Portsmouth CITY COUNCIL

Health Overview & Scrutiny Panel

Review of alcohol-related hospital admissions

Review of alcohol-related hospital admissions

Preface

Alcohol misuse is a very serious problem nationally; particularly in Portsmouth. The tragedy is that a lot of the suffering and premature deaths that it causes could be prevented.

The Panel was very concerned to learn that the city's rate of alcohol-related hospital admissions is higher than the national and South East averages and wanted to know what was being done to tackle this issue and what improvements could be made to ensure that these issues were being dealt with effectively.

This review seeks to build upon good research that has been carried out and published in successive strategies involving partner agencies to ensure a holistic approach to tackling alcohol misuse, from all the agencies involved.

The Strategy for Public Health in England, contained within the Public Health White Paper issued on 30 November 2010, recognises that changing adults' behaviour could reduce alcohol-related premature deaths as well as save the NHS an estimated £2.7 billion. It is hoped that this review will be seen as a foundation for future work to tackle this issue, thereby saving the local health economy money that could be re-invested elsewhere.

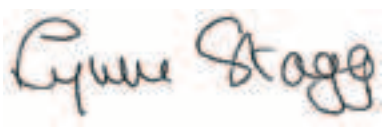
As local authorities are preparing to take on more responsibility for health improvement in future years, this is an ideal opportunity for the council to implement the recommendations within its remit and encourage partner agencies to implement those relevant to them in order to make a real difference in relation to reducing health inequalities across the city.

I would like to take this opportunity to thank everyone who was involved in this review including council officers, external organisations and the community for being open and honest with us and taking the time to give evidence for this review.

I would particularly like to thank the staff and clients at alcohol treatment centres, who provided moving personal accounts about the human impact of alcohol misuse and the members of the public who took the time to give the Panel their views so that we could gain a deeper understanding of all the issues involved.

Whilst this is an excellent platform to build upon, my one regret is that we have been able to investigate only the more obvious manifestations of alcohol abuse such as binge drinking. We have been unable to look at the `hidden` problems of long-term alcohol abuse and its effects on families including domestic abuse and children living with alcoholism in the home. Not only does this cause major physical and social problems but it also accounts for the biggest cost to the NHS of alcohol abuse.

The complexities involved in dealing with alcohol-related issues have demonstrated the need for a multi-agency, holistic approach to a problem that although huge, is everybody's responsibility. Working together, we will improve the health and well being of our local community.



Councillor Lynne Stagg, Chair, Health Overview & Scrutiny Panel

Date: 27 January 2011

▲ Councillor Lynne Stagg, Chair, Health Overview & Scrutiny Panel, Portsmouth City Council

take part

pathfinder

Date published: 27 January 2011.

Under the terms of the Council's Constitution, reports prepared by a Scrutiny Panel should be considered formally by the Cabinet or the relevant Cabinet Member within a period of eight weeks, as required by Rule 11(a) of the Policy & Review Procedure Rules.

Contents

Executive summary

The Health & Overview & Scrutiny Panel identified the need to prioritise a review of alcohol-related hospital admissions due to concerns about the high number of people in Portsmouth who drink at levels which could harm their health and the fact that the city has the highest level of alcohol-related hospital admissions in the South East. Alcohol abuse affects not only the individual who has the problem but their family, friends, colleagues, neighbours, local businesses and the wide range of professionals and volunteers who deal with the alcohol-related incidents or issues.

Dealing with alcohol-related issues is a clear priority set out in all local partnership documents for Portsmouth. This report follows on from the work already carried out by many organisations including the Safer Portsmouth Partnership and attempts to highlight all the issues involved and to identify areas where improvements could be made.

The Panel is proud to have been awarded Scrutiny Development Area status in the Centre for Public Scrutiny's Health Inequalities Programme, which raises the profile of scrutiny as a tool to promote community well being and assists councils and their partners address health inequalities in their areas. The review will help develop and test a Scrutiny Resource Kit, which will be used by Health Overview & Scrutiny Panels nationwide.

The Panel carried out extensive outreach work in order to canvass the views of stakeholders. This included holding a video diary event, conducting an online survey, work shadowing the police, ambulance service, CCTV control operators and the Portsmouth Street Pastors as well as visiting the Emergency Department (ED), the Medical Assessment Unit (MAU) and the Intensive Care Unit (ICU) at Queen Alexandra Hospital (QAH), the ambulance control centre, service providers and attending stakeholder group meetings. These proved very informative and gave Panel members a first-hand view of the work involved in dealing with alcohol-related issues. The Panel also welcomed the views submitted by several members of the public and representatives from local retailers and Pubwatch.

To understand the national and local picture of alcohol abuse

Nationally, alcohol consumption has increased over the last 17 years and alcohol-related hospital admissions are increasing. This is particularly the case for women, middle and older age groups and very young adolescents.

A significant amount of the UK alcohol revenue comes from those who drink too much and there is a strong correlation between alcohol consumption and affordability.

There is a huge variation in alcohol harm in the South East with coastal cities having higher rates than inland cities, with the exception of Chichester. High rates tend to be found in deprived areas with higher unemployment and more vibrant night time economies.

The health risks and subsequent costs associated with long-term, heavy drinking are significant.

Ten percent of hospital attendances to the ED at Southampton General Hospital are recorded as being alcohol-related; however it is known that reasons for attendance are not consistently recorded therefore the real figure could be higher. Whilst alcohol-related hospital admission levels in Southampton are higher than the Government Office of the South East and South Central Strategic Health Authority areas they are lower than Portsmouth rates.

Portsmouth has high levels of alcohol consumption particularly in adults and young adolescents who are more likely to drink alcohol and binge drink than the national average.

Although alcohol misuse is generally higher in areas of deprivation within the city, further analysis shows a more complex picture. The 2005 Health and Lifestyle Survey revealed that younger affluent, healthy professionals, white collar single people living in terraced housing in the Southsea area have the heaviest wine consumption and disadvantaged multi ethnic younger adults throughout the city with high levels of smoking have the heaviest beer consumption. The numbers of older people accessing treatment for alcohol dependency in the city has increased over the last few years.

The Panel recognised that this is a multi-faceted, complex problem that would require the commitment of a multi-agency approach in order to be effective.

To understand the number and categories of alcohol-related admissions at Queen Alexandra Hospital and to evaluate the methods used to record alcohol-related admissions

Levels of alcohol-related hospital admissions are considerably higher in Portsmouth than the national and South East averages and increased by 59% between 2002/3 and 2009/10. There are approximately 60 different diseases which are either wholly or partly attributable to alcohol. Patients with chronic conditions make up 60% of alcohol-related hospital admissions at Queen Alexandra Hospital (QAH) and binge drinkers make up a significant amount of ED attendances.

The value of using alcohol screening tools in hospitals is recognised nationally. The Paddington Alcohol Test (PAT) is a very good alcohol assessment tool, but it has not been used consistently by staff at the ED since its introduction in 2009. This means that the exact number of alcohol-related hospital admissions in Portsmouth is not known. The test was replaced in October 2010 by scratch cards containing the Alcohol Use Disorders Identification Test (AUDIT) screening tool. These will be given to all patients on arrival for completion and handing back to staff for advice if required. A version of the PAT will be introduced in inpatient wards in spring 2011.

Collection of reliable data is essential in order to target resources appropriately. ED, the police and ambulance personnel are expected to routinely collect information from assault victims (location, weapon and incident type) and pass it onto the Safer Portsmouth Partnership in order that police and council resources can be targeted appropriately as well as providing evidence to support effective coordination of services within partner agencies. This is currently not happening even though the facilities are in place to do so.

Many drunken patients are abusive to staff at the ED and dealing with them diverts resources away from other patients' needs. The data required to determine whether the introduction of security staff in the Emergency Department has had a significant affect on this problem was not available to the Panel.

The impact of alcohol misuse on Portsmouth City Council Services

The complexities in dealing with alcohol-related issues, involves working across a wide range of services including housing, culture, education and children's services, adult social care, traffic and transportation, trading standards, health improvement and development service, licensing and planning.

To understand the causes and impact of alcohol abuse on different sections of society

The causes of alcohol abuse are complex and numerous; genetic, biological, environmental, psychological and sociocultural factors may all play a part.

Alcohol abuse affects all parts of society to some extent, but its impact is particularly apparent in the economy. This is due to the fact that the heaviest drinkers tend to be of working age and their increased sickness, inability to work and premature deaths in this group, as well as having unavoidable human loss, has a significant detrimental impact on the economy. The Safer Portsmouth Partnership has recently recommended that all its members have a clear staff substance misuse policy. Consequently, Portsmouth City Council's staff code of conduct which currently permits alcohol consumption during the working day provided it does not affect performance is being reviewed.

Portsmouth is ranked 25th out of 127 primary care organisations for the highest level of alcohol-attributable crimes. The Panel was impressed with the joint working between night time economy staff, Portsmouth Street Pastors, CCTV operators, the ambulance service and the police to prevent crime and to support vulnerable people.

Whilst many people drink to socialise, many others do so in order to cope with feelings of stress, anxiety and depression. However, the Panel noted that high levels of alcohol

consumption can make people more susceptible to mental health problems.

To understand the treatment services available and the referral system.

The alcohol misuse treatment services are classified into four tiers:

- Tier one services are provided by a range of non-specialist professionals who screen and refer patients to the appropriate service. Examples include GPs, hospital staff, court staff, probation and social services.
- Tier two services comprise alcohol specialist information and advice, screening, referral to structured alcohol treatment, brief psychosocial interventions, harm reduction interventions and aftercare. These are mainly provided by the Alcohol Intervention Team, Cranstoun Drug Services and the Portsmouth Alcohol Arrest Referral Service, which provides brief interventions and referral to specialist services for clients involved in the criminal justice system.
- Tier three services comprise community-based specialised alcohol assessment and coordinated care-planned treatment. Cranstoun Drug Services provides some tier three services but Kingsway House is the main provider.
- Tier four services comprise residential specialised alcohol treatment, which are care planned and care coordinated. The main providers are Baytrees and ANA treatment centre, which is a private not-for-profit organisation.

It is also important to recognise the good work carried out by the numerous housing associations, not-for-profit organisations and charities who support people with alcohol misuse issues.

The Alcohol Specialist Nurse Service introduced at QAH aims to shorten stays in hospital and prevent re-admissions by identifying alcohol issues at an early stage. It is estimated that the service will save approximately £500,000 per annum.

A range of initiatives are in operation including QAH's Medical Assessment Unit patient referral programme to Alcoholics Anonymous which has received national interest and may be extended to other parts of the region. Other examples include Portsmouth Street Pastors, Safe Space, the Community Health Practitioner based in Guildhall Walk, Portsmouth Users Self Help Group, Drug and Alcohol Stakeholder Meetings, Peer Recovery Facilitators, Al-Anon Family Groups, the Criminal Justice Alcohol Reduction Group, the pharmacy based alcohol advice project, the Crime Reduction Initiative, Save Dave Campaign, the Alcohol Improvement Programme, Frequent Flyers project, Pharmacy Brief Intervention Pilot Project, Alcohol Advisory School Nurse, Alcohol Project Worker, the Evening and Late Night Economy Partnership and Pubwatch.

To understand the work carried out in the following areas: prevention of alcohol abuse and enforcement and to gain the views of service users and professionals involved

Alcohol is a clear priority set out in all local partnership documents including the Safer Portsmouth Partnership Plan 2008-11, Portsmouth Alcohol Strategy 2009-11 and the Safer Portsmouth Partnership's Needs Assessment of Crime, Anti Social Behaviour and Substance Misuse.

To learn from examples of good practice elsewhere

This is a very topical issue and many local authorities are introducing measures to deal with alcohol-related issues. The Panel considered the work of Blackpool Borough Council, City of Edinburgh Council, Edinburgh's Operation Astrodome, Scottish Parliament, Brighton & Hove Council, Manchester City Council, Middlesborough Council and Oldham Council.

Having reviewed the evidence during the course of the review, the Panel has formulated some conclusions and recommendations for all the agencies involved with a view to developing the services available.

To develop recommendations to improve the alcohol abuse and misuse services in the city

Appendices

Purpose

1

Public consultation near a key area for drinking, July 2010

The purpose of this report is to present the findings of the Health Overview and Scrutiny Panel (HOSP) following its review of alcohol-related hospital admissions. A glossary of the acronyms used in this report is attached as appendix one.

Background

2

2.1 The Panel selected this subject because it was concerned about the high number of people who drink at levels which could harm their health and the fact that Portsmouth has the highest level of alcohol-related hospital admissions in the South East[1]. (Details are shown in sections 3.4 and 4.1). Alcohol abuse also affects significant numbers of people indirectly such as the family, friends and colleagues of these heavy drinkers. Most people are affected or know someone who is affected by this issue either directly or indirectly. Queen Alexandra Hospital (QAH) serves residents from Portsmouth and its surrounding areas. It was felt that conducting this review would give members an overview of alcohol abuse in the whole area.

2.2 The Health Inequalities Scrutiny Programme is a two-year programme funded by the Healthy Communities Team for Local Government Improvement (formerly the Improvement and Development Agency) to raise the profile of scrutiny as a tool to promote community well-being and help councils and their partners address health inequalities within their local community. The Centre for Public Scrutiny invited local authority scrutiny committees to apply to become Scrutiny Development Areas to help develop and test a Scrutiny Resource Kit.

2.3 The Panel recognised that taking part in the Health Inequalities Scrutiny Programme would bring access to an expert advisor with an invaluable wealth of ideas and experience. The additional funding available would allow innovative ways of raising the profile of this scrutiny review including a video diary booth, stands, flyers, posters, surveys and articles in local media. On 6 January 2010, the Centre for Public Scrutiny awarded Scrutiny Development Area status to the Portsmouth HOSP for its review into alcohol-related hospital admissions[2].
A copy of the bid submitted is attached to this report as appendix two.

2.4 At a meeting held on 20 January 2010, the HOSP agreed the following objectives for a scrutiny review of alcohol-related hospital admissions:

1. To understand the number and categories of alcohol-related admissions at Queen Alexandra Hospital.
2. To understand the national picture for alcohol abuse.
3. To evaluate the impact alcohol-related hospital admissions has on Portsmouth City Council Services.
4. To understand the causes and impact of alcohol abuse on different sections of society.
5. To evaluate the methods used to record alcohol-related admissions at Queen Alexandra Hospital
6. To understand the treatment services available and the referral system.
7. To understand the work carried out in the following areas: prevention of alcohol abuse; treatment services, enforcement and to gain the views of service users and professionals involved.
8. To learn from examples of good practice elsewhere.
9. To develop recommendations to improve the alcohol abuse services in the city.

1. Portsmouth Alcohol Strategy 2009-2013.
2. Ten Scrutiny Development Areas were recruited. More information can be found at www.cfps.org.uk

2.5 Until 18 May 2010, the HOSP comprised the following members:

Portsmouth City Council Councillors
David Horne (Chair)
Margaret Adair (Vice Chair)
David Stephen Butler
Margaret Foster
Jacqui Hancock
Robin Sparshatt
Standing Deputies
Cheryl Buggy
Lee Mason
Mike Park
Jim Patey
Paula Riches
Caroline Scott
Linda Symes
Co-opted Councillors
Brian Bayford, Fareham Borough Council
Dorothy Denston, East Hampshire District Council
Peter Edgar, Gosport Borough Council and Hampshire County Council
David Gillett, Havant Borough Council
Vicki Weston, Winchester City Council

From 18 May 2010 the Panel comprised:

Portsmouth City Council Councillors
Lynne Stagg (Chair)
David Horne (Vice Chair)
Margaret Adair
Margaret Foster
Jacqui Hancock
Robin Sparshatt
Standing Deputies
Cheryl Buggy
David Stephen Butler
Lee Mason
Mike Park
Jim Patey
Caroline Scott
Steve Wemyss
Co-opted Councillors
Dorothy Denston, East Hampshire District Council
Keith Evans, Fareham Borough Council
Peter Edgar, Gosport Borough Council and Hampshire County Council
David Gillett, Havant Borough Council
Patricia Stallard, Winchester City Council

2.6 The objectives of the review were formally amended for clarity on 26 August 2010 to the following:

1. To understand the national and local picture for alcohol abuse
2. To understand the number and categories of alcohol-related admissions at Queen Alexandra Hospital and to evaluate the methods used to record them.
3. To evaluate the impact alcohol abuse has on Portsmouth City Council services.
4. To understand the causes and impact of alcohol abuse on different sections of society.
5. To understand the treatment services available and the referral system.
6. To understand the work carried out in the following areas: prevention of alcohol abuse; treatment services; enforcement, and to gain the views of service users and professionals involved.
7. To learn from examples of good practice elsewhere.
8. To develop recommendations to improve the alcohol abuse services in the city

2.7 The Panel met formally to take evidence on eleven occasions between 20 January 2010 and 27 January 2011.

2.8 A list of meetings held by the Panel and details of the written evidence received are attached as appendix three. The minutes of the Panel's meetings and documentation reviewed by the Panel are published on the council's website at www.portsmouth.gov.uk/yourcouncil/8312.html; copies are available from customer, community and democratic services upon request.

2.9 In order to gain a better understanding of the issues involved and to ensure that as many views as possible were heard the Panel carried out a number of visits on several occasions to Queen Alexandra Hospital (ED, Intensive Care Unit and Medical Assessment Unit), service providers and stakeholder groups, work shadowed the police, ambulance service, Portsmouth Street Pastors and the CCTV operators, held a public participation event and conducted an online survey. A full list of outreach engagement work carried out by the Panel is attached as appendix four.

To understand the national and local picture for alcohol abuse

3

3.1 **National Figures**

Alcohol abuse can affect people at any stage of their lives, arguably from pre-conception to grave. Alcohol is implicated in over 7,000 miscarriages[3]. Six thousand babies are born every year with Foetal Alcohol Spectrum disorders[4]. Up to 2.6 million children are at risk of neglect because their parents drink at hazardous levels[5]. Alcohol is recorded as a factor in 25-33% of known cases of child abuse[6] and over 50% of child protection cases[7]. In 2007/08 there were 39,000 reports of serious sexual assaults on adults where alcohol was a factor[8]. It is one of the leading causes of accidents, leading to many injuries and deaths[9]. There were 1.2 million incidents of alcohol-related violence in 1999[10] and 9,031 premature deaths[11]. It is worth noting that these statistics relate to recorded incidents; it is not possible to estimate how many unrecorded incidents are attributable to alcohol although arguably this figure could be significantly higher.

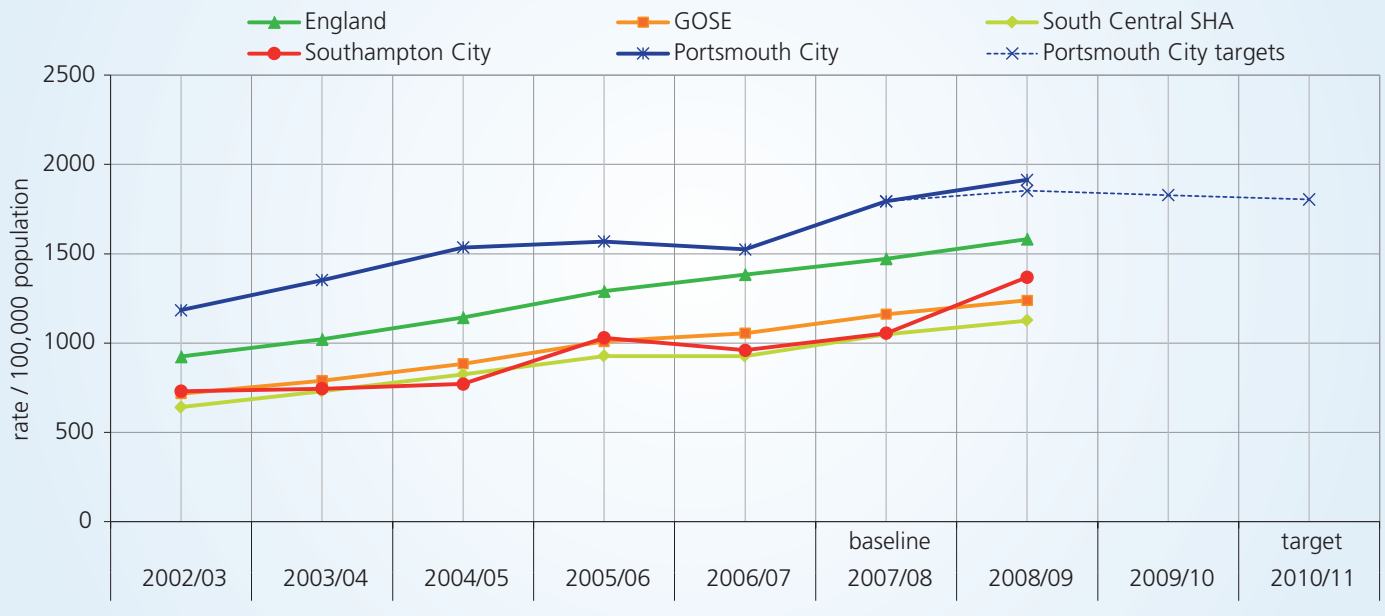
3.2 The Local Alcohol Profiles for England (LAPE 2010) released on 1 September 2010 by the North West Public Health Observatory (NWPHO) contain 23 alcohol-related indicators for every local authority and 24 for every Primary Care Trust in England. In 2010 key indicators in healthcare, criminal justice, benefit claimants, drinking patterns and life lost due to alcohol were used to identify and map those areas of alcohol-related harm. Alcohol-related harm is defined as any of the range of adverse effects of drinking alcohol experienced by the drinker or by other people.

3.3 According to the LAPE 2010, two thirds of all the local authorities suffering the highest levels of overall harms are in the North West and North East regions of England. By comparison the East of England and South East regions contain two thirds of all the local authorities with the lowest overall harm.

3.4 Trends in alcohol-related harms vary between local authority areas. For instance, 64% saw an increase of over 5% in hospital admissions for alcohol-related harm in 2008/09, whilst only 7% showed a decrease of over 5%.

3. Passive drinking: the collateral damage from alcohol – annual report 2008 by the Chief Medical Officer p19.
4. Ibid p19.
5. Swept under the carpet: children affected by parental alcohol misuse – report by Alcohol Concern and The Children's Society – published on 18 October 2010.
6. Alcohol Harm Reduction Strategy for England 2004
7. Alcohol Concern, 2003
8. British Crime Survey 2007/08
9. www.drinkaware.co.uk
10. British Crime Survey 2000.
11. Office for National Statistics.

Alcohol-related hospital admission rate per 100,000 population
Portsmouth City tPCT, 2002/03-2010/11



Source: North West Public Health Observatory. NB: tPCT: Teaching Primary Care Trust, SHA: Strategic Health Authority, GOSE: Government Office for the South East.

How the Figures for Alcohol-Related Hospital Admissions Are Calculated

3.5 All the conditions known to be either wholly or partially attributable to alcohol are identified as well as the proportion of the population who might be affected. Alcohol Attributable Fractions (AAFs) are used to express the extent to which alcohol contributes to a health outcome. The AAFs used to calculate hospital admissions for alcohol-related harm match the fractions used to calculate hospital admissions for alcohol-related harm published by the North West Public Health Observatory in July 2008, following a review commissioned by the Department of Health. AAFs for England identified relative risk estimates from a number of epidemiological reviews and studies of the health impacts of alcohol; estimates of different levels of alcohol consumption in the population were obtained from the General Household Survey 2005. From these a set of age group and gender specific AAFs were derived for each alcohol-related condition, defined in terms of International Classification of Diseases (ICD10) codes. More details of the process for calculating alcohol-related hospital admissions can be found at appendix five.

Government Targets

3.6 Public Service Agreements (PSAs) set out the key priority outcomes that the Government wants to achieve in the next spending period and explain how the targets will be achieved and measured.

3.7 In 2004, the Government introduced legislation and guidance on alcohol including the Alcohol Harm Reduction Strategy, which required local partnerships to collaborate on strategies. These partnerships were reinforced by the introduction of PSA 25 in 2007 to reduce the harm caused by alcohol and drugs, which provided for the first time a delivery plan and focused targets.

3.8 In 2007 the Government launched 'Safer Sensible Social', Next Steps in the Alcohol Strategy, which identified three priority areas: under 18 drinkers; 18-24 year old binge drinkers and harmful drinkers who regularly drink above recommended levels.

3.9 Since 2008, the Government has used National Indicators (NIs) to monitor the performance of local authorities and local partnerships. The Operating Framework, published at the end of 2009, introduced a new approach to planning and managing priorities, both nationally and locally: the Vital Signs, which are used to develop local operational plans to deliver against national priorities and to select and create local priorities. The Vital Signs framework provides a series of indicators from which Primary Care Trusts select those that reflect the priorities for health in their area. NI 39 (also Department of Health Vital Signs Indicator VSC26), 'Rate of Hospital Admissions per 100,000 for Alcohol-related Harm', provides a measure in which to compare alcohol-related health problems.

3.10 In 2009 the Department of Health published 'Signs for Improvement – commissioning interventions to reduce alcohol-related harm', which identified a number of High Impact Changes that are calculated to be the most effective actions for those local areas that have prioritised the reduction in alcohol-related harm. High Impact Changes have been extensively used across the NHS and local government to highlight practical measures that can be implemented at local level:

1. Work in partnership
2. Develop activities to control the impact of alcohol misuse in the community
3. Influence change through advocacy
4. Improve the effectiveness and capacity of specialist treatment
5. Appoint an Alcohol Health Worker
6. Interventions and Brief Advice.
7. Amplify national social marketing priorities

National Trends in Alcohol Consumption

3.11 According to the British Beer and Pub Association (BBPA) Statistical Handbook there was a 6% reduction in alcohol consumption in 2009; the sharpest year-on-year decline since 1948 and the fourth annual drop in five years. It states that UK drinkers are now consuming 13% less alcohol than in 2004. It also reports that sales from pubs, bars, off-licences, restaurants and supermarkets fell according to the HM Revenue and Customs data from UK producers and importers. The high tax rate was indicated as the main cause of this reduction. The BBPA is not in favour of the introduction of a minimum price and instead recommends measures targeted at those who misuse alcohol. Dr Stuart Flanagan, who works in accident and emergency, advised that these figures had to be seen in the context that alcohol consumption had actually been rising over the last 60 years[12]. The Director of Public Health and Primary Care for Portsmouth stated that it is the amount of alcohol consumed which has increased over the last 30 years and not the number of people drinking; 5% of the population drinking 30% of the total alcohol consumed.

3.12 The Joseph Rowntree Foundation, which is a British social policy research and development charity published 'Drinking in the UK: an exploration of trends' in May 2009[13]. It was a systematic review of research relevant to trends in alcohol consumption over the last 20 to 30 years in the UK and drew the following conclusions:

3.12.1 The average number of units of alcohol consumed by men and women in Great Britain increased between 1992 and 2009.

3.12.2 There has been an increase in drinking amongst women. The report speculated that this might be due to the historically recent emancipation of women in Western society, the pressure of positive advertising and also the increased financial security and independence of women.

3.12.3 There has been an increase in drinking among middle and older age groups. The report stated that this might be partly due to the fact that older people are financially better off now. This apparent trend may also reflect a generation of drinkers with drinking habits established during former years when alcohol generally has been more affordable and acceptable.

3.12.4 Although there is a possible recent decrease in drinking among 16 to 24 year-olds, the report states that it is not possible to interpret this as a convincing downward trend as variability in consumption between successive survey years is greater in this age group than any other. It is, however, consistent across different surveys and different consumption measures.

3.12.5 Alcohol consumption amongst very young adolescents has increased. Reasons might include the fact that they have a higher disposable income, alcohol advertising and promotional activities that are

12. www.stop-drinking.co.uk/news_alcohol.html
13. www.jrf.org.uk/publications/drinking-in-the-uk

particularly appealing to young people and can influence the initial development of drinking behaviour. However, these possibilities would not necessarily lead to different effects on younger versus older teenagers. Therefore, the most compelling consideration when trying to explain the rising trend in consumption amongst 11 to 13 year olds compared with older teenagers and young adults is the influence of parents, family, friends and the home environment. A 2007 Joseph Rowntree Foundation report indicated that the home is increasingly where young people learn to drink and, as such, young people's drinking habits need to be understood and addressed in relation to parental attitudes to and use of alcohol.

3.13 The Government's last Alcohol Strategy entitled 'Safe. Sensible. Social' published in 2007, reported that the 11 to 13 year-old boys who had drunk alcohol in the last week consumed 11.9 units per week in 2006, up 6.4 units from 2001. The 11–13-year-old girls who drank consumed 8.4 units a week in 2006, up 2.7 units since 2001.

The Alcohol Market

3.14 The Director of Public Health and Primary Care for Portsmouth informed the Panel that in 2006 the UK alcohol market was worth £33.4 billion, of which £25 billion came from people who drink too much.

3.15 Data from the Office of National Statistics shows that alcohol advertising expenditure rose from £150 million to £250 million annually between 1989 and 2000. Over the same period, average weekly alcohol consumption by young people aged 11 to 15 years also rose in a highly correlated manner.

Affordability

3.16 The Substance Misuse Coordinator for Portsmouth informed the Panel that one of the key determinants of alcohol consumption is affordability. The Choosing Health 2007 report stated that there is a direct correlation between the availability and price of alcohol and levels of consumption.

3.17 The Substance and Misuse Coordinator and the Director of Public Health and Primary Care for Portsmouth recommended the introduction of a minimum price per unit for alcohol. Thames Reach a London based charity helping homeless and vulnerable people to find accommodation is calling for the government to act by introducing a minimum price for alcohol. At the time of undertaking this review, Blackpool Borough Council is the lead authority for a partnership review on minimum pricing of alcohol. It is working with Lancashire County Council, Blackburn and Cumbria Councils. Section 10 has full details of this review.

3.18 The Director of the North West Public Health Observatory commented "We need to see the real cost of alcohol reflected in the price it is sold at and the warnings about the dangers that alcohol represents not relegated to a tiny corner in alcohol adverts, but written large enough for people to recognise the seriousness of the risks."

3.19 Evidence from the Portsmouth Street Pastors, door staff and Pubwatch indicates that many people drink heavily before going out, a practice known as 'pre-loading' and therefore minimum pricing would not affect pubs and clubs as much as supermarkets. Examples of pre-loading were evidenced during the work

shadowing and video diary event that the Panel undertook. Pubwatch stated that most licensed premises would like to increase their prices but feel it would simply increase the appeal of pre-loading. This would also force venues to reduce prices as they compete for reduced numbers of customers.

3.20 Alcohol Concern (the national agency on alcohol misuse which campaigns for effective alcohol policy and improved services for people whose lives are affected by alcohol-related problems) issued a press release on 31 August 2010 stating that the tax on alcohol should rise by 10% to reduce deaths, fund treatment and discourage the production of extra strong beer. It states that stronger ciders are cheaper than lower strength beers, which does not encourage consumers to drink fewer units of alcohol. The introduction of a minimum price would be required in order to ensure that the full duty rate is reflected in the price. It also reported that in July 2010 the supermarket Asda stopped selling alcohol below cost defined as duty plus VAT. Drinks giant Diageo wants changes in the tax structure and is in favour of a duty + VAT definition for cost but denies a link between price and consumption. The Morning Advertiser, a weekly UK pub trade publication, reported fears that the off-trade can beat the below-cost ban with a duty + VAT definition. The BBPA stated that production and distribution costs should be included.

3.21 In July 2010 the Government produced a consultation paper on its proposed licensing reforms entitled Rebalancing the Licensing Act. The aim of the reforms is to give more power to local authorities and the police to help them deal with alcohol-related crime and disorder, while also promoting responsible business. The Government asked all stakeholders for their views on the implications of implementing the proposals. The consultation ended in September 2010. The proposals included:

- Overhauling the Licensing Act to give local authorities and the police much stronger powers to remove licences from, or refuse to grant licences to premises that are causing problems
- Allowing councils and the police to permanently shut down any shop or bar that is repeatedly selling alcohol to children
- Doubling the maximum fine for those caught selling alcohol to minors to £20,000
- Allowing local councils to charge more for late-night licences, which will help pay for additional policing
- Banning the sale of alcohol below cost price

The consultation on the licensing reform also asked for stakeholders' views on how a 'below cost ban' should be defined.

3.22 Panel members attended the consultation workshop for stakeholders arranged by Portsmouth City Council in March 2010. The views were collated and submitted to the Government.

Timescales for Changes to the Licensing Act

3.23 The Local Government Regulation (LGR), part of the Local Government Group overseen by the Local Government Association, states that 'the Home Office (HO) has confirmed that it intends for the majority of the proposals in its consultation to be introduced via the Police Reform and Social Responsibility Bill, due to be introduced into Parliament early in

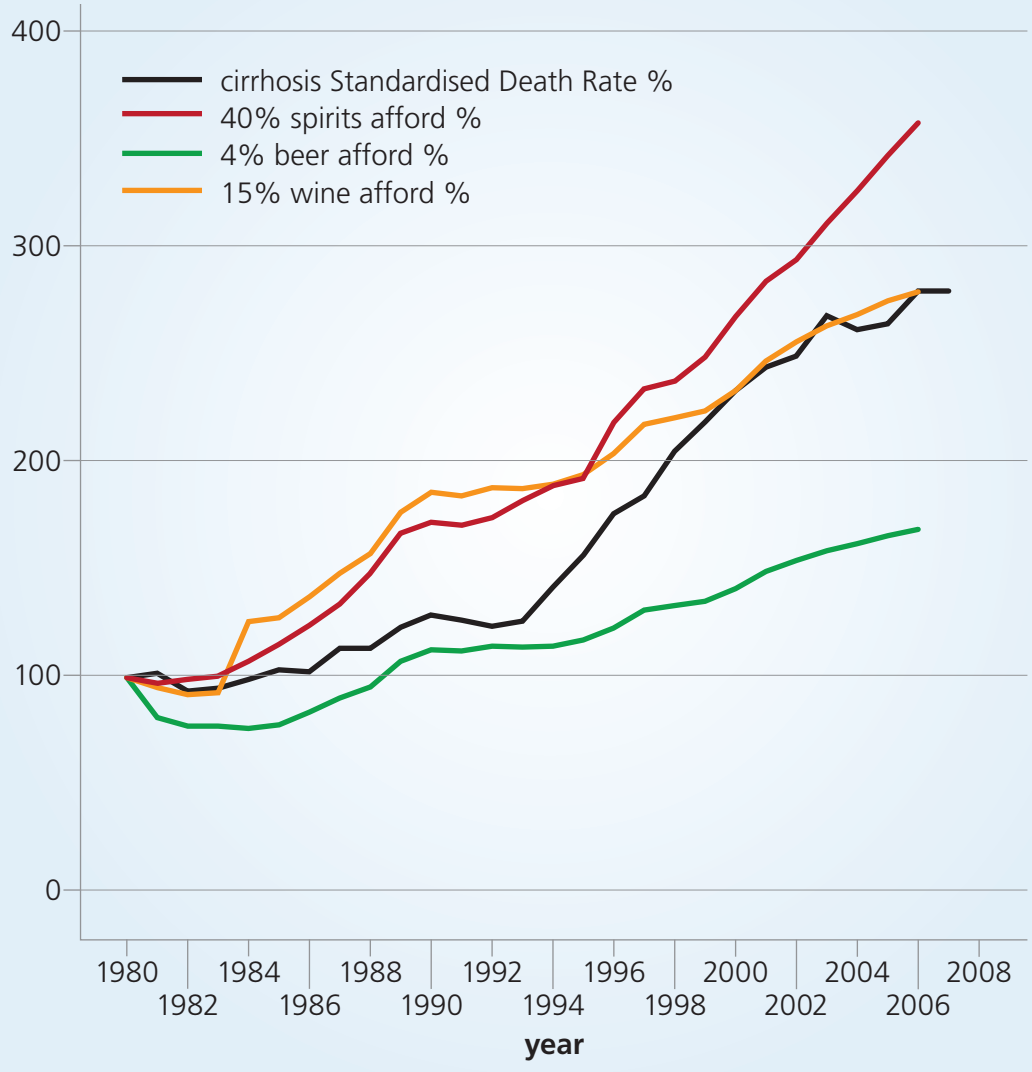
the first session. Implementation dates however will be subject to Parliamentary passage of the Bill and the date for Royal Assent has yet to be confirmed. Whilst some of the proposed changes will be within the primary legislation, others will require secondary regulations and changes to the section 182 guidance.

3.24 LGR would add that it would expect regulations and the guidance to be subject to consultation which could further impact on timescales. As previously advised, even though one of the proposals in the consultation is to remove the three-yearly requirement for reviewing licensing policy statements, this will not be implemented in time to change the current primary legislative statutory requirements to review licensing policies in time for January 2011. Therefore, authorities should not attempt to pre-empt any changes to the current legislation. Authorities are legally required to continue with their policy reviews, and should base that review on the provisions of the Licensing Act 2003 as it currently stands[14].

3.25 A report by Anderson and Baumberg in 2006 estimated that using taxation to raise the price of alcohol by just 10% within the European Union's 15 wealthiest member states would save 9,000 lives within a year.

14. www.lacors.gov.uk/lacors/ContentDetails.aspx?id=24330

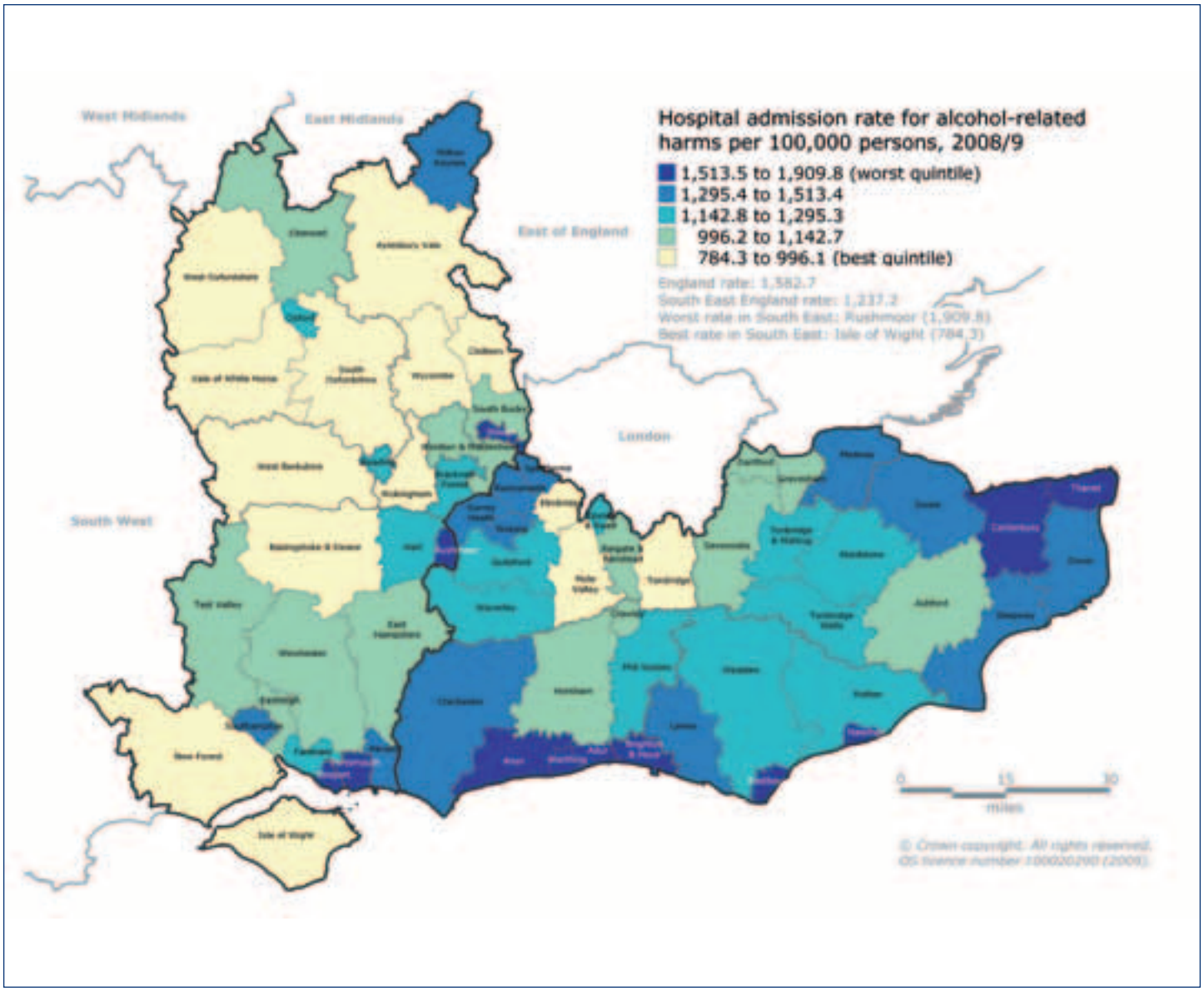
UK liver death rates and affordibility index of spirits, wines and beers compared with 1980 = 100%



3.26 Despite the UK having amongst the highest taxes in the European Union, beer was nearly twice as affordable in 2007 than in 1970. Since 1980 the affordability of alcoholic drinks increased: spirits by 350%, wine by 280% and beer by 170%. Alcohol was 65% more affordable in 2007 than in 1980 and accounts for only 5.2% of household spending compared with 7.5% in 1980[15]. Using the latest data, alcohol in 2009 was 70% more affordable than it was in 1980, highlighting the trend of increasing alcohol affordability[16].

3.27 The following map shows the huge variation in the rates of alcohol-related hospital admissions in the South East. The darker the area, the higher the rate of alcohol-related hospital admissions. The coastal cities have higher rates than those inland apart from Chichester. These areas tend to have more areas of deprivation, higher unemployment, as well as more vibrant night time economies.

15. Office for National Statistics, 2007.
16. Office for National Statistics 2010.



The impact of alcohol abuse on health

3.28 National research has highlighted the increased risks of ill health to heavy drinkers[17], which is shown in the table below. These statistics have been adjusted to take into account that regular drinkers are more likely to smoke and lead unhealthy lifestyles. Therefore only the affect that drinking has on their health is shown.

17. For men, heavy drinking is typically defined as consuming an average of more than 2 drinks per day. For women, heavy drinking is typically defined as consuming an average of more than 1 drink per day – Centres for Disease Control and Prevention.

	Increased risk	
Condition	**Men**	**Women**
Hypertension (High blood pressure)	4 times	Double
Stroke	Double	4 times
Pancreatitis	Triple	Double
Liver disease	13 times	13 times

The top three causes of alcohol-attributable deaths by age and sex

Age group	Male	Female
16-24 year olds	Road traffic accidents – non pedestrian, intentional self harm and pedestrian traffic accidents	Intentional self-harm, road traffic accidents – non pedestrian and epilepsy and status epilepticus
25-34 year olds	Intentional self-harm, road traffic accidents – non pedestrian and alcoholic liver disease	Intentional self-harm, alcoholic liver disease and epilepsy and epilepticus
35-44 year olds	Alcoholic liver disease, intentional self-harm and road traffic accidents – non pedestrian	Intentional self-harm, alcoholic liver disease and epilepsy and epilepticus
45-54 year olds	Alcoholic liver disease, intentional self-harm and unspecified liver cirrhosis	Alcoholic liver disease, malignant neoplasm of breast and intentional self-harm
55-64 year olds	Alcoholic liver disease, malignant neoplasm of oesophagus and unspecified liver cirrhosis	Alcoholic liver disease, malignant neoplasm of breast and unspecified liver cirrhosis
65 -74 year olds	Alcoholic liver disease, malignant neoplasm of oesophagus and haemorrhagic stroke	Alcoholic liver disease, malignant neoplasm of breast and unspecified liver cirrhosis
75+	Malignant neoplasm of oesophagus, cardiac arrhythmias and haemorrhagic stroke	Cardiac arrhythmias, malignant neoplasm of breast and hypertensive diseases

Southampton

Attendances

3.29 Between 1 January 2009 and 30 June 2009 the ED at Southampton General Hospital recorded 42,419 attendances of which 3,976 were deemed to be alcohol-related. These accounted for 9.4% of total attendances. However, from the manual review of assault attendances, it is known that ED clinicians miss some of the alcohol-related attendances when coding. Therefore 9.4% is likely to be an under-estimate[18]. National estimates suggest that between 25-35% of all ED attendances are alcohol-related. The Substance Misuse Coordinator for Portsmouth informed the Panel that the under-reporting of alcohol-related presentations is also common in Portsmouth, as the involvement of alcohol as a factor in the attendance or admission is not routinely recorded.

Admissions

3.30 Southampton General Hospital is a large teaching hospital and provides specialist expertise to the South of England region. The rate of alcohol-related hospital admissions in Southampton General Hospital was 1,405 per 100,000 of the population in 2008. The graph in section 3.4 shows the rate of alcohol-related hospital admissions for England, South Central Strategic Health Authority (SHA) and Southampton from 2002 to 2009.

3.31 Alcohol was a contributory factor in 69% of assaults to staff between July and September 2009[19].

3.32 At Southampton General Hospital between January and June 2009 there was an increase of 295% in assaults on staff at the weekends (Friday – Sunday nights).

Portsmouth

Alcohol consumption

3.33 The Portsmouth Alcohol Strategy 2009-13 states that over 90% of Portsmouth residents drink alcohol; most at sensible levels. However, an estimated 40,000 drink above the recommended guidelines; over 8,000 of whom drink at high risk levels i.e. over 35 units per week for women and 50 units per week for men and about 7,000 are likely to have an alcohol dependency. That figure equates to 1 in 20 adults in Portsmouth.

3.34 The North West Public Health Observatory (NWPHO) estimates there are 32,326 'Increasing Risk Drinkers' in Portsmouth. These are people who drink above recommended low risk levels (22-49 units per week for men, 15-34 units per week for women). In addition the NWPHO estimates there are 8,628 'Higher Risk Drinkers' (35+ units for women and 50+ units for men).

Attendances and Admissions Costs

3.35 The average cost of an attendance at ED is £86.83. The average cost of an admission through ED is £1,502. Deployment of an ambulance crew, treatment at the scene and transport to the ED costs approximately £300.

By electoral ward, groups of people and type of alcohol consumed in Portsmouth

3.36 The Portsmouth Alcohol Strategy 2009-13 concluded that alcohol misuse was higher in areas of deprivation, such as the Charles Dickens and Paulsgrove wards. These wards also reported greater social, economic and health inequalities.

3.37 The 2005 Health and Lifestyle Survey revealed that younger affluent, healthy professionals, white collar singles or sharers in terraces in the Southsea area have the heaviest wine consumption.

18. www.southampton.gov.uk/modernGov/mgConvert2PDF.aspx?ID=2135
19. Southampton City Council's Environment and Sustainability Scrutiny Inquiry – Night Time Economy.

20. 50% had drunk an alcoholic drink, compared to 42% nationally
21. 21%, compared to 17% nationally.
22. 53% think it is good enough, compared to 59% nationally.

Disadvantaged younger adults throughout the city with high levels of smoking have the heaviest beer consumption at levels above the recommended safe levels.

3.38 11% of respondents reported in the 2005 survey that they had drunk alcohol everyday in the last 12 months. 20% of residents in St Thomas Ward reported that they drink every day, 18% in Cosham, 17% in Eastney and Craneswater and 2% in Copnor.

3.39 The percentage of persons aged 18 and over who binge drink, (defined as drinking alcoholic beverages with the primary intention of becoming intoxicated by heavy consumption of alcohol over a short period of time), varied from 45% in Eastney and Craneswater to 16% in Drayton and Farlington. Applying these percentages to the population in 2009, there will be almost 40,000 persons aged 18 and over who binge drink. The Health and Lifestyle Survey is based on respondents self-reporting therefore the accuracy of the information cannot be verified.

3.40 The Alcohol Strategy Lead for the Safer Portsmouth Partnership meets with the University of Portsmouth to discuss how to promote sensible drinking. The student pub crawls that are often advertised in the Guildhall Walk area especially at the start of the academic year are not organised by the University. It was noted that the number of students that attend ED are not recorded.

3.41 When the police come across a minor i.e. a person under 18 years of age drinking alcohol in a public place the parents are informed by letter. If this is the second offence, the police will visit the parents to discuss the situation. A referral will also be made the new Alcohol Advisory School Nurse who was appointed on 20 September 2010. (Details are shown in section 8.22).

3.42 The Tell Us survey was undertaken across England by the Office for Standards in Education (Ofsted) in Spring 2007, 2008 and 2009 and asked pupils from years 6, 8 and 10 (i.e. 10–15 year olds) for their views about their local area and behaviour. This annual survey has been discontinued by the Coalition Government. The Health Improvement and Development Service is developing a questionnaire to include same key questions as Tell Us, albeit on a smaller scale.

3.43 869 primary school pupils and 647 secondary pupils in Portsmouth from 20 schools completed the 2009 Tell Us survey. The results indicate that they are more likely to drink than the national average[20] have been drunk at least once over the last four weeks[21] and are less likely to consider the alcohol information and advice they receive is good enough[22]. Although alcohol education would form part of Personal, Social and Health Education, this is not a statutory part of the curriculum, so may not be covered in schools. The target for pupils responding 'none/ never' to the question 'In the last four weeks how many times have you been drunk? is 66 pupils for March 2011. In March 2010, 61 pupils gave that response.

3.44 During a visit by the Panel to the ED in July, a consultant expressed her concern about the increase of young people, some as young as 13, attending with alcohol-related conditions or injuries. She explained that there are consistent issues with teenagers who have been binge drinking, which sometimes necessitates an admission to the paediatric ward for observation, as the hospital will not release any patient under 16 unless this is into the care of a responsible, sober adult. This is not a good use of staff and causes concern to the other patients.

Trends

3.45 The Portsmouth Alcohol Strategy 2009-13 states that its focus groups identified white males as most at risk of alcohol misuse; however they also identified an increasing trend for problem drinking amongst women.

3.46 Portsmouth's Baytrees Detoxification Unit managers informed the Panel that there had recently been an increase in older clients entering the service. (Section 7.55 gives more details on this unit).

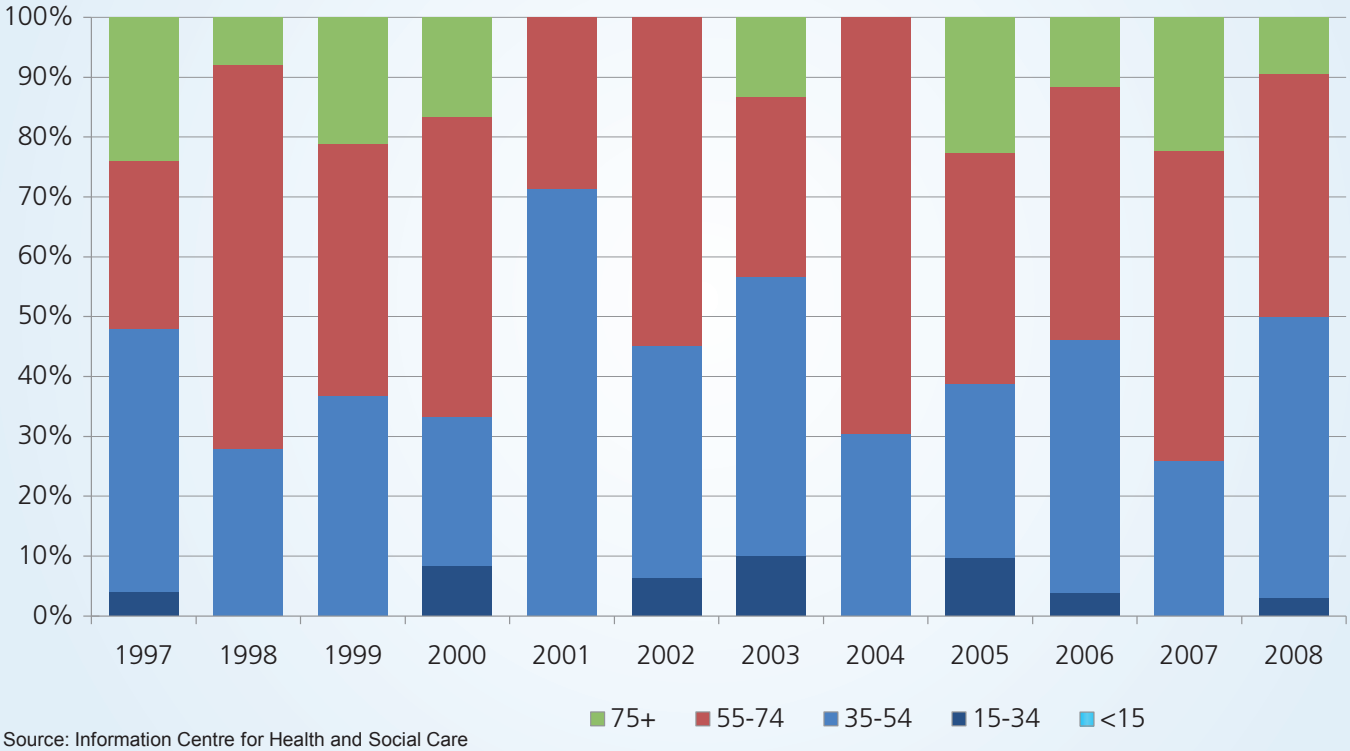
Health Risks

3.47 The average male in Portsmouth dies 10.2 months early due to alcohol-related illnesses[23]. The number of deaths with an alcohol-related underlying cause from 1997-2008 in Portsmouth are shown below:

23. Portsmouth Alcohol Strategy 2009-2013.

Alcohol related mortality rates
Number of deaths with an alcohol-related underlying cause of death
Portsmouth City teaching Primary Care Trust, 1997-2008, by ageband

Agebands	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
<15	0	0	0	0	0	0	0	0	0	0	0	0
15-34	1	0	0	2	0	2	3	0	3	1	0	1
35-54	11	7	7	6	15	12	14	7	9	11	7	15
55-74	7	16	8	12	6	17	9	16	12	11	14	13
75+	6	2	4	4	0	0	4	0	7	3	6	3
All ages	**25**	**25**	**19**	**24**	**21**	**31**	**30**	**23**	**31**	**26**	**27**	**32**



Source: Information Centre for Health and Social Care

1. Cause of death was defined using the International Classification of Diseases, Ninth Revision (ICD-9) for the years 1997 to 2000 and Tenth Revision (ICD-10) for 2001 onwards. The specific causes of death categorised as alcohol-related and their corresponding ID-9 and ICD-10 codes, are shown in the boxes below.
2. All primary care organisations are Primary Care Trusts (PCTs) other than Bexley, Northumberland, Solihull and Torbay which have Care Trust status, and North East Lincolnshire, which has Care Trust Plus status. Not all primary care organisations (PCOs) are entirely within the boundaries of the strategic health authorities (SHAs) to which they report, so the sum of the deaths in the PCOs included in an SHA are not always equal to the total figure shown for that SHA.
3. Based on boundaries as of 2009.
4. Figures are for deaths registered in each calendar year.
5. Figures for deaths registered in 2008 are provisional.

3.48 In Portsmouth the number of deaths with an alcohol-related underlying cause has increased by 28% since 1997.

Liver Disease

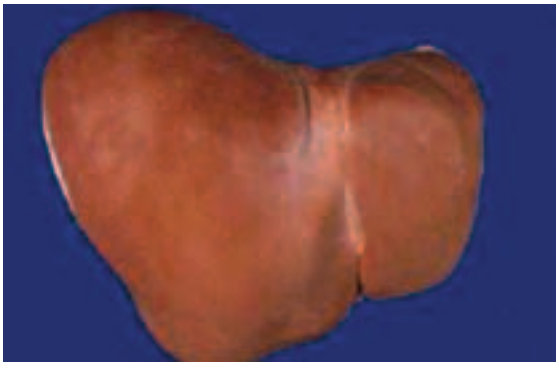
3.49 The Consultant Hepatologist, who is also the Alcohol Champion at QAH gave a presentation to the Panel on liver disease. A summary of the points he raised follows:

3.49.1 The national liver disease epidemic is largely attributable to alcohol. The high levels of liver disease in Portsmouth are due to alcohol misuse, obesity, diabetes and hepatitis C. It has therefore been estimated that 95% of liver cirrhosis is potentially preventable with public health measures.

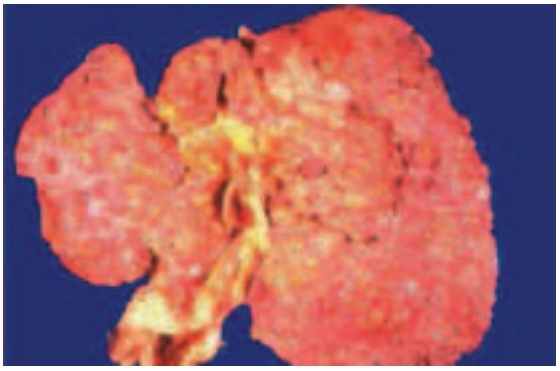
3.49.2 At Queen Alexandra Hospital there was a 50% increase in admissions and bed occupancy rate due to alcoholic liver disease between 2004 and 2006. The length of stay rose more steeply than admissions as patients now tend to be more ill and require longer stays.

3.49.3 The Liver Advisory Group of UK Transplant (the NHS agency responsible for the administration of organ transplants) recognises alcoholic cirrhosis as an accepted indication for a liver transplant. The main condition in place for potential recipients is that they must have stopped drinking; therefore the Alcohol Liaison Nurses play a key role here.

3.49.4 The average age of death from heart attacks is 78, strokes 81 and for liver cirrhosis 56, reflecting that liver disease is a killer of relatively young individuals. Patients are now presenting with liver cirrhosis at a progressively younger age. There has been a particular increase in the numbers of women with chronic liver disease. This may reflect a higher sensitivity to the effects of alcohol. Chronic liver disease has very few specific symptoms and patients are usually unaware of the condition until relatively advanced stages, sometimes only after many years of harmful drinking.



▲ A healthy liver



▲ A liver with cirrhosis

3.49.5 When a patient is identified as being potentially suitable for a transplant, they would typically be seen in clinic at a liver transplant unit within a few weeks. In most units, they would subsequently be admitted to hospital for a formal 4-5 day "assessment" period. If all goes well, they would then be added to the transplant waiting list and discharged home to await an organ. It is essential that patients who are deteriorating are identified promptly before they become too seriously ill to receive a transplant. To this end the list is constantly being reviewed to ensure that those with the highest need are at the top of the list.

3.49.6 Shock education programmes in schools are effective in raising awareness of the dangers of alcohol misuse.

3.49.7 There are many interventions that can be carried out to halt the progression from liver scarring to cirrhosis and to reduce the chances of complications e.g. propranolol which is a very cheap beta blocker drug that lowers the risk of internal bleeding in liver cirrhosis. However, audits elsewhere have shown only approximately 20% of patients who could benefit from this treatment are receiving them. It is important that health care professionals are aware of all the options available.

3.49.8 Patients with liver disease are now being treated in large district hospitals rather than being sent to specialist tertiary centres. In the last few years, more hospitals have adopted a specialist model for managing acute medical admissions which involves an early triage of patients to ensure that they are seen by the appropriate consultant as soon as possible. This should improve patients' outcomes.

3.49.9 Rates of liver disease have increased since the change in licensing laws. There is a definite link between availability, lower prices and alcohol consumption.

Licensed Premises

3.50 The Director of Public Health and Primary Care for Portsmouth explained that the annual increase in alcohol-related hospital admissions nationally and in Portsmouth is irrespective of any changes in licensing laws. However, some areas of the city might have seen an increase in antisocial behaviour as a result of the extended opening hours for pubs and clubs. In his opinion the jury is out on whether this extension has had a positive or negative affect on antisocial behaviour and health. Although the extension of licensing hours has not increased the volume of alcohol-related hospital admissions, the problems are experienced over a longer period.

▲ 'We serve drinks not drunks' campaign to encourage responsible alcohol sales

3.51 The Substance Misuse Coordinator for Portsmouth informed the Panel that evidence indicates that loud music and reduced seating leads to increased consumption of alcohol, presumably because there is no opportunity for clients to sit down and talk.

3.52 In July, eleven bars in the Guildhall Walk area of Portsmouth made a voluntary agreement not to sell drinks below £1.50; premises failing to adhere may expect to be called to a licensee committee review if their venue experiences problems.

3.52 In April 2010 the first phase of the mandatory code for alcohol retailers came into force, banning irresponsible drinks promotions such as 'buy one get one free' and requiring free tap water to be provided for customers.

To understand the number and categories of alcohol-related admissions at Queen Alexandra Hospital and to evaluate the methods used to record alcohol-related admissions.

4

Alcohol-related hospital admissions figures (ARHAs).

4.1 In Portsmouth the rate of alcohol-related hospital admissions has increased from 1,184 per 100,000 population in 2002/03 to 2,017 per 100,000 total population in 2009/10; that is an increase of 59%. The trend shows that it is likely to rise to 2,521 by 2014/15. The target set out in the Portsmouth Alcohol Strategy 2009-13 is to reduce the number of alcohol-related hospital admissions to 1,794 per 100,000 population by 2013. In 2007/8 Portsmouth's rate of alcohol-related hospital admissions was 22% higher than the national average[24], 55% higher than the South East average[25] and 36% higher than Southampton[26].

4.2 The current data shows that this rate has continued to rise, and the total for the year to date is 5% more than in 2008/09 (1,914 to 2,017 per 100,000).[27]

4.3 The rate of alcohol-related hospital admissions is increasing nationally by 10% each year. The rate is much higher in Portsmouth but is increasing at a lower rate. The aim of the Portsmouth Alcohol Strategy 2009-13 is to stop the rate increasing so that it falls beneath the national average.

A breakdown of alcohol-related hospital admissions (ARHAs).

4.4 Sixty per cent of ARHAs relate to chronic conditions, 23% to mental and behavioural conditions and 17% to acute conditions. Mental and behavioural conditions are more prevalent in the under 16s, whilst acute conditions, often linked to binge drinking, are most common amongst 16 to 24 year olds. The older the individual the higher the chance of chronic conditions. This is unsurprising as these are usually obtained from long term heavy drinking.[28]

4.5 People suffering from the effects of binge-drinking make up a significant amount of alcohol-related attendances to ED, whereas patients with chronic conditions make up the highest number of alcohol-related hospital admissions.

4.6 The Substance Misuse Coordinator explained that most presentations of deliberate self-harm are associated with alcohol consumption and many overdoses are taken when drunk.

4.7 The list of conditions includes approximately 60 different diseases which are either wholly attributable to alcohol e.g. alcoholic liver disease or partly attributable e.g. some cancers.[29] The most significant in terms of numbers in 2008-9 were hypertensive diseases, mental and behavioural disorders and cardiac arrhythmias.

The Paddington Test

4.8 The Royal College of Physicians' 2001 report "Alcohol – Can the NHS afford it?" recommended that each acute hospital trust have: "one or more dedicated alcohol health worker employed by and answerable to the acute trust." Professor Robin Touquet at St Mary's Hospital, Paddington, London found that "46% of patients who were identified as misusing alcohol returned [for follow-up purposes] when offered further help." The Paddington Alcohol Test (PAT) was designed in 1996 for use within St. Mary's Emergency Department to flag up alcohol problems so that patients can be directed to the alcohol nurse. The PAT is revised every year by the St Mary's Alcohol team. A copy of the test is attached to this report as appendix six.

24. The average for England is 1,473 per 100,000 of the population. The average for Portsmouth is 1,794. See graph in section 3.4
25. The average for the South East is 1,914 per 100,000 of the population.
26. The average for Southampton is 1,055 per 100,000 of the population.
27. Strategic assessment of crime, anti social behaviour and substance misuse.
28. The Director of Public Health and Primary Care for Portsmouth.
29. More information can be found in the Portsmouth Alcohol Strategy 2009-2013.

▶ Queen Alexandra Hospital, Cosham

4.9 The National Health Promotion in Hospitals Audit (NHPHA), a web-based audit designed to measure the delivery of health promotion to hospitalised patients within all English hospitals recognises the value in the use of alcohol assessment tools and recommends that basic training be available to ensure healthcare professionals feel confident in using them. (Section 7.71 gives details of this audit).

Queen Alexandra Hospital (QAH)

4.10 One third of patients at QAH come from the city of Portsmouth and two thirds from surrounding areas.

4.11 As a result of one of the recommendations in the Portsmouth Alcohol Needs Assessment in 2009, staff at ED were asked to use the PAT to screen all patients that present with the most frequent alcohol-related conditions to determine whether they need to be referred to an Alcohol Interventions Team worker. In order for the tool to be effective it should be used routinely, but the hospital was unable to ensure that staff did so. Only 82 referrals were made for the whole of 2009/10. A Consultant and the Operational Manager for the ED, Portsmouth Hospitals Trust explained that it was difficult to ensure staff complete the PAT, due to their heavy workload.

4.12 The use of PAT within ED was replaced with an alcohol scratch card, containing a short version of the Alcohol Use Disorders Identification Test (AUDIT) screening tool during Alcohol Awareness Week 18-25 October 2010. All patients are given a scratch card on arrival and asked to hand it in completed to the clinician for advice. The Substance Misuse Coordinator explained that implementation has been slow to date and referrals low.

4.13 A version of the PAT will be introduced to the inpatient wards within QAH in spring 2011. The alcohol questions will be added to the VitalPac IT system. This will allow clinicians to quickly screen patients using a handheld device as noted in section 7.84.

Assault Data Collection

The Public Health Group South East, the Department of Health.

Assault Data Collection

4.14 The report entitled Effective NHS Contributions to Violence Prevention – The Cardiff model by Cardiff University published in October 2007 recognises how important it is for EDs to pass on details of assaults (location, weapon and incident type) to Community Safety Partnerships. This enables the police to target resources effectively and to ultimately reduce alcohol-fuelled violence. A model pioneered in Cardiff reduced ED violence related attendances by 40% between 2002 and 2006. Six EDs have fully implemented the College of Emergency Medicine Guidelines with Community Safety Partnership (CSP) Engagement.[30]

4.15 The College of Emergency Medicine Clinical Effectiveness Committee recommends that in order to reduce community violence EDs should routinely collect data about assault victims at registration and produced guidelines for this process. It states that only three additional items are required: incident type, assault type and location. This data should be shared with the local Crime and Disorder Reduction Partnership (CDRP) and crime analysts in an anonymous and aggregate form. It also recommends that a senior physician should attend the Community Safety Partnership meetings[31].

30. Development Manager, Dept of Health, South East.
31. Information Sharing to Reduce Community Violence in EDs guidelines - September 2009 (Revised May 2010)

The Public Health Group South East, the Department of Health

4.16 At the ED in QAH an assault data collection scheme was introduced in 2007 whereby patients who have been assaulted are asked where the assault took place, the time and the number of assailants. This anonymous data is then collated and sent to the Safer Portsmouth Partnership in order that police and council resources can be targeted appropriately. However, an average of only 20-30 patients a month have been interviewed, which is surprisingly low as Southampton General Hospital records over 100 a month. The numbers have increased slightly since August 2010 (60-70 per month). The police feel hampered by this lack of data as it is needed to gather evidence to enforce licensing arrangements more effectively, target limited resources where they are needed most and calculate trend analysis. The Consultant Hepatologist was appointed as Senior Champion for Alcohol in October 2010 and along with the Medical Director will attend the Alcohol Steering Group, which monitors the delivery of the alcohol strategy. There is also a committee which oversees the work of the Alcohol Liaison Nursing Service.

4.17 The Substance Misuse Coordinator informed the Panel that although the ambulance and police services have the facilities in place to record whether alcohol is a contributing factor in incidents that they attend, this is not currently happening. For instance when recording violent crime incidents, the alcohol section was only completed in 50% of cases by the police. The ambulance

service has been asked for data relating to calls to licensed premises, but this has not been provided regularly.

ED Abuse to staff

4.18 Many drunken patients are abusive to staff, particularly receptionists and nurses; dealing with them diverts resources away from other patients' needs. Most patients when informed of their behaviour when they are sober are unrepentant. The introduction of security staff in the ED at QAH from 2001 on a daily basis 9pm to 5am reduced the number of abusive incidents. The Contractor Manager explained that as this was instigated so long ago, and prior to Carillion running the service, he was unable to provide any statistics which might indicate any reduction in incidents.

4.19 The Substance Misuse Coordinator suggested that all patients who were admitted with alcohol-related conditions be sent a letter after discharge informing them of the cost of their treatment. Every Monday an administrator would go through the admission details over the weekend and write to those patients whose condition was obviously alcohol-related and self-inflicted e.g. alcohol poisoning rather than victims of drunken assaults. A template letter could be used covering a) the approximate cost of their visit, £100 – attendance only; £400 – transportation by ambulance and treatment or £1,800 – overnight admission, b) information on sensible drinking and c) where to get help if they are concerned about their drinking.

4.20 During their visit to the ED at QAH from 10pm to 1am on 6 August 2010, members of the Panel witnessed an abusive drunk man with a head injury be warned that if his behaviour did not improve, he would be escorted from the premises. Later another abusive patient was removed from the premises because of unacceptable behaviour. An ED Consultant at QAH informed the Panel that it would not be practical for the hospital to introduce fines or any other form of punishment for alcohol-related conditions or abusive drunk patients.

To evaluate the impact alcohol abuse has on Portsmouth City Council Services.

5

5.1 It is difficult to evaluate the full impact that alcohol has on Council services as most are affected either directly or indirectly. The Substance Misuse Coordinator for Portsmouth recommended that dealing with alcohol abuse be a core part of all service plans.

Community Housing and Regeneration.

5.2 Most of the Supporting People housing support services funded by the council deal with service users with alcohol problems. Services are preventative and help reduce the likelihood of relapse, eviction from home and other consequences, including hospital admissions due to accidents, assaults etc. As the service is not specifically set up to deal with alcohol issues, staff rely on advice and policy from the Safer Portsmouth Partnership and other treatment organisations.

5.3 The services have some link with the alcohol abuse agenda, perhaps through work commissioned via their provider network which engages some community members recovering from alcohol and other substance abuse. ANA, Two Saints and Cranstoun (drug and alcohol treatment services) have all received training via the provider network in respect of this.

5.4 The manager of Supporting People informed the Panel that there is evidence that housing support reduces use and abuse of not only alcohol but also other harmful dependencies (drugs, smoking etc).

5.5 A number of the teams working with such issues use housing support as part of the therapy and intervention programmes they deliver but there is no joined-up approach to how this takes place, links up, is funded or sustained beyond short term programmes. (Section 7.88 gives details of funding for beds for detoxification treatments).

Cultural Services

5.6 The Head of Culture informed the Panel that their service's involvement is mainly in two areas: prevention – providing alcohol education and raising awareness; and enforcement – in tackling the impact of alcohol-related crime and anti social behaviour.

5.7 Libraries play an essential role in the prevention of alcohol abuse. The Schools' Library Service and the Public Library's book loan collections include material on alcoholism as a social issue and dealing with alcohol-related problems within the family or as an issue for the individual. The Public Library also has many leaflets and information which signpost people to support services. Alcohol-related incidents and disruption by members of the public are an issue to be managed. This specifically relates to the People's Network and the fact that libraries are a warm place of shelter which can be accessed freely. There are no specific policies. Individuals would be dealt with under policies related to abusive behaviour and inappropriate use of the People's Network. The percentage of staff time spent on dealing with alcohol abuse is very difficult to assess as these are ad hoc situations but the number of incidents do not appear to be increasing.

5.8 The Parks and Open Spaces and the Sports Development services promote healthy lifestyles. Alcohol abuse can be relevant for general nuisance, criminal damage and noise complaints in Parks and Open Spaces. However, it is often difficult to determine whether alcohol is a factor in these offences. There are between 4,100 and 4,500 incidents of alcohol litter dealt with by the contractors each year (each incident could be one bottle or hundreds). These incidents are slightly on the decrease but there are so many

caveats with this measure that no firm conclusions can be made. The whole of Portsmouth has had a Designated Public Place Order (DPPO) in place since 2005. There is no alcohol ban in any particular park. The DPPO means that people have the right to enjoy alcohol but if they start causing a public nuisance, the police can seize alcohol and if warnings are unheeded fines could be issued. The percentage of time dealt with this is minimal; contractors deal with the incidents of litter and the Community Wardens deal with incidents in Parks and Open Spaces.

5.9 In the Seafront Management area, Cultural Services involvement is mainly regarding enforcement. It is often difficult to determine whether alcohol is a factor in anti-social behaviour, vandalism and other criminal offences.

5.10 The Museum and Records Service has a licence to sell alcohol for special events such as wedding receptions at Southsea Castle. This is managed by outside caterers who are responsible for complying with the law relating to the sale of alcohol. The theme of alcohol abuse is touched upon in museum interpretation of images or historic events especially for stories by Dickens, the Press Gang etc but nothing is specifically targeted at raising awareness or educating residents or visitors on alcohol misuse in the Museums Records and Archives.

5.11 Staff in the Tourism Visitor Services and Events Service are aware of the issues with alcohol in the city and the negative impact that it can have on residents and the visitor experience. They promote areas to visitors that are safe and enjoyable. The manager is part of the Evening and Late Night Economy Partnership board.

5.12 The events application process highlights alcohol-related risk as part of the general risk assessment. A New Premises Licence was secured for specific Portsmouth Open Spaces as part of response to new legislation introduced in 2003. This general licence does not include the sale of alcohol. If event organisers wish alcohol to be part of the event they apply for a New Premises Licences if the event will attract over 499 people; or if the event will attract fewer, if appropriate, it is possible to apply for a Temporary Event Notice. However, along with a licence approval, the overall event still has to be approved through the Event Management process to check the risks involved with alcohol are managed to ensure it is an enjoyable and safe event for residents and visitors.

5.13 The percentage of time dealt with alcohol-related issues is difficult to asses as many of the functions are an integral part of the work such as the events application process. The management of the impact of alcohol in the city for the team is increasing both within the team and in liaison with partners. This may be because they are more aware of the issues through their extensive events experience.

Personal, Social, Health and Economic (PSHE)

5.14 The PSHE Advisor explained that at present alcohol education is incorporated into Drug and Alcohol Education which is in turn included within planned programmes of PSHE delivered by teachers with contributions from a range of external services and agencies. However it is not mandatory.

5.15 Ninety four percent of schools that have achieved National Healthy Schools Status have confirmed that they have a drug and alcohol policy

that also includes processes for dealing with related incidents.

5.16 Opportunities for staff to engage in Professional Development Learning in drug and alcohol education have been limited by the need for all schools to prioritise teaching and learning in the statutory curriculum. As far as drug and alcohol education is concerned there are parts of the national curriculum for science which are statutory; however these are largely related to factual information. Research regarding the effectiveness of drugs education strongly suggests that facts on their own have a limited effect on young people's health related behaviour. The Health Improvement & Development Service (HIDS) is now developing Alcohol Champions in schools and six secondary schools have shown an interest to date.

5.17 The National Curriculum for Science requires that in Key Stage One, in the section 'Life processes and living things' pupils be taught about the role of drugs as medicines. In Key Stage Two the requirement in the section life processes and living things is that pupils be taught 'about the effects on the human body of tobacco, alcohol and other drugs, and how these relate to their personal health.

5.18 The majority of primary schools augment this requirement at both Key Stage One and Two by teaching a programme of non-statutory PSHE education to further engage young people in developing the knowledge, skills and competencies to begin to make informed decisions to protect their health and well being. This would include the building of self-worth and confidence, social bridging and bonding skills, and the competence to resist negative peer influence.

5.19 At Key Stage One for example in PSHE pupils are likely to explore such issues as: what goes in my body, what goes on in my body, what decisions as a child can I make myself, what decisions can I make with a trusted adult's help and what decisions should I leave entirely to an adult. This would usually lead to exploring adult roles, trust and even the law. Many Key Stage One children would recognise that alcohol and drugs would have a place in this exploration and a skilful teacher would be able to work with the knowledge level of individual groups to reinforce positive messages emerging from groups and to deal with misinformation should it arise. These active teaching processes also allow teachers to become aware of particular attitudes and misinformation that might indicate particular vulnerabilities in individual pupils which could then be further explored or could even lead to a referral to a more specialist service should the need arise.

5.20 The issue nationally and locally is not to introduce new parts to the curriculum but to support what is currently in place and to encourage all schools to work together to establish as far as possible consistency and progression in the delivery of both the statutory and non-statutory elements of this work.

The Schools Champion

5.21 The School Champion service was introduced in September 2010 and supports schools current PSHE input around substance misuse. It will be involved in policy development and signposting young people to the available supporting agencies (i.e. education project workers for substance misuse and carers support workers).

5.22 The service focuses on the needs of all school pupils but will focus primarily on those more vulnerable including looked after children, young carers

and those with substance misusing parents.

5.23 The service is considering a dedicated worker in each of the city's secondary schools with the option of extending this role into primary schools and colleges once established or where a need has been highlighted.

5.24 A 'wasted voices' booklet was produced by a working group comprising Health Improvement and Development Service, PUSH, Police Liaison Officers, Healthy Schools Co-ordinator, Adolescent Health Programme and Children, Families and Learning in response to the feedback received from a young people's consultation event hosted at Admiral Lord Nelson School that included representation from schools and pupil referral units from across the city. It highlighted locally many of the gaps felt by young people around this agenda; this is also supported by 'Tell Us' data. The project aims to build capacity in schools by providing training and support for an allocated worker to develop school programmes around the substance misuse agenda and to be the point of contact both internally and externally in the support of individual young people's needs.

Human Resources

5.25 There is a Substance Misuse Policy and Violence at Work Policy for Council employees. (Details can be found at section 6.8). The latter is currently being reviewed. In the last three years the Occupational Health service has received no referrals specifically related to alcohol and no alcohol-related incidents have been reported to the Health and Safety Team.

Financial Services

5.26 The Financial Assessments and Benefits Team and the Bailiffs Team may come into contact with clients under the influence of alcohol but the manager reports that there is no cause for concern. Financial Services provides financial support to those services who deal with alcohol-related problems directly.

Adult Social Care

5.27 The Head of Adult Social Care explained that it is very difficult to quantify the amount of staff time taken up with assisting clients with substance abuse issues. Most are reluctant to ask for or to accept assistance which makes referrals difficult. Although only approximately 10% of referrals are related to alcohol issues, these take up more than 10% of staff time. The work involves meeting with clients, discussions with other professionals, in and outside of the county, recording etc. Staff also refer clients to the Alcohol Intervention Team. Most clients only need housing and advice or support from the substance misuse team.

5.28 There is an integrated service with health for drug and alcohol users. Council social workers are part of this service. Staffing, funding for care management and rehabilitation costs approximately £168,000 for both alcohol and substance abuse.

5.29 Adult Social Care provides £40,000 for Portsmouth Counselling Service and approximately £40,000 for the project run by Cranstoun Drug Services that offers advice and treatment.

Local Authority Housing

5.30 The Housing Service reports that it has no specific policies related to alcohol abuse as it is not a particularly significant problem. In the majority of cases it is one of a range of factors contributing to poor decisions.

Traffic and Transportation

5.31 The Road Safety and Sustainable Travel Team manager informed the Panel that it manages drink drive campaigns. According to the Reported Road Casualties Great Britain: 2008 Annual Report, a fatality has an economic cost of approximately £1.4 million. In 2010 the service spent approximately £300 on t-shirts, advertising and other promotional items such as an interactive measure guidance wheel in order to raise awareness of the dangers of drink-driving. The advert on the mobile display vehicle is covered under the current licence. Over previous years, drink-driving campaigns cost between approximately £1,500 and £5,000 depending on the media used. Free media such as Twitter and Facebook will be used in future. Two key campaigns are run annually, one in the summer months and one over Christmas and the New Year. This usually takes two members of staff between five and ten days to run and up to 20 hours of planning.

Customer, Community and Democratic Services

5.32 The Head of Service informed the Panel that the impact of alcohol abuse is largely secondary e.g. dealing with reports about anti-social behaviour, crime and litter which might be caused by alcohol abuse. The Communications team works closely with the Safer Portsmouth Partnership on campaigns including some on alcohol awareness.

Asset Management Service

5.33 This service is involved in the prevention and repair of damage caused through vandalism of which a proportion is due to alcohol abuse. It is not possible to identify the cost of dealing with vandalism due to alcohol abuse.

Trading Standards

Under age sales and proxy sales

5.34 The core aims of the best practice training is offered to all off sales premises are to:

- Increase key areas of staff knowledge
- Reduce sales to minors, particularly in the areas of alcohol and tobacco
- Reduce sales to drunks
- Reduce anti-social behaviour

5.35 The alcohol training programme has been developed by Portsmouth City Council Trading Standards Officers and has been endorsed by the Department of Health Smoke Free South East. The training covers all age restricted goods with a special emphasis being placed on alcohol and tobacco sales. Training is given to businesses or individuals that have expressed a desire or shown a need to increase their knowledge within the workplace to avoid illegal sales. Key triggers for this are:

- New alcohol license applications and variations
- Officer compliance visits
- Test purchase failures
- Responses to marketing
- Requests for guidance and advice from businesses
- Changes in legislation

5.36 Candidates take a test at the end of the training under strict exam conditions and if successful receive a certificate from Trading Standards demonstrating their competency.

Underage sales and proxy sales - Best Practice Guide and Toolkit

5.37 The syllabus used to deliver the best practice training is available as a stand alone best practice and due diligence toolkit. The toolkit enables retailer managers to deliver their own in house training at a

low cost whilst ensuring their own knowledge is maintained on a year to year basis as legislative updates are provided. The product can be obtained when facilitated training takes place or ordered directly as a result of marketing. The core aims are to:

- Increase key areas of staff knowledge
- Reduce sales to minors, particularly in the areas of alcohol and tobacco
- Reduce sales to drunks
- Reduce antisocial behaviour
- Provide a low cost training and due diligence solution

Award in Responsible Alcohol Retailing (ARAR) (on licence)

5.38 The ARAR meets an industry wide need to demonstrate commitment to responsible alcohol retailing in pubs and clubs. This national award is designed to train those responsible for the sale of alcohol the key points of the licensing Act such as public and staff safety, protecting children from harm, as well as reducing drunkenness and crime. Portsmouth City Council Trading Standards service is the only local authority in the country accredited by the British Institute of Inn keeping (BIIAB) to deliver this nationally recognised qualification.

Alcohol Awareness Award (AAA)

5.39 The AAA has been developed by the BIIAB in response to a government initiative to raise awareness of issues linked to alcohol consumption by young people aged 13-16 and young adults.

5.40 Portsmouth trading standards service is currently the only local authority service accredited to deliver the service which involves 10 hours structured training to each pupil. The cost of the training is paid by local retailers wishing to sponsor a child and become part of a city wide solution whilst demonstrating they care about their community. £1,500 has been donated already which will fund 30 local children. Key aims of the award are to understand:

- The nature of alcohol strengths and different drinks
- How alcohol effects the body and the dangers of drinking too much
- The effects of binge drinking and alcoholism
- The risks of irresponsible drinking and sexual health
- The dangers of drink / drug driving, basic licensing law and offences
- Drugs and offensive weapons on licensed premises
- How the industry promotes sensible drinking and its value to the economy

National Certificate for Personal Licence Holders (NCPLH)

5.41 All licensed premises require at least one individual to hold a personal licence The NCPLH covers the syllabus set by government to enable candidates to understand the law in relation to:

- The roles, responsibilities and functions of licensing authorities within the framework of the licensing objectives
- The application process for a personal licence
- The role and legal responsibilities of the personal licence holder, and the penalties relating to failure to comply with the law
- The premises licence
- The content and purpose of operating schedules
- The role and duties of the designated premises supervisor

- Unauthorised and temporary licensable activities
- Rights of entry to licensed premises
- Police powers with regard to suspension and closure of licensed premises
- The specific prohibitions for the sale of alcohol
- The strengths of alcoholic drinks, and the effects of alcohol on the human body
- The protection of children from harm
- The responsible retail sale of alcohol.

Test purchase operations

5.42 Trading Standards run regular intelligence test purchase operations to assess the impact of their work, check premises due diligence and follow up leads from partners and members of the public. Since the introduction of its training programme the city test purchase failure rate has fallen from 34% to just 2.8%, currently one of the lowest in the country. (Approximately 100 premises are tested per year).

Licensing

5.43 Trading standards actively challenge all new license applications and variations if they do not demonstrate the required levels of due diligence and training. It takes a proactive stance to instigating licensing committee hearings and has had a number of reviews successfully upheld.

Enforcement

5.44 As a responsible authority trading standards have substantial powers under the Licensing Act 2003 to instigate closures, hearings and prosecutions if advice and training fails to achieve compliance in the first instance.

Proxywatch

5.45 Trading Standards maintain the Proxywatch intelligence hot lines and advises shops in accordance with intelligence received. Resources permitting, operations are conducted with the police to deal with adults who actively purchase and supply children with alcohol. Typically this occurs when members of the public are approached outside of licensed premises. Of the 200 plus member stores committed to the scheme 77% stated they had a reduction in anti-social behaviour since joining and 58% stated they had noticed a reduction in youths outside their shop approaching adults.

5.46 Members of the Panel accompanied Trading Standards Officers in a tour of the city in November to learn more about the work carried out including:

- Close working with the police
- Offering training to bars
- Running a 'we serve drinks not drunks' campaign.
- Researching fake ID.
- Adding conditions to a license to sell alcohol.
- Developing action plans on a number of issues.
- Collecting evidence on premises that are breaking their licence conditions for the licensing committee.
- Engaging with shops, bars and other venues to train staff.
- Carrying out test purchases.
- Investigating reports of alcohol being sold from unlicensed premises.
- Working with the Licensing Manager on a statement of licensing policy.

5.47 The effectiveness of their work across the city was evidenced by dispersal areas being removed in one area; a reduction in the number of test purchases and a very good take-up of training.

5.48 Trading Standards is working with the Licensing Manager on a statement of licensing policy and there is an expectation that premises will receive training on this. Trading Standards is also examining at

"cumulative impact districts" to limit the amount of off-licences and shops in certain areas, similar to the restrictions on Houses of Multiple Occupation in certain areas.

5.49 For smaller retailers, the service produces a booklet "Preventing Under Age Sales"; they tend to have less training and are not always aware of updates in licensing policy (though with bigger retailers training can be more about protecting their business). Smaller premises sometimes break the law to survive commercially.

5.50 Young people sometimes steal alcohol from their parents. Alcohol-related litter is often collected by Trading Standards to identify the areas with the biggest problem.

Health Improvement & Development Service (HIDS)

5.51 The Council's Health Improvement & Development Service provides school health education officers and an Alcohol Project Worker.

Licensing and Planning

5.52 The council's Licensing Policy Statement was agreed by Full Council on 14 December 2010. The Licensing Manager and the Assistant Head of Planning Services informed the Panel that although they have distinct licensing regimes the two services work closely together particularly with regard to possible breaches of conditions.

5.53 Applications for a new premises or a change of use are made to the Planning Committee and licence applications are made to the Licensing Committee. Conditions can be placed on planning applications regarding use, hours of operation etc. It is not possible to impose a planning condition prohibiting a bar area or limiting the consumption of alcohol to customers who are dining. The Planning Committee will only consider local residents' amenities. Licensing conditions must have a direct correlation with one of the four licensing objectives.

If a breach of use or condition is suspected, the planning service will collect evidence to establish that this has occurred.

5.54 The planning authority, the police and Environmental Health are responsible authorities and therefore can object to a licensing application. People who cause a nuisance on their way home are dealt with under other controls. The potential to cause a public nuisance could be considered a material consideration for the Planning Committee when considering an application. However, in areas that already have many licensed premises it would be impossible to prove that that one premises would cause a problem.

5.55 A client could appeal to the licensing service to obtain an extension on the operating hours that were put in place by the planning department. However the licensing department would be informed when the application is received and would have the opportunity to object.

5.56 Members of the public are entitled to make deputations to both the planning and the licensing committees regarding licensing applications subject to certain restrictions.

5.57 The council's adopted policy is to encourage licensed premises in the Guildhall Walk area. However, the licensing committee has the authority to deviate from this if other considerations are greater.

5.58 Since April 2010 local authorities can impose mandatory conditions on alcohol licenses e.g. prohibiting irresponsible drinks promotions. There are no strict criteria; this allows the local authority some flexibility on how this could be defined.

To understand the causes and impact of alcohol abuse on different sections of society.

6

Causes

6.1 Genetic, biological, environmental, psychological, and sociocultural factors play a part in alcohol abuse.

6.2 Age is an important demographic characteristic that influences alcohol consumption. There is overwhelming evidence to suggest early initiation to alcohol could lead to higher alcohol use later in life[32]. Parental alcohol use, parental monitoring, poor parent-child relationships and family conflict also influence a child's alcohol use[33]. Children of parents with alcohol problems are at increased risk of developing emotional and psychological problems and are more likely to display anti-social behaviour and to under-achieve at school[34].

6.3 Easy access to alcohol through long opening hours of pubs and supermarkets coupled with cheaper alcohol prices are influencing alcohol use in the UK. (Details on the correlation between alcohol availability and affordability and levels of alcohol consumption can be found in section 3.16 and 3.49.9).

6.4 The various individual factors that the focus groups in the Joint Strategic Needs Assessment identified as associated with the risk of experiencing alcohol misuse in Portsmouth were: age; gender and ethnicity. Research has indicated that men in their 30s make up over 60% of alcohol-related hospital admissions. This research resulted in the launch of the Save Dave campaign specifically targeted at this demographic. (Section 8.5-8.6 has more details).

6.5 The psychological attributes identified include mental health problems, lack of aspiration, boredom, loneliness and stress.

Sections of society affected

The Economy

6.6 The heaviest drinkers, and thus those with the greatest likelihood of experiencing alcohol problems, tend to be concentrated in those of working age. The Strategy Unit Alcohol Harm Reduction project, Interim Analytical Report for the National Alcohol Harm Reduction Strategy 2003 states that drinking can reduce the productivity of the UK economy in a number of ways. This occurs through:

a. Increased sickness absence: drinking 7+ (for women) or 14+ (for men) units per week raises the likelihood of absence from work through injury by 20%. This equates to approximately 17 million working days annually.

b. The inability to work (unemployment and early retirement)

c. Premature deaths among economically active people (people of working age).

Combined, these three factors account for a total alcohol-related output loss to the UK economy of up to £6.4bn annually.

6.7 One measure of the impact of ill-health on the workforce is the proportion of those of working age who are incapacitated and receiving welfare benefits. In May 2005, approximately 4,400 (1.8%) of the 239,100 people in the South East claiming incapacity benefit or severe disablement allowance had a diagnosis of alcoholism (although it is important to note that the diagnosis used is narrow and will not capture all those incapacitated in part by their drinking). This figure is significantly above the national average and is the fourth highest of the nine regions in England[35].

6.8 Portsmouth City Council's staff code of conduct permits alcohol consumption during the working day provided it does not affect performance. During this review a member of staff requested that the Panel consider recommending banning alcohol consumption

32. Joint Strategic Needs Assessment.
33. www.oxfordjournals.org
34. Strategy Unit 2003.
35. Alcohol Concern 2006 (citing Office of Population Censuses and Surveys, 1995. Occupational Health Decennial Supplement).

36. Joint Strategic Needs Assessment.
37. www.nwph.net/alcohol/lape
38. Strategy Unit 2003.
39. Gilchrest et al 2003.
40. Portsmouth Alcohol Strategy 2009-2013.

during the working day. The Substance Misuse Coordinator for Portsmouth agreed. He informed the Panel that the Safer Portsmouth Partnership had recommended that all partners review their policies following a recommendation from the National Support Team (Section 8.40 (12) has further details). The Chief Executive of Portsmouth City Council has indicated that the Council's policy would be reviewed.

6.9 In a government consultation document on transforming the welfare state entitled 21st Century Welfare published in July 2010, the Secretary of State for Work and Pensions states that alcohol addiction is one of the root causes of poverty.

Crime

6.10 The impact of alcohol on crime is well established[36]. The Local Alcohol Profiles for England (LAPE) published in September 2010 show that for alcohol attributable recorded crimes Portsmouth is ranked 127th out of 152 local primary care trust areas[37]. A rank of 1 is the best local authority and 152 is the worst.

6.11 The distribution of alcohol-related hospital admissions in the South East is strongly linked to deprivation levels. According to the Choosing Health in the South East: Alcohol 2007 report by the South East Public Health Authority disorderly behaviour in public places is often related to alcohol. The number of Penalty Notices for Disorder (PNDs) issued varies between police authorities. The rate issued for alcohol-related offences in the South East is higher than the national average. It also noted that alcohol is a contributory factor in 5% of road accidents and 17% of road deaths. Research has suggested that two thirds of male and one third of female prisoners have a problem with alcohol. Offenders are likely to have a range of problems which exacerbate their alcohol use. Alcohol misuse plays a significant role in re-offending[38]. Home Office research on domestic violence offenders has shown that nearly three quarters had consumed alcohol prior to the offence[39].

6.12 The Safer Portsmouth Partnership's Strategic Assessment for 2008 reported that 71% of Probation clients (425 out of 598) had some sort of alcohol problems identified during their assessment. This highlights a significant correlation between alcohol and offending, but also highlights that this group are also more likely to suffer from alcohol-related health problems.

6.13 In 2009 Hampshire Constabulary undertook a snap shot analysis of violent crime during a typical spring week in Portsmouth. The survey found that 143 occurrences of rowdy and inconsiderate behaviour were reported, along with 119 assaults. 22% of the violent offences were linked to licensed premises, 37% took place in a private place/ dwelling and 41% in other public places. Further analysis of these violent crimes suggested alcohol played a part in 61% of these offences[40].

6.14 During the review, a member of the public informed the Panel that he felt that older people are effectively house bound at night due to the drinking culture that exists within the city, particularly in the Guildhall Walk area. Additionally a Southsea resident contacted the Panel to express his concerns regarding alcohol abuse and subsequent anti-social behaviour in his neighbourhood. He felt that this was due to lack of employment and positive role models.

6.15 Panel members visited the Portsmouth CCTV Control Room on two occasions in July 2010 from 22:30-01:30 in order to understand the impact that alcohol has on the control room operators' work and their liaison with other agencies to

tackle alcohol-related antisocial behaviour. During these visits, concern was expressed regarding poor lighting in Guildhall Walk, foliage blocking the view of the cameras in some areas and thereby impairing their effectiveness. Members were impressed with the close working with the police and pleased to note that a number of problems are prevented thanks to the CCTV control room operators.

6.16 The Panel also noted that the cameras in Guildhall Walk did not provide full coverage of that area. The CCTV Control Room Manager informed members that a survey had been conducted in December 2009 with a view to installing a new camera that would increase coverage. However, this year's CCTV control room budget was reduced by £50,000 and this camera installation appears to have been put on hold.

6.17 The figures for incidents recorded by CCTV in 2009 are as follows: 354 arrests activated and recorded by CCTV; 520 arrests were activated by others and recorded by CCTV; 64 incidents of drunkenness were activated and recorded by CCTV. A total of 1,330 offences were activated and recorded by CCTV control operators. The police used the CCTV control room on 36 occasions.

6.18 A floodlight experiment was conducted in Guildhall Walk on 4 April 2010. This appeared to work very well as it allowed the CCTV control room to more effectively monitor this area. However, there was anecdotal evidence from licensees that the bright lights encouraged people to stay in the areas, not disperse as had been hoped. On 7 July 2010 the Cabinet Member for Community Safety approved additional expenditure to permanently enhance the lighting in and around Guildhall Walk. This work was completed on 22 November 2010.

6.19 Over two evenings in June 2010, Panel members accompanied police officers on the beat in the Guildhall Walk area and observed that a high number of police resources are deployed to focus on dealing with this area. Using the Civic Offices for police briefings at the start of a shift was deemed a good use of council resources. Members raised concerns regarding poor lighting in and around Guildhall Walk and Guildhall Square between 11pm and 4am as this the time when there are the most people in that area. They also noted the apparent inconsistent methods for dealing with inebriated customers used by door staff and reported foliage blocking the views of a CCTV camera. The Chair of the Panel contacted Colas and arranged for the tree to be pruned.

Mental Health

6.20 Alcohol is often consumed to aid relaxation and sociability, but many people drink in order to cope with feelings of stress, anxiety and depression. Individuals with high levels of alcohol consumption are particularly susceptible to mental health problems[41].

6.21 The association between deliberate self-harm and problem drinking is well established. It is estimated that between 16 to 41% of suicides are attributable to alcohol and as many as 70% of men consume alcohol before killing themselves[42].

Ethnic groups

6.22 Contrary to the pattern for many other conditions, people from white ethnic groups have higher alcohol-related morbidity (reflecting higher levels of alcohol consumption) than those from black and minority groups[43].

41. Dr Deborah Cornah, 2006.
42. Strategy Unit, 2003
43. Department of Health 2004.

To understand the treatment services available and the referral systems

7

Signposting

7.1 A centre named Safe Space was opened on 27 August 2010 in the Mountbatten Gallery in the Guildhall Square and is open every Friday and Saturday from 10pm until 3am. A paramedic treats minor injuries and the Portsmouth Street Pastors bring vulnerable people there from Guildhall Walk. The Pastors talk with them, signpost those with alcohol issues to the appropriate service at a later date and keeps them safe until a friend or family member collects them. The paramedic also checks on people in the local police station cells (Details can be found in section 7.107). The aim of this service is to reduce the number of unnecessary hospital attendances for minor injuries. It is initially a six month pilot. Funding is in place longer term if it is deemed successful by NHS Portsmouth. Pubwatch stated that it is widely felt that the launch of the new 'Safe Space' centre in Guildhall Square is an extremely good idea and has proved to be effective from the outset. The hospital has expressed concerns that symptoms of serious injuries or conditions might be hidden by drunkenness.

7.2 Treatment services are classified into tiers 1-4:

7.3 Tier one alcohol services are provided by a range of non-specialist agency staff who have generally received training in alcohol awareness, screening and referral for substance abuse problems and brief interventions. The Joint Strategic Needs Assessment concluded that this is "the most crucial component in the alcohol misuse "identification prevention- treatment" chain. Developing a proper structure to Tier one with responsibilities and accountability is required."

7.4 The Development Manager, Public Health Group South East, Department of Health stated that those drinking at increasing risk or higher risk tend to respond best to Identification & Brief Assessments (IBAs). It is essential that the information given at tier 1 stage is correct because if a person does not receive the right advice when they ask for it, they will not request it again.

7.5 **Tier two interventions** comprise alcohol specialist information and advice, screening, assessment, referral to structured alcohol treatment, brief psychosocial interventions, harm reduction interventions and aftercare. These are mainly provided by the Alcohol Intervention Team (AIT) and Cranstoun Drug Services.

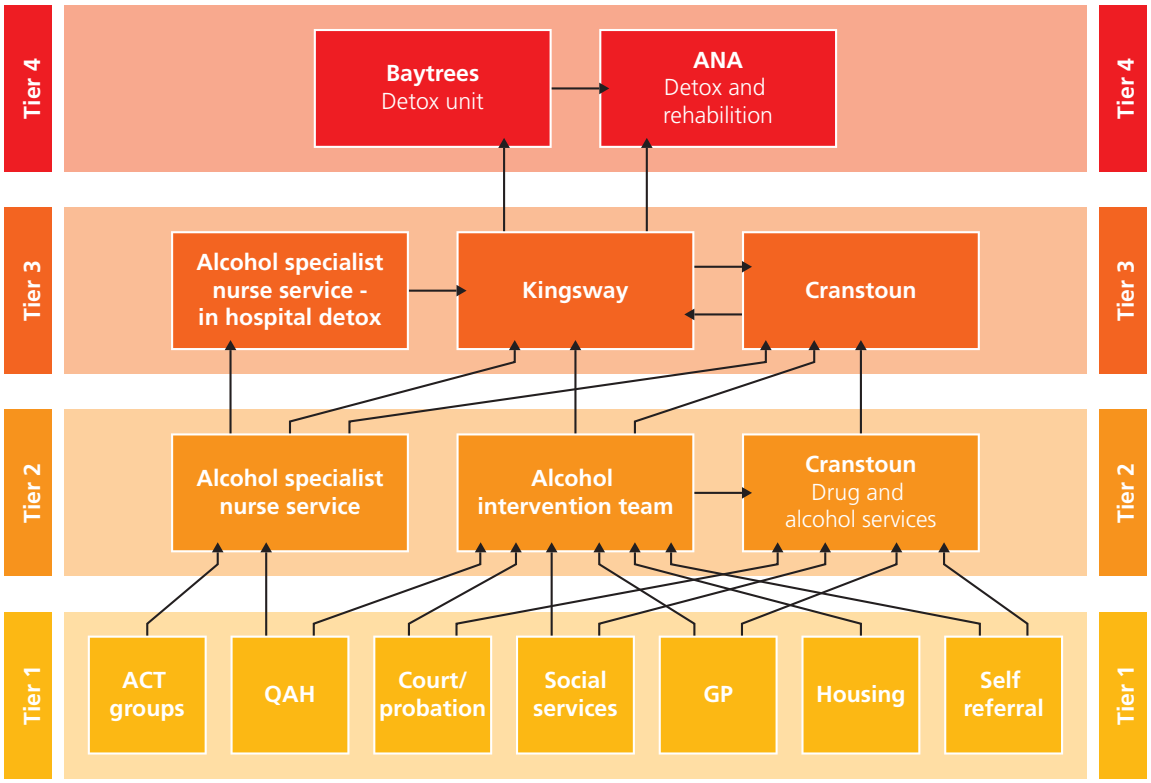
7.6 **Tier three interventions** comprise community-based specialised alcohol assessment and coordinated care-planned treatment. Referrals are through tier two services. The community based integrated Health and Social Care team provides a localised substance misuse service for people who are experiencing problems around drugs and alcohol, enabling them to make informed choices. Kingsway House in Southsea is the base for this service. (Details are shown in section 7.37-54).

7.7 **Tier four interventions** comprise residential specialised alcohol treatment which is care planned and care co-ordinated to ensure continuity of care and aftercare. Baytrees Detoxification Unit is a tier four services and details of this service can be found at section 7.55.

Tier one services

7.8 Mill House provides temporary accommodation for homeless people and is operated by Two Saints Housing Association. The maximum length of stay is two years but 80% of residents leave after three months. It has 47 bedrooms and many bathrooms and shower rooms. It is a 'wet house', which means that alcohol

Treatment Pathways



is permitted on the premises. It accommodates clients who take substances and have related abuse issues and directs them to the appropriate service for assistance. For residents who have an alcohol problem it is the main reason that they are homeless. Currently the percentage of residents at Mill House with an alcohol abuse or dependency problem is 42%.

7.9 A consultant psychiatrist used to make weekly visits, which proved very useful for early identification of mental health issues. There are no plans to recommence this service at Mill House, due to a lack of resources and the same applies for a Community Psychiatric Nurse. Mental health assessments are now made through the GP, which is proving to be a much slower process.

7.10 A Night Outreach service was piloted between October and March 2010. £15,000 was provided by Portsmouth City Council for a worker to collect homeless people from the streets between 18:00 and 02:00. Six people were collected on a first come, first served basis and given overnight accommodation on put up beds in the hostel's lounge area, access to showers, a change of clothes and a meal. The next morning they were given breakfast and then referred to a day centre for access to advice and support. A local supermarket provided food for this project. During the severe weather, when the temperature dropped to below freezing this service was extended to everyone that needed it. 116 individuals have been helped on this scheme and 40 no longer live on the streets. The Night Outreach service has been included within the accepted proposals which Two Saints put forward for the restructure of support at Mill House from 1/12/10 to 31/3/11. The details are currently being finalised but is expected to be eight beds rather than six. Two Saints have proposed that it will still be included from 1/4/11 to 31/3/12.

7.11 Residents with an alcohol problem are referred to treatment services

including Cranstoun and Kingsway House. Staff from Cranstoun hold a weekly surgery at Mill House and see on average four people a week. The take up can vary but it is estimated that approximately 50% of those referred stay with the service for a while. If a resident obtains a place on a detoxification programme, it is essential that there is somewhere stable and dry for them to go to afterwards. There are 20 move-on rooms available; these are located in Locksway Road, Foster Road and Yew House and a few other smaller houses. Locksway Road is a purpose built centre that caters for 18 people where they can learn intensive life skills. Foster Road is suitable for those with drug and or alcohol addictions. There are flats in Paulsgrove which are move-on accommodation from Foster Road. Yew House is suitable for those with mental health problems. Most of the beds are funded by Supporting People. The flats in Paulsgrove are funded by the Safer Portsmouth Partnership.

7.12 The Manager of Mill House informed the Panel that many people who have completed a detoxification programme return to Mill House and start drinking again. Mill House staff are part of the Accommodation Pathways Group which works to find dry accommodation for people leaving detoxification programmes. Approximately 12 people a year successfully make it to independent living.

7.13 Originally funding came from several different funding streams, but now the funding comes from the Council's Supporting People Budget, with more coming in from a share of Housing Benefit that contributes to their stay.

Tier two services

7.14 **Portsmouth Alcohol Arrest Referral Service** provides brief interventions and referral to specialist services for clients involved in the criminal justice system. NHS Portsmouth provides ongoing mainstream funding. It is not possible to determine the impact that these have on behaviour as the contact time with prisoners is usually brief.

7.15 **Cranstoun Drug Services (CDS)** provides tier two and three services for people with substance misuse issues. The majority of clients to the tier two service are referred from the Alcohol Intervention Team and GPs and those attending the tier three service are referred from Kingsway House.

Tier two services at CDS

7.16 Members of the Panel visited CDS and learnt that it carries out a needs assessment for each client to determine which services are appropriate and then refers them to the relevant agency. It offers a needle exchange service, outreach, open access and structured day services, education, training and employment service and volunteer coordination, limited support for carers and families and the Frequent Flyer service. The vast majority of clients are self-referrals with the next biggest referral cluster from GPs. The main barriers to engaging with treatment included denial and inappropriateness of current housing. The typical client is between 25 and 55 years old and single.

7.17 CDS offers a drop in service four afternoons a week at Fratton Community Centre. Service users do not need to be drug or alcohol free on the day that they attend. Support, advice, information and education is provided about drug and alcohol issues. It also promotes healthy living by providing weekly sessions of sport and yoga and runs a monthly social activity to give people the experience of having an enjoyable day out without drugs or alcohol.

44. National Alcohol Treatment Monitoring System.

7.18 A structured service is also open for people to attend without an appointment. More emphasis is put on group work, which is aimed at people who have already managed to bring about some change in their use of drugs and alcohol and equips them with the skills they need to make and maintain further changes. These tend to focus on the person rather than the substance, helping them to reach their full potential as an individual no longer defined by their use of drugs or alcohol. The outreach service will see people wherever they want to be seen and will accompany them to further assessment appointments as required. Other areas that do not have outreach services do not have the same number of clients.

7.19 During 2009-10, 570 people were assessed and 42 reassessed. 430 had been referred to Kingsway House. This figure includes both drug and alcohol treatments. During 2009/10 Cranstoun supported 153 alcohol clients[44].

7.20 CDS is funded through the Safer Portsmouth Partnership, Portsmouth City Council and NHS Portsmouth. The current five year funding expires in 2012 when the contract will be put up for retendering. It costs approximately £800,000 per year for drug and alcohol treatment. 57% of clients leaving CDS's structured service are discharged drug and alcohol free. Referral numbers are not recorded. There are poor records of discharged clients' outcomes.

7.21 **Alcohol Interventions Team (AIT)** is a predominantly tier two service which supports people to reduce their level of alcohol consumption using brief interventions. The team has been running since May 2008. During 2009 the service received its one thousandth referral as well as their two hundredth referral from probation. Between 1 April 2009 and 31 March 2010 the team received 663 referrals, which is a significant increase to the previous year and therefore shows a growth in the service and a need for this type of treatment. Contributing factors to this growth include a greater understanding by other agencies of the nature of the AIT as well as the service becoming an established and recognised agency. The team has also increased the work it is doing in primary care and the joint working with other agencies has been extended.

7.22 66% of referrals were male. The main age group referred to the service is between the ages of 19 and 54 but with 24% being between 35 and 44 years. 21% of people referred live within the PO2 postcode area, which covers Buckland, Tipner, Hilsea and North End. The largest proportion of referrals came from GPs (37%). There is anecdotal evidence that a fair number of self-referrals are patients who have been given details of the AIT by a GP and told to contact them directly. The second largest numbers of referrals came from the probation service (25%). 12% of referrals came from the Emergency Department at Queen Alexandra Hospital. AIT aim is to receive 80 referrals a month.

7.23 Of the 242 people referred from GP surgeries 137 (57%) were male and 105 (43%) were female. In September 2009 all GP surgeries in Portsmouth became engaged in actively referring clients into the service. Although some surgeries are more proactive than others, AIT has had a steady stream of referrals coming in with only a slight dip around Christmas. The AIT has continued to add pressure on GPs to refer by regularly attending their practice meetings and raising the awareness of the service by

attending their in-house training and building up relationships with practice managers.

7.24 A client completes an Alcohol Use Disorders Test (AUDIT) when entering the service and again 12 weeks later. The aim of this test is to identify people with hazardous and harmful patterns of alcohol consumption and to provide them with a framework for intervention to reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking.

7.25 The AIT worker follows up with the client after six months. Previously the recording of this had been inconsistent especially around the six month date. This was due to a number of reasons one of which was that workers were not informing the client that they would be contacting them in six months time when they had left the service. They were then contacting patients by post with a RSVP envelope and receiving very few returns. Also the workers were not aware of when this six month audit was due and lost track of the client once the file had been closed. Clients are now informed that they will be contacted when completing the initial paperwork, which has improved the rate of responses. The database now works more efficiently by automatically generating the follow up dates and informing workers when audits are due. A list is generated once a month for the team meeting with the names of clients whose audits are due and name of practitioner who worked with the client and is responsible for contacting them.

7.26 The average final AUDIT score is still above low risk levels, but there is a substantial decrease from the initial screening (22 to 12). The average patient referred to the service could have a possible dependence issue, rather than being a hazardous or harmful drinker and this should be the main focus of the service. The team is considering changing the timescales for the repeat AUDIT to six weeks and then three months.

7.27 Two AIT staff started work at the hospital on 1 July 2009 to raise awareness of the service with the nurses and consultants. They are based within the hospital and initially received many referrals. However as other health initiatives and priorities were introduced in the hospital the momentum slowed down along with the number of referrals. Many referrals are coming from the Medical Assessment Unit, however, referrals are not coming from the rest of the hospital. The Alcohol Specialist Nurse Service launched in December 2010 should assist with this. Section 7.53 has details of this service. The AIT staff are now able to spend more time in the waiting rooms talking to patients and working on self-referrals rather than waiting for the staff to refer them. This is enhanced by literature available and advertising services in waiting areas.

7.28 An AIT information pack is given out to patients on the MAU to patients with an identified alcohol problem. These have been well received by staff and patients. An alcohol awareness booklet is also sent to GP surgeries.

7.29 The AIT continues to deliver alcohol brief advice training to Health Care Support Workers at QA. They have trained approximately 100 staff.

7.30 Practitioners working in hospital settings will wear special AIT promotional t-shirts so that they are more identifiable and more accepted by staff.

7.31 In May 2010 an additional AIT worker was recruited and one of her main priorities is engaging with patients in the waiting rooms. Since 18 October, she hands out

scratch cards and goes through the results with patients as they wait to be seen in order to administer brief intervention to a huge number of patients. She also liaises with the Hepatology Consultant to discuss work she may be able to undertake around reducing alcohol consumption with people receiving treatment for Hepatitis C.

7.32 Referrals from the staff at QAH to the AIT during 2009-10:

Department	Number of referrals
ED	82
MAU	31
QA other	10
Total	**123**

7.33 The AIT runs weekly drop-ins and promotional stands at the Ella Gordon family planning unit, in the maternity department at Queen Alexandra Hospital and also delivers information sessions with the Teenage Pregnancy staff. Additionally, open slots are held at St Mary's Walk in clinic in the evenings and these are generally well attended.

7.34 Various promotional literature has been produced and displayed around the city. In 2010 a bimonthly AIT newsletter was launched for all GPs and other healthcare professionals.

7.35 The AIT works closely with other organisations such as Portsmouth Counselling Services and mental health services as well as making referrals to the Triple P (Positive Parenting Programme) course in 2009 and the Early Intervention Project.

7.36 The AIT set up the Portsmouth Alcohol Support Network, a drop-in service in June 2010 on Thursdays 7-9pm at Buckland Community Centre. It was open to any Portsmouth resident who is concerned about their drinking and wishes to get support to cut down. Nutritional advice, education and counselling sessions and acupuncture was offered. This was originally intended to run as a six month pilot but it was closed in August due to low attendance levels and a need in this area is being assessed.

Tier Three

7.37 Members of the Panel visited Kingsway House in September 2010. It is a community based integrated Health and Social Care team, providing a localised tier three substance abuse service for people who are experiencing problems regarding drugs and alcohol, to enable them to make informed choices. Referrals are via the tier two service. It provides motivational interviewing, group work, acupuncture, substitute prescribing, community detoxification, referrals for residential detoxification or rehabilitation and advice and information. It accepts clients from the city of Portsmouth.

7.38 It is part of the NHS and is funded partly by Solent Healthcare, the National Treatment Agency and also receives social care funding for rehabilitation placements and direct payments.

7.39 It has an integrated team comprising substance misuse practitioners who have backgrounds such as nursing or social work, senior support workers and care assistants. There are three full time administrative staff. There is a shared care worker who works with GPs and a practitioner who works between adult substance misuse and children and family services.

7.40 It works closely with other agencies including housing, mental health, the domestic violence unit and many others to ensure all clients' needs can be met. It also employs volunteers and buddies; PUSH (Portsmouth Users' Self-Help group)

is the local service user group and is well established. The two clinical managers report to the Service Co-ordinator for the three community centres (the other two are Orion and Avalon).

7.41 The current case load has approximately 550 clients (drugs and alcohol cases). There are 30 – 40 referrals each month and this is fairly consistent throughout the year. The number of referrals for drugs and alcohol is quite even. There are a number of people who pass through the service many times. The service is currently running over capacity by approximately 80 cases.

7.42 It is open Monday to Friday during the day and holds an evening clinic every other week. A seven day service per week would be better. Mixed access does not deter clients (an alcoholic is not deterred from accessing treatment because there are drug addicts on the premises).

7.43 Clients are referred mainly from Cranstoun Drug Service but also more recently the Alcohol Intervention Team and Probation.

7.44 There is a three-week target for clients to commence on a prescription from the point of referral. There is an Advancing Practice Group that looks at service improvement for example, the prescription collection scheme, and this meets every two weeks

7.45 A comprehensive assessment is completed, the case discussed at the multi disciplinary team meeting and a key worker is then allocated and the appropriate intervention offered. Homelessness is a big issue and a lot of work is done to engage with homeless people. A worker who goes to Central Point (day centre in Kingston Crescent for single homeless adults) and Mill House.

7.46 The clients engage on a voluntary basis and they cannot be forced into treatment. This can be very distressing for family members at times because the client has to want to do this no matter what the family wishes are.

7.47 Substance misuse can affect anyone. In the current economic situation substance misuse is likely to increase as when people lose their jobs they lose structure in their lives and may no longer be able to finance and manage their drink or drug problem.

7.48 There is a separate service for the under 18s called "E"s up. Services have to be appropriate for the age group. Kingsway House is a treatment service and as such only treats clients that are dependant on drink or drugs. A binge drinker for example would remain with Cranstoun for appropriate support.

7.49 When a client's behaviour is entrenched in their substance misuse it is a huge life change to move forward from this. Sometimes other people put peer pressure on them but it is not possible to change entrenched behaviour in a couple of sessions. Clients are seen on a weekly basis. Treatment comprises group sessions, 1:1 sessions, pre-detox sessions, acceptance value based commitment therapy, Cognitive Behavioural Therapy, although all programmes are individually tailored to meet that client's needs.

7.50 There are regular reviews with other agencies involved in a client's care which the client also attends. This supports the client to achieve the best outcome and will highlight any concerns from professionals or the client and also what is working well. Firm boundaries can be particularly helpful for chaotic clients as there can be a conflict between what they want and what they need at this particularly difficult stage in their cycle of change. If all options have been exhausted to

keep a client engaged in the service with no success then their case will be discussed at the multi-disciplinary team review to agree to discharge.

7.51 Barriers to accessing help may include the stigma surrounding addiction, lack of childcare or fear of children being removed. With ethnic minorities it is often the culture to keep the problem within the family. There has been an increase in clients from Eastern Europe and interpreters are used when required.

7.52 Frustrations for staff are the constant data reporting requirements and the lack of a common data recording system. Much time is wasted contacting other agencies (in particular mental health and social care) to gather and share vital information. Data is submitted to the National Drug Treatment Monitoring System. The Treatment Outcomes Profile is a standard form which follows the client if they transfer to another area but the only feedback to agencies is the percentage of forms completed at correct time and the percentage of successful outcomes.

7.53 A "one stop shop" model would benefit clients making services more accessible. Having several appointments at different locations for clients with chaotic lifestyle presents hurdles and the system needs to be more amenable. This could also prove to be far more cost effective.

7.54 There is a growing feeling that much time is wasted on government initiatives and there are too many directives from people who do not understand the client group and the nature of addiction. The more years people spend away from the frontline, the more they forget what it is like. Job satisfaction comes form seeing clients improve and recover. This is something that statistics can never fully convey.

Tier Four

7.55 **Baytrees** offers medical detoxification and coordinates life skills activities for those with drug and alcohol dependencies in Portsmouth, Fareham, Gosport, Havant, Petersfield, Isle of Wight, Southampton, Hampshire and surrounding counties. The 85% occupancy target is usually met and the unit is normally 80-90% full. Clients are referred from Kingsway House. The target maximum waiting time for checking in at Baytrees is three weeks. This is achieved about 80% of the time. Upon arrival clients agree a care plan and receive Librium for a week and the rest of the stay is taken up predominantly with group therapy to discover the causes for the dependency. The care plan includes aftercare.

Clients are required to be abstinent for the duration of their stay. If a client leaves early, an appointment with their key worker at Kingsway House is arranged. Professionals from community treatment services visit the unit to explain the options available after Baytrees. A 'Rebound Group' funded by NHS Portsmouth and run by carers for carers is held every Tuesday evening. To promote the service and to share learning, Baytrees staff attend service providers' forums and give presentations. They also accompanied the Street Pastors one evening in September 2010 in order to forge stronger links.

7.56 Clients occasionally move on to residential rehabilitation after completing the detoxification programme. They are encouraged to undertake rehabilitation in another city in order to make new friends and new habits and move away from negative influences. They stay in shared houses for mutual support and are given support in the community. There are not sufficient places for clients after detoxification and dry housing.

7.57 The National Treatment Agency (NTA) provided £20,000 for the purpose-built sensory room at Baytrees and other funding over the years. NHS Portsmouth provides baseline funding. Baytrees submits bids for relatively small amounts of funding for specific projects throughout the year from the NTA.

7.58 The Substance Misuse Coordinator for Portsmouth informed the Panel that a lack of supported follow-on housing meant that clients were drinking again after detoxification. More coordination with the relevant agencies is required. A number of patients undergo repeat detoxification programmes. Between June 2009 and July 2010, 11 patients underwent two detoxification programmes and 5 patients underwent three.

7.59 A lift would be useful for disabled staff and clients and a games room. It was suggested by Panel members that the building that is currently vacant next to Baytrees could be used for follow on residential rehabilitation; however NHS Portsmouth who own the property informed the Panel that it would involve a substantial capital investment to make the property fit for this purpose.

7.60 The directors of Baytrees informed the Panel that the fact that it is a combined drug and alcohol treatment centre has not been a deterrent for clients.

7.61 **ANA Treatment Centre** is a private not-for-profit organisation that offers an abstinence-based primary treatment for alcoholism and drug addiction. Members of the Panel visited the centre in December and spoke to staff and clients. There are three phases to treatment, to which access is dependent on funding.

7.62 The first phase, which lasts twelve weeks is based at the centre in Farlington and involves an assessment/ care plan, medical examination and plan, detoxification if required, Cognitive Behaviour Therapy, motivational work, life story and AA/NA step one. During this time, the days are very structured, mobile telephones are not permitted and there are no unaccompanied trips outside. All necessary services come to the centre.

7.63 The second phase, which lasts seven weeks, is based at the centre in Southsea. The emphasis is on putting in place and building on lessons learnt in the first phase with behaviour evaluation, on-going treatment plans, AA/ NA steps two and three, client choice, talks, workshops and seminars.

7.64 The third phase can last up to twelve months and the emphasis is on building life skills, relapse prevention, housing, education and aftercare plans.

7.65 A weekend group for families was recently introduced to promote understanding of the illness, enabling behaviours and effective support.

7.66 One client explained that they had carried out four detoxification programmes and had waited between two and four months. Whilst waiting they had been advised to continue drinking and to attend a series of appointments at Cranstoun. If they had missed any appointments, they would have lost the chance to enter a detoxification programme. The only support available during this time was anti-depressants prescribed by their GP. Alcoholics can die whilst waiting for access to a detoxification programme.

7.67 Two clients explained that they had not been aware of the services available to help them and so had searched online and had found ANA through the triage site. One client explained that they had arrived at ANA within 48 hours of contacting them through the triage

website. The process had been speeded up because they were self-financed.

7.68 Here is a summary of other issues that were raised during the visit:

- Treatment for addictions is not a mandatory part of GP training.
- The first step in the road to recovery is to believe that it is possible to live drink-free.
- There is not one single reason for drinking. One client explained that at first they were chasing the good feeling that it had originally given them and then they needed a daily drink or several to function normally.
- Thirty percent of binge drinkers will go on to become chronic drinkers.
- It would be useful if information on the twelve-step programme was given at detoxification programmes and during rehabilitation.
- Rehabilitation after a detoxification programme is essential.
- An increase in the price of alcoholic drinks would not deter chronic drinkers.
- Some pupils would be deterred from drinking by a hard-hitting education programme.
- Alcohol is not the problem; the problem lies in the choices that an individual makes.
- ANA works closely with other services including Cranstoun.
- A more co-ordinated approach is required to ensure that clients are aware of all the services available.
- A significant proportion of the NHS Portsmouth budget for alcohol treatment is allocated to Baytrees.
- ANA used to provide talks at schools but the effectiveness was questioned. Teachers were reluctant to invite speakers come in to talk about alcohol.
- NHS has never commissioned ANA.
- ANA contracts doctors from the Osborne Practice to carry out detoxification programmes on site and to be on call. Other GPs do not refer people to the centre.

7.69 The Substance Misuse Coordinator for Portsmouth asked the Panel to note the following points:

a. The NHS funds detoxification programmes for clients at ANA and the Council's Social Care department funds the rehabilitation programme.

b. It is important that the necessary tests are carried out prior to entry to a detoxification course to ascertain the commitment of the client to the process. During the wait, clients are monitored and can be prioritised for treatment if they become ill.

c. An estimated 25% of the NHS budget for alcohol treatment is allocated to Baytrees Unit.

7.70 The **Alcohol Specialist Nurse Service** at Queen Alexandra Hospital was partly established in July 2009 and its official launch was at the start of Alcohol Awareness Week on 18 October 2010. It was fully staffed at the beginning of December. Three Alcohol Specialist Nurses are employed and one administrative assistant. It is expected to cost approximately £200,000 per year. The Primary Care Trust funds this service on an on-going basis. Hampshire PCT has agreed short term funding to support the project. The team is responsible for detoxification treatment. Patients who are discharged before this is completed are asked to come in every day for their prescription and health care advice. The new service will shorten stays in hospital and prevent re-admissions. It is estimated that the service will save approximately £500,000 per

annum in reduced ED attendances and hospital admissions. The Consultant Hepatologist who is also the Alcohol Champion informed the Panel that this service is very effective at identifying alcohol problems early.

7.71 The National Health Promotion in Hospitals Audit (mentioned in section 4.9) designed to measure the delivery of health promotion to hospitalised patients within all English hospitals recognises that it is 'vital that hospitals have appropriate services to address the treatment and health promotion needs of those who misuse alcohol and are dependent drinkers. One of the best means of ensuring an optimal alcohol service is delivered is through the employment of alcohol liaison nurses/workers.'

Brief Interventions

7.72 These are carried out at the moment of admission to hospital or to a prison cell at the weekend for alcohol-related issues to make people aware of the damage that they are doing to themselves and to others. The Identification and Brief Advice scheme (IBA) has also been expanded: hundreds of health and social care professionals have been given training on how to provide brief interventions to people that need advice for alcohol abuse. In October 2010 a pharmacy based alcohol advice project was launched, which aims to provide alcohol brief advice to over 5,000 people per year.

7.73 Research shows that advice from a professional is often heeded. Trials have shown brief interventions lead to an average reduction in drinking of between 13-34%[45]. Evidence indicates that for every eight people who receive advice, one will reduce their drinking to within low-risk levels. This compares favourably with smoking advice, where only 1 in 20 will act on the advice given, or 1 in 10 when nicotine replacement therapy is offered[46].

7.74 A Community Health Practitioner from the Ambulance Service is stationed at Guildhall Square and other areas with a high concentration of licensed premises on Friday and Saturday nights to assist people with minor injuries and therefore reduce the number of unnecessary alcohol-related hospital attendances. The role is 80% within the Guildhall Walk area although the ambulance control can redirect the resource to any other emergency nearby. The resource does not impinge upon any other ambulance resources within the city and is in addition to the normal staffing levels. Since 2007, the practitioner provides an arrest referral service operated at Portsmouth Central police station on Saturday mornings to offer advice, guidance and referral to people who have been arrested. Since this has been in place over 1,000 people have been seen of whom 85% positively engaged in the programme.

7.75 The Department of Health Alcohol Harm Reduction Unit's National Support Team recommended that partner agencies that work with high risk clients needed to train staff in delivering IBAs.

7.76 A half day online training course on delivering IBAs is available to Council staff via the Managed Learning Environment.

Capacity

7.77 There was previously insufficient capacity within the treatment system to meet the needs of residents. The Department of Health recommends that 15% of an area's alcohol dependant population should engage in alcohol treatment each year in order to reduce alcohol

45. Alcohol Misuse Interventions, DoH 2005
46. Safe, Sensible, Social. National Alcohol Strategy 2007.

problems. In Portsmouth in 2008/9, 604 people received alcohol treatment. It is estimated that this is just under 9% of the dependant drinker population. In order to meet the 15% threshold the number of people accessing services needs to increase by 1,009.

7.78 Alcohol abuse is not identified sufficiently in the tier one services. This is often due to professionals not being confident to ask about alcohol consumption. The Alcohol Interventions Team is undertaking training with healthcare professionals in a range of settings to address this issue, however there are many areas still to engage with. Key health and social care and housing agencies could make alcohol training more of a priority.

7.79 The demand for residential rehabilitation has increased as a result of better highlighting of alcohol-related issues and easier access to treatment services. This is an expensive (approximately £5,000 for a 12-week placement), but very effective treatment option, especially for more chaotic drinkers). Portsmouth City Council provides £120,000 for alcohol and drug residential rehabilitation. These funds provide approximately 19 alcohol treatment placements per annum, which is now deemed insufficient according to the Substance Misuse Co-ordinator.

7.80 Investment in alcohol treatment and support services have proved successful on a local and national level in reducing alcohol-related hospital admissions. In 2009 Brighton invested an extra £750,000 in alcohol services; their rate of admissions is now falling (3% in 2009/10), so the benefits of the extra investment in Portsmouth should be seen in the next one to two years.

Support Groups

7.81 **Alcoholics Anonymous (AA)** runs many meetings in the city, effectively supporting hundreds of people in their sobriety. The Health Liaison Officer for AA in Hampshire and three members of Alcoholic Anonymous attended a meeting of the Panel to talk about their personal experiences of alcoholism and rehabilitation. They explained that they had started drinking at a very young age to give them more confidence but had soon become addicted. Their addictions had caused many problems in their personal and professional lives and had also damaged their health. However, now with the continued support of AA, they feel they can deal with problems without drinking. Here is a summary of points raised at this meeting:

- AA is free and independent.
- It was established in 1936 and now exists in every country. Twenty one years ago there was only one meeting a week being held in Portsmouth; now there are two a day.
- It is important to realise that anyone from any walk of life can become an alcoholic.
- The group is anonymous at a personal level but is not a secretive group; it is open to all.
- It is not the place of last resort.
- Alcoholism is an illness that cannot be dealt with by a course of treatment over 12 weeks; it requires life-long treatment like diabetes.
- AA aims to fill the void created when someone gives up alcohol.
- Alcoholism can run in families.
- It would be helpful if the definition of alcoholism was universally agreed by the medical profession.
- If a person relapses they can continue to attend AA meetings.

- If a person continues to drink alcohol they can develop encephalopathy.
- Every AA member helps a new recruit on their journey to sobriety.

7.82 AA members give an annual presentation to students at Brighton and Southampton medical schools and conduct regular visits to GP surgeries. These have been welcomed enthusiastically by the majority of surgeries.

7.83 The Sister at the Medical Assessment Unit (MAU), Queen Alexandra Hospital and the AA Health Liaison Worker set up a referral programme in 2008. When a patient is admitted to the MAU with an alcohol-related condition, they are asked if they would like help with their alcohol problem. If they agree, the local AA is contacted and a member will come to talk to them at their bedside. Before this programme was put in place, the patient would have been referred to a treatment centre, and a place would not have been available until a few weeks later. Two members of AA explained that it was after speaking to someone at the MAU they started attending meetings and stopped drinking. This referral programme is unique and has been very successful. It is hoped that it will be extended to other hospitals. The Chair of the South Downs Group of AA explained that there are local groups, regional groups and two larger groups which ensure that information and good practice is shared across the country. The referral programme is being discussed nationally and St Richard's Hospital in Chichester has shown an interest. At a HOSP meeting, the Development Manager, Public Health Group South East, Department of Health offered to showcase this programme regionally.

7.84 In the MAU clinicians are prompted to ask alcohol-screening questions by the VitalPac, the hand-held device which records patients' observations. This will be extended to all wards by April 2011.

7.85 Two ex-service users are employed as part-time Peer Recovery Facilitators by Social Care for up to a year. They are part of the expansion of Alcohol Psychosocial Treatment services and are developing self-help groups across a range of venues (e.g. Mill House) based on the evidence-based SMART Recovery model[47]. The posts are funded by a South East Alcohol Innovation Programme grant and funding from the Primary Care Trust.

7.86 **Al-Anon** Family Groups provide support to anyone whose life is, or has been, affected by someone else's drinking. It is an international organisation with over 800 support groups in the UK and Republic of Ireland. Relatives and friends of alcoholics share their experience in order to solve their common problems.

7.87 **The Criminal Justice Alcohol Reduction Group** is a support group for potential and current offenders that was set up in February 2010. It runs on a Monday evening on a six-week rolling programme, accepting referrals from anyone misusing alcohol and at risk of offending. The group has been very well received by clients and probation staff.

7.88 **The Supporting People programme** funds beds for clients with drug and alcohol issues: There are 19 supported beds dedicated to drugs and alcohol but another 20 are probably required. In 2008/09, 183 clients out of 1,316 clients that passed through the short term services alone had an alcohol problem and needed support with this issue. Using 14% for an

47. www.smartrecovery.org.uk/about

48. Alcohol – Can the NHS Afford it? http://bookshop.rcplondon.ac.uk/details.aspx?e=9

estimated snapshot, this would mean that excluding sheltered services for older people there are about 156 people using these services with an alcohol problem at any one time. The number of support services and treatment capacity is expanding, including Acceptance and Commitment Therapy (ACT) based on Cognitive Behavioural Therapy (CBT).

7.89 Referrals from the **probation service** to the AIT increased between April 2009 to March 2010, so another worker was placed within this part of the service in April 2009. Since then the referrals have continued to increase with March 2010 having a record number of referrals to the AIT service.

7.90 **The Crime Reduction Initiative (CRI)** provides a range of specialist interventions to support individuals in criminal justice and community settings. It was contracted to deliver Alcohol Treatment Requirements which are court-ordered alcohol treatment programmes until June 2010 and has not been replaced by another service. At this time the probation service changed the eligibility criteria for provision of ATRs; only those clients with an AUDIT score of 30+ will be offered them. The number of offenders being issued with ATRs will reduce from 75 to approximately 15 per year as a consequence.

The National Offender Management Service suggests that a score of 20+ be used and in September 2010 during a visit to Portsmouth the Department of Health for Reduction of Alcohol Harm National Support Team recommended that the Probation Service reconsider its threshold. More offenders are simply referred to Kingsway House without any extra support and the drop out rate for Kingsway House has increased as a result. However as offenders will still require support around alcohol issues the AIT anticipates that referrals will increase. 87% of probation referrals in April 2009 – March 2010 were male and 31% were between 19 and 24 (the largest group). The introduction of Alcohol Specified Activity Orders for clients who receive an AUDIT score of between 20 and 30 is currently being considered.

7.91 The Department of Health and National Treatment Agency for Substance Misuse have also stated that alcohol liaison posts would help promote alcohol interventions and treatment within hospital settings.

7.92 The Royal College of Physicians highlighted the need for each trust to have 'one or more dedicated alcohol health workers employed by and answerable to the acute trust.'[48]

7.93 The Substance Misuse Coordinator for Portsmouth informed the Panel that he has not been able to persuade some other council services of the importance of Identification and Brief Advice training for staff e.g. social care and housing.

7.94 At a drug and alcohol stakeholder meeting in April 2010, Panel members asked service providers and users the following questions:

1. What services are available in the city?
2. How would you evaluate their effectiveness?
3. How would you suggest that they be improved?

7.95 A summary of the responses to the second two questions is set out below:

- Housing – It is essential that people coming out of detoxification treatment have a dry house to go to. At the moment, many people have no choice but to go to wet hostels which seriously increases the likelihood of a relapse.

- Families should be involved in the recovery programme to ensure that the appropriate support and understanding is in place.
- More peer support services are required in the community.
- There is a lot of stigma attached to treatment services. It is difficult for alcoholics to admit that they have a problem and some are reluctant to attend a known drug services centre.
- There is a need for more services in the community.
- All stakeholders involved in treatment services should hold regular meetings to ensure a coordinated approach.
- It is recognised that license holders act in a more responsible manner now.
- Early intervention is essential e.g. working with sure start children's centres.
- Easier and quicker access to detoxification services is required.
- More multi-agency working is needed.
- More effective working with GP links would be beneficial.
- Treatment pathways need to be clearer.
- Prescribed thinking skills training (e.g. cognitive behaviour therapy) are very effective and should be made more readily available.
- More outreach services are required especially aimed at families.
- University and supermarkets must be encouraged to assume their responsibility towards the community.
- Accessibility to services must be improved.
- The services infrastructure is already in place.
- Individual services are very effective but more working together is required.
- The people who are currently not accessing services need to be targeted.
- Funding is available.
- It is essential to remember that detoxification is only the start of the process for addicts.
- Education is key.
- Binge-drinking is a problem but the associated anti-social behaviour is the main problem.
- More support is required for education and training.
- Peer-based models are more successful.
- The supported housing treatment service provided at Foster Road could be improved. The building is poor and was not designed for the service it provides. Service users are at all levels of recovery.
- More effective communication is required between service providers for patients with dual diagnosis (mental health and substance abuse).

7.96 The stakeholder group suggested the establishment of a mobile outreach service based in community centres, GPs and pharmacies. The staff would be from all services and also include ex-service users. Counsellors would refer people (users and carers) to the services available and to aid home detoxification. Additionally, there would be peer-led support groups.

Access to treatment

7.97 The Director of the Centre for Public Innovation gave a presentation to the Panel on alcohol services and said that although binge drinkers often set in place behaviours for the future and have high profiles they are not the main users of alcohol treatment services.

7.98 The Alcohol Needs Assessment by the University of Portsmouth concludes that people are not

accessing services because of the stigma, co-location of alcohol and drug services and accessibility (opening times and location).

7.99 Members of the Panel attended a Pathway Mapping Event in April 2010, which the Alcohol Intervention Team organised for health service providers. Three presentations were given on the general situation in the South East and Portsmouth in particular. The providers were then asked to give details about their services so that a directory could be compiled.

7.100 Most alcohol abuse services are combined with drug dependency services. The Substance Misuse Coordinator for Portsmouth informed the Panel that feedback indicates that this deters potential clients from accessing the alcohol services. Service users and providers at the drug and alcohol stakeholder meeting in March 2010 said that combined services were a barrier to accessing services. However, managers from Baytrees informed the Panel that they have not received any feedback to indicate that the combined service is a barrier.

Dual Diagnosis

7.101 The Manager of CDS explained that people who have a dually diagnosed mental health problem and drug or alcohol problem present a more complex picture generally. Overcoming a drug or alcohol problem is likely to be the most difficult thing a person does in their life which requires vigilant commitment and learning to think differently. Mental health problems vary in type and severity, but are equally likely to be the most difficult thing a person deals with in their life; to have both creates a mountain that can seem impossible to climb. This can affect motivation, amongst other things, a person's ability to turn up to appointments, to sit in a room with other people, to be able to understand a group process, to be able to cognitively engage with treatment. The Substance Misuse Coordinator for Portsmouth said that often, drugs or alcohol are used to self-medicate for symptoms of mental illness and can be preferable for an individual to medication from their doctor, which can have unpleasant side effects. With people who are not yet diagnosed with a mental health problem, the picture becomes even more complicated, as symptoms of drug and alcohol use can be the same as symptoms of mental illness, and so assessing their mental state can be very difficult and individuals can have a mental health problem and a drug or alcohol problem for quite a long time before the mental health problem is identified. There is a strategy in place for dual diagnosis, but it does not appear to have been implemented adequately.

7.102 The **taxi marshal scheme** began in Guildhall Walk in 2007 as a response to the high levels of disorder in the Guildhall Walk taxi rank. The rank was positioned in an area where in the past, fast food establishments were also a draw, which resulted in large congregations of people. It serves customers who visit the licensed premises in the area, which mostly close at the same time, resulting in large congregations of people.

7.103 Between 2007 and 2010, the taxi marshal scheme was funded from various sources including the Safer Portsmouth Partnership, the police and the City Council. In order to gain agreement from the licensed premises to fund the taxi marshals a number of initiatives were put in place including pedestrianisation of Guildhall Walk between 6pm and 6am and the implementation of a new taxi rank in King Henry I Street.

7.104 On 7 July 2010, the Cabinet Member for Environment and

Community Safety decided that the Guildhall Walk taxi marshals on Friday and Saturday nights be funded by the licensed premises in Guildhall Walk and Hackney Cab drivers in the city. Eleven out of twelve premises have agreed to pay an annual contribution of £1,040. The remaining licensed premises will provide and fund the services of two licensed taxi marshals to monitor the new taxi rank on King Henry I Street at their cost between 22:00 and 02:30 every Saturday and Sunday. Hackney drivers as a whole will contribute £1,625 to the scheme. This equates to £3 on each licence. The City Council will act as administrator for the taxi marshals' scheme at no extra cost to the licensed premises. The Council will hold the contract and the payments will be made to the Council.

7.105 **The Portsmouth Street Pastors Scheme** consists of 65 volunteers from 14 churches who offer assistance to vulnerable people in Guildhall Walk every Friday and Saturday night from 10pm to 3am. The scheme was set up in Portsmouth in 2008 and has engaged with 9,000 people. On average every month they calm 9 aggressive situations; support 23 vulnerable people; give out many flip flops, bottles of water and space jackets and dispose of 127 discarded bottles. The aim of their service is to aid vulnerable people and to reduce the number of alcohol-related hospital admissions.

7.106 The Joint Strategic Needs Assessment evaluation pointed out the need to have regular and long term funding to ensure continued operation of the scheme and as a result NHS Portsmouth has committed to providing £15,000 annually. Other funding comes from the following sources: the police £4,000; the churches contribute between £8,000 and 10,000 a year and the bar Yates sponsored a pastor in 2010 for £500. The National Support Team recommends that a levy be put on licensed premises to help fund the Street Pastors. The Government's consultation on licensing law permits a late night levy. The Safer Portsmouth Partnership gave £8,000 in 2009 to train and equip the new volunteers but unfortunately this did not happen in 2010.

7.107 From 27 August 2010, the Street Pastors have also been based at Safe Space, and they bring vulnerable people back there. (Details can be found in section 7.1).

7.108 At the Street Pastors annual launch of new recruits in March 2010, which Panel members attended, the police praised the scheme. Members also accompanied the pastors over several evenings and reported that they were very impressed with the work that the pastors do and the great working relationship that they have with all the services involved and the public. They are part of the Pubwatch radio link scheme and often get called upon to assist.

7.109 The service was extended to Albert Road in Southsea during July and August 2010 to evaluate the need for Street Pastors in this area; at the time of this review the results were being analysed.

Partnership working

7.110 The Substance Misuse Coordinator for Portsmouth suggested that more dry accommodation be made available to people who have completed detoxification treatment. He also suggested that staff involved in sexual health services be trained to deliver brief alcohol interventions as a recent study showed that 80% of clients were drinking beyond sensible levels.

7.111 The police in Portsmouth monitor licensed premises for alcohol-related issues.

7.112 The Evening and Late Night Economy Partnership is a group of stakeholders with an interest in the late night economy, defined as all public activity that occurs anywhere in the City between 6pm and 6am. The terms of reference are as follows:

1. To serve as an inclusive cross sector forum for issues relating to the evening and late night economy of the whole city of Portsmouth.
2. To own a shared vision/strategy for Portsmouth's evening and late night economy and to oversee its implementation via the approval of an ongoing action plan.
3. To oversee the marketing and promotion of Portsmouth's evening and late night economy as a sub-regional attraction that contributes to the broader marketing of the city as a whole for both residents and visitors.
4. To consider future evening and late night economy initiatives and sources of funding that will enable a continued programme of improvements.
5. To foster a philosophy of customer care and responsibility to the wider community amongst all evening and late night economy service providers.
6. To ensure that any proposed initiatives concerning the evening and late night economy of the city are tested for viability and then delivered in a responsible and manageable way.
7. To link into and report to the Local Strategic Partnership's Economic Wellbeing Partnership, and maintain a close relationship with the Safer Portsmouth Partnership to ensure the development and delivery of joint objectives.
8. To link into and report to the relevant stakeholder associations, including:
   - Guildhall Watch Pub / Club Watch
   - Gunwharf Quays Residents' Association
   - Gunwharf Quays Management Company
   - Taxi Federation
   - City Centre Steering Group
   - Neighbourhood Forums
   - Community Boards
9. To have an input into relevant policies and strategies including:
   - Portsmouth's Community Strategy
   - Portsmouth's Licensing Policy
   - Portsmouth's Local Development Framework
   - Portsmouth's Local Transport Plan
   - Portsmouth's Cultural Strategy
   - Portsmouth's Community Safety Strategy
   - Portsmouth City Teaching Primary Care Trust's Local Delivery Plan

Membership

10. Membership of the Partnership will be encouraged to be as wide and diverse as possible.

    The key stakeholders are:

    - Portsmouth City Council
    - Portsmouth's Local Strategic Partnership
    - Hampshire Constabulary
    - Portsmouth City Teaching Primary Care Trust
    - Portsmouth University
    - Pub owners/managers
    - Club owners/managers
    - Restaurateurs and other food outlet operators
    - Retailers
    - Hoteliers
    - Events/entertainments organisers
    - Transport operators

- Landlords
- Tourism Service

Every effort will be made to ensure that all of these groups are represented at all meetings.

11. The Evening and Late Night Economy Partnership must avoid exclusivity by accommodating new members when appropriate and the constitution should allow for the group to change as the initiative evolves.
12. Other individuals will be invited to report on particular initiatives as and when required.

Operation

13. The partnership will meet approximately every two months.
14. The partnership will operate a quorum of one third of the Evening and Late Night Economy Board members, including either the chair, Deputy Chair, or a deputy nominated by the Chair, for the meeting and any decisions to stand.
15. Due to the fluid and dynamic nature of this group, it would be impossible to assign strict voting rights to each member and expect this to be truly representative. Instead, votes will be taken based on the representation at the meeting. Where possible unanimity (or close to it) will be sought. Where a vote is close or tied on an important or contentious issue, the decision will be deferred and the entire membership of the group will be contacted by e-mail (or post) and asked to vote. The result will then be relayed back to the group at the next meeting (or earlier by e-mail/ post if speed is required). Where the decision is not contentious, the Chair holds the deciding vote.
16. To implement actions effectively a small number of subgroups will be set up at the request of the partnership to drive forward priority issues. The subgroups will be formed from the membership of the partnership, although it will be necessary to consult with a wider range of stakeholders. The subgroups will agree reporting and monitoring arrangements with the partnership board.

Reporting

17. Individual groups represented within the Evening and Late Night Economy Partnership will need to seek authority through their own reporting systems. The Partnership as a whole however comes under the ownership of Portsmouth City Council.
18. Major strategic decisions and/or milestones will need to be put before the relevant City Council Executive meetings.
19. Certain key decisions/milestones or ones that are considered contentious, or to have a wider impact, may need to be presented to the full Executive Committee of Portsmouth City Council.
20. The Partnership will report into the Local Strategic Partnership's Economic Wellbeing Partnership. Support for all major decisions and initiatives will be sought from the LSP and its statutory partners.
21. The Evening and Late Night Economy Board will arrange Evening and Late Night Forum assemblies. At least one Forum will be held during each calendar year. Forums will bring together all interested parties. The board will present its programme of activities, discuss Action Plans and note achievements. Additionally the board will seek guidance on new initiatives.
22. The Partnership will also maintain a regular dialogue between the Safer Portsmouth Partnership and the Evening and Late Night Economy Partnership to ensure the development and delivery of joint objectives.

To understand the work carried out in the following areas: prevention of alcohol abuse and enforcement and to gain the views of service users and professionals involved.

8

Strategy

8.1 Portsmouth launched its first alcohol strategy in 2006. The Alcohol Harm Reduction Strategy for Portsmouth 2006-9 focused on four key areas of work: the home; the workplace public places and the health service. The main achievements have been the development of Identification and Brief Advice (IBA) in a range of settings including the development of the Alcohol Interventions Team, which works in Primary Care, Probation and ED. A progress report is attached as appendix one of the Portsmouth Alcohol Strategy.

Indicators

8.2 Portsmouth included National Indicator 39 (see section 3.9 for details) within its Local Area Agreement for 2008/9 and retained the measure for 2009/10. The target was to reduce the trend of admissions to 1,804 per 100,000 by 2010/11 i.e. by 12%. The Portsmouth Alcohol Strategy 2009-2013 has the target to reduce the numbers to 1,794 by 2013. The Substance Misuse Coordinator for Portsmouth explained that due to the ever increasing rise of hospital admissions it is unlikely this target will be met in this timescale despite the significant additional investment by NHS Portsmouth in 2010/11. This will be monitored by the Alcohol Strategy Group and the Safer Portsmouth Partnership through quarterly reports. The Deputy Head Nurse at Queen Alexandra Hospital will attend the Alcohol Strategy Group, which the Director for Public Health and Primary Care chairs.

The Safer Portsmouth Partnership Plan 2008-11

8.3 The Safer Portsmouth Partnership Plan 2008-11 identified drugs and alcohol as priority areas to focus on and its aim is to reduce the harm caused by drugs and alcohol focusing on alcohol-related violence, parental substance misuse and drug and alcohol dependency. The list of activities for 2010/11 includes:

- Roll out Best Bar None scheme to promote and encourage the responsible management of licensed premises in order to reduce the risk of alcohol-related harm, crime and disorder across the city.
- Develop a plan to address the high number of young people who are victims of violence and work to reduce the number of violent young offenders.
- Work with the Anti-Social Behaviour (ASB) Priority Group to identify links/escalation from ASB to violence.
- Further analysis to identify top ten violent young offenders.
- Continue training and support for Portsmouth Street Pastors project within Guildhall Walk and set up new city centre multi agency one stop resource opening late night at the weekends (Safe Space).
- Run a pilot of Body Worn Video (BWV) vest cams to secure best evidence when first attending domestic incidents.
- Offer domestic and sexual abuse support and advocacy as part of 'Safe Space'

8.4 The Safer Portsmouth Partnership has a dedicated Alcohol Strategy Group, which has overseen the Alcohol Needs Assessment and the development of the Alcohol Strategy. The alcohol agenda, being so broad, is also covered by all the SPP's delivery groups, including the Violent Crime Priority Group, the Anti-Social Behaviour Priority group, the Young People's Safer Portsmouth Partnership and the Substance Misuse Joint Commissioning Group.

8.5 **The Save Dave Campaign** is aimed at men aged 35 and over

49. 2009 market analysis in Portsmouth

who account for 60% of alcohol-related hospital admissions[49]. The campaign encourages individuals to seek help for their alcohol misuse and also friends and family of heavy drinkers to encourage them to seek help. Thirty-five years ago Dave was the most common name for boys and it rhymed with save and so was chosen for the campaign. The AIT phone number appears on all the Save Dave publicity and literature.

8.6 It is funded by NHS Portsmouth and has a budget of £30,000. The marketing campaign has used both indoor and outdoor media. Research conducted by the Council's helpdesk revealed that 30% of residents are aware of the campaign and 65% of these people said that if they or a loved one had an issue with alcohol, the campaign would encourage them to seek further information. Pubwatch stated that it felt that this is a good campaign which has been supported by members in varying degrees. It is felt that the message is delivered well.

8.7 **Alcohol Awareness week** is a national campaign which ran from 18 to 25 October 2010. The main theme in the marketing campaign is to ask people to consider the possible impact that their drinking has on their children.

8.8 The Development Manager, Public Health Group South East, Department of Health recommended that in order to succeed in tackling health harms from alcohol, people must be supported in order to change their behaviour by using the following approaches:

1. Give individuals the advice and support they need to make healthy choices using social marketing and segmentation, unit and health labelling on products, Point of Sale information, Drink Aware and the Campaign for Smarter Drinking.
2. Create an environment in which the healthy choice is the easier choice through pricing and taxation, advertising regulation, setting a mandatory code for alcohol retailing, effective deterrents to prevent underage sales, the use of disorder measures and the Coalition for Better Health, which the Department of Health is building to bring together senior decision makers from across the health agenda, including major commercial, public sector and Non-Governmental Organisation partners.
3. Identify, advise and treat rapidly and effectively those at risk using Identification and Brief Advice, Direct Enhanced Service (DES) on alcohol advice for new patients, specialist treatment services and national and regional support.
4. Ensure proper prioritisation and alignment of government to tackle harm using the PSA indicator 25, the alcohol learning centre and the regional support to early implementer Primary Care Trusts

8.9 **The Alcohol Improvement Programme** was established in April 2008 by the Department of Health to help reduce alcohol-related hospital admissions across the NHS. It is an outcome-based investor approach for innovative projects to solve local problems. It is funded by the Public Health Group South East, Department of Health (Alcohol Investors Programme) and funds a wide range of activities:

Evidence

- Local Level Data (e.g. North West Public Health Observatory local profiles)
- Tools and guidance
- A new National Treatment Monitoring System
- The Screening and Intervention and Programme for Sensible drinking

(SIPS) research programme (covering IBA interventions in ED, primary care and probation)

- High Impact Changes

Support/ Training

- Regional Alcohol Managers
- Alcohol Learning Centre
- National Support Team visits
- Ready reckoner tool to support investment in reducing hospital admissions
- A programme integrating alcohol training into undergraduate medical curricula (£6,000 per annum.)
- Alcohol Certificate course for Primary Care practitioners
- An e-learning module for IBA in primary care
- Harmful drinkers social marketing strategy

Implementation

- 20 Early Implementer Primary Care Trusts receiving extra £3 million per annum.
- A £8 million Directed Enhanced Service to identify higher risk drinking in newly registered GP patients aged 16 and over, in all Primary Care Trusts.

Type of intervention.	Target group.	Effectiveness.
Mass marketing.	Drinkers who are concerned about their drinking and are motivated to visit a website, call a number or see their GP. They may change their drinking behaviour, but this may not necessarily be a cause of short-term costs to NHS.	Measured solely by short term savings to the NHS. Mass marketing and interventions in primary care are the least cost effective measures.
Primary care Interventions.	Men aged between 34-74 years old drinking over 50 units are responsible for 60% of all alcohol-related hospital admissions.	Their value is best seen in their place within a "stepped model of care" and their longer-term effectiveness in reducing alcohol consumption within society.
ED / Specialist Clinic Interventions.	Harmful drinkers who have caused themselves harm and are easily identified. They create the biggest overall cost to the NHS.	Harmful drinkers represent the biggest cost to the NHS and by targeting this population potentially the greatest savings can be made.
Specialist Treatment.	Dependent drinkers who cost the NHS twice that of a normal drinker.	Treatment prevalence within the dependent drinking population is very low (1 in 18). There is a great opportunity to reduce hospital admissions through meeting this demand for specialist treatment. In the short-term this intervention is the most cost-effective.

8.10 The Alcohol Innovation Programme's budget for 2011/12 is more than £100,000. Eight projects throughout the UK designed to tackle alcohol misuse and reduce alcohol-related hospital admissions have been awarded grants. One example of this is the pilot scheme in Redcliffe Hospital in Winchester where every patient attending the Emergency Department who had been assaulted at home was asked if they were a parent or guardian. The results identified 500 children who were living in households where violence was occurring and who were not known to social services, highlighting the hidden elements of alcohol misuse.

8.11 In Portsmouth £8,500 was awarded for IBA training for Healthcare Support Workers in ED, the Medical Assessment Unit and Gastro-enterology wards at Queen Alexandra Hospital. The Alcohol Champion explained that training in IBA is a routine part of staff education and can be delivered in an e-learning module.

8.12 NHS Hampshire was awarded £15,500 for its Pharmacy Brief Intervention Pilot Project which builds on a previous programme to enable pharmacists to conduct risk assessments and brief interventions on low and medium risk drinkers. It will focus on Gosport, Havant, Fareham, Basingstoke and Rushmoor, where 70% of residents do not regularly visit a GP. As part of Portsmouth's Local Enhanced Service, Portsmouth is replicating this scheme with a budget of £50,000. Pharmacies will screen high risk groups, offer advice and onward referral.

8.13 The Frequent Flyers Support Workers project was awarded £15,000 and was so successful that it is being adopted in a number of areas across the South East. Its aim was to engage dependent alcohol users, whose alcohol use impacted on their health so significantly that they were the most frequent people admitted to hospital for alcohol-related issues. Five individuals were identified by the MAU in QAH and referred to the community based specialist worker. The project ran from mid January to mid April 2010. The worker's aim was to proactively contact the individuals and seek to engage them in a full assessment of their needs, linking with and coordinating the care and treatment from other specialist services. By offering dedicated care management involving daily calls and visits the specialist worker aimed to reduce repeat admissions to hospital.

8.14 The following table shows the outcomes of the frequent flyers pilot.

	Patient		
	1	2	3
Admissions in 2009	56 (4.7 per month)	23 (1.9 per month)	33 (2.75 per month)
Admissions during pilot (4 months)	0	3	1

8.15 An average ED admission costs approximately £1,500 hence the project is likely to have generated considerable savings. Having this time with the patient permitted the worker to achieve a more effective and coordinated approach to their treatment. A more holistic care model was used focussing on offering support in multiple areas. Notable achievements were in accessing support for health, housing, mental health and accessing welfare benefits.

8.16 Since the project ended patient 1 has remained sober and has had no further admissions but the other patients have relapsed and gone back to the cycle of regular admissions, although anecdotally admission stays are shorter than

previously. This shows that the pilot was too short and would have had a more longer lasting impact if it had run for a longer period. The PCT has put funding in place to fund a Frequent Flyers post, initially for a further one year trial, which runs from July 2010.

Pubwatch

8.17 This is a voluntary organisation which aims to achieve a safer social drinking environment in all licensed premises in the area. All premises agree on a number of courses of action against those individuals who cause or threaten damage, disorder, violence, use or deal in drugs in their premises or are a general nuisance. Normally this action consists of agreeing to refuse to serve perpetrators. During a visit to the CCTV control room on 11 June 2010, members observed that the local Pubwatch scheme appeared to be working well. However it did not appear to operate as effectively when they accompanied the police on another evening as the door staff did not seem to be keeping their counterparts at other venues up to date.

8.18 Responsibility for monitoring alcohol consumption seems to be passed directly to the bar staff once the client has entered the premises. Bar staff are legally responsible if a sale is made to a drunken customer. Police officers are asked to look out for long queues at the bar which could prevent the bar staff from seeing to whom they are selling drinks.

8.19 Members of Pubwatch agreed that the 'below cost price' rules would be unenforceable. A minimum price per unit was seen as a much more viable option.

Alcohol Education in Schools

8.20 The Director for Public Health and Primary Care explained that there are various ways of getting involved with schools in order to raise awareness of alcohol abuse. At the moment, head teachers of secondary schools are focusing on childhood obesity and teenage pregnancies. The latter issue is linked to risk taking behaviour e.g. drug taking, smoking, having unprotected sex and binge drinking. He suggested that a national campaign be launched to encourage parents to talk to their children early on in life about responsible drinking.

8.21 The Department for Education and Skills (now known as the Department for Education) teenage pregnancy strategy 2006 suggested that teenagers who regularly smoke, drink and experiment with drugs are more likely to start having sex before the age of 16. Other studies have found that contraception is less likely to be used under the influence of alcohol. Alcohol contributes to risky sexual behaviour in young people which can lead to unwanted sex, unintended pregnancy and the risk of sexually transmitted diseases. It can also potentially affect physical and mental health and school performance. In response to this the Health Improvement and Development Service (HIDS) is delivering a targeted programme in schools focusing on some of the most vulnerable young people.

Alcohol Advisory School Nurse

8.22 The Alcohol Advisory School Nurse funded by HIDS started on 18 October 2010. The target for numbers of young people referred by Operation Bourne[50] and ED to the Alcohol Advisory School Nurse by the end of December 2010 is 50.[51]

Alcohol Project Worker

8.23 From March 2010 an Alcohol Project Worker has been in place

50. Operation Bourne targets anti-social behaviour, under age drinking and criminal damage, in partnership with the Community Wardens.
51. Portsmouth's Children & Young People's Plan 2009-11.

52. A sports/arts-based programme run by Portsmouth Football Club to aid personal and social development of 5-25 year olds.
53. A charity which aids 8-25 year olds to access better life chances and to reduce offending and anti-social behaviour.

within HIDS at Portsmouth City Council to work with young people in order to help them make informed and educated decisions in relation to alcohol consumption. This is offered as a free service for all young people in Portsmouth. The officer delivers sessions to whole classes, assemblies or targeted pupils in small groups regarding alcohol prevention and awareness work, as well as looking at associated risks including sexual health and teenage pregnancy. The following services are also provided:

- Drop-in sessions in schools and youth groups for information and signposting relating to alcohol consumption.
- Training and advice for teachers, parents and carers on (In Service Training) INSET days or as a twilight session covering national policies, guidelines and campaigns or raising basic awareness.
- Manned or unmanned stands and advice at health awareness days and weeks, parents' evenings, sports days, etc in schools, colleges and the wider community.
- One-off or a series of sessions on alcohol misuse. This can be within a wide range of locations (youth clubs, schools, college, Youth Offending Programmes).
- Supporting Personal, Social and Health Education (PSHE) lessons.
- Establishing peer led education programmes within schools or colleges around the subject of alcohol awareness.
- Working jointly with organisations that work with or deliver services to young people to provide an integrated approach to alcohol prevention. E.g. Motiv8, Integrated Youth Support Services, Teen-Pregnancy Team and Safer Portsmouth Partnership.

8.24 Since March 2010, the Alcohol Project Worker has delivered alcohol awareness and misuse prevention sessions to Year 8 students at Springfield School, Year 9 students at Mayfield School, Students aged 16-19 at Highbury City College, students aged 16 at the 'Respect' programme[52], Year 9 students from City Girls at Motiv8[53], and a drop-in session with young people aged 12-17 years at the Brook Club. They also have up and coming sessions booked in with Portsmouth Foyer and King Richard School. With Substance Misuse Champions being identified in schools from September 2010, it is hoped to extend this further work to reach even more young people across the city.

Enforcement

8.25 Trading Standards carries out work to enforce the licensing laws. Details can be found at sections 5.34 to 5.50.

8.26 During this review, a member of the public who had lost his son to alcohol abuse contacted the panel to say that he believed the £80 fixed penalty notice for selling alcohol to minors is not an effective deterrent.

Supermarkets

8.27 Two supermarkets contacted the Panel to give details of the measures they undertake in order to ensure that they sell alcohol responsibly. Under the licensing regulations in England and Wales, each store manager undertakes training to the Government-recognised level 2 licensing qualification provided by the British Institute of Inn Keeping and is licensed by the appropriate local authority as a Designated Premises Supervisor. Iceland informed the Panel that it is their policy to train

◀ Guildhall Walk

two other members staff in each store to the same standard, ensuring that a fully qualified person is on the premises at all times. Additionally, all staff are given training on the sale of alcohol as part of their induction programme and this is refreshed every six months. At the point of sale they operate Challenge 25 policy, requiring customers who appear to be under the age of 25 to produce appropriate proof of age and identity.

8.28 Pubwatch stated that members feel that they are effectively monitoring themselves. There was concern that the same level of attention is not paid to 'off-licensed' premises. They also commented that while a great deal of pressure is put on the retailers, little or no action is taken against those attempting to make purchases although they understood the desire not to criminalise people.

Police

8.29 Section 3.41 gives details of the police's policy for dealing with minors drinking in public.

8.30 Section 27 of the Violent Crime Reduction Act 2006 was designed to prevent potential alcohol-related disorder and gives the police powers to move individuals on from a specified area for up 48 hours. Section 27 notices cannot be issued to anyone who is drunk as they are intended as a preventative measure. Officers are assigned licensed premises to visit to ensure that security officers are fulfilling their role in respect of drunkenness. All incidents are forwarded to a designated local officer to ensure that an accurate build up of intelligence is collated, which is then used as evidence when premises are having their licences considered or when the police request conditions be added to existing licences.

Licensing

8.31 A member of the public contacted the Panel to say that the Council should reduce the number of outlets selling alcohol and ensure that they close at an acceptable time.

8.32 The Licensing Act 2003 sets out four key objectives for alcohol

licensing: preventing crime and disorder; preventing public nuisance; public safety (physical safety of customers and not wider public health concerns associated with alcohol consumption) and prevention of harm to children.

8.33 The Substance Misuse Coordinator for Portsmouth suggested that joined up working at a senior level is required to draw up a plan for the city centre. The Council could consider applying for the Purple Flag accreditation scheme[54] which recognises great night time economy that offers a positive experience to visitors. Achievement of this status would require co-ordinated effort between Planning, Regeneration, Transport, Culture and Community Safety departments. Purple Flag was developed by the Association of Town Centre Management (ATCM) and the Purple Flag Advisory Board research carried out by the Civic Trust as part of its Night Vision project which showed that:

- More people would use centres at night if they were safer, more accessible and offered more choice.
- A good mix of clientele can lessen intimidation and improve perceptions.
- A wider range of attractions and consumers leads to longer term economic viability.

8.34 The Trading Standards Business Services and Underage Sales Manager outlined the business case for the introduction of an Off Watch scheme and explained that the large supermarkets and the small retailers had expressed interest. The aim is to provide valuable regular contact with key agencies enabling members to tap into information and legislation that will assist them to remain compliant and help them to protect and sustain their business. Providing a support mechanism would help businesses trade in a responsible way and assist key areas of the city councils strategy to reduce alcohol related hospital admissions, alcohol-related crime and disorder and antisocial behaviour. Sales of alcohol to people under the age of 18 are rarely made out of wilful neglect and normally indicate a lack of training. "Off Watch" will provide opportunities for businesses to tap in to low cost staff training; regular legislative updates from licensing and trading standards as well as allowing them to seek guidance from the police in respect of local crime issues and problem individuals. The Substance and Misuse Coordinator for Portsmouth informed the Panel that the police have considered the possible advantages of introducing Off Watch for supermarkets, a scheme similar to Pub Watch and concluded that as these are more spread out they did not necessarily see the value in this.

Public views on alcohol use and abuse.

8.35 As part of this review, the Panel carried out a survey between April and August 2010. Respondents were asked a number of questions and asked to express their views on alcohol use and abuse. All participants were entered into a free prize draw to win an Ipod Nano and the survey was promoted widely using the following methods:

- A presentation given at the National Health Conference held on 25 March 2010.
- Posters displayed in the Civic Offices, Council housing blocks, community centres, schools, hospitals, colleges, the University of Portsmouth, supermarkets, theatres, libraries and music venues.

54. http://www.atcm.org/purple-flag/index.php

- A public participation event held in July in the Guildhall Square, where passers by were invited to complete the survey and give their views in the video booth.
- Articles on Twitter, The News; local radio stations; Portsmouth Hospitals Trust publications, Portsmouth City Council publications; community newsletters; Neighbourhood Forums; the Council website and the Council's intralink.
- Paper copies of the survey were also available at the city's seven libraries.

8.36 The report giving the results of this survey is attached as appendix seven. A total of 974 responses were received, which means that the results meet the sample size required for a 95% confidence level with a 4% margin of error (based on 2009 Portsmouth population estimates). Here is a summary of the responses:

- Over two thirds of respondents under estimate the economic impact of alcohol abuse.
- While almost three quarters have not missed any time off work or study because of drinking too much, younger respondents and male respondents were far more likely to have missed five or more days.
- Most respondents indicated that if the price of their favourite alcoholic drink were to be increased, they would just pay more. Just over a quarter of respondents said they would drink less of the same drink.
- The majority of respondents said they did not go into town at night because of the drunken behaviour of other people.
- Most respondents felt schools should teach children about the dangers of alcohol abuse between the ages of nine and eleven. Respondents aged under 25 and male respondents were more likely to think this education should wait until children were older.
- The majority of respondents indicated they bought most of their alcohol from supermarkets. Almost 30% said most of their alcohol came from pubs, bars and clubs.

8.37 The winner of the survey prize draw was selected at random and the Lord Mayor of Portsmouth presented the prize on 11 November 2010.

8.38 The National Support Team (NST) which is part of the Alcohol Improvement Programme was set up by the Department of Health to work with selected local organisations to achieve their targets for reducing the rate of hospital admissions for alcohol-related harm. (Details can be found in section 8.9). It has visited 30 areas to review the work being carried out to reduce alcohol-related hospital admissions. It was very impressed with the work being carried out in Portsmouth and ranked it in the top three areas.

8.39 Following interviews with Portsmouth stakeholders in September 2010, it reported that it was pleased with the following aspects of work in Portsmouth:

- Additional investment into alcohol interventions and treatment in 2010-11
- Alcohol is a 'flagship' issue for the City and is included in all the key strategic documents
- Overview and Scrutiny have prioritised alcohol as an area for investigation
- Dedicated capacity to coordinate the alcohol strategy
- Willingness to innovate to manage alcohol harm

- Highly commendable Alcohol Strategy, informed by a needs assessment
- Excellent alcohol commissioning and project plans for NHS Portsmouth funded initiatives

8.40 In its report on its findings, the National Support Team made the following recommendations:

1. Alcohol is a clear priority set out in all your local partnership documents. Although chief officers are fully engaged in the agenda there appears to be an over reliance on two individuals translating this into delivery. The NST believes that the priority afforded to alcohol and the objectives of the Alcohol Strategy have not been integrated into the core business of some partner agencies. In order for the senior level commitment on alcohol to be translated into delivery, the Local Strategic Partnership (LSP) should specify the accountabilities and responsibilities for the delivery of the Alcohol Strategy for each partnership board. This contribution should be reflected in each partnership board delivery plan. This work should be brought together in a partnership-wide delivery plan for the Alcohol Strategy, which can be monitored by the Alcohol Strategy Group (ASG).
2. We heard concerns about lack of engagement from QA Hospital in the alcohol agenda. We recommend that QA Hospital take the following steps to maximise their contribution to reducing alcohol-related admissions:
   - Identify a senior champion for alcohol
   - Ensure senior representation at the ASG
   - Develop a delivery plan for their contribution to the Alcohol Strategy
   - Utilise the new hospital alcohol service steering group to coordinate the various elements of the hospital alcohol delivery plan
   - Take responsibility for implementing the ED assault data collection project
3. The design and management of the night time economy needs to be an integral part of the new Regeneration Strategy for Portsmouth and the overall aspiration for the City to be "the premier waterfront City with an unrivalled maritime heritage – a great place to live, work and visit", as set out in 'Vision 2008-2018'
4. There appear to be good arrangements for analysis of alcohol data and a strong recognition of the need to use data to inform commissioning. However we heard some concerns about the validity and reliability of some source data. We recommend that partners actively review how data collection and recording can be improved and that there is a thorough critical appraisal of any data that is used to inform commissioning.
5. During the visit we were unable to obtain a clear understanding of the extent of IBA delivery by frontline services. We recommend that you identify target groups who should receive IBA and train staff in these areas.
6. We heard that the number of community detoxifications being delivered is low and that there is a large waiting list for inpatient detoxification. There appears to be a culture of inpatient detoxification, with an over reliance on this intervention as opposed to community detoxification – this needs reviewing

7. We heard widespread concern regarding the service response to people with a dual diagnosis.
8. We understand that some changes have recently been made to Alcohol Treatment Requirement (ATR) provision, which have moved the threshold for ATRs to an AUDIT score of 30+. As this has reduced the number of offenders being issued with an ATR we recommend that you consider the appropriateness of this threshold
9. Ensure there are links between alcohol and domestic abuse agendas
10. Portsmouth's Licensing Policy is being reviewed and is currently undergoing consultation. This presents an opportunity to:
    - Confirm a clear shared vision for the night time economy
    - Reinforce the objectives of the cumulative impact policy in Guildhall Walk
    - Consider other areas for cumulative impact policies e.g. Albert Road
    - Improve data collection and sharing protocols to develop a more intelligence led approach to test purchases and enforcement
    - Formalise roles and responsibilities of all key partners and Responsible Authorities
11. The NST was unable to ascertain which aspects of alcohol and management of the night time economy are covered in: the Evening and Late Night Economy Partnership (ELNEP); the Portsmouth Business Crime Reduction Partnership (PBCRP); and Pubwatch. We recommend a review to clarify which group takes the lead on particular alcohol issues to avoid duplication
12. As Portsmouth has adopted alcohol as a flagship priority, it is important to ensure that all partners have workplace alcohol policies for their staff. This should include providing brief advice in the workplace.
13. In the challenging financial climate there may be economies of scale in joining up commissioning across a range of health issues and risk taking behaviours e.g. substance misuse, teenage pregnancy and smoking, through the Children's Trust. The new Children's Trust structure, based on age-banded Boards should assist in developing this holistic approach
14. There is also a need to ensure close links between substance misuse commissioning for children and young people with the Alcohol Strategy and commissioning of services for adults.
15. Given the impact of parental alcohol use on young people's behaviour, there is a need to ensure that all available opportunities are utilised to tackle parental alcohol use.
16. Develop a delivery plan to support implementation of the Alcohol Strategy and ensure that delivery is integrated into core business of partner agencies.
17. The Acute Trust needs to ensure that it is fulfilling its responsibility for delivering the Alcohol Strategy, including implementing ED data sharing.
18. Develop a clear model for the alcohol treatment system that makes best use of available resources.
19. Ensure all public sector workplace alcohol policies are fit for purpose.
20. Clarify the scope of the re-tendering exercise and the model for delivering services for under 25s.

To learn from examples of good practice elsewhere

9

9.1 Blackpool Borough Council

Blackpool Borough Council is the lead authority for a partnership review on minimum pricing of alcohol. It worked with Lancashire County Council, Blackburn and Cumbria Councils.

The Joint Director of Public Health for Blackburn wanted East Lancashire to follow in the footsteps of Liverpool City Council, which was at the forefront of the smoking ban four years ago, claiming good work done on reducing heart disease was being undone by alcohol-related deaths. He stated that a minimum of 50 pence per unit would help cut alcohol-related deaths and alcohol-fuelled crime.

The NHS Trust in Blackpool developed a model to test and demonstrate the most effective strategies for driving down alcohol-related hospital admissions.[55]

At the example minimum price of 50 pence, a bottle of vodka would be just over £13, compared to below £8 in some supermarkets. Cheap white cider, currently selling at about £2 a bottle, would go up to over £7 a bottle. The Joint Director of Public Health for Blackburn said that there would be initial outrage then within a year or two people would accept it as normal and wonder why alcohol was ever sold cheaply to children.

Outcomes

Blackpool Council has recently agreed on a motion to introduce minimum pricing. It now has an agreement with pubs that they will keep to a minimum price of £1.50 per drink from Thursday through to Sunday evening. Pubs are happy to cooperate as long as they are all doing the same. It may not be legally possible to include supermarkets.

9.2 City of Edinburgh Council

In September 2009 Edinburgh Licensing Board (ELB) tried to ban happy hours by introducing laws stipulating that the price of alcoholic drinks must remain the same for a 72-hour period. The intention being that publicans would not be able to maintain low prices for such a lengthy period. The ELB also prohibited retailers from offering any alcoholic product as part of a multi-buy promotion.

Outcomes

Many pubs started operating a two-tier price structure, with cheaper prices offered on weekdays. The Scottish Licensed Trade Association admitted that the result was the opposite of what was intended.

Critics say that as the Scottish Government was planning a separate Alcohol Bill it would mean that Scottish supermarkets, off-sales and other chains will have to apply different practices in their Edinburgh stores than elsewhere. They also criticise the ELB for improvisation of and unclear interpretation of legislation.

9.3 Edinburgh – Operation Astrodome

The Edinburgh Community Safety Partnership, the City of Edinburgh Council, Lothian and Borders Police and the British Transport Police have been running Operation Astrodome during the festive season for three years. It focuses on a range of initiatives to combat alcohol-related violence and disorder, help people get home safely after a night out and bolster public reassurance through a highly visible presence.

Approximately 88 litres of alcohol were seized from under-18's in December 2009. The majority was seized at the beginning of the operation and the number of seizures decreased towards the end

55. www.liv.ac.uk/PublicHealth/obs/publications/issues/Alcohol_minimum_pricing.pdf

of December and the beginning of January. Officers from Lothian and Borders Police and Environmental Wardens made regular patrols of "hot spot" areas throughout Operation Astrodome.

9.4 **Scotland – Scottish Parliament**

On 9 November 2010 opposition parties in the Scottish parliament rejected measures to charge 45p a unit for alcoholic drinks as part of an ambitious programme to tackle Scotland's substantial alcohol abuse problems. Members of the Scottish Parliament also voted down proposals to stop supermarkets giving loyalty points for alcohol, and offering discount vouchers or "meal deals" including alcohol. However, the following measures were agreed:

- Extending a ban on irresponsible drinks promotions by off-licences and small shops, which prohibit them from offering discounted bulk-buying and cheap drinks promotions.
- Allowing local councils to introduce a new, discretionary "social responsibility" tax on shops in areas troubled by drunkenness and alcoholism.
- Age laws will be toughened, with all retailers required to ask for proof of age for shoppers who look under 25.
- Licensing authorities will be required to publish a "detrimental impact statement", to assess the effect of selling alcohol to under-21s will have in their area.

Outcomes

Political parties and leading drinks industry bodies, including the Scottish Whisky Association, said a minimum price was potentially illegal, possibly leading to cross-border "booze runs" to Carlisle and Berwick, and would unfairly penalise responsible drinkers. The global drinks firm SAB Miller said that policymakers need to focus on effective solutions such as the strict enforcement of existing laws to crack down on underage drinking and antisocial behaviour.

The British Medical Association Scotland was frustrated and disappointed that opponents voted down minimum pricing but did not propose any credible alternative.[56]

Designated areas for alcohol in shops.

Since 1 September 2009 alcohol can only be displayed in a designated off license section or behind the counter (as designated by the store's operating plan); these locations cannot be changed. The promotion of alcohol in other parts of the shop, including at the checkout is prohibited.

Other policies in place include:

- A challenge 25 policy.
- During the week, alcohol can only be sold from 10am.
- Designated license holders must be present on the premises at all times.
- Test purchasing by the police, resulting in heavy fines or imprisonment for those found breaking the rules.
- There are also restrictions in place in respect of alcohol promotions in pubs/clubs etc. The promotion must be in force for a 72 hour period, hence the almost overnight withdrawal of "happy hours" as they would have to sell all their promoted drinks at that price for a minimum period of 72 hours.

9.5 **Brighton & Hove City Council**

There is currently no ban on public drinking in Brighton & Hove. However, a designated public places orders (DPPO) is in place to enable the police to confiscate alcohol from people engaging in anti-social behaviour. The DPPO was introduced through the Criminal Justice and Police Act in 2001 and Brighton & Hove has had a city wide DPPO in place since 2003.

The city applied for the order to deal with alcohol-related anti-social behaviour and specifically to help resolve serious problems with anti-social street drinkers. The DPPO is part of a wider strategy to deal with street drinkers which includes regular police patrols in hot spot areas and outreach workers who assist street drinkers into accommodation and treatment and work closely with individuals to help them change their behaviour.

Outcomes

The aim of the DPPO is not to ban street drinking but to allow Sussex Police to remove alcohol from those causing anti-social behaviour. The intention is to ensure that the city is a safer more pleasant place for visitors and local residents and not to prevent law abiding people from enjoying themselves.

In 2009, Brighton & Hove was awarded 'Beacon status' for its partnership work in tackling alcohol-related disorder in the city.

9.6 **Manchester City Council**

The Association of Greater Manchester Authorities (AGMA), of which Manchester is one of the ten members, reported back from the task group on minimum pricing and discussed the first draft of the by-law at their Executive Board meeting on 27 November 2010[57]. It proposes an introduction of a ban on the selling of alcohol at less than 50p

56. www.guardian.co.uk/society/2010/nov/10/cut-price-alcohol-sales-banned-scotland
57. http://www.agma.gov.uk/cms_media/files/11_minimum_unit_price_for_alcohol.pdf

58. www.agma.gov.uk

per unit and cut-price loyalty cards at pubs could be banned. Anyone found to have broken the proposed rules would be handed a £500 fine. However, the legislation would need national approval because competition laws currently prevent unfair discrimination against firms which can supply alcohol at the lowest prices.

Outcomes

A bottle of wine would cost at least £4.50 and a two-litre bottle of cider £5.50. Council chiefs estimate minimum pricing would cut alcohol-related hospital admissions by up to 5,000 a year. The bylaw, if implemented, would make Greater Manchester the first part of the country to ban the sale of cheap alcohol. Councils in Cheshire, Merseyside, Sussex and Devon – as well as the Welsh Assembly and the government of Jersey – have considered following suit.[58]

9.7 **Middlesborough Council**

Middlesborough Council launched a consultation in July 2010 on its proposal to impose a minimum unit price of 50 pence per unit for all alcohol products sold under a Premises Licence in order to deter pre-loading and binge drinking. The consultation ended on 4 October 2010. Where premises are found to be selling alcohol below this price, a review of the premises licence would be sought, if relevant representations are made.

9.8 **Oldham Council**

Oldham Council introduced measures to control the selling of alcohol at very low prices in bars and clubs and subsequently in off-licensed

premises. The measures were introduced in August 2009 and then extended to off-licensed premises in November 2009.

The measures for bars and clubs

- Minimum price of 75p per unit (about £1.88 for a pint of strong lager)
- Post office style queuing systems rather than going to the bar directly
- Maximum of two drinks per person

The measures for supermarkets

- A licence requirement that 'designated alcohol sales zones' be identified on the operating schedule of the premises. The specific location and size would vary according to the premises' size, but would typically be two aisles
- Advertising of alcohol on sale below 50p per unit of alcoholic strength would not be permitted outside the designated zone
- The designated zone be delineated by a barrier with entrance gates clearly showing that no unaccompanied under 18's are permitted in the zone
- Each designated zone be patrolled during opening hours by an Securities Industry Association (SIA) registered security officer
- The promotional material for alcohol on sale below 50p per unit of alcoholic strength be limited to a size less than 20cm by 10cm
- One of a choice of five social responsibility messages be displayed within a circle of 1 metre diameter (field of vision) for each location where alcohol is on sale below 50p per unit of alcoholic strength.
- In calculating the price of alcohol, instead of using the retail unit price, the lowest price at which the alcohol is available regardless of quantity purchased would be used. Thus, if the individual price is £1, but that price reduces to 60p when taken as part of a multiple purchase offer, the 60p price would be used

Outcomes

- Most of the bars and clubs accepted the council's conditions or a variation of them.
- One bar successfully appealed as they felt they were being unfairly condemned for violence that was happening elsewhere
- Some bars and clubs thought it would cause aggravation with queue-jumping
- Violent night time crime in the town centre fell by 27%
- Over the festive season there was a 63% drop in "serious violent crime" and a 28% fall in "serious crime", according to new figures from Greater Manchester Police
- Other alcohol-related problems such as health and relationships can now be targeted

  Oldham's Trading Standards recently sent 15 supermarkets the written proposal on measures to adopt should they wish to sell alcohol below 50 pence per unit.

  At the time of this report, the response from supermarkets was not known. Recently it was confirmed that a mandatory code for responsible retailing has become statute, though the conditions are not set and will not prevent heavy discounting by the off-trade.

To develop recommendations to improve the alcohol abuse and misuse services in the city

10

	Conclusions	Evidenced by	Recommendation	Lead Officer
1.	Pleased that the HOSP has Scrutiny Development Area status.	2.2, 2.3	N/A.	N/A
2.	Concerned that the levels of alcohol consumption and alcohol-related hospital admissions in Portsmouth are considerably higher than the national and South East averages.	3.4, 3.5, 3.27, 4.1, 4.2, 4.3.	N/A.	N/A
3.	Pleased that there is a significant amount of good work going on to tackle this problem as recognised by the Department of Health's National Support Team.	8.38, 8.39	N/A	
Portsmouth City Council				
4.	The effect of alcohol misuse is far reaching. All council services have a role to play in either prevention, signposting/ referral to treatment or enforcement.	5.1- 5.52	Recognition and dealing with alcohol misuse be part of all the Council's service plans and policies. All frontline services that deal with clients with alcohol issues be trained in Identification and Brief Advice. Social care, housing, community wardens amongst others. A Councillor be appointed Alcohol Awareness Champion.	Chief Executive. Chief Executive. Leader of the Council, City solicitor and strategic director.

	Conclusions	Evidenced by	Recommendation	Lead Officer
5.	Concerned that young adolescents in the Portsmouth area are more likely to drink alcohol and binge drink than the national average.	3.42-3.44.	Appropriate alcohol-awareness education in primary schools be introduced and the Head of Children's Services encourage head teachers of all schools to include alcohol awareness in their curriculum. This opportunity be used to build confidence amongst children without the need to hide behind the bravado of alcohol, dispelling the macho image. All secondary schools (both state and private) be encouraged to appoint an Alcohol Champion through the Health Improvement and Development Service (HIDS) scheme, which is already in place, and that the scheme be extended to include further and higher education. Seek to work in partnership with the Be Your Best Foundation (Rock Challenge) to promote the dangers of alcohol misuse as well as drug misuse. Work with HIDS and schools in respect of the public health element of alcohol misuse including increased sexually transmitted infections and unplanned pregnancies. In line with proposals in the Health Inequalities White Paper, Local Authorities will be instrumental in educating the public in respect of alcohol abuse, addressing health inequalities in particular. This could be through a range of options including Surestart and Children's Centre's to educate young and expectant mothers of the potential dangers.	Director of children's services and strategic director, Primary and secondary head teachers Principals of further education institutions The vice-chancellor of the University of Portsmouth.
6.	There is a link between affordability and consumption.	3.16-3.20, 3.49.8, 9.6, 9.7, 9.8.	Monitor the progress made by the Association of Greater Manchester Authorities (AGMA) which is currently drafting a by-law on minimum pricing. If it is successful, then the council consider introducing it in Portsmouth.	The Member Alcohol Awareness Champion.

	Conclusions	Evidenced by	Recommendation	Lead Officer
7.	It is important that the council has a clear staff alcohol policy that is implemented and offer support for employees with misuse issues.	6.8	Portsmouth City Council lead by example by prohibiting alcohol consumption by staff and members during the working day and being under the influence of alcohol at work. The Lord Mayor be exempted from this rule and exercise their discretion in this matter.	Leader of the Council Chief Executive.
8.	Pleased with the joint working between the planning and licensing services.	5.52-58.	The planning and licensing departments continue to work together when a premises applies for a change of use.	Director of regeneration and strategic director. City solicitor and strategic director.
9.	Pleased with the work of the Portsmouth Street Pastors and the setting up of the Safe Space centre.	2.9, 7.1, 7.105-109, 3.19, 7.55, 8.3	The Portsmouth Street Pastors be thanked for their contribution to dealing with the night time economy. The effectiveness and the long-term service delivery of Safe Space be evaluated.	Director of Public Health and Primary Care.
10.	Pleased that the setting up of an Off Watch scheme is being investigated.	8.34	Support be given to this scheme.	Director of regeneration and strategic director.
11.	Disappointed that the Tell Us Survey which asked pupils from years 6, 8 and 10 for their views about their local area and behaviour has been discontinued.	3.42-43, 5.24	Support the Health Improvement & Development Service questionnaire that will replicate the Tell Us survey on a local level.	Director of adult social services and strategic director Director of children's services Head teachers.
12.	Pleased to note that alcohol is a clear priority set out in all local partnership documents but concerned that it is not being fully implemented.	8.1- 8.4.	Support the National Support Team's recommendation that the Local Strategic Partnership should specify the accountabilities and responsibilities for the delivery of the Alcohol Strategy for each partnership board.	Director of Public Health and Primary Care
13.	Pleased with the preventative work of the CCTV Control Room Operators.	2.9, 6.15-6.19, 8.17	That the licensed premises owners in the Guildhall Walk and environs contribute to install additional CCTV with the council picking up the maintenance costs thereafter.	City solicitor

	Conclusions	Evidenced by	Recommendation	Lead Officer
14.	Pleased that the trees in Guildhall Walk that were obstructing the view of the CCTV cameras in that area were promptly pruned by Colas following a request by the Health Overview & Scrutiny Panel Chair.	6.19	An annual pruning programme be introduced in areas agreed by the CCTV Control Room Manager and Colas.	Director of regeneration and strategic director.
15.	Concerned that Guildhall Walk has high levels of alcohol attributable anti-social behaviour and crime and dealing with this is costly and resource-intensive.	6.14, 6.15-16, 6.19, 7.1, 7.74, 7.102, 7.105.	Robust enforcement action be put in place by the licensing department and the police to reinforce the message of what is and is not acceptable. Support the introduction of a late-night levy on licensed premises' takings as being considered in the Governments consultation document Rebalancing the Licensing Act.	Director of Public Health and Primary Care in conjunction with Chief Superintendent, Hampshire Police, Portsmouth Sector
16.	Concerned that there are insufficient places for the 1,057 alcohol dependent people in Portsmouth who should access treatment services per annum according to local targets.	7.77	Ensure that patients accessing treatment are captured on the appropriate database, as stipulated in the provider services' contract with the Council from 1 April 2011.	Director of Public Health and Primary Care.
17.	The management of the night time economy requires joint working at a senior level.	8.33	The council and partners consider working towards Purple Flag status for the night time economy to provide a focus to tackle the long-term problems. The design and management of the night time economy be an integral part of the Regeneration Strategy for Portsmouth, as recommended by the National Support Team.	Director of regeneration and strategic director.
Portsmouth Hospitals Trust (PHT)				
18.	Disappointed that the Paddington Alcohol Test was not used routinely by staff in ED at QAH.	4.11	The new alcohol screening scratch card be implemented fully within the ED with a target of 100 referrals per month. This be monitored by the Alcohol Champion (currently the Consultant Hepatologist).	Chief executive of PHT.

	Conclusions	Evidenced by	Recommendation	Lead Officer
19.	Disappointed that the key information regarding alcohol-related assault data is not being routinely collected by staff in ED at QAH.	4.16, 8.40.2	Alcohol Champion be given responsibility for ensuring that staff collect this data routinely and send it to the Safer Portsmouth Partnership.	Chief executive of PHT
20.	Abuse to staff at the Emergency Department (ED) at Queen Alexandra Hospital is not acceptable. The Panel is pleased that a security guard is in place everyday and that seems to be reducing the number of incidents. However, it is disappointed that the impact of the introduction of security guards at the ED was not available to the Panel.	4.18- 4.20	A method of monitoring the levels of abuse to staff at ED and evaluating the effectiveness of the security guards in reducing incidents be introduced at Queen Alexandra Hospital. Every Monday morning all patients who attended or were admitted to the ED over the previous week with alcohol-related conditions be sent a letter after discharge informing them of the approximate cost of their treatment.	Chief executive of PHT
South Central Ambulance Service and Hampshire Police Service				
21.	Disappointed that although the ambulance and police services have the facilities in place to record whether alcohol is a contributory factor in incidents that they attend, this is not currently happening routinely.	4.17	That improvements be made by the ambulance and police services to the way that information is recorded and collated to provide the evidence base for dealing with alcohol-related incidents. These services provide monthly data relating to incidents in night time economy areas to the Safer Portsmouth Partnership.	Chief Superintendent, Hampshire Police, Portsmouth Sector. Head of Operations Hampshire (South Central Ambulance Service)
22.	There is a strategy in place for dual diagnosis, but it does not seem to have been implemented.	7.101	Support the National Support Team recommendation to review the current Dual Diagnosis strategy to ensure full implementation. Determine the effectiveness of the dual diagnosis strategy and ensure that health and health and social care professionals adhere to it.	Director of Public Health and Well Being.

	Conclusions	Evidenced by	Recommendation	Lead Officer
23.	Concern that the consultant psychiatrist's regular visits to Mill House was stopped.	7.9	A business case be established to demonstrate the cost saving benefits of re-introducing this service to Mill House.	Director of Public Health and Well Being.
24.	People with alcohol misuse and mental health issues are not accessing appropriate treatment.	7.101, 8.40.7	Closer inter-agency working be introduced between health service providers and alcohol misuse providers in order to promote understanding of the complexities of each other's roles through work shadowing and regular meetings.	Director of Public Health and Well Being/ Director of adult social services and strategic director
The Probation Service				
25.	Concerned that the Probation Service raised the threshold for Alcohol Treatment Requirements (ATRs) to 30+ for their clients in June 2010 and has not put in place an alternative service for those clients with alcohol misuse issues but are no longer referred for ATRs.	7.90, 8.40.8	The Probation Service lower the threshold for ATR referrals to 20+ in line with the National Offender Management Service guidelines and the recommendation from the Department of Health National Support Team. The Probation Service develops Alcohol Specified Orders by April 2011.	Offender Management Director for Portsmouth Local Delivery Unit, Hampshire Probation Services.
Safer Portsmouth Partnership				
26.	Appalled that the IT systems of different agencies are not compatible.	7.52, 8.40	Safer Portsmouth Partnership consider introducing a client data collection or case management system. Agencies involved in alcohol-related issues make better use of their own IT systems to accurately record information that can be used to enforce licensing. For example, a police running log similar to that used for major events, to record incidents throughout the evening, which can later be analysed to build up a solid evidence base against persistent individuals or premises.	Chief Executive, Portsmouth City Council. Chief Superintendent, Hampshire Police, Portsmouth Sector.
27.	Pleased that there is some good joint working by licensed premises, the police, the ambulance service and the Portsmouth Street Pastors.	7.1, 7.74,	Support for joint working continue including using the Civic Offices for the Safe Space.	Director of Public Health and Well Being.

	Conclusions	Evidenced by	Recommendation	Lead Officer
28.	Disappointed with the poor recording of outcomes for clients discharged from treatment services.	7.20, 7.25.	Commissioners ensure that outcomes are recorded. An element of outcome-related payments to service providers be introduced whereby 10% is paid only if the client is still sober three months after discharge.	Director of Public Health and Well Being.
29.	The National Support Team concluded that there was not sufficient use of community detoxification programmes.	8.40.6	The use of community detoxification programmes be reviewed as recommended by the National Support Team. The Substance Misuse Joint Commissioning Manager collate and analyse the long-term outcome data for clients discharged from treatment services in order to review the balance and effectiveness of community and in-patient detoxification.	Director of adult social services and strategic director.
30.	Concerned that there is limited communication between agencies.	4.16, 4.17, 7.52, 8.40	Everyone involved meet regularly to agree a data-sharing protocol and introduce regular service manager contact.	Chief Executive, Portsmouth City Council.

Equality Impact Assessment (EIA)

11

11.1 Due regard to EIA has been given to each of the recommendations enclosed within the report and the panel is satisfied that no group would be disadvantaged by their implementation. The recommendations, if approved, would benefit all equally, or in the case of recommendation one, benefit the health of young people most and promote improved engagement and understanding between shop owners and staff with the Council and the Police. A full EIA will be included with the officer response report.

The beneficial impact on society and the health economy will see real benefits for all of society as any subsequent savings can be re-distributed to other vulnerable groups.

Legal comments

12

12.1 Legal Services have checked this report and have advised that the recommendations within this report are lawful but if the recommendations are to be implemented (and become policy) a full EIA should be undertaken.

Appendix 1

Glossary

A1

AA	Alcoholics Anonymous
AAF	Alcohol Attributable Fraction
ACT	Acceptance and Commitment Therapy
AGMA	Association of Greater Manchester Authorities
AIP	Alcohol Innovation Programme
AIT	Alcohol Interventions Team.
ARAR	Award in Responsible Alcohol Retailing
ARHA	Alcohol-related hospital admissions.
ASB	Anti-Social Behaviour
ASNS	Alcohol Specialist Nurse Service
ATR	Alcohol Treatment Referral
AUDIT	Alcohol Use Disorders Test
BIIAB	British Institute of Inn keeping
BBPA	British Beer and Pub Association
BWV	Body Warn Vest
CCTV	Closed Circuit Television
CDAS	Cranstoun Drug Agency Services
CRI	Crime Reduction Initiative
DPPO	Designated Public Place Order
DES	Direct Enhanced Services
DFES	Department for Education and Skills
DPPO	Designated Public Place Order
ED	Emergency Department.
EIA	Equalities Impact Assessment
ELB	Edinburgh Licensing Board
HIDS	Health Improvement & Development Service.
HOSP	Health Overview & Scrutiny Panel
IBA	Identification and Brief Advice
ICD	International Classification of Diseases
INSET	In-service training (for teachers)
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAPE	Local Area Profiles for England
LGR	Local Government Regulation
MAU	Medical Assessment Unit
NGO	Non-Governmental Organisation
NHPHA	National Health Promotion in Hospitals Audit.
NHS	National Health Service.
NI	National Indicators
NWPHO	North West Public Health Observatory
OFSTED	Office for Standards in Education
PAT	Paddington Alcohol Test.
PCO	Primary Care Organisation
PCT	Primary Care Trust
PND	Penalty Notice for Disorder
PSA	Public Service Agreement
PSHE	Personal, Social and Health Education
SDA	Scrutiny Development Area
UKATT	UK Alcohol Treatment Trial
QAH	Queen Alexandra Hospital.
WHO	World Health Organisation

Appendix 2

Bid document

A2

Portsmouth CITY COUNCIL

Portsmouth's bid for

Scrutiny Development Area status

for the Health Inequalities Scrutiny Programme

Dear Ms Turner,

One of the four key principles of scrutiny is "enabling the voice and concerns of the public". Portsmouth City Council has found this to be essential in its scrutiny work over the last 8 years particularly when conducting health scrutiny reviews.

As Chairman of the Health Overview & Scrutiny Panel, I feel that we engage the public very effectively in our scrutiny reviews. However, as we are continuously striving to improve, I believe that more effort should be focussed on giving the public a sense of ownership of the health services that are available to them.

The Portsmouth Alcohol Strategy 2009-2013 estimates that over 40,000 people in Portsmouth drink at levels that may harm their health. Alcohol misuse also affects significant numbers indirectly such as the family, friends and colleagues of these heavy drinkers.

Queen Alexandra Hospital serves residents from Portsmouth and its surrounding areas. The Portsmouth Health Overview & Scrutiny Panel has six co-opted members from Gosport Borough Council, Fareham Borough Council, Havant Borough Council, East Hampshire District Council, Winchester City Council and Hampshire County Council. Therefore, we believe that scrutinising alcohol-based hospital admissions at Queen Alexandra Hospital would give us an overview of alcohol misuse in the entire area. In turn, this will also allow us to reach more people, as we would be linking resources with multiple councils.

Being chosen as a Scrutiny Development Area would give us access to an expert advisor with an invaluable wealth of ideas and experience enabling the Panel to generate new schemes to better engage the communities that use the services, which are under scrutiny. The additional funding available would allow the Portsmouth Health Overview & Scrutiny Panel to develop new means of raising the profile of this scrutiny review including video diary rooms, stands, flyers, posters, surveys and articles on local media thereby increasing the interactivity between the public and the scrutiny panel.

Thank you for taking the time to consider Portsmouth Health Overview & Scrutiny Panel's bid to become a Scrutiny Development Area as part of the Centre for Public Scrutiny's Health Inequality programme.

Yours sincerely,

take part
pathfinder

Councillor David Horne, Chair of the HOSP

Portsmouth's bid for
Scrutiny Development Area status
for the Health Inequalities Scrutiny Programme

SECTION 1

Portsmouth Health Overview & Scrutiny Panel (henceforth referred to as the Panel) is a standing panel set up by Portsmouth City Council in 2003 in accordance with the Health and Social Care Act 2001. Representatives from surrounding local authorities (Gosport, Fareham, Havant, East Hampshire, Winchester and Hampshire) have all been co-opted onto the Panel. This is to ensure that where there is likely to be a significant impact upon these areas through the redevelopment of services in Portsmouth (particularly acute, or hospital services), the view of residents in those areas are considered and help to formulate any decision making process. It also helps to give the Panel a greater understanding of the wider health economy.

Other neighbouring local authorities with whom we engage regularly for health scrutiny work have expressed an interest in this review although are unable to commit resources. These include the Isle of Wight and Southampton.

The lead authority is Portsmouth City Council.

The Chair of the Panel is Councillor David Horne.

The contact officer is Jane Di Dino, Scrutiny Support Officer, Tel: 023 9283 4060, email: jane.didino@portsmouthcc.gov.uk.

SECTION 2

a. What is the health inequality that the partnership area wishes to review?

The Portsmouth Alcohol Misuse Needs Assessment, which was published in July 2009, outlined that 'research has shown that drinking occurs in all social classes. However, the problems from heavy drinking occur more from lower social classes.' It also revealed that alcohol misuse in Portsmouth and the surrounding areas affects all aspects of society regardless of gender, nationality and age. It is the impact that this has on hospital admissions that the Panel wishes to review.

b. Why the partnership area has chosen that subject; the benefits that the review will realise and why they should be a Scrutiny Development Area.

The Panel chose this issue because Portsmouth has a significant problem with alcohol misuse. The Portsmouth Alcohol Strategy 2009-13 estimated that 'over 40,000 people in Portsmouth drink at levels that may harm their health. Of these, over 8,000 drink at high-risk levels, this is over 35 units per week for women and 50 units per week for men. This high level of drinking all too often leads to health-related problems. Portsmouth has the highest rate of alcohol related hospital admissions in the South East region.' Portsmouth's rate of alcohol-related hospital admissions is also higher than the national average.

Queen Alexandra Hospital in Cosham offers acute services to patients from Portsmouth and the surrounding areas. The Panel has therefore decided to examine the impact of hospital admissions that are due to alcohol related illnesses, accidents and crime.

The benefits of the review will be enjoyed by all sections of the community, as none are untouched by this issue. In the current economic climate and with regard to health cuts over the coming years, it will raise awareness of the health services available, highlight the areas for improvement and recommend ways to ensure that the appropriate measures will be implemented. Overall, the public will gain a greater sense of ownership of the health services that they use.

Being chosen as a Scrutiny Development Area as part of the Health Inequalities Programme would give the Panel the opportunity to explore new and innovative ideas to engage less accessible sections of the community and share best practice with other authorities. This will be achieved by developing new ideas with the help of the expert advisor and the additional funding available through the Health Inequalities Programme. The Panel will also work with the Portsmouth Take Part! Pathfinder project officer

and the University of Portsmouth in order to increase the community's engagement with local democracy.

High quality involvement with the public is fundamental to Portsmouth City Council as required under section 138 of the Local Government and Public Involvement in Health Act 2007, which came into effect on 1 April 2009. Priority 7 of the Local Strategic Partnership's vision for Portsmouth is to "Encourage and enable healthy choices for all and provide appropriate access to health care and support." The Local Area Agreement priority 7.1 relates to National Indicator 39 "Rate of hospital admissions per 100,000 for alcohol related harm."

c. Who the partnership will include in the review (partners and community) at all stages.

Views will be sought from the following people and organisations during the review:

- Residents of Portsmouth, Gosport, Fareham, Havant, East Hampshire, Winchester and Hampshire.
- The Education Service.
- Director of Public Health and Wellbeing, Primary Care Trust.
- Service Manager Provider Services – Primary Care Trust.
- School Nurses.
- Education Support Workers.
- The University of Portsmouth.
- Representatives from the night time economy.
- Off licences.
- Portsmouth City Council's licensing department.
- The Street Pastors Scheme.
- Portsmouth City Council's Community Wardens.
- Hampshire Constabulary Service.
- Police Community Support Officers.
- South Central Ambulance Service.
- Portsmouth Hospitals Trust (PHT).
- Brief Intervention Teams.
- Service users of Queen Alexandra Hospital's A&E Department
- Portsmouth City Council's Trading Standards Service.
- Alcohol Arrest Referral Service.
- Alcohol public health lead for the Government Office for the South East.
- Hampshire Drug and Alcohol Teams.
- Salvation Army and Two Saints Housing Association.
- Victim Support.
- Alcoholics Anonymous.
- Community Safety.
- Anti Social Behaviour Unit.
- Voluntary Sector Treatment Services.
- Hampshire Probation Services.
- Court Service.
- The You Trust (Formerly Southern Focus Trust), which is a non-statutory partner in the Local Area Agreement.

This list is not exhaustive and other relevant witnesses will be added as the review progresses.

d. How the partnership will run the review, including how it will involve the community and the cost breakdown and request for funding.

The Panel proposes to run the review by actively participating in the following way:

1. Work with the Portsmouth Take Part! Pathfinder Project Team to reach a wider audience.
2. Receive presentations and reports at its meetings in the Civic Offices and a variety of venues in the community including Children Centres, schools and higher and further education establishments.
3. Work shadow key personnel who deal first hand with people misusing alcohol in Portsmouth to gain first-hand knowledge and understanding of the complexity of the issues involved.

4. Map a 24-hour period of the Guildhall Walk area, which has a high density of licensed premises, in order to measure the transformation from daytime to nighttime economy.
5. In conjunction with the Primary Care Trust, run an alcohol awareness information stand in the Guildhall Walk to highlight the review.
6. Conduct surveys of residents, health professionals and other relevant stakeholders.
7. Attend Neighbourhood Forum meetings to understand the views of residents and the impact it has on their community.
8. Attend a Local Involvement Network (LINk) meeting to canvass the views of members and gain an insight into how this effects the work they undertake utilising Community Voices Online.
9. Actively participate at a Drug and Alcohol Stakeholder workshop.
10. Host online consultations, forums and make the review available on Twitter as a means of interacting with the public at a time that suits them.
11. Engage with a wide variety of local media to publicise the review.
12. Produce scratch cards inviting people to participate in an online forum about alcohol misuse and be entered in a prize draw.
13. In conjunction with the Media Studies Department at the University of Portsmouth, install a video diary booth in the Guildhall area and Queen Alexandra Hospital to canvass the views of the general public.
14. Display posters to highlight the profile of the review in local authority housing blocks, community centres and glass recycling points.
15. Produce flyers highlighting the review and seeking feedback from employees and their families. These will be distributed with wage slips for Primary Care Trust, Portsmouth City Council and Portsmouth Hospitals' Trust staff.
16. Set up of a Comments Box for staff and service users in the A&E Department at Queen Alexandra Hospital.
17. Host a design charrette inviting a wide spectrum of professionals involved in alcohol misuse treatment services.

Detailed costs breakdown and the amount of funding being bid for.

Activity.	What would the funding cover?	Exactly how much is being requested?
Meetings at the Civic Offices.	Room booking, officer time, refreshments, IT equipment and parking.	Costs absorbed by Portsmouth City Council scrutiny budget.
Production and distribution of agendas and meeting papers.	Writing, compilation and distribution.	Costs absorbed by Portsmouth City Council scrutiny budget.
***Meetings in the community.**	Booking of venues across the city, officer time, refreshments, IT equipment and parking.	A proportion of costs would be absorbed by Portsmouth City Council's scrutiny budget. However, a maximum of £500 for venue hire that are not owned by the Council
***Flyer.**	Design, printing and distribution.	Costs subject to final design and specification up to a maximum of £500.
***Scratch cards.**	Design, printing, distribution, evaluation and prize draw.	Subject to final design and specification up to a maximum of £1,500
***Poster.**	Design, printing and delivery.	Subject to final design and specification up to a maximum of £500.
Attendance at LINk meetings.	Paperwork would be produced as part of the review.	Costs absorbed by Portsmouth City Council scrutiny budget.
Attendance at Neighbourhood Forum meetings.	Officer and member time and paperwork, distribution.	Costs absorbed by Portsmouth City Council scrutiny budget.
Activity.	What would the funding cover?	Exactly how much is being requested?
***Residents Survey.**	Design, production, researcher time to conduct the survey and evaluation of results.	A proportion of costs would be absorbed by Portsmouth City Council's scrutiny budget. However, up to a maximum of £750 for researcher costs and evaluation would be requested.
***Design Charrette.**	Booking of venue, facilitator costs including travel, refreshments, parking, IT equipment and production of information sheets, invitations and publicity.	A proportion of costs would be absorbed by Portsmouth City Council's scrutiny budget. However, up to a maximum of £250 would be set aside to cover additional costs.
Online consultations, forums and publishing on Twitter.	Design, production and hosting.	Costs absorbed by Portsmouth City Council scrutiny budget.
***Map a 24-hour period of the Guildhall Walk area.**	Officer and member time and utilisation of CCTV.	Costs absorbed by Portsmouth City Council scrutiny budget.
Attendance at Residents Participation Meetings.	Officer and member time, publicity and information about how to participate in the review.	Costs absorbed by Portsmouth City Council scrutiny budget.
***Video Diary Booth.**	Equipment hire, security, venue hire, publicity and evaluation.	Subject to final specifications, a maximum cost of £1,000 assuming the participation of the University of Portsmouth.
		Total: £5,000.

Those activities marked with an * will be subject to successful bidding for funding.

e. When the review will be carried out (including the timescales of the stages of the review).

20 January 2010
Health Overview & Scrutiny Panel will agree the terms of reference for the review.

February 2010
The Panel will commence the review with an introductory presentation in order to understand the situation in Portsmouth and the surrounding areas in terms of alcohol related hospital admissions due to illnesses, victims of alcohol-related crime and accidents.

March 2010
Surveys of residents and health service professionals will be conducted and the online consultations and forum will be set up. Additionally, three groups of four members will work shadow key personnel working in the following areas: prevention and reduction, treatment of the effects of alcohol and enforcement.

The Panel is committed to working within the timetable set out by the Centre for Public Scrutiny (CfPS). However a level of flexibility will be required due to the local and general elections. During the purdah period, which lasts from the day that the elections date is published to the actual date of the election, policy & review panels do not undertake reviews (excluding any matter which is the subject of call in). However, desk-based research and collation of information is carried out during this time.

SECTION 3

Set out how the proposed project meets these criteria:

1. **Answer fully all of the application questions above.**
   This is clearly demonstrated in section 2.
2. **Demonstrate the desire to adopt new and innovative approaches to Scrutiny and how being chosen as a Scrutiny Development Area will help you achieve this.**
   Section 2 d sets out our commitment to a range of methods to actively and innovatively engage inhabitants locally and in the surrounding areas.
3. **Show that consideration of local public health issues including the wider determinants of health has been given.**
   Section 2b sets out the major health issues in Portsmouth.
   The national and local issues surrounding alcohol related hospital admissions highlights the need to respond positively and act accordingly.
4. **Show a commitment to equality and diversity.**
   As health scrutiny in Portsmouth sits in the wider team of Democratic & Community Engagement, which includes equalities and diversity the review will utilise these resources to ensure maximum exposure for the review.
5. **Give a commitment to run with the review to the end of the programme.**
   Section 2 e demonstrates the Panel's commitment to completing the review.
6. **Show how your organisation will use this process to enhance Scrutiny within your area.**
   Innovative and collaborative working with stakeholders and surrounding local authorities will enhance the profile of scrutiny and encourage the public to actively engage and help to shape the changes to local services.

SECTION 4

The costs (exclusive of VAT) and the amount of funding being bid for are set out in section 2. The charging arrangements as determined by CfPS will be adhered to.

Portsmouth CITY COUNCIL

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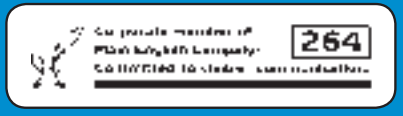

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Appendix 3

Meetings Held by the Panel

A3

Date	Witnesses	Documents Received
20 January 2010		The project brief for the review of alcohol-related hospital admissions.
4 March 2010.	Dr Paul Edmondson-Jones, Director of Public Health & Primary Care. Simon Mullett, Consultant, Portsmouth Hospitals Trust. Debbie Zimmerman, Operational Manager for the Emergency Department, Portsmouth Hospitals Trust.	1. The Portsmouth Alcohol Strategy 2009-2013 2. The Portsmouth Alcohol Misuse Joint Needs Assessment Study Report 3. Alcohol-related Hospital Admissions presentation by Dr Paul Edmondson-Jones. 4. Analysis of Alcohol-related Hospital Admissions presentation by Portsmouth Hospitals Trust. 5. Strategic Review of Health Inequalities in England Post 2010 - - Sir Michael Marmot 6. Portsmouth Street Pastors information sheet and newsletters dated June 2009, October 2009 and February 2010. 7. Street Pastors' observers' agreement.
10 June 2010.	Alan Knobel, Substance Misuse Coordinator, Portsmouth City Council.	1. Update on the Review of Alcohol-related Hospital Admissions; includes Visits and Work Shadowing Programme 2. Letter from Portsmouth resident regarding the promotion and selling of alcohol 3. Paddington Alcohol Detection Test 4. Paddington Test – amended version used by QA Hospital 5. Alcohol Screening Tools 6. Health Improvement & Development Service work with schools 7. List of ICD codes used and attributable fractions for VSC26/NI39/ PSA25.2 (List of illnesses/ accidents/ diseases that are attributable to alcohol) 8. Alcohol-related mortality rates in Portsmouth 9. Above average wine consumption map 10. Above average beer consumption map 11. Drinking every day figures by ward 12. Binge drinking figures by ward 13. Big Drink Debate report 14. Oldham Council measures introduced to reduce alcohol consumption 15. Links to the following documents: • Southampton's presentation on alcohol-related hospital admissions. http://www.portsmouth.gov.uk/yourcouncil/8312.html • The two presentations given at the HOSP meeting held on 4 March. http://www.portsmouth.gov.uk/yourcouncil/17561.html

Date	Witnesses	Documents Received
22 July.	Health Liaison Officer for Alcoholics Anonymous in Hampshire. David Sheehan, Development Manager, Public Health Group South East Dept of Health, Simon Mullett, Consultant, Portsmouth Hospitals' Trust	1. Summary of the public's views submitted to the Panel. 2. Notes from visit to Cranstoun Drug Services on 17 June. 3. Notes from work shadowing the police on 18 June. 4. Summary of Street Pastors visit by Chair on 16 July – to follow. 5. Summary of CCTV Control Room visits – 11 June. 6. CCTV control room statistics 2009. 7. Mill House operations strategy. 8a. Notes from informal meeting at Mill House and possible further questions. 8. Alcohol Intervention Team – annual report 1 April 2009 – 31 March 2010. 9. Department of Health Alcohol Harm Reduction National Support Team (NST) Visit to Portsmouth, 7-10 September. 10. Buckland Community Centre – Alcohol Support Centre Pilot. 11. Local Involvement Network annual report 12a. LINK report - appendix 4. 12. Tell Us Survey. 13. Evaluation of Frequent Flyers Pilot. 14. Information on the Taxi Marshals in Guildhall Walk. 15. Alcohol in the South East: Portsmouth CC HOSP presentation by David Sheehan. 16. Choosing Health in the South East: Alcohol by the South East Coast SHA and the South Central SHA 17. Effective NHS Contributions to Violence Prevention: The Cardiff Model. 18. Guideline for information sharing to reduce community violence by the College of Emergency Medicine
4 August	Action learning review.	
26 August		1. Portsmouth Users Self Help Group's presentation given out during the Chair's visit on 8 July. 2. Article on Alcohol Advertising by Lisa Dowd, Midland's correspondent published on 2nd June. 3. British Medical Journal article published on 21 January regarding alcohol advertising. 4. Definition of alcohol-related hospital admissions by the North West Public Health Observatory 5. Further information on the Frequent Flyers Pilot. 6. 'Extract from the National Health Promotion in Hospitals Audit 2009. 7. Proposed timetable for the scrutiny review of alcohol-related hospital admissions. 8. Summary of views given by the public at the public participation event held on 30 July 9. Notes from the Panel's visit to the Emergency Department at Queen Alexandra Hospital on 6 August

Date	Witnesses	Documents Received
26 August *continued*		10. Notes from the South Central Ambulance Services Deployment Review held on 21 July. 11. Action Learning Set notes from the meeting held on 4th August. 12. Framework for Assessing Substantial Change and Variation in Health Services, which was agreed by the Joint Health Overview & Scrutiny Committee in March 2005. 13. Extracts regarding alcohol from the Joint Strategic Needs Assessment 2009.
23 September		1. Profile of alcohol-related harm - Portsmouth City Teaching 2. New Alcohol Profiles for England provide national map of alcohol-related harms 3. Alcohol consumption Article on 03/09/10 BBC News website 4. Alcohol consumption Article on 03/09/10 Beer and Pub website 5. Coalition for Better Health information 6. Local voluntary minimum pricing – Article 23/06/10 Alcohol Policy 7. Summary of views from the public regarding this review 8. Notes from the visit to the South Central Ambulance Service Emergency Operations Centre on 27th August 9. National Institute for Clinical Excellence - interventions in schools to prevent and reduce alcohol use among children and young people 10. Information on the Emergency Department at Queen Alexandra Hospital
19 October		1. Alcohol review survey results. 2. Presentation of some of the National Support Team's recommendations.
25 November.		1. Presentation on the work of Portsmouth City Council's Trading Standards service.
17 December.	Nickii Humphreys, Licensing Manager Claire Upton-Brown Assistant Head of Planning Services.	
27 January 2011.		Business Case for the introduction of an Off Watch Scheme.

Appendix 4

Visits and work shadowing carried out by the Panel

A4

Date	Details
March to August 2010	Public survey.
12 and 13 March 2010	Work Shadowing with the Portsmouth Street Pastors.
27 March 2010	Work Shadowing with the Portsmouth Street Pastors. Attendance at the Portsmouth Street Pastors Launch.
14 April 2010	Alcohol Pathfinder Mapping Event
30 April 2010	Drug & Alcohol Stakeholder Meeting.
11 and 12 June 2010	Visits to the CCTV Control Room.
17 June 2010	Visit to Cranstoun Drug Services.
18 and 25 June 2010	Work Shadowing with the Police.
8 July 2010	Visit to Baytrees Detoxification Unit.
16 July	Work Shadowing with the Portsmouth Street Pastors.
26 July 2010	Visit to Portsmouth Users Self-Help (PUSH) Group.
30 July 2010	Public participation event.
6 August 2010	Visit to the Emergency Department at Queen Alexandra Hospital.
15 August 2010	Visit to the Medical Assessment Unit and the Intensive Care Unit at Queen Alexandra Hospital.
27 August 2010	Work Shadowing with the Ambulance Service.
27 August 2010	Observe at the Emergency Operations Centre.
27 August 2010	Visit to the Launch of the Safe Space centre.
27 August 2010	Visit to the Emergency Operations Centre, South Central Ambulance Service.
3 September 2010	Licensing Proposals Consultation Workshop.
23 September 2010	Visit to Kingsway House
8 December 2010	Visit to ANA Treatment Centre, Farlington.

Appendix 5

Explanation of how alcohol-related hospital admission figures are calculated

A5

Stock photo, posed by model.

How Numbers of Alcohol-related Hospital Admissions Are Calculated.

The production of measures of admission to hospital related to alcohol is dependent upon identifying all conditions known to be either wholly or partially attributable to alcohol (i.e. there is a risk associated with the consumption of alcohol) and the proportion of the population who might be affected.

The alcohol attributable fractions (AAFs) used to calculate hospital admissions for alcohol-related harm match the fractions published by the North West Public Health Observatory (NWPHO) in July 2008, following a review commissioned by the Department of Health. Briefly, alcohol-attributable fractions for England identified relative risk estimates from a number of epidemiological reviews and studies of the health impacts of alcohol; estimates of different levels of alcohol consumption in the population were obtained from the General Household Survey 2005. From these a set of age group and gender specific AAFs were derived for each alcohol-related condition, defined in terms of ICD10 codes. For most alcohol-related conditions, relative risk estimates were only available for adults, and the AAF for persons aged 15 or under was set to zero. The exception was conditions for which alcohol is a contributory factor in all cases, e.g. acute alcohol intoxication, where the AAF was set to 1 for all age groups.

Definition

Identification of hospital admissions with alcohol-related diagnoses

Data source: Hospital Episode Statistics [www.hesonline.org.uk]

The list of alcohol-related ICD10 codes and associated age group and gender specific AAFs was taken from the findings of the recent Department of Health review. Alcohol attributable fractions for England published in July 2008. Negative attributable fractions are not used (that is, they are set to zero).

The following criteria were used to select records for analysis. The text in square brackets shows how the selection criteria were defined in terms of HES dataset fields.

Further information can be found in the HES data dictionary at

[www.hesonline.org.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=571]

It was a finished episode [epistat = 3]

It was an admission episode [epiorder = 1]

The primary diagnosis or any of the 13 secondary diagnoses [diag_01 to diag_14] contained an ICD10 code that was in the list of alcohol-related codes in Table 1.

The sex of the patient was valid [sex = 1 or 2]

A valid age at start of episode was recorded [startage between 0-120 or between 7001- 7007]

The admission was an ordinary admission, day case or maternity [classpat = 1, 2 or 5]

The region of residence was one of the English regions, no fixed abode or unknown [resgor <= K or U or Y]

Estimating alcohol attributable admissions

For each episode identified in step 1 above, an attributable fraction was applied, based on the diagnostic codes, age group and gender of the patient. Where there was more than one alcohol-related ICD10 code among the 14 possible diagnostic codes, the one associated with the largest attributable fraction was selected. In the event of two or more codes with the same attributable fraction, the code from the earliest diagnostic position was used ['diagnostic position', takes an integer value between 1 and 14, corresponding to the 14 diagnosis fields diag_01 to diag_14].

Children aged under 16 were only included if they had an alcohol specific diagnosis i.e. where the attributable fraction = 1, meaning that alcohol consumption is a contributory factor in all cases. For other conditions, estimates of the alcohol attributable fraction were not available for children.

In some cases, the PCT of residence is recorded in the Hospital Episode Statistics data set but the Local Authority is not. To ensure that the figures for coterminous PCTs and LAs are the same, details of the Local Authority were added where this information could be ascertained from PCT residency.

Standardised rate calculation

Alcohol attributable admissions from step 2 above were aggregated by age group (5-year age bands to age 84, and 85years and over), gender and area of residence.

Mid-year population estimates were used to derive age group and gender specific rates for each area.

The directly age standardised rate is obtained as a weighted sum of the age-group and gender specific rates, where the weights are the proportion of the European Standard Population in each age and gender group.

[www.nchod.nhs.uk/NCHOD/Method.nsf/0/19bd7f5d961a822f65256cd2001eae50?OpenDocument]

http://www.nwph.net/alcohol/lape/NI39Technical_Dec2008.pdf

Appendix 6

The Paddington Alcohol Test

A6

Patient identification sticker

Only affix patient identification sticker if patient agrees to see the alcohol health worker. Otherwise leave blank.

ALCOHOL SCREENING TOOL FOR QA ED
FOR PATIENTS AGED 16+

(Based on Paddington Alcohol Test – PAT)

Reason for presentation: .....

Contact tel no:.....

Do you suspect alcohol use and does the patient have one or more of the following top 10 alcohol-related ED presentations? Please answer by placing a cross in the box (you may cross more than one box)

☐ FALL (inc trips) ☐ UNWELL ☐ ACCIDENT

☐ NON SPECIFIC G.I. ☐ HEAD INJURY ☐ REPEAT ATTENDER

☐ CARDIAC ☐ ASSAULT ☐ COLLAPSE (inc fits)

☐ PSYCHIATRIC (inc. DSH & OD, please specify)

If one or more of the top 10 conditions are met proceed to Q1. If not, please terminate this screening.

"We routinely ask all patients having ... (above presentation)... whether or not they drink alcohol."

Q1: Do you drink alcohol?

☐ Yes (go to Q2) ☐ No (end)

Q2: What is the most you will drink in any one day?

Use the below to estimate the total daily units (standard pub measures in brackets). (U.K. alcohol units)

REGULAR BEER /LAGER (Fosters/ Carling/ Guinness, approx. 4%)	Pints (2)	Cans/Bottles (2)	
PREMIUM BEER /LAGER /CIDER (Stella/Budweiser/Kronenbourg/ Strongbow/Magners, approx. 5%)	Pints (3)	Cans/ Bottles (3)	
WINE (Av. 12%)	175 ml Glass (2)	750ml Bottle (9)	
FORTIFIED WINE (14-25%)	750ml Bottle (10.5–19)	Litre Bottle (14–25)	
SPRITS (36-40%)	Glass (1) Singles (1)	750 ml Bottle (27–30)	Litre Bottle (36–40)
ALCOPOPS	330ml Bottle (1.5)	Litre Bottle (5)	

If more than twice daily limits (8 units/day men, 6 units/day women) then PAT +ve (Continue to Q3 for all)

Q3: How often do you drink?

☐ Every day

☐ .....Times a week

☐ .....Times a month

☐ Less than once a month

Q4: Do you feel your attendance here is related to alcohol use?

☐ Yes (PAT +ve)

☐ No

If PAT +ve give feedback e.g. "Can we advise you that your drinking is harming your health?". "It is recommended that you do not regularly drink more than 4 units/day (men) 3 units/day (women)".

Q5: We would like to offer you further advice. Would you be willing to see our alcohol health worker?

☐ Yes

☐ No

If YES ensure you have contact telephone number & patient location & place in AIT tray. If No give information leaflet.

☐ ADMITTED TO WARD: .....

Referrer's Name & Ward/Department: .....

Referrer's Signature: .....

Date: .....

☐ DISCHARGED:

☐ LEAFLET GIVEN:

Appendix 7

Alcohol review survey results report

Contents

A7

Introduction

Portsmouth has the highest rate of alcohol related hospital admissions in the South East. In November 2009 the city council's Health Overview and Scrutiny Panel agreed to conduct a review into the subject to investigate the causes and impact of alcohol misuse on different sections of society. This was with a view to evaluate what impact alcohol related admissions are having on council services and to develop recommendations to improve alcohol prevention and misuse services in the city.

As part of public engagement in the review a survey was carried out between April and August 2010. Respondents were asked a number of questions and asked to express their views on alcohol use and misuse. This report highlights the results of this survey.

Responses and analysis

A total of 974 responses were received to the survey. This means the results meet the sample size required for a 95% confidence level with a 4% margin of error (based on 2009 Portsmouth population estimates).

Results are displayed as percentages and non-replies to questions are not counted towards these percentages. Where appropriate, results have been broken down by age group, gender and ethnicity. Statistical significance testing has been carried out using a z-test.

Further analysis

Further analysis of the results may be possible. For further information or for help in interpreting the results please email marketresearch@portsmouthcc.gov.uk or call 9283 4075.

Summary

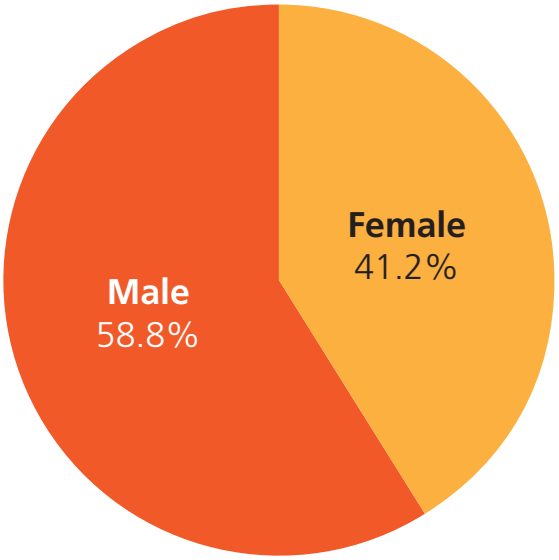
- Over two thirds of respondents under estimate the economic impact of alcohol misuse.
- While almost three quarters have not missed any time off work or study because of drinking too much, younger respondents and male respondents were far more likely to have missed five or more days.
- Most respondents indicated that if the price of their favourite alcoholic drink were to be increased, they would just pay more. Just over a quarter of respondents said they would drink less of the same drink.
- The majority of respondents said they did not go into town at night because of the drunken behaviour of other people.
- Most respondents felt schools should teach children about the dangers of alcohol misuse between the ages of nine and eleven. Respondents aged under 25 and male respondents were more likely to think this education should wait until children were older.
- The majority of respondents indicated they got most of their alcohol from supermarkets. Almost 30% said most of their alcohol came from pubs, bars and clubs.

Profile of respondents

Respondents were asked a number of questions to determine what groups they fit into. This allows results to be broken down by different population groups to give further insight. Some of these characteristics are shown below.

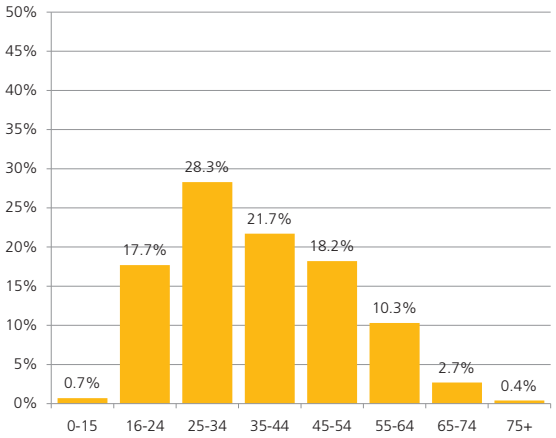
Gender:

Chart 1: How would you describe yourself?



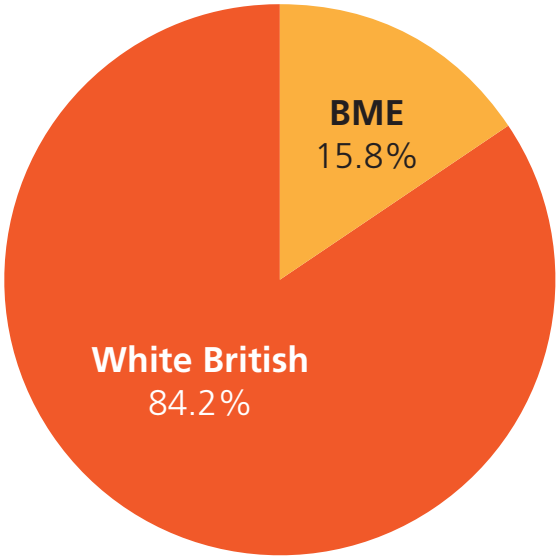
Age group:

Chart 2: What age group do you fit into?



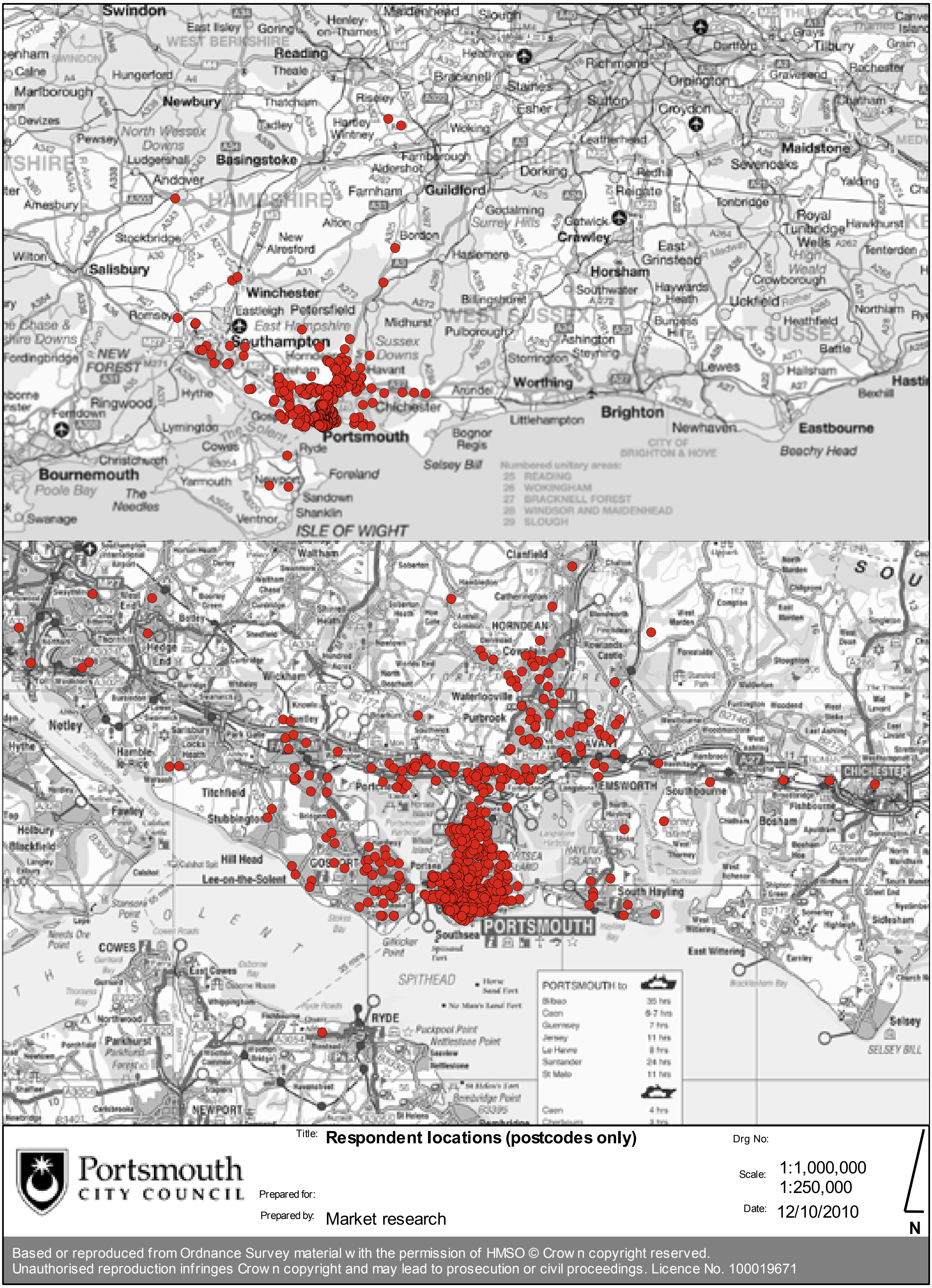
Ethnicity:

Chart 3: Which of the following ethnic groups do you belong to?



Location:

Respondents were asked to enter their postcode on the survey. This allows responses to be mapped and, if necessary, analysed geographically, while maintaining respondent anonymity. Map 1 shows the geographic distribution of these postcodes. This map shows where the majority of responses are from, although a couple of replies were from further afield.

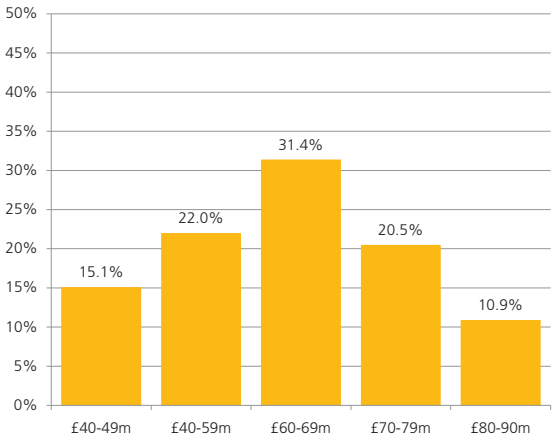


Map 1: Respondent locations (postcodes only).

Cost of alcohol misuse

Respondents were first asked how much they thought alcohol misuse costs Portsmouth's economy each year.

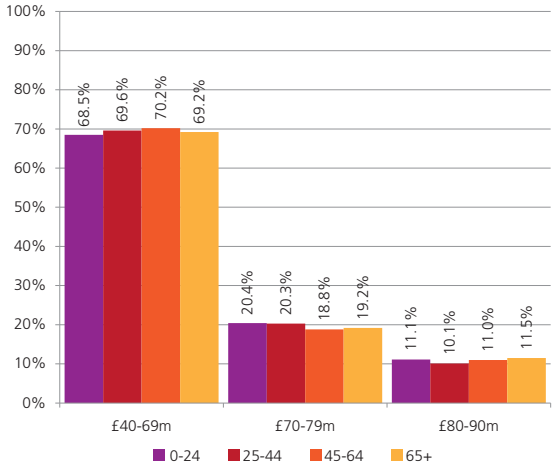
Chart 4: How much do you think alcohol misuse costs Portsmouth's economy per year?



Almost one third thought it costs the city's economy between £60m and £69m each year.

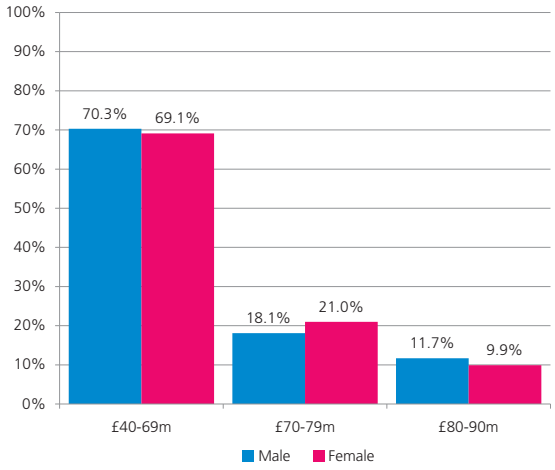
Alcohol misuse in fact costs the city around £74m each year. The results of the survey show that more than two thirds of respondents, around 69%, underestimate the cost of alcohol misuse to Portsmouth's economy.

Chart 5: How much do you think alcohol misuse costs Portsmouth's economy per year? By What age group do you fit into?



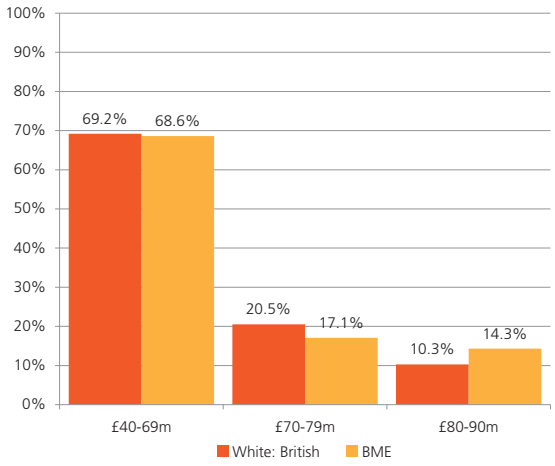
Roughly speaking the same proportion of people across all age groups were likely to underestimate the cost of alcohol on the city's economy.

Chart 6: How much do you think alcohol misuse costs Portsmouth's economy per year? By How would you describe yourself?



The results were also similar between male and female respondents.

Chart 7: How much do you think alcohol misuse costs Portsmouth's economy per year? By Which of the following ethnic groups do you belong to?

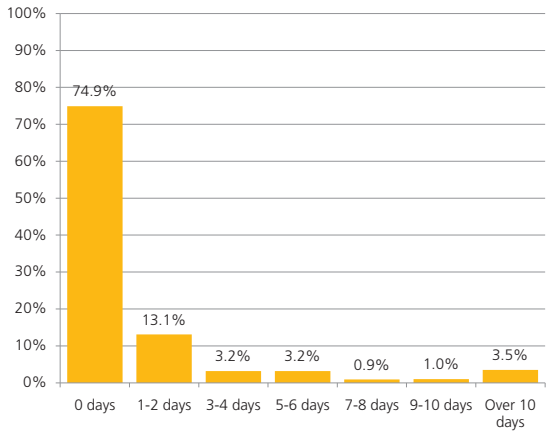


The differences between white British and black and minority ethnic groups were also only slight.

Missing work or study because of alcohol

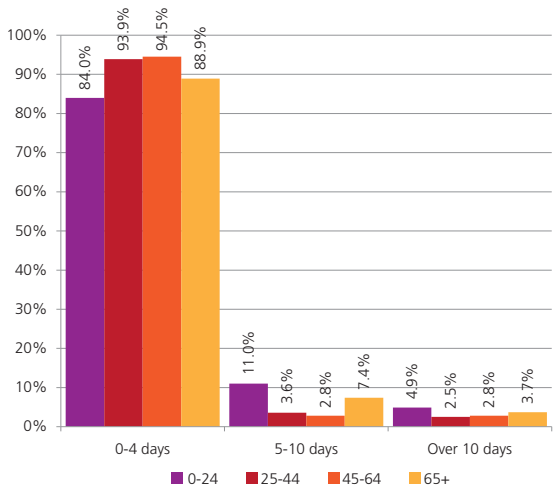
Respondents were asked how many days they had missed work, a place of study or been unable to function normally over the last year due to drinking too much.

Chart 8: How many days have you missed work, place of study or been unable to function normally over the last year due to drinking too much?



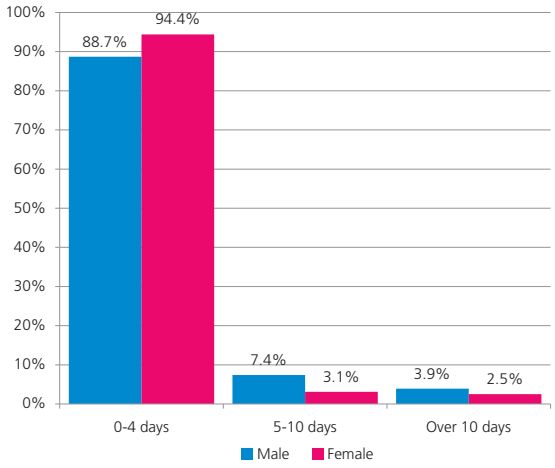
Three quarters had not missed any days due to drinking too much. Just over 5% had missed between five and ten days, while over 3% had missed over ten days.

Chart 9: How many days have you missed work, place of study or been unable to function normally over the last year due to drinking too much? By What age group do you fit into?



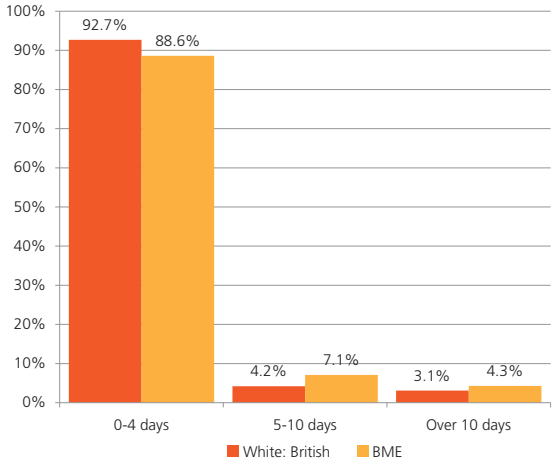
Respondents aged under 25 were more likely to have missed five or more days from work or study due to drink. The difference compared with respondents aged 25 to 64 is statistically significant.

Chart 10: How many days have you missed work, place of study or been unable to function normally over the last year due to drinking too much?



Male respondents were far less likely to have missed between none and four days and far more likely to have missed five days and over because of drinking too much. Males are therefore more likely to miss longer periods of work or study because of drinking too much. Indeed, the difference compared with female respondents is statistically significant.

Chart 11: How many days have you missed work, place of study or been unable to function normally over the last year due to drinking too much? By Which of the following ethnic groups do you belong to?

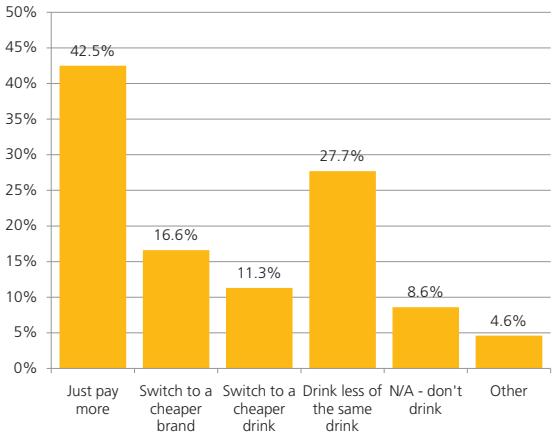


There was no statistically significant difference in the response between white British and black and minority ethnic groups.

Increasing the price of alcohol

Respondents were asked, if the price of their favourite alcoholic drink increased, what would they do to change their drinking habits.

Chart 12: If the price of your favourite alcoholic drink increased, what would you do to change your drinking habits?



Over 40% of respondents said they would just pay more. Over a quarter, or 28%, said they would drink less of the same drink. Just under 10% felt this question was irrelevant as they did not drink anyway.

Responses for those that said "other" are shown in Table 1.

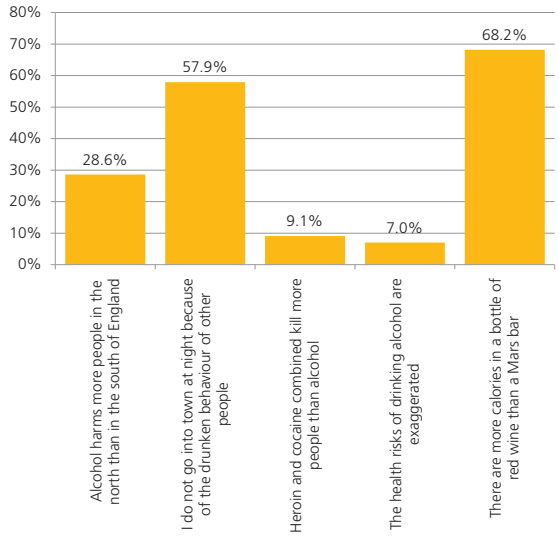
Table 1: If the price of your favourite alcoholic drink increased, what would you do to change your drinking habits? Responses for "other".

Comments under "other".
Or if too expensive drink homebrew.
Not drink.
Stop sale of drink from supermarkets. Restrict hours of drinking.
Go out less but when go out drink more.
Start at home.
Brew my own.
Stop drinking.
At first and then change my drinking habits.
Boycott.
Don't drink much.
Why should I be penalised. I am responsible. Educate the person who cannot drink to enjoy but drinks to excess.
I would also be very angry. How dare the majority be punished for the inability to cope of the minority? No to government interference in private lives!
Stop drinking.
Not drink.
Guinness.
Brew my own.
Just pay more on those big nights out, but other nights drink less, probably go out less often.
Buy it in the supermarket rather than pub.
Drink before going out.
Alternatively, find activities and events and participate without drinking.
I am in recovery 16 months but will answer according my previous drinking habits.
Or find somewhere cheaper.
Buy in bulk.
Do nothing.
Probably not drink.
I don't have a favourite drink.
A little of all of them and favourite when on offer.
Give up.
Drink ethanol.
Especially as I drink very little!
Buy it from the shops in bulk and drink before I go
Drink at home with friends and family rather than in pubs or restaurant.
Home brewing.
Grey economy, cheap EU imports.
Drink at home.
I do not have a favourite drink.
Drink at home rather than the pub. And go out less often.
Brew my own.
I don't really have a favourite.
It depends how much it increased by, surely?
I always buy my wine in France, better quality for the price.
Go to the pub/bar/clubs less frequently.
Irrelevant, it does each budget anyway.

True or false

Respondents were given a number of statements and asked to indicate which ones they thought were true.

Chart 13: Which of the following statements do you think are true?



Over one quarter, or 29%, thought it was true that alcohol harms more people in the north than in the south of England. This statement is, in fact, correct.

Almost 60% of respondents said they did not go into town at night because of the drunken behaviour of other people.

Only 9% though that heroin and cocaine combined kill more people than alcohol was true. This statement is, in fact, false.

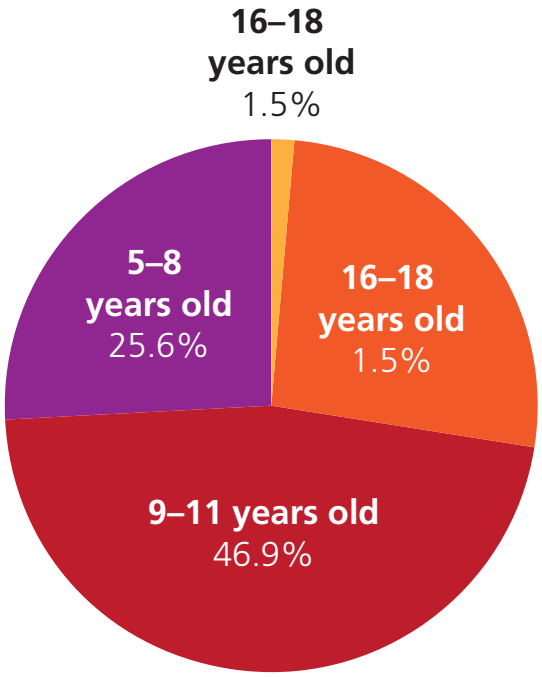
Only a small minority, 7%, felt the health risks of drinking alcohol are exaggerated.

Over two thirds, or 68%, believed it was true that there were more calories in a bottle of red wine than a Mars bar. In reality, this statement is true.

Alcohol misuse education

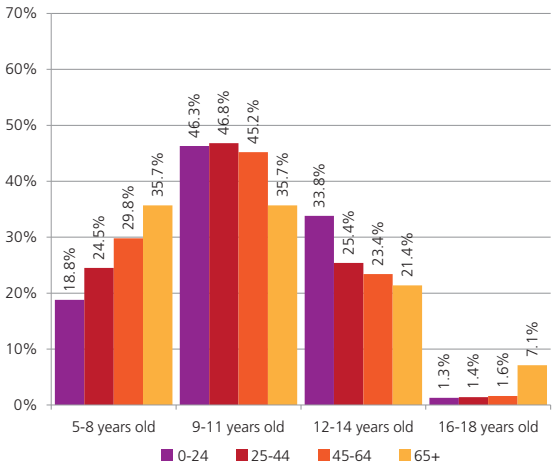
Respondents were asked at what age should schools start teaching children about the dangers of alcohol misuse.

Chart 14: At what age should schools start teaching children about the dangers of alcohol misuse?



Just over a quarter believed the dangers of alcohol misuse should be taught to five to eight year olds. Almost half the respondents felt it should be taught to nine to eleven year olds. Just over another quarter felt it should be taught to 12 to 15 year olds. Only a very small minority, 1.5%, felt teaching children the dangers of alcohol misuse should wait until they are 16 to 18 years old.

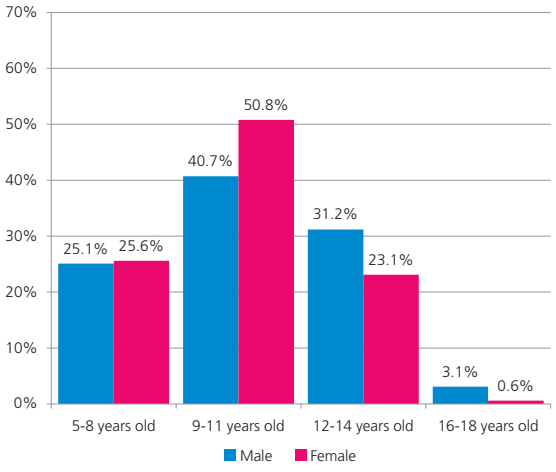
Chart 15: At what age should schools start teaching children about the dangers of alcohol misuse? By What age group do you fit into?



Generally speaking, younger respondents were more likely to suggest children should be taught about the dangers of alcohol misuse when they are older as opposed to younger.

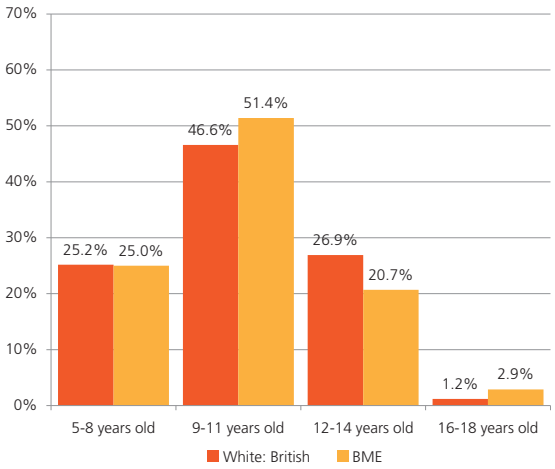
This is the opposite for older respondents, who are more likely to feel children should be taught from a younger age. However, respondents in all age groups felt the optimum age to teach children about the dangers of alcohol misuse was between nine and eleven years old.

Chart 16: At what age should schools start teaching children about the dangers of alcohol misuse? By How would you describe yourself?



Compared with female respondents, male respondents were more likely to think children should be taught about the dangers of alcohol misuse when they were older as opposed to younger. The difference with female respondents in this respect is statistically significant.

Chart 17: At what age should schools start teaching children about the dangers of alcohol misuse? By Which of the following ethnic groups do you belong do?

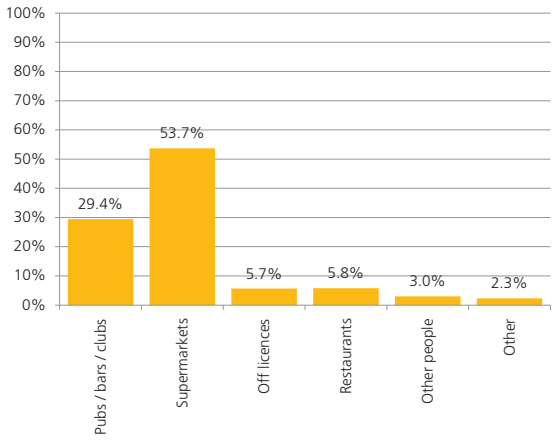


There was no real statistically significant difference in the responses between white British and black and minority ethnic groups.

Where does alcohol come from?

Respondents were finally asked, in general, where does most of the alcohol they drink come from.

Chart 18: In general, where does most of the alcohol that you drink come from?



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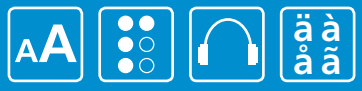

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