce alcohol-related crime and disorder

Alcohol is linked to crime and disorder and draws a disproportionality large resource from the police and impacts on public services like A&E and the Ambulance services, the community and businesses.

We will:

- Explore the feasibility of increasing local availability and reducing pricing of non-alcoholic drinks in licensed premises
- Using local health, crime and related trauma data, map the extent of alcohol-related problems locally before developing or reviewing a licensing policy
- Use licensing powers effectively to limit availability of alcohol where the density of licensed premises causes disorder including increasing community awareness of licensing reviews including introduction of Cumulative Impact Zones (CIZ)
- Increase work to tackle problems associated with 'pre-loading' and increased vulnerability due to increased intoxication

*including people with relevant physical conditions; relevant mental health problems; who have been assaulted; at risk of self-harm; who regularly experience accidents or minor traumas; who regularly attend GUM clinics or repeatedly seek emergency contraception; involved in crime or other antisocial behaviour; at risk of domestic abuse; whose children are involved with child safeguarding agencies; with drug problems

- Work with the North Yorkshire Community Partnership and Safer York to ensure a coordinated response to reduce disorder
- Support local partnerships to effectively manage their Night Time Economy to minimise harm from alcohol
- Work with 95 Alive Partnership to reduce the impact of alcohol on road safety

Alcohol treatment and recovery services in some settings may also impact on crime and disorder.

3.3. Underpinning Values

To enable the realisation of those outcomes, we have identified three underpinning themes or values:

- Working in partnership
- Reducing inequalities and protecting the vulnerable
- Ensuring effectiveness and value for money whilst encouraging innovation

3.3.1. Working in partnership

Central to this strategy is the call to action for all partners who play a part in reducing harm from alcohol. Only by working together will the outcomes be achieved. There are a number of actions working together that will facilitate better outcomes:

- Efficient and timely data and intelligence sharing between organisations including fire, ambulance, rescue service NYP, local authorities
- Pooling of resources to meet the need coherently rather than duplicating effort
- Working with the drinks industry and licensed trade to effect positive changes
- Ensuring cross cutting action across other strategic areas

Working in partnership is a question that needs to be asked in the development of all our actions - can we do this better if we work together on this, and if so, how do we enable this to happen?

3.3.2. Reducing inequalities and protecting the vulnerable

We know that there are inequalities within North Yorkshire with some districts having double the rate of alcohol related deaths than the England average, and some having higher antisocial disorder rates than others. Males are more likely to die from alcohol related disorders, but the female rate appears higher than expected when comparing to the England rates.

We also know that there are some groups that are more vulnerable to alcohol use than others are. For example, children and young people who live with people who are dependent drinkers may have safeguarding issues; military personnel are at higher risk of harmful drinking and may not wish to access military health services; people with mental health disorders have a higher risk of alcohol use.

In all actions, we need to ask - is this helping reduce inequalities, and are there particular groups we need to target? Some actions will be universal, but some

actions will need to be more focused either geographically or to a particular group.

3.3.3. Ensuring effectiveness and value for money whilst encouraging innovation

Some actions have clear evidence that they are effective, and save money in the future. However, not all actions have the same level of evidence. Therefore, we need to ensure that we continually evaluate whether actions are achieving their stated aims, and if not, change it, or invest in something else which shows promise.

In these times of austerity, we need to ensure that investments achieve value for money, as well as achieving better outcomes.

Where there is potential for innovation, this should be encouraged, with clear measures of success criteria and timeframes, and not being afraid to say something has not worked.

4. How will we measure success?

4.1. Governance

The alcohol strategy steering group is accountable to the North Yorkshire Substance Misuse Board. Once the action plan has been developed, this group will review its membership and evolve into an Alcohol Strategy Implementation Group. The Alcohol Strategy Implementation Group should be accountable to the North Yorkshire Substance Misuse Board but will report into the North Yorkshire Community Safety Partnership and Children's Trust Board.

The action plan will use project management systems to ensure delivery. Process measures will be used to ensure that actions are being implemented in a timely way.

4.2. Outcome indicators

Over the five years of this strategy, we need to demonstrate that the actions are impacting on the desired outcomes. We are developing some outcome indicators linked to the vision and each of the outcome areas which will be monitored regularly. Some outcomes (e.g. alcohol related deaths) have a delay in them, in that it takes time for actions to affect death rates, and death rates for a particular year are normally released approximately two years later once all the data has been collated and validated. We therefore need a mix of real-time outcomes or proxy measures as well as more long term outcome measures.

Outcomes	Indicator areas
Overarching	• Alcohol related deaths • Crime and disorder • Community outcomes measure (perceptions)
Establish responsible and sensible drinking as the norm	• Local prevalence of alcohol consumption (not currently available) • Alcohol consumption in children (Y6, Y8 and Y10) • Number of underage sales • Alcohol related visits to Emergency Departments • Growing up in North Yorkshire survey - % of pupils finding lessons about alcohol education useful
Identify and support those who need help into treatment through recovery	• Number of people who have been screened effectively • Number of people who are in effective treatment • Alcohol related admissions to hospital
Reduce alcohol-related crime and disorder	• Violent crime related to alcohol • Hate crime related to alcohol • Criminal damage related to alcohol • Antisocial behaviour related to alcohol • Sexual crime related to alcohol • Domestic violence related to alcohol • Alcohol related road traffic collisions • Reduction in vulnerability (child sexual exploitation)

An outcome framework with measures will be developed to monitor progress against the aims.

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Appendix 1: Definitions

The Department of Health defines alcohol misuse into three categories:

Hazardous drinking (also known as increasing risk) - these people are drinking above recognised sensible levels but not yet experiencing harm. Increasing risk limits are defined by the Department of Health as drinking more than 3-4 units a day for men and more than 2-3 units a day for women on a regular basis.

Harmful drinking (also known as higher risk drinking) - this group are drinking above recommended levels for sensible drinking and experiencing physical and/or mental harm. Higher risk drinking is classified as the regular consumption of more than 8 units a day for a man (more than 50 units a week) or more than 6 units per day for a woman (more than 35 units a week). Individuals categorised as higher risk drinkers are not dependent on alcohol.

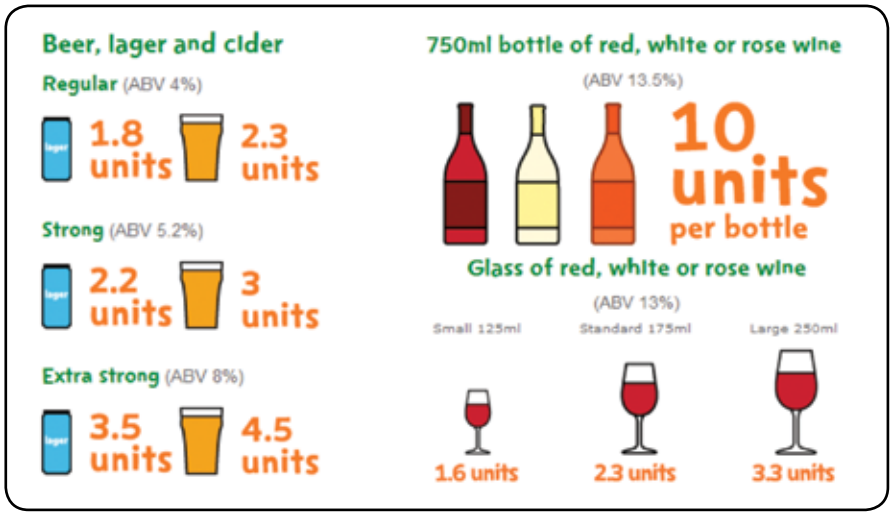
Dependent drinkers - this group are drinking above recommended levels, experiencing an increased drive to use alcohol and feel it is difficult to function without alcohol. Dependent drinking can be sub-divided into two categories; moderate dependence and severe dependence, traditionally known as chronic alcoholism.

In addition **binge drinking** is defined as drinking at least twice the daily recommended amount of alcohol in a single drinking session (8 or more units for men and 6 or more units for women). Binge drinking usually refers to people drinking a lot of alcohol in a short space of time or drinking to get drunk.

Lower risk drinking is defined as men drinking no more than 3-4 units a day and women drinking no more than 2-3 units a day on a regular basis.

Units

One unit of alcohol is about half a pint of bitter or ordinary lager (ABV [alcohol by volume] 4.5%), or a single measure of spirits (25ml). However, a 175ml glass of wine (13% ABV) is 2.3 units and a pint of strong beer (ABV 8%) is 4.5 units. The number of units in particular drinks are different, depending on the strength of the alcohol in them and the volume of the drink.



Please let us know what you think about North Yorkshire's Alcohol Strategy

You can tell us what you think about the strategy by emailing your views to **nypublichealth@northyorks.gov.uk** or writing to:

Public Health
Health and Adult Services
North Yorkshire County Council
County Hall
Northallerton
North Yorkshire
DL7 8DD

If you would like this information in another language or format such as Braille, large print or audio, please ask us.
Tel: 01609 780 780
Email: communications@northyorks.gov.uk

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Find out more about North Yorkshire's Health and Wellbeing Board at **www.nypartnerships.org.uk**

Appendix 2: Engagement Report

North Yorkshire Alcohol Strategy

Consultation Report

Victoria Marshall

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1. Introduction

This report outlines the findings from North Yorkshire County Council's consultation on the North Yorkshire Alcohol Strategy, held from Monday 28th April until Wednesday 29th May 2014.

The Strategy was developed in partnership with key stakeholders including North Yorkshire Police, Clinical Commissioning Groups, North Yorkshire Police and Crime Commissioner's office and the Yorkshire Ambulance Service. The purpose of the Strategy is to galvanise partners within North Yorkshire to collectively reduce the harms from alcohol.

2. Methodology

In order to gather feedback from all stakeholders including the general public an online questionnaire was developed. Respondents were asked to comment on the vision and direction of the strategy and the priorities identified within the strategy. Respondents were also asked if there were any other priorities they felt should be included in the Strategy.

Feedback was also received in a separate document from North Yorkshire Police, further detail of which is outlined below.

3. Feedback from online questionnaire

Overall, the majority (81%) of those who completed the survey agreed with the vision and strategic direction of the draft strategy. Those that did not agree were concerned with the following:

- A significant amount of time and money is spent dealing with and, in a sense, condoning the problem.
- It was suggested that fines could be imposed on individuals.
- A specific focus on educating those most at risk is needed.
- It was acknowledged that while education in schools is vital, parents should also be educated.

Respondents were asked to comment on the priorities outlined in the Strategy which are outlined below:

- Establish responsible and sensible drinking as the norm
- Identify and support those who need help through recovery
- Reduce alcohol-related disorder

An overwhelming majority of those who completed the survey (94%) agreed with the above priorities. Those who did not fully agree submitted specific comments which will be considered when developing the final Strategy.

Thirdly, stakeholders were asked if they felt any other priorities should be included. A number of responses were received for this question, including the following:

- Integrating with Alcoholics Anonymous and using resources within communities
- Raising public awareness regarding alcohol consumption through brief interventions
- Reduce the impact of alcohol-related demand on public services.

Lastly, respondents were asked for any other comments on the Strategy. A number of comments were submitted, all of which will be considered when finalising the Strategy.

4. Feedback from North Yorkshire Police

A separate feedback document was submitted by North Yorkshire Police, providing the following, general comments:

1. The strategy should contain an understanding of current gaps in provision;
2. Cognisant of point 1, the strategy should link to a delivery plan;
3. There would be significant benefit from aligning the strategy to NYP Draft Alcohol Outcomes Framework.

Regarding the vision, NYP considered it to be all encompassing and provides sufficient flexibility to incorporate emerging issues / trends as they develop within the 5-year life of the strategy.

Regarding the priorities, overall NYP was supportive of the priorities detailed within the Strategy but also provided additional feedback in relation to the weighting of the Strategy, which will be taken into account when finalising the document.

Further comments were received regarding specific phrases and points within the Strategy, which will be taken into account when finalising the document.

5. Next Steps

All the feedback received as part of the consultation will inform the final version of the Strategy.

Following final sign-off of the North Yorkshire Alcohol Strategy, an implementation plan will be developed in partnership with key stakeholders.

North Yorkshire Alcohol Implementation Plan 2014-16
Version 3

	Source	Ref	Action(s)	Key actions	Organisational Lead Responsible	Supported by	New Funding required?	Actions and timeframe	Indicator	Outcome
1	**Establish responsible and sensible drinking as the norm**				PH					
1.1	support schools to deliver consistent and high quality personal, social, health and economic (PSHE) education around alcohol (and other risky behaviours)	**1.1**	Support schools in developing a planned PSHE programme which includes alcohol education, using Key Stage 1 to 4 PSHE Entitlement framework. Focus should be on knowledge and understanding, decision-making, social norms and needs analysis. Quality standards must be maintained, for example the effective drug and alcohol education for schools from the **Alcohol and Drug Education and Prevention Information Service** (ADEPIS) March 2014. High standards should also be produced in teaching materials, with guidance from standards of the **National Institute for Health and Care Excellence** (NICE: http://publications.nice.org.uk/school-based-interventions-on-alcohol-ph7/public-health-need-and-practice). The core aims will be: • To encourage children **not** to drink • **Delay** the age at which young people currently start drinking at • Reduce the harm that drinking can inflict on individuals This should be achieved by: • Increasing children's knowledge of the physical, mental and social risks associated with drinking, including **legal consequences.** • Helping children to develop independent decision-making, assertiveness, verbal/non-verbal skills • Guiding children in improving their self-esteem • Increasing children's awareness of how the media, advertisements, role models and the views/perceptions of parents, peers and society can influence alcohol consumption. • Monitoring and evaluating the impact of this education according to **Ofsted** subject-specific guidance, **ADEPIS** standards for drug and alcohol education, and **Growing Up in North Yorkshire** school & county report data. • Identifying further education establishments and using existing social marketing to target students effectively	To develop a business case to identify trends and gaps in current service provision. Business case to be submitted to the alcohol strategy group for consideration	NYCC CYPS Clare Barrowman Education Development Adviser, Wellbeing - Risk Taking, Quality and Improvement (CYPS)	CYPS	Potential investment required - due to restructure in CYPS	To coincide with restructure in CYPS - school survey	Percentage of children who had at least one alcoholic drink in the last 7 days Percentage of schools who take up the offer % of schools completing evaluation and showing improvement after the intervention	Number of under 18s alcohol-specific hospital admissions from baseline First time entrants to the youth justice system, aged 10-17 years from baseline

1.2	increase awareness of the harms of alcohol, support available, identification tools, and benefits of sensible drinking across the whole population but specifically with: - parents and children (through the recommissioning of the Healthy Child Programme) - women of child bearing age and young mothers - further education establishments including colleges and universities - middle aged males - other population groups as needs are identified (eg workplace, over 65s)	**1.2.1**	work with HCP commissioners to ensure that HCP covers the alcohol agenda. To include targeted interventions, early help and prevention, and health promotion	To ensure HCP includes targeted interventions including alcohol and to work with CYPS HCP lead to identify potential gaps in provision or opportunities	PH & CYPS	CYPS Louise Dunn PHE	PH commissioned service	New service commissioned,Awarded November 2014 Harrogate Foundation Trust, More Life, and Compas Reach	Indicators identified within HCP service specification;	Outcomes identified within HCP service specification Number of under 18s alcohol-specific hospital admissions from baseline First time entrants to the youth justice system, aged 10-17 years from baseline
		1.2.2	ensure maternity services and 0-5 years support has access to effective information around alcohol	CSU to look at current maternity contracts and opportunities for staff training and introduction of AUDIT C screening	PCU manage contract	CCGs NHS	CCG contract	Current maternity contracts include alcohol interventions will need to review and make additions at next contract review 2015	Inclusion of a recoginsed alcohol tool as paft of the initial maternal assessment. Training for staff to be included in core competencies.	increase % of alcohol treatment users: parent living with own children from baseline
		1.2.3	use contracting levers (eg CQUIN, contract refresh) to ensure maternity and health visiting (HV) services have the skills and capacity to deliver healthy alcohol advice	CSU to look at current maternity contracts and opportunities for staff training and introduction of AUDIT C screening	PCU - John Clare	PH	within existing resources potential cost of training	HV contracts will move over to PH responsibility in October 2015	Procurement of HV services	increase % of alcohol treatment users: parent living with own children from baseline
		1.2.4	develop or use existing social marketing to target populations including; children and young people, middle aged males and older people	PH to look at commissioning a social marketing campaign to raise the profile of alcohol related harms. To look at opportunities to commission this jointly with PCC and Police	PH	Police and PCC	additional funding required from PH investment	Develop joint task group with PCC and Police to develop business case for North Yorkshire and York, January to April 2015	Business case developed, Service procured 3 yearly campaigns	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline

1.3	increase the capacity to prevent under-age sales (including proxy sales), sales to those who are intoxicated, non-compliance with any other alcohol licence condition, irresponsible drinks promotions and illegal imports of alcohol and ensure sanctions are fully applied to businesses that break the law	**1.3.1**	ensure that Trading standards have the appropriate resources to maintain and increase these activities.	Funding achieved for intelligence based criminal investigations and targeted educational work	NYCC, TSD - David Miller	PH	PH allocated 4 year investment into Trading Standards total investment 400k	2014 - 2017	Increase in trading standards activity Increase in training Increased activity with licensed premises/ reviews To support the LAAA work in Scarborough night time economy issues	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline
		1.3.2	PHE to support licencing authorities with examples from elsewhere	To provide examples and evidence to inform local work in North Yorkshire	PHE Wayne Sivyer	alcohol task group	within existing resources	on-going	Evidence, shared practice, Evaluation of LAAA	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline
		1.3.3	ensure that licensing authorities have the appropriate resources to maintain and increase these activities.	Develop task and finish group to look at how PH data informs licensing decisions	District Councils Licensing P.Mepham	PH & NYCC trading standards	No	on - going through task group development and implementation	Establishment of a licensing framework; decrease in underage sills; increase in legislative compliance	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline

		1.3.4	proactive partnership work to promote non under age sales where a need is identified	Develop Task and Finish Group to identify actions according to evidence of need and effectiveness. The evidence of under-age sales is thin. This item should be given a month or two timeframe to assemble evidence and draw up actions supported by funding as necessary. Contributors would be District Councils, Licensing Authorities, Trading	NYCC, Trading Standards, David Miller	police District Council Licensing	PH investment identified to support additioanl capacity in Trading Standards see 1.3.1	Q1 2014/15	the percentage of children who had at least one alcoholic drink in the last 7 days - school survey	reduction in under 18s alcohol specific related admissions;
1.4	work with businesses to encourage sensible drinking and explore the feasibility of local minimum pricing of alcohol	**1.4.1**	Identify localities which are willing to explore minimum pricing further (linked to LAAA), gaining political support. Work with business organisations – such as supermarkets – to test feasibility. Learn from the pilot for other areas. Encourage commitment from District Councils to work towards proactive promotion of sensible drinking, and towards reducing the reliance on alcohol consumption as a means of supporting the night-time economy.	Visits to businesses to ensure legislative compliance. Licensing Authorities and Environmental Health Services promote alcohol policies amongst businesses as part of their health & safety function as well as licensing function. This could similarly be organised by a Task and Finish Group to co-ordinate activities, initiatives, avoid duplication or gaps. Learn from LAAA areas	NYCC, Trading Standards, David Miller	Supported by PH and PHE	PH investment identified to support additioanl capacity in Trading Standards see 1.3.1	LAAA pilot 2014/15	Development of task and finish group Number of premises who have had licensing reviews	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline
2	**Identify and support those who need help into treatment through recovery**				PH					

2.1	Develop a clear pathway that specialists and non-specialists can use from identification to support and referral, depending on the level of risk identified, alongside a directory of local resources available.	**2.1.1**	collate information about pathways (based on new providers and other providers) across all Tiers	Establish a task and finish group to develop shared pathways	PH	Supported by treatment providers, CCG, health, police, NYCC HAS	No	December 2014 March 2015	Development of shared pathway Successful referral of individuals	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline
2.2	Develop the awareness, skills and capacity of professionals (eg police custody, ambulance, emergency departments, primary care, probation) who come regularly into contact with people who are suffering the consequences of alcohol[1] to identify harmful and hazardous alcohol use, offer brief advice, and refer to specialist treatment appropriately	**2.2.1**	develop and/or commission a programme to train professionals who regularly come into contact with people suffering the consequences of alcohol in different settings in identification and brief advice tools (at Tiers 1 and 2) to standardise current practice and ensure more staff have the skills. This could use the train the trainer approach so that skills can be cascaded through an organisation	Develop a business case to identify a suitable training providers to deliver IBA training to NYCC staff and external partners	PH		Business case submitted to agree 25k allocation from PH grant funding	December Business case agreed. January ITQ February award contract	Commissioned training provider to deliver training to; 700 people trained	reduction in alcohol related admissions
		2.2.3	encourage CCGs to use contracting levers such as CQUINS to improve the use of identification and brief interventions tools with patients presenting in hospitals and mental health services who have conditions attributable to alcohol [1] DES	PCU to ensure contract reviews ensure all staff are using evidence based screening to ensure patients have appropriate information and support	PH	PCU John Clare PHE, provider service	within existing resources	2014/15	included in secondary care contracts	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline

		2.2.4	Commission IBA in a variety of settings	PH to identify opportunities to commission IBA in various settings, to develop business case for interventions in pharmacies, probation, custody, social care and potential opportunities for extension of the current DES	PH	LPC/LMC/CCG's	Business case submitted to contract pharmacies to deliver IBA identified 200k for IBA	Business Case submitted for approval to commision pharmacies to deliver IBA	Contract agreed Number of pharmacies signed up Numbers assessed using IBA	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline
2.3	Support the development of specialist services in settings where professionals come regularly into contact with people who are suffering the consequences of alcohol [1] and an increased need is identified (eg A/E, custody, probation, street drinking)	**2.3.1**	work with the new provider of treatment services to ensure that outreach is provided and prioritised in appropriate settings	To review need and demand for service and ensure flexibility to meet needs. To use contracting levers as required	PH	provider	Current PH contract	Contract awarded on going contract monitoring	people in treatment numbers exceed 15% estimated dependent drinkers (in line with Signs for Improvement recommendation)	Linked to contract outcomes
		2.3.2	ensure that the RAID (Rapid, Assessment, Interface and Discharge) psychiatry liaison teams in hospitals include alcohol identification and brief advice and signposting, and work closely with new alcohol treatment services	work with PCU/CCG's to ensure alcohol IBA is part of the RAID model	PCU/CCGs	PH	Training to be provided through commisioned training provider	Identify people to be trained	evaluation of RAID with alcohol related activity	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline
2.4	Increase awareness and the use of simple identification tools and effective advice and signposting in the wider public health workforce (eg housing agencies, social care, community pharmacies)	**2.4.1**	link alcohol strategy to MECC (Making Every Contact Count) roll out and training and targets specific groups that deal with at risk groups	Ensure alcohol awareness is part of the MECC training	PH - Phillipa Selstrom	NYCC and District Councils	PH investment identified	2014/15	Agreed MECC framework; staff trained in MECC	Reduction in increasing and higher risk drinking from baseline
2.5	Ensure that specialist services have the capacity to deal with the expected need	**2.5.1**	work with the new provider to ensure they are identifying and establishing treatment services in line with need	Ensure contract levers are used to monitor the effectiveness of the current treatment provider.	PH	PHE	Current PH contract	2014/15	people in treatment numbers exceed 15% estimated dependent drinkers (in line with Signs for Improvement recommendation)	Link to contract monitoring

2.6	Increase the uptake and ensure the effectiveness of the GP led NHS Health Checks for the population aged 40-74 years in identifying people who are at risk of harm from alcohol, and providing appropriate support	**2.6.1**	ensure practices have the right skills to deliver high quality identification and brief intervention through training and/or awareness raising (links to 2.2.1)	PH will commission Alcohol IBA training. Work with PHE to review the current DES	PH - Health Check Lead	PHE, CCG's and GPs	additional funding maybe required	on-going	clinicians who perform NHS Health Check can demonstrate competencies; Numbers of IBA interventions carried out	Reduction in increasing and higher risk drinking from baseline
		2.6.2	develop programme to raise awareness in the target population and/or incentive schemes for practices to increase uptake of NHS Health Check	To ensure work developed through the NHS Health Check uses the same screening tool as the current DES and community IBA. To look at alternatives to delivery of Health Checks in the local community to target those at greatest risk	PH - Health Check Lead	GPs	within existing resources	2014/15	increased uptake of NHS Health Checks; Number of IBA interventions carried out	Reduction in increasing and higher risk drinking from baseline
2.7	Pilot and evaluate innovative programmes like police Alcohol Referral Schemes and street triage	**2.7.1**	work up service spec and costing's for Alcohol Arrest Referral Scheme with brief screening and brief interventions delivered in custody setting. This needs to include working with the new provider of treatment services to explore if this is feasible under the current contract (links to 2.3.2)	see 2.2.4	PH	Police, PCC, CSP's	PH investment identified see 2.2.4 - 200k combined investment for IBA delivery	to develop proposals joint to loook at options for deliver see 2.2.4 2014/15	funding allocated Pilot programme commissioned	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline

		2.7.2	explore other innovative programmes like street triage	see 2.2.4	PH	Police, CCG's, PHE	Look at opportunities for joint investment between CCG's/PH and Police	look at street triage national pilot evaluation in Scarborough coordinated through the police to look at opportunities to develop similar models across North Yorkshire	see 2.2.4	reduction in under 18s alcohol specific related admissions from baseline reduction in alcohol related admissions to hospital from baseline reduction in under 75 mortality rate for cancer/liver disease from baseline reduction in increasing and higher risk drinking from baseline
2.8	Ensure antenatal screening, support and interventions are effective	**2.8.1**	Training for staff	see 2.2.1	PH	CCG's	PH investment identified see 2.2.1	see 2.2.1	see 2.2.1	Reduction in increasing and higher risk drinkers from baseline
2.9	Work with NHS England in the local implementation of the Liaison and Diversion programme	**2.9.1**	Await dissemination of learning from pilots and further guidance from NHS	Review current actions against national and local developments and amend accordingly	PH	NHS PHE CCGs	within existing resources at present	2016	Successful implementation of the liaison and diversion service and future model	Reduction in increasing and higher risk drinkers from baseline
3	**Reduce alcohol-related disorder**									
3.1	Explore the feasibility of increasing local availability and reducing pricing of non-alcoholic drinks in licensed premises	**3.1.1**	links to 1.4	see 1.4	PH	PHE/LAAA	within existing resources	Developments from task group review 1 year LAAA pilot	maximum price introduced	Reduction in alcohol related admissions Reduction in increasing and higher risk drinkers from baseline % of ASB related to alcohol % of sexual related crime related to alcohol % of criminal damage related to alcohol
3.2	Using local health, crime and related trauma data, map the extent of alcohol-related problems locally before developing or reviewing a licensing policy	**3.2.1**	continue planned work to develop process to map alcohol related problems and roll out across NY (links to source 1.3)	Use NYCC software to map complaints and intelligence and inform local profiles see 1.4.1	PH	Police, licensing, Trading Standards, David Miller	within existing resources	linked to 1.4.1	process developed to map problem areas number of changes to license premises	decrease in the % of violent crime related to alcohol
3.3	use licensing powers effectively to limit availability of alcohol where the density of licensed premises causes disorder	**3.3.1**	use information from source 1.3	Use information available including local profiles to inform licensing decisions	PH	Police, licensing, Trading Standards, David Miller	within existing resources	linked to 1.4.1	process working number of premise reviews and license amendments	decrease in the % of violent crime related to alcohol

3.4	work with the North Yorkshire Community Partnership and Safer York to ensure a coordinated response to reduce alcohol related disorder and impact on domestic violence, sexual crime and hate crime	**3.4.1**	ensure that strategy is discussed and disseminated at both partnerships	Investigate allegations of sales to minors and associated anti-social behaviour.	PCC/CSPs	District licensing Supported by TSD, David Miller	within existing resources	Establish links to local TAHRF to look at opportunities for joint working	process working number of premise reviews and license amendments	decrease in the % of violent crime related to alcohol from baseline decrease in the % of sexual related crime related to alcohol from baseline decrease in the % of domestic violence related to alcohol from baseline
		3.4.2	plans are streamlined into NY wide actions and local actions (eg training for door staff)	Provision of education and enforcement identified through local task groups	PCC/CSPs	Supported by TSD, David Miller, police and licensing	within existing resources	on-going	Task group meetings and coordination to tackle issues Work with CSP's to dentify suitable training for door staff	decrease in the % of violent crime related to alcohol from baseline decrease in the % of sexual related crime related to alcohol from baseline decrease in the % of domestic violence related to alcohol from baseline
3.5	support local partnerships to effectively manage their night time economy to minimise harm from alcohol	**3.5.1**	consistent funding is identified for CSPs	To work with PCC to ensure funding for local initiatives are coordinated	CSP's/PCC	PHE/PH/District licensing	additional funding maybe required for those activities not funded by the PCC	on-going	joint programme of work	decrease in the % of violent crime related to alcohol from baseline decrease in the % of sexual related crime related to alcohol from baseline decrease in the % of domestic violence related to alcohol from baseline

3.6	work with 95 Alive Partnership to reduce the impact of alcohol on road safety	**3.6.1**	identify opportunities to share awareness raising and ensure consistent messages	NYCC to identify potential gaps and messages to deliver as part of this campaign link to social marketing work	PH/Road safety partnership	PH	within existing resources	on-going	joint programme of work	Reduction in the % of serious collisons involving drink from baseline decrease in the % of slight collisions involving drink from baseline decrease in the % of total collisions involving drink from baseline
		3.6.2	opportunity to increase IBA on roadside - potential to link to 2.2.1	link to 2.2.1 and 2.2.4	PH	Partners	PH investment identified see 2.2.1	see 2.2.1	see 2.2.1	reduction in alcohol related admissions, reduction in increasing and higher risk drinkers from baseline
4	**Cross cutting**									
4.1	Improve data sharing across organisations	**4.1.1**	identify issues, and work towards solutions	Task to develop processes to share information in relation to licensing decision, antisocial behaviour, health data to ensure a coordinated response to alcohol	PH - intelligence	alcohol task group	within existing resources	on-going	no data sharing issues	
4.2	Develop outcomes framework	**4.2.1**	review draft proposals and formulate into outcomes framework	Outcome framework being developed	PH	partners	within existing resources	Q1 2014/15	outcomes framework	
[1] including people with relevant physical conditions; relevant mental health problems; who have been assaulted; at risk of self-harm; who regularly experience accidents or minor traumas; who regularly attend GUM clinics or repeatedly seek emergency										

Key

PH Public Health
CCG Clinical Commissioning Groups
AT Area Team (NHS England)
PHE Public Health England
NHSE NHS England
CYPS Children and Young Peoples Services (NYCC)
CSP Community Safety Partnerships
GP Individual GP practices
A/E Accident and Emergency
Local Alcohol Action Area LAAA
NYCC North Yorkshire County Council

PCU Partnership Commissioning Unit

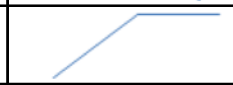
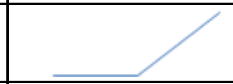
Health

	Year	Gender	Age group	North Yorkshire	Unit	North Yorkshire Trend	Years of data available	North Yorkshire 5 Year Projection	England
Under 18s alcohol-specific hospital admissions	2010/11 - 12/13	Persons	<18 yrs	48.5	Rate per 100,000 population	#	1	#	44.9
2.18 - Alcohol related admissions to hospital	2012/13	Persons	All ages	577.2	Admissions per 100,000 population		3	591.0	636.9
4.05ii - Under 75 mortality rate from cancer considered preventable	2010 - 12	Persons	<75 yrs	77.2	Rate per 100,000 population		10	70.4	84.9
4.05ii - Under 75 mortality rate from cancer considered preventable	2010 - 12	Male	<75 yrs	82.0	Rate per 100,000 population		10	71.8	92.7
4.05ii - Under 75 mortality rate from cancer considered preventable	2010 - 12	Female	<75 yrs	73.1	Rate per 100,000 population		10	69.3	77.9
4.06i - Under 75 mortality rate from liver disease	2010 - 12	Persons	<75 yrs	14.2	Rate per 100,000 population		10	15.6	18.0
4.06i - Under 75 mortality rate from liver disease	2010 - 12	Male	<75 yrs	17.6	Rate per 100,000 population		10	16.6	23.7
4.06i - Under 75 mortality rate from liver disease	2010 - 12	Female	<75 yrs	11.1	Rate per 100,000 population		10	14.7	12.6
Increasing and higher risk drinking	2009	Persons	16+ yrs	24.1	%	#	1	#	22.3

Only one year of data is available, therefore trends and projections cannot be calculated.

	Significantly better than England
	Significantly worse than England

Community

	Year	Gender	Age group	North Yorkshire	Unit	North Yorkshire Trend	Years of data available	North Yorkshire 5 Year Projection	England
1.01i - Children in poverty (all dependent children under 20)	2011	Persons	0-19 yrs	11.4	%		2	10.4	20.1
1.01ii - Children in poverty (under 16s)	2011	Persons	<16 yrs	11.9	%		2	10.9	20.6
1.05 - 16-18 year olds not in education employment or training	2012	Persons	16-18 yrs	3.8	%		2	0.3	5.8
Percentage of alcohol treatment users: Parent living with own children	2013/14	Persons	<18 yrs	19.0	%		3	27.0	19.0
Percentage of alcohol treatment users: Not a parent living with children	2013/14	Persons	<18 yrs	7.0	%		3	9.3	7.0
Percentage of alcohol treatment users: Parent not living with children	2013/14	Persons	<18 yrs	13.0	%		3	10.7	27.0
Percentage of fatal collisions involving drink	2013	Persons	All ages	25.0	%		6	30.9	- *
Percentage of serious collisions involving drink	2013	Persons	All ages	11.5	%		6	12.7	- *
Percentage of slight collisions involving drink	2013	Persons	All ages	3.5	%		6	3.9	- *
Percentage of total collisions involving drink	2013	Persons	All ages	5.8	%		6	6.5	- *

* Colllisions data were collected locally by BES.

	Significantly better than England
	Significantly worse than England