Strategy to Reduce Alcohol Related Harm 2016-2019

Introduction

Drinking is part of our culture and is reflected in how we socialise, celebrate and respond to life's milestones. Whilst many people use alcohol sensibly, regular and excessive drinking can lead to a number of alcohol related harms. Health can be seriously affected by regular drinking, at worst resulting in premature death through some cancers and liver disease. Alcohol can also affect personal relationships, heighten social isolation and physical capacity, as well as increase the chance of being a victim of crime. Under the influence of alcohol reduced inhibitions and heightened aggression can also increase the likelihood of perpetrating a crime impacting on anti-social behaviour, crime and disorder within communities. The costs to society are wider with alcohol contributing to lost work days and productivity, creating both individual and wider economic financial loss. Regularly drinking can also affect family life and influence young people's own drinking behaviour. Harmful drinking can compromise parenting, subjecting children to mistreatment, neglect and abuse.

Reducing alcohol related harm is a public health priority ranking among the top five risk factors for disease disability and death globally. Alcohol related harm contributes to health inequalities within communities with children, young people and the elderly more vulnerable.

Early initiation to alcohol before the age of 14 years is a predictor for impaired health status and an increased risk of alcohol dependence in later life. Furthermore, research has found when young people do drink, they tend to consume larger amounts in a single drinking episode and are less risk adverse.

People's drinking behaviour can alter across the life course. As people start to get older those that continue, tend to drink more frequently than their younger counterparts. With ageing, people's tolerance levels decline increasing the risk of unintentional injuries, such as trips and falls.

Whilst harmful use of alcohol is a significant risk factor in premature deaths of men aged 15-59 there is growing evidence that women may be more vulnerable to alcohol related harms.

Women's vulnerability is due to a range of factors in relation to physiology, lower weight, smaller livers and greater proportion of overall body fat. Breast cancer is one of seven cancers that can be attributed to alcohol and is particularly prevalent in women in comparison to men. Drinking during pregnancy can increase the risk of foetal alcohol spectrum disorder (FASD) and other preventable health conditions within new-borns. Women are also more at risk of interpersonal violence from male partners.

Tackling alcohol related harm requires a multi-agency approach. No one agency can tackle alcohol on its own. To achieve the ambitions of this strategy public services will continue to work together to improve early identification of harm, promote sensible drinking and ensure those who need help get the right support when they need it.

Our Approach

The purpose of this strategy is to galvanise partners (statutory, non-statutory, the community and businesses) to work together to reduce alcohol related harm in the county. It is recognised by the Health and Well Being Board (HWB) and other strategic partnerships reducing alcohol related harm requires a long term consistent approach if we are to succeed. The approach of this strategy is to build on the partnership work undertaken to date to reduce alcohol related harm.

All public services are under considerable financial challenge. The current cost of alcohol misuse on society in England is estimated to be £21bn, of which £11bn is due to crime, £7bn due to lost productivity and £3.5bn spent on the NHS. Therefore, it is integral to the delivery of this strategy that all stakeholders work together to minimise costs and add value.

There is a substantial body of evidence on how alcohol related harm can be reduced. Some of this evidence requires a central government response such as the minimum unit price (MUP), however, a lot of activity can and is delivered and co-ordinated locally. The delivery of this strategy will be achieved using the evidence base to ensure interventions and activities undertaken are cost effective and produce the best outcomes

Delivery of this strategy cannot just be the responsibility of public services. Local business can support this strategy by adopting Challenge 25 and discouraging heavy drinking behaviour through alcohol promotions. People also need to review their own relationship with alcohol and make changes as necessary. Changing the drinking culture needs a multi-pronged approach. Only by raising awareness, promoting social responsibility, utilising powers to create the right drinking environment and providing the right intervention at the right time, will the ambitions of this strategy be realised.

What we already do

Many partnership agencies already tackle alcohol related issues on a daily basis as part of their core business. Tackling underage sales, licence compliance, protecting communities from anti-social behaviour and managing patient care are just some of the activities undertaken. Since 2003 partners have been working together to co-ordinate activity to reduce alcohol related harm throughout the county. The 2012 to 2015 alcohol strategy was ambitious and set out a range of activities to reduce alcohol related harm. Implemented at a point of unprecedented restructure of the public sector and a period of austerity, key achievements include:

- Implementation of the Community Alcohol Project in key areas of Shropshire
- Establishment of the alcohol liaison nurse (ALN) team within Royal Shrewsbury Hospital
- Evaluation of the alcohol liaison nurse project
- Implementation of the Joint Working Protocol between Substance Misuse Services and Children and Family Services
- Re-established Oswestry Pub watch
- Recommissioned Alcohol Specialist services
- Increased the number of alcohol successful treatment completions.

Understanding the local profile

Shropshire is a large rural county that is sparsely populated, 54% of the population live in the main market towns which equates to 6% of the land. There are 306,100 people who live in Shropshire with a fairly equal gender split. As with many rural areas 98% of the population is White British. Shropshire is also home to round 2% of armed forces personnel. Compared to the national average Shropshire's population is weighted towards the older age groups, with a greater proportion living in the county aged 45 years and above. This is an important factor when planning health services as the negative effect of regularly drinking on health can take between 10 to 20 years to appear.

Overall the county is fairly affluent with only 4% of the population living in the most deprived fifth areas in England. The electoral wards that have the greatest levels of deprivation are Harlescott, Meole Brace, Monkmoor, Battlefields and Heathgates in the Shrewsbury area, Market Drayton East in the north of the County and Castle in the Oswestry area. Shropshire also has a low wage economy due to the nature of agriculture and small businesses. There is an adverse relationship between alcohol and deprivation known as the alcohol harm paradox. Areas of low socioeconomic status have a greater susceptibility to the harmful effects of alcohol despite little difference in consumption.

To understand how alcohol affects the population a needs assessment was undertaken during the summer of 2015 as part of the Joint Strategic Needs Assessment. The following information is derived from this work.

Night Time Economy

The night time economy is centred on the main five market towns of Shrewsbury, Oswestry, Whitchurch, Bridgnorth and Ludlow who offer a variety of pubs, bars, restaurants and night clubs. Shrewsbury is the main centre for entertainment within Shropshire, attracting people from around the county and from neighbouring areas further afield. Shropshire also attracts a large number of tourists.

The night-time economy also provides a number of employment opportunities from bar staff to those employed in the 17 microbreweries in Shropshire and workers who provide travel solutions.

As with all night-time economy activity, town centres can become tainted with drink related anti-social behaviour and violence, if unregulated and unplanned. A vibrant, diverse well planned night-time economy can produce many benefits to the community.

Drinking Behaviours

The health harms associated with alcohol consumption are measured on risks associated with units consumed over the course of a week. Following a review of the most recent evidence the Chief Medical Officer has published new guidance on regular drinking and its associated health risks. For both men and women who drink regularly the advice is to drink no more than 14 units over the course of the week, with alcohol free days between. People drinking at this level would be defined as lower risk drinkers. Increasing risk drinkers are those who regularly drink above the lower risk drinking levels but below 35 units a week. At this level people may not be experiencing any direct effect from alcohol consumption but their drinking is storing up potential health harms in the future. Higher risk drinking is defined as regular drinking that exceeds 35 units or more a week. Some people within this group may have dependency issues but not all. Many will be experiencing some level of harm whether

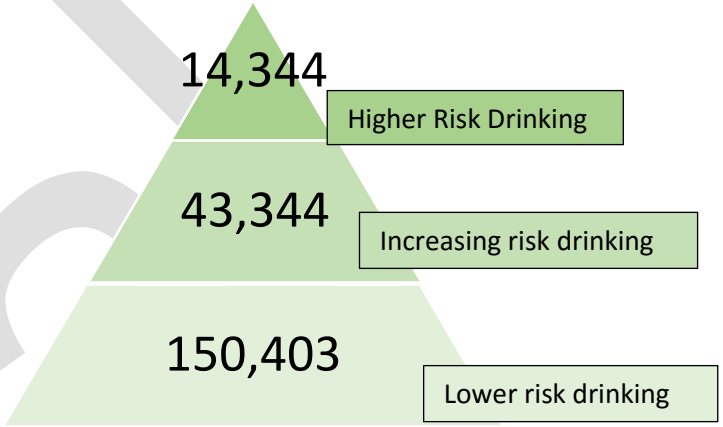
health related, work or in personal relationships.

Understanding estimates of regular drinking behaviour helps to define the action required at the population level to reverse the negative impact of alcohol related harm. Figure 1 opposite illustrates the estimated number of people drinking at the different levels of risk within Shropshire for the population aged 16 years plus based on 2014 synthetic population estimates. Please note, these figures are based on the previous categories of harmful drinking behaviour which for increasing risky drinking behaviour is between 22 – 50 units a week for men and 35 units for women. Higher risk drinking is defined as the consumption of 50 units of alcohol or more for men and 35 units or more for women. The estimation is also based on the assumption that the proportion of those engaging in lower, increasing and higher risky drinking behaviour have not changed since 2008

Other measures on alcohol consumption include estimates on those who abstain from drinking. In Shropshire it is estimated the proportion of people aged 16 years and over who abstain from drinking alcohol is lower than in the West Midlands.

Binge drinking is a behaviour associated with the night-time economy and mainly young people. However, the old definition for binge drinking was any consumption of alcohol that doubled the daily unit allowance, in any one drinking episode. Under the new guidelines binge drinking is based on the significant increase of risk of harm and injury following drinking just 5-7 units over a three to six-hour period.

Figure 1 Synthetic population estimates of drinking behaviour in all people aged16 years and older.



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Alcohol Related Crime

Since 2010/2011 Shropshire's recorded alcohol related crime rate, including violent crime, has consistently fallen below the national average.

Despite this in 2013/2014 over a fifth (22%) of rapes reported to the police involved either alcohol or drugs. In the same year, 37% of domestic abuse cases reported to the police recorded alcohol as a factor for either the victim or the perpetrator.

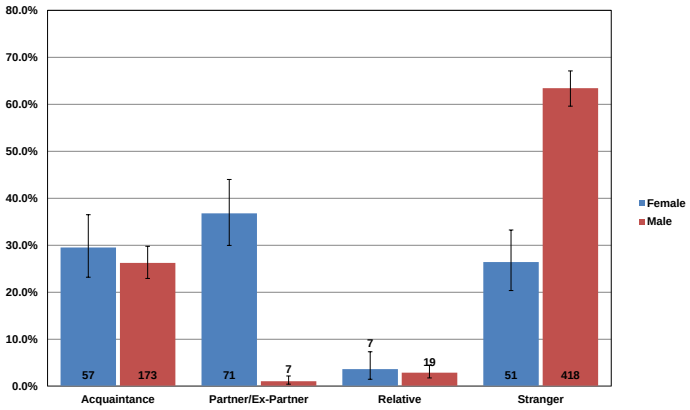
In addition to the information provided by the police the Lynx data system within the Shrewsbury & Telford Hospital Trust provides a record of all presentations for medical attention resulting from an injury due to violence. Between 2011 and 2014 there were a total of 1424 incidents reported to the system of which, just over 68% (974) reported alcohol as a contributing factor to violent incident.

The data also illustrates a clear gender split in attendees, with over three quarters of incidents reported by males compared to females. Not surprisingly the 16 - 24-year-old age group recorded the highest proportion of presentations due to a violent incident requiring medical attention, followed by the 25 to 34-year-old cohort. There is no significant gender difference within these age groups.

The data also provides some insight into the types of violent crimes that occurred and whether the perpetrator was known to the

victim. For males the majority of incidents were perpetrated by a stranger, whereas females were more likely to be a victim of a violent crime committed by someone they knew. Over a third of all incidents reported by women involved a partner or ex partners and a further third of incidents by an acquaintance (see graph 1 below).

Graph 1: Percentage of alcohol related violent incidents reported at A&E by gender and perpetrator



Source: LINX dataset SATH 2011-2013

As well as violent crime, another criminal offence directly linked to alcohol is drink driving. Shropshire has a higher proportion of road traffic accidents, where at least one driver failed a breath test following an accident, where someone was either killed or injured, compared to both the West Midlands and England average.

Table 1: Alcohol Related Road Traffic Accidents per 1000

Period	Count	Shropshire	West Midlands	England
2010 - 2012	91	44.2	37.5	27.7
2011-2013	88	45.3	36.1	27.6
2012-2014	78	41.8	33.1	26.4

Source: Joint Strategic Needs Assessment Support Pack for Alcohol and Drugs in Shropshire 2013/14 and 2014/15, Public Health England. 2015

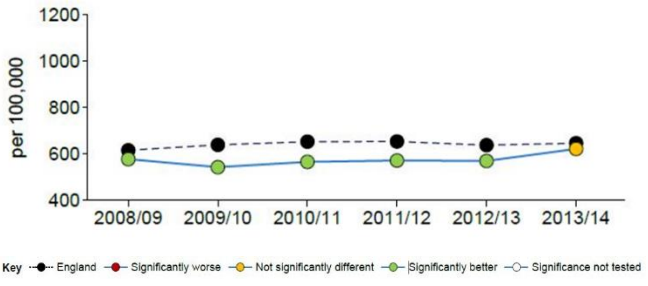
Alcohol Health Harms

The impact of alcohol consumption on health is well documented. At the national level there has been a significant increase in the number of people requiring medical assistance for alcohol related harm over the last ten years. Presentations nationally for alcohol poisoning at A&E has doubled and planned admission rates have increased threefold. Around 1 in 3 people was admitted to a ward when alcohol was a factor of presentation, compared to 1 in 5 of all other attendances. The pressures on the health service are not just experienced by the acute sector, 3 out of 4 attendances at A&E for alcohol poisoning arrived by ambulance in 2013/2014.

There are also significant differences in A&E presentations for alcohol poisoning between age groups. There have been substantial increases in the number of younger people aged 15 to 24 years attending A&E over the last few years, particularly in those aged twenty years plus. However, the highest attendance rates of all groups nationally is within older men aged between 45 – 65 years.

The rate of hospital related admissions in Shropshire has been better than the England average since 2008. However, the latest data available (Chart 1 below) shows between 2012/2013 to 2013/2014 the rate of hospital admissions increased at a rate that put Shropshire on the same level as the England average.

Chart 1: Rate of hospital related alcohol admissions per 100,000.



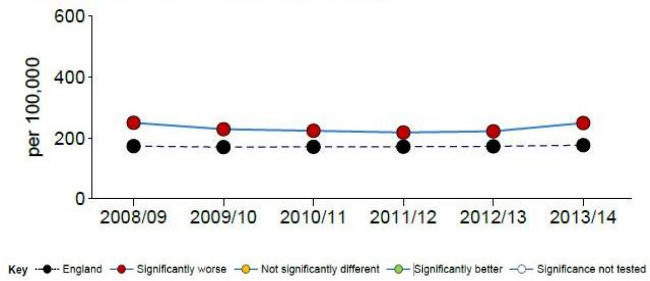
Source: Joint Strategic Needs Assessment Support Pack for Alcohol and Drugs in Shropshire 2013/14 and 2014/15, Public Health England. 2015

Alcohol directly contributes to seven types of cancer; mouth, throat, larynx, oesophagus, breast, liver and bowel. The rate of hospital admissions for alcohol related cancers in

Shropshire has been higher than the England average for a number of years.

Between 2012/2013 to 2013/2014 England rates of alcohol related cancer admissions appear to have stabilised whereas in Shropshire rates have continued to increase (Chart 2).

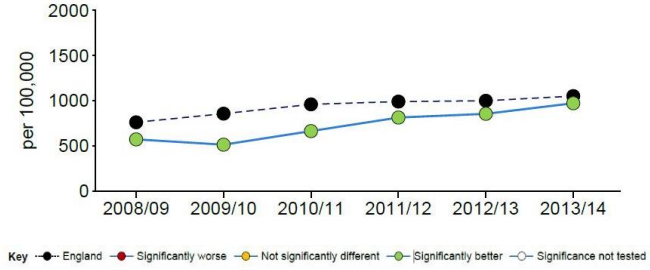
Chart 2: Rate of Hospital Admissions per 100,000 for alcohol related cancers



Source: Local Alcohol Profiles for Shropshire and England 2015

As well as cancer, alcohol is also attributable for other chronic health conditions, including hypertension, cardiovascular and liver disease. It is estimated nationally that 12% of all hypertension is due to regular drinking. Whilst these specific health conditions fall below the England average locally there are signs they are increasing with cardiovascular disease increasing at a faster rate than the England average (Chart 3).

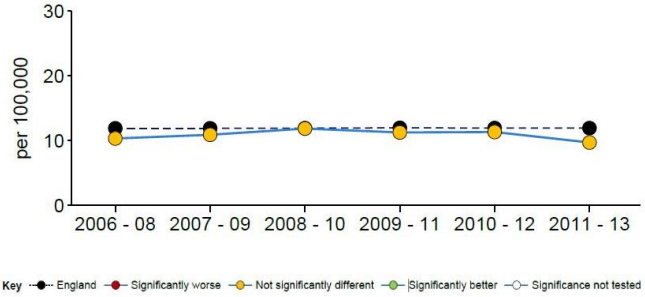
Chart 3 Rate of hospital admissions per 100,000 for cardiovascular disease.



Source: Local Alcohol Profiles for Shropshire and England 2015

Alcohol related deaths in the county remain lower than the England rate, decreasing between 2010 and 2011 despite rises in some health conditions (Chart 4).

Chart 4: Rate of alcohol related deaths per 100,000 of the population.



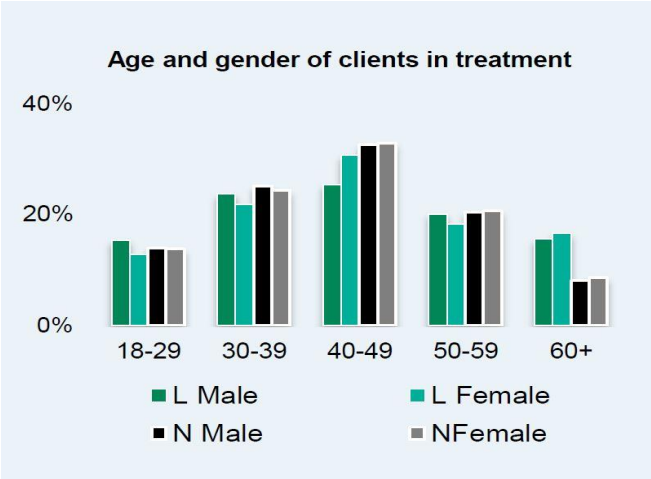
Source: Local Alcohol Profiles for Shropshire and England 2015

Alcohol Treatment

Alcohol treatment is available throughout the county and can be accessed either through a self-referral or third party referral. On contacting treatment people will be assessed to identify needs and discuss the best treatment option based on those needs.

Most referrals in Shropshire come through a self-referral. As Chart 5 illustrates the majority of people in alcohol treatment during 2013/2014 was aged between 40 - 49 years. The chart also helps to make comparisons with the national treatment profile, illustrating the higher proportion of older people aged 60 plus in treatment, than the national average.

Chart 5: Age and gender of people in alcohol treatment 2013/2014



Source: Joint Strategic Needs Assessment Support Pack for Alcohol and Drugs in Shropshire 2013/14 and 2014/15, Public Health England. 2015

Shropshire has a good reputation for supporting people to make sustainable changes in their lifestyles to succeed in their recovery. Table 2 illustrates the effectiveness

of treatment in Shropshire compared to the national average.

Table 2 Percentage of people who successfully completed treatment and did not return within 6 months

Year	Shropshire	National
2012	30%	36%
2013	45%	36%
2014	56%	38%

Source: Joint Strategic Needs Assessment Support Pack for Alcohol and Drugs in Shropshire 2013/14 and 2014/15, Public Health England. 2015

Treatment is also a protective factor for families. As people seek help the risks associated with parental alcohol misuse is reduced. In 2013/2014 just over a quarter of the treatment population reported living with children, either their own or other people's children; a further 29% were parents not living with their children.

Policy Drivers

The Governments Alcohol Strategy 2012

The 2012 National Alcohol Strategy set out the government's ambition to 'radically' tackle alcohol related harm by stemming the availability of cheap alcohol and changing people's attitudes and drinking behaviour. The expected outcomes:

- A change in behaviour so that people think it was not acceptable to drink in ways that it causes harm to them and others.
- A reduction in the amount of alcohol fuelled violent crime.
- A reduction in the number of people drinking above recommended guidelines.
- A reduction in the number of people binge drinking
- A reduction in the number of alcohol related deaths.
- A sustained reduction in number of 11 to15 year olds drinking and the amounts consumed.

The Governments Drug Strategy 2010 Reducing demand, restricting supply, supporting people to live a drug free life.

This strategy was a step change in preventing and tackling drug misuse with clear outcomes around enforcement and recovery. It put more responsibility on individuals to seek help and overcome their dependence. It also placed emphasis on a more holistic approach to tackling drug dependency by addressing other issues such as offending, housing and employment. The strategy's ambition would be realised by achieving the following outcomes:

- Freedom of dependence on drugs and/ or alcohol;
- Prevention of drug related deaths and blood borne viruses;
- A reduction in crime and re-offending
- Sustained employment and the ability to access and sustain suitable accommodation;
- Improvement in mental and physical health and wellbeing;
- Improved relationships with family members, partners and friends;
- The capacity to be an effective parent

Health and Social Care Act 2012

Under the provisions of the Act the public health function was moved to local authorities to maximise opportunities to build on the population approaches to secure better health for all. Other aspects of the Act included the establishment of Health and Well Being Boards, bringing together a range of partners with statutory responsibility to improve population health and well-being and reduce health inequalities.

To support improvement in health and well-being the Act also marked the development of the Public Heath Outcome Framework (PHOF). This framework provides authorities a number of outcomes to be achieved to improve the health and well-being of the community together with ring-fenced budget. Reducing alcohol related harm contribute to

the achievement of a number of the PHOF outcomes to improve health and well-being and reduce premature mortality.

Licensing Act 2003

The Licensing Act 2003 established a single integrated system for licensing premises that serve alcohol and late night food outlets. Through the licensing application process and specifically the associated operating policy, applicants must demonstrate how their business will meet the four licensing objectives that are set out in the Act:

- The prevention of crime and disorder
- Public safety
- The prevention of public nuisance
- The protection of children from harm

These objectives form the basis on which the licensing authority determines what is in the public interest when carrying out its functions.

High Impact Changes (2009)

The Department of Health published guidance for local areas in 2009 on activities that would support reducing alcohol related harm. These still hold firm today and whilst many have been introduced they still underpin the direction of this strategy to:

- Work in Partnership
- Develop activities to control the impact of alcohol misuse in the community
- Improve the effectiveness and capacity of specialist treatment
- Appoint an alcohol worker
- Identification and Brief Advice – provide more help to encourage people to drink less
- Amplify national social marketing priorities

Outcomes

The aim of the strategy is to reduce the burden of alcohol related harm across the life course. To do this we need to have a consistent approach to promote sensible drinking and deter behaviour that can do most harm. This strategy will encorporate both environmental approaches to reducing harm and promoting opportunities to address individual risks.

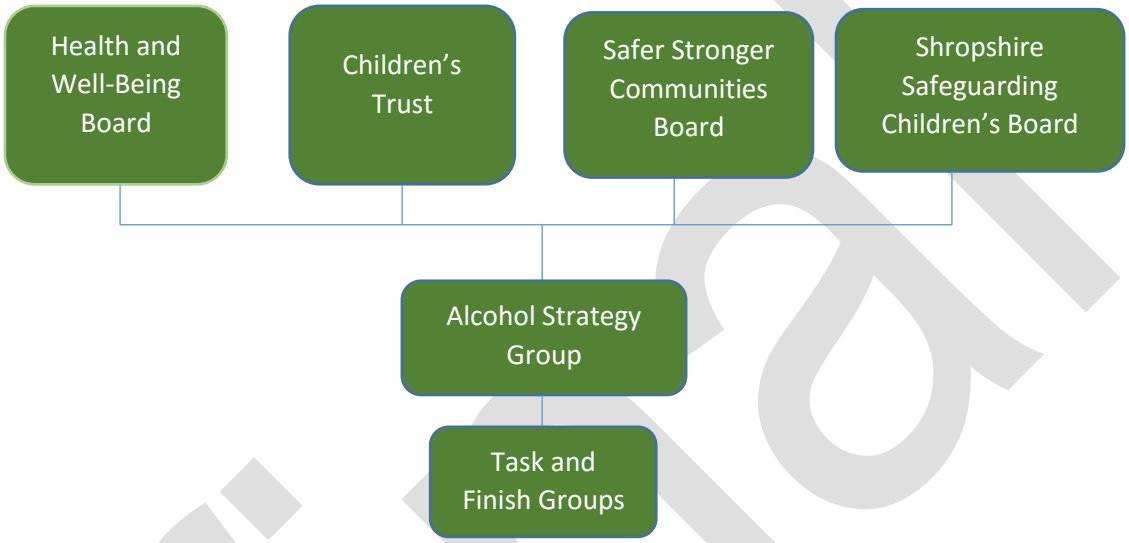
Promote Safer Communities	Improve Health and Well-being	Protect Children and Young People	Create capacity
• Reduce the incidence of alcohol related crime and anti-social behaviour. • Improve the management and planning of the night-time economy. • Improve the managment of alcohol misusing offenders	• Promote sensible drinking • Prevent further increases in levels of chronic and acute ill health caused by alcohol	• Reduce alcohol related harm among children and young people • Support and protect children and young people affected by parental substance misuse.	• Strengthen data collection, and utilisation across stakeholders to support the development of future plans • Increase capacity through workforce planning and development

Implementation of the Strategy

As with previous strategies, these ambitions will require a multifaceted approach and whilst this strategy sets out a framework for action, delivery can only be strengthened through close links with other partnerships. Working together will strengthen resource efficiencies and reduce duplication within the system through key strategic links.

The Health and Well Being Board will provide the strategic overview and ensure this strategy is embedded across the partnerships. The Safer Stronger Communities Board, the Children's Trust and Shropshire Safeguarding Board will be responsible for ensuring the aims and objectives within this strategy are delivered through their strategic plans. The governance structure is illustrated below.

Alcohol Strategy Governance Structure:



- The coordination of the strategy implementation will be carried out by the Alcohol Strategy Group.
- The strategy will be reviewed yearly to monitor the progress and agree priorities for the following year.
- Commissioning decisions to support treatment improvements and preventative services will be decided through the Substance Misuse Commissioning Group.
- Task and Finish groups will be established to undertake specific time limited pieces of work to support the delivery of the strategy as agreed by the partnerships.

Strategic Links

The primary aim of this strategy is to reduce alcohol related harm, as a cross-cutting theme the objectives will need to be carried through a range of local strategies and initiatives.

Early Help	**Community Safety Strategy**	**Health and Well Being Strategy**
Children's Trust Plan	**Mental Health Strategy**	**Prevention Strategy**
Reducing Re-offending Strategy		**Domestic Violence Strategy**

Outcome: Promote Safer Communities

- **Improve the management, planning and diversity of the night-time economy.**
- **Reduce the incidence of alcohol related crime and anti-social behaviour.**
- **Improve the management of alcohol misusing offenders**

Alcohol related crime can be divided into two categories, either defined offences such as drink driving or drunk and disorderly offences, or where alcohol was a contributing factor in the offence such as alcohol related violent crime and disorder. Shropshire's overall crime rate is low when compared to other areas with similar demographics, socio-economic status and geographic characteristics. Recorded alcohol related crime, including violent crime, has consistently fallen in Shropshire, and is below the national average. However, Shropshire has a significantly higher proportion of drink driving offences that resulted in injury than other areas in the West Midlands.

The relationship between alcohol, crime and disorder is complex and is linked to both environmental and individual risk factors. A number of studies have shown an association between alcohol related crime and density of licensed premises. As the night-time economy plays an important part of town centre life by creating jobs and bolstering local economies, it is important local areas have an agreed approach to their development. Statutory partners have an important role in helping to shape a diverse night-time economy through licensing and planning.

As well as the environment, individual characteristics, age and gender can increase the risk of being a victim or perpetrator of alcohol related violence. Men are more likely to be victims or perpetrators of violent crime involving strangers; whereas women are more likely to know their attacker.

Once in the criminal justice system perpetrators of alcohol related crime need to be supported to access appropriate support to reduce the risk of alcohol related re-offending.

What we will do to reduce the incidence of alcohol related crime and disorder.

- Work with the licensing and planning committees to utilise the powers under relevant legislation to create a safe and vibrant night–time economy that offers diversity in entertainment.
- Develop guidance to promote greater understanding of planning and licencing priorities that support a safe and vibrant diverse night-time economy.
- Develop and implement an Integrated Community Management approach across appropriate areas of the county to respond to low-level alcohol related crime and anti-social behaviour.
- Work with partners to maintain and, where appropriate, extend the Purple Flag scheme.
- Develop a systematic approach to tackle alcohol related crime, including drink driving.
- Where alcohol is a contributing factor ensure appropriate disposal of the offence and referral into treatment compliments other criminal justice interventions.
- Improve support to victims of alcohol violent crime, including cases of domestic abuse.

Outcome: Improve Health and Well-Being

- **Promote Sensible Drinking**
- **Prevent further increase in levels of chronic and acute ill health caused by alcohol**

Alcohol, after smoking and obesity, is one of the three biggest lifestyle risk factors and accounts for 10% of the UK burden of disease and death.

Recent guidelines from the Chief Medical Officer has recommended both men and women should not drink more than 14 units a week over a minimum period of three days, with alcohol free days in between. Many people are unaware their drinking may be doing them harm and find it difficult to understand units in relation to the volume of alcohol they drink

What we will do to promote sensible drinking

To help people to understand more about safe drinking levels we will use national campaigns to promote sensible drinking, utilising work places across public and private sector, health and community services

We will build on our work with businesses to create an on and off licensed trade that supports a sensible approach to the sale of alcohol and deters excessive consumption.

What we will do to prevent further increase in levels of chronic and acute ill health caused by alcohol.

Identification and brief advice (IBA) is proven to be an effective intervention in reducing consumption. Health checks for people aged 40 to 74 year olds and new GP registrations provide an opportunity to assess people's current level of drinking and take appropriate action. We want to extend this within other areas of health and social care to ensure we are able to identify health risks early.

We will achieve this by:

- Encouraging all statutory partners to have a systematic response for managing alcohol issues as part of their service delivery.
- Identifying champions within partner organisations to lead delivery of the strategy and be responsible for its implementation.
- Embed the principles of every contact counts through screening and brief interventions within a range of settings using validated screening tools.
- For people with complex needs and the homeless we will deliver appropriate responses including responding to 'treatment resistant' and dual diagnosis to support individual's needs.
- Target interventions to those populations who are most at risk of harm, e.g. middle aged men and homeless population.

Outcome: Protect Children and Young People from alcohol related harm

- **Reduce alcohol related harm among children and young people.**
- **Support and protect children and young people affected by parental substance misuse.**

Over the last decade young people are less likely to take drugs and alcohol than their counterparts did in 2001. Whilst this is encouraging England still ranks amongst the countries with higher levels of young people's alcohol consumption. For those young people who do drink, they are more likely to binge drink than our European neighbours. Problematic drug and alcohol use in young people rarely happens in isolation, and is usually a symptom of other issues in the young person's life. It can often present with other risk factors such as truancy, offending and poor mental health.

It is important young people are supported to build resilience to prevent further harm.

What we will do to reduce alcohol related harm amongst young people.

- Build resilience through partnership work by providing support and advising schools to deliver alcohol education as part of good quality PSHE, which includes the Shropshire developed relationship and sex education and mental health curriculum, supporting schools to manage alcohol related incidents and develop policies in line with best practice.
- Ensure an appropriate and proportionate enforcement response is applied to businesses that break the law in respect of under-age and proxy sales, including adopting the principles promoted by the Community Alcohol Partnership approach.
- Develop a clear care pathway for managing alcohol related harm following hospital presentation by young people aged up to 18 years old.
- Introduce brief interventions and extended interventions into a range of young people's settings to manage harmful drinking behaviour.

Unfortunately, children and young people exposed to problematic drinking by parents suffer a range of poor outcomes. These can range from low self-esteem and poor educational attainment to behaviour and psychological problems. There is also a greater risk of exposure to domestic abuse, sexual exploitation, self-harm and developing drug and alcohol related problems in later life.

What we support and protect children and young people affected by parental substance misuse by:

- Ensuring parenting capacity is appropriately assessed and acted upon.
- Strengthening commissioning arrangements between adult mental health, domestic abuse and children and family services.

Outcome: Create Capacity

- **Strengthen data collection, sharing and utilisation across stakeholders to improve support to those in need**
- **Increase capacity through workforce planning and development**

Shropshire has an established history for partnership working across the public sector. This strategy has been developed recognising this strength of this whilst acknowledging more needs to be done to ensure there is the capacity and knowledge to direct resources appropriately.

The changes that have occurred across the public sector since 2013 mean new information sharing arrangement need to be forged with agencies and organisations that have changed their status.

It is recognised across the partnership that in order to use scarce resources effectively decisions need to be informed by robust data and intelligence.

What we will do to strengthen data collection, sharing and utilisation across stakeholders to support the development of future plans

- Work together to identify an agreed process for the collection and sharing of data, including agreeing local common definitions to support analysis.
- Implement PHE minimum data set for hospitals as part of overall response to improving hospital pathway.
- Undertake a regular cycle of alcohol needs assessments to understand local profiles to support service planning and development.

The level of increasing and higher risk drinking within the county far outstrips anything a local specialist service could support. There is substantial evidence that supports the implementation of Identification and Brief Advice (IBA) as a tool to effectively reduce alcohol related health harms. To roll IBA out effectively there needs to be a skilled workforce who can use opportunistic moments to make every contact counts.

What we will do Increase capacity through workforce planning and development.

- Develop a workforce strategy to support implementation of IBA across the partnership.
- Identify workforce champions to support roll out of IBA.

References

Alcohol Concern (2014) Working with Change Resistant drinkers.
http://alcoholconcern.org.uk/wp-content/uploads/2015/01/Alcohol-Concern-Blue-Light-Project-Manual.pdf

Department for Health (2009) Signs for Improvement: commissioning interventions to reduce alcohol related harm.
https://www.nice.org.uk/guidance/cg115?unlid=834611753201611919132

HM Government (2010) Drug Strategy 2010 Reducing demand, restricting supply, building recovery: supporting people to live a drug free life.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf

HM Government (2012) The Governments Alcohol Strategy 2012.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf

Institute of Alcohol Studies (2013) Crime and social impact of alcohol.
http://www.ias.org.uk/Alcohol-knowledge-centre/Crime-and-social-impacts.aspx

Institute of Alcohol Studies (2014) Availability and Licensing Factsheet.
http://www.ias.org.uk/Alcohol-knowledge-centre/Availability-and-licensing.aspx

Local Government Association and Alcohol Research UK (2013) Public health and alcohol licensing in England, LGA and Alcohol Research UK briefing.
http://www.local.gov.uk/c/document_library/get_file?uuid=a9c78d54-db3f-4d8f-bef2-d915dc8db1d5&groupId=10180

NICE (2010) Alcohol use disorders: diagnosis and management of physical complications. Clinical guidance CG100.
https://www.nice.org.uk/guidance/CG100

NICE (2010) Alcohol use Disorders: Prevention. Public health guidance 24.
https://www.nice.org.uk/guidance/ph24/resources/alcoholuse-disorders-prevention-1996237007557

NICE (2011) Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Clinical guidance CG115.
https://www.nice.org.uk/guidance/cg115?unlid=834611753201611919132