Sandwell NHS Primary Care Trust

Sandwell Metropolitan Borough Council

JSNA

Alcohol

Sandwell PCT Public Health

Information and Intelligence Team

January 2010

Information Reader Box

Document Purpose	For information
Title	JSNA – Alcohol 2010
Author	Dr. Richard Wilson
Publication Date	January 2010
Target Audience	Alcohol Commissioning group, Sandwell PCT, Sandwell MBC, partners and public
Circulation List	Sandwell PCT, HWBB, LSP, JSNA website
Description	To provide evidence on alcohol its harms and the recommended areas for action.
Cross Ref:	JSNA executive summary, Community Safety Partnership report, JSNA 2008
Superseded Docs.	N/A
Action Required	N/A
Timing	To be reviewed in 2012
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Executive Summary

"Safe. Sensible. Social, The next steps in the National Alcohol Strategy", published in June 2007, set out the Government's agenda on alcohol misuse and built on the strategy produced in 2004.

Excessive drinking is a major cause of disease and injury, accounting worldwide for 9.2% of disability-adjusted life years with only tobacco smoking and high blood pressure as higher risk factors. For the NHS alone, the estimated financial burden of alcohol misuse is around £2.7 billion in hospital. In 2007/8 there were 91,500 hospital admissions wholly or partially attributable to alcohol which continued a year on year increase in these admissions. One in four A&E attendances is related to alcohol in some areas. Health inequalities are clearly evident as a result of alcohol-related harm where Department of Health analysis of ONS data indicates that alcohol-related death rates are about 45% higher in areas of high deprivation.

Sandwell was visited by the National Support Team for alcohol related harm who have subsequently provided guidance and support. In October 2009 we held a Visioning Day in Sandwell to bring all key agencies and members of the public together to create a vision of Sandwell with fewer alcohol problems, along with a partnership plan to achieve the vision.

We currently have a Local Area Agreement target to double the number of people receiving 2 or more specialist interventions over 3 years which will be completed in March 2010. A National Indicator, NI39, measures the rate of admissions to hospital, both alcohol specific and alcohol attributable and will help focus services locally to reduce these numbers.

The broad national aims for alcohol services are to achieve:

- a reduction of both alcohol consumption and dependence
- amelioration of alcohol-related health problems – such as liver disease, malnutrition or psychological problems
- amelioration of alcohol-related social problems – such as family and interpersonal relationships, ability to perform effectively at work, avoidance of criminal activity
- a general improvement in health and social functioning.

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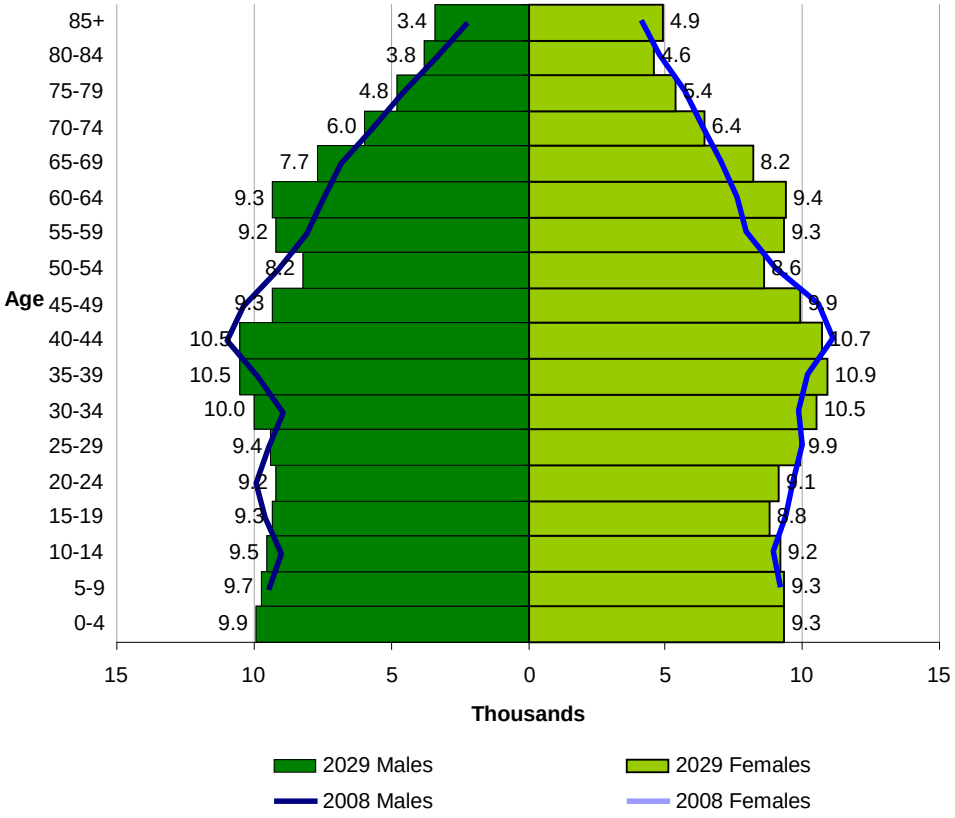
1 Sandwell Population

The current population of Sandwell is estimated at 287,700. By 2029 it is estimated at 304,000. Sandwell is predicted to grow at only half the speed of England, up 5.5% compared to England growing 10.2%. The growth in the population is greatest in those aged over 55, as people benefit from improvements in life expected (Figure 1). There are some concerns whether these estimates adequately reflect the increasing birth rate in our black and minority ethnic (BME)

Figure 1: Population of Sandwell by age and sex, 2008 compared to 2029



Source: ONS Mid-Year estimates and Projections

It would be wrong to suggest the whole of Sandwell is ageing in the same way. Across the wards there are considerable variations in the ratio of young to old. In St Pauls and Soho and Victoria there are nearly five under 15 year olds to every person aged over 75 (ratio of 4.9:1). In Old Warley there are three people under 15 year olds to every two people aged over 75 (ratio of 3.2:2). Maps have been produced that show the variations and these are included on the JSNA website.

Sandwell is an ethnically diverse place with 20.3% of the population from a BME group. The largest non-white ethnic groups are Indian at 9.1% and Black Caribbean 3.3% (Table 1: Ethnic profiles of Sandwell Wards, 2001). The most ethnically diverse wards are St Pauls (63.6% non-white, 31.0% Indian), Soho and Victoria (58.8% non-white, 17.5% Indian, 16.6% Pakistani and 13.2% Black Caribbean) and West Bromwich Central (49.2% non-white 27.1% Indian).

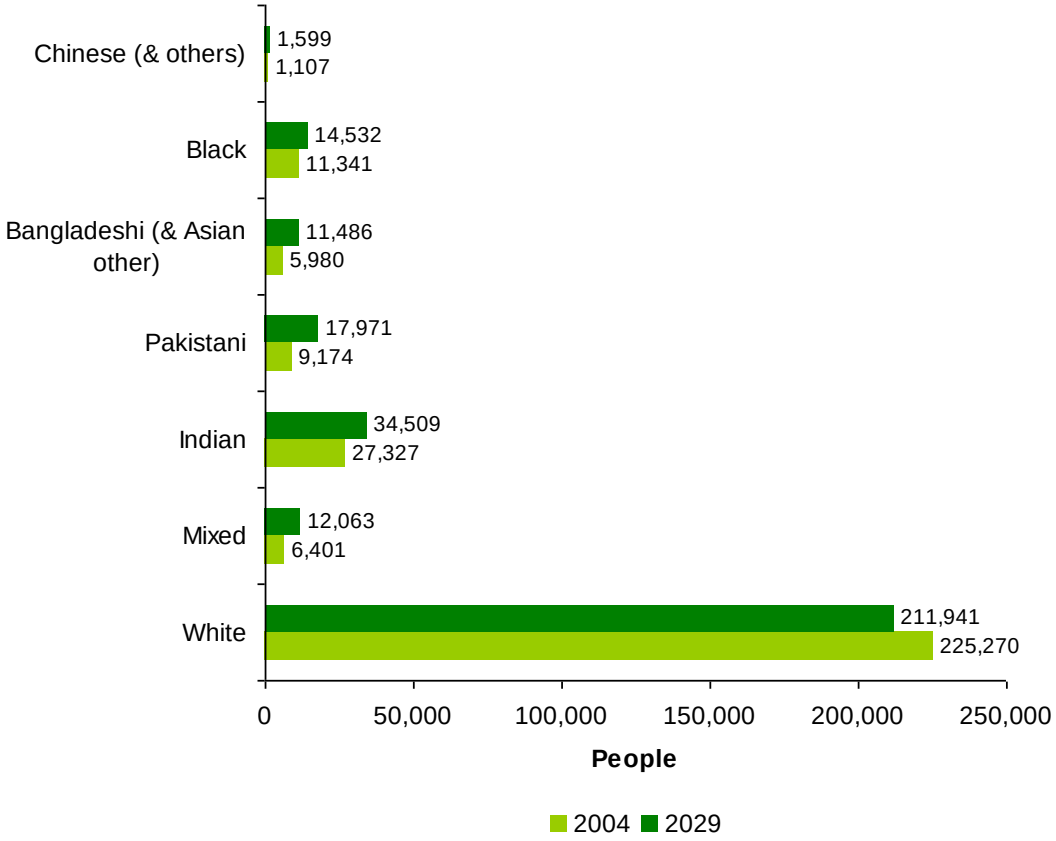
Table 1: Ethnic profiles of Sandwell Wards, 2001

Ward	White	Mixed	Indian	Pakist-ani	Bangl-adeshi	Black Carib-bean	Black African	Other
Abbey	83.7	2.9	6.6	1.7	0.1	3.5	0.5	0.9
Blackheath	91.0	1.6	2.6	1.8	0.6	1.4	0.0	1.1
Bristnall	85.9	2.6	6.4	0.9	0.2	3.0	0.2	0.7
Charlemont	86.1	1.5	8.2	0.4	0.1	2.3	0.3	1.1
Cradley Heath & Old Hill	91.0	1.6	0.8	4.3	0.4	0.9	0.1	1.0
Friar Park	95.0	1.5	1.9	0.2	0.1	0.9	0.1	0.3
Great Barr	83.2	1.5	10.8	0.5	0.4	2.0	0.3	1.3
Great Bridge	88.9	1.4	5.1	1.5	0.4	1.8	0.1	0.9
Greets Green & Lyng	67.8	2.3	14.2	3.9	4.7	4.2	0.3	2.6
Hateley Heath	85.0	2.6	7.2	0.3	0.7	3.5	0.2	0.6
Langley	83.6	2.1	8.5	1.5	0.1	3.2	0.2	0.9
Newton	80.9	2.2	9.0	0.5	0.2	5.3	0.2	1.7
Old Warley	88.9	1.7	5.4	0.5	0.1	2.3	0.1	1.0
Oldbury	64.3	2.4	16.1	9.4	0.3	5.4	0.1	1.9
Princes End	95.0	1.5	1.8	0.1	0.1	1.2	0.0	0.4
Rowley	93.1	1.7	1.8	1.7	0.2	1.0	0.0	0.5
Smethwick	56.8	3.9	19.2	10.1	0.4	5.9	0.7	3.2
Soho and Victoria	41.2	5.1	17.5	16.6	1.1	13.0	1.2	4.2
St. Pauls	36.4	3.3	31.0	9.0	9.1	7.2	0.3	3.6
Tipton Green	75.3	1.8	10.0	5.5	2.3	3.5	0.1	1.4
Tividale	93.0	1.4	2.3	0.5	0.1	2.1	0.1	0.5
Wednesbury North	88.8	1.5	3.5	0.3	4.3	1.0	0.1	0.4
Wednesbury South	81.4	1.8	11.8	0.4	0.6	2.8	0.1	1.1
West Bromwich Central	50.8	2.6	27.1	5.5	3.0	7.9	0.1	3.1
Sandwell	79.7	2.1	9.1	2.9	1.2	3.3	0.2	1.3

Source: 2001 Census

It is not just the age profile of Sandwell that is changing the ethnic profile is changing rapidly. By 2029, the BME population of Sandwell will have grown to be 30% of the population. The largest projected increases are in the Bangladeshi, and Pakistani populations that double in size due to a higher birth rate (Figure 2).

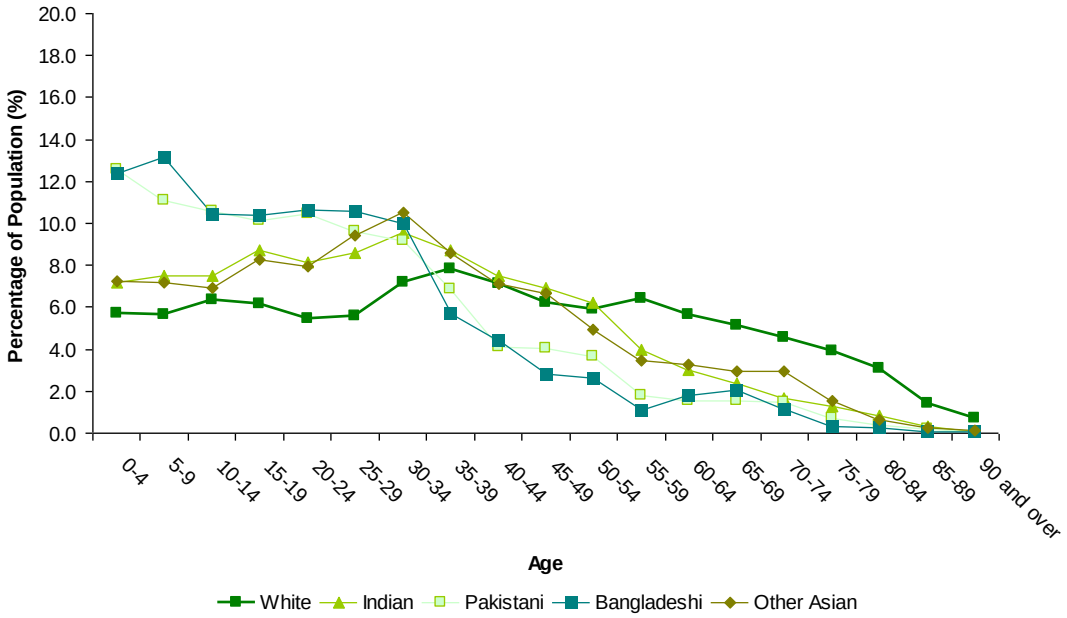
Figure 2: Population of Sandwell by ethnic group, 2008 compared to 2029



Source: ECOTEC HDAM model Dec 2007

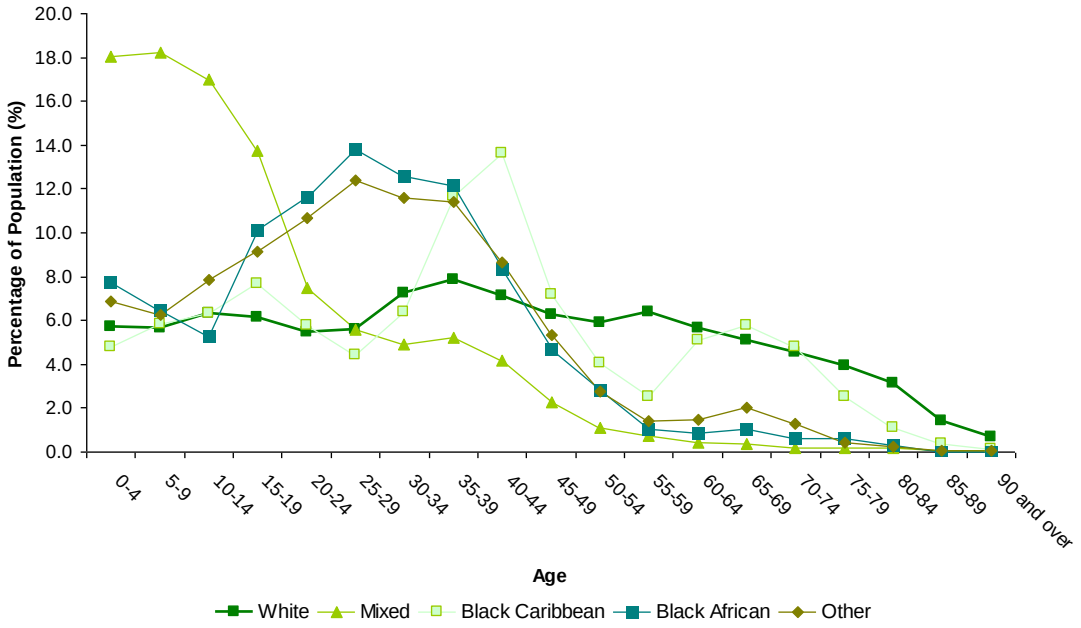
The age profiles of the different ethnic groups will affect how we plan services to be both culturally and clinically relevant. Mixed group are the youngest with over 50% being under the age of 20 (Figure 3). 40% of the Pakistani and Bangladeshi are also under the age of 20, which compares to 25% of the white population.

Figure 3: Age profile of the different ethnic groups, Asian and White, Sandwell



Source: ECOTEC HDAM model Dec 2007

Figure 4: Age profile of the different ethnic groups, Black, Others and White, Sandwell



Source: ECOTEC HDAM model Dec 2007

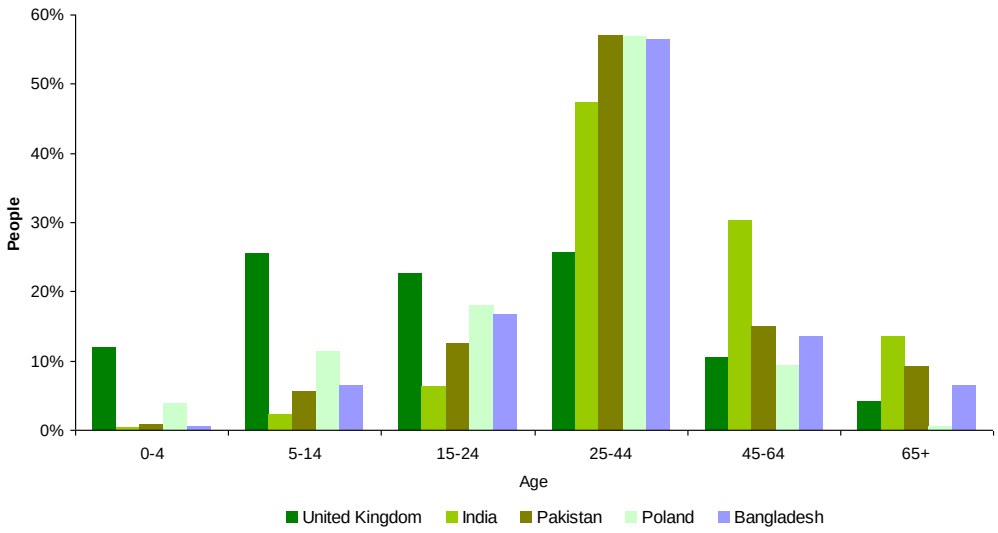
There are weaknesses in the estimate of ethnic populations as they do not reflect the influx of migrants from the accession states of the European Union. Using data from our GP registrations it is possible to get an idea of how our population is changing. For example, there are over 2,000 people newly registered with our GPs (1.3% of the total population from Poland) (Table 2). These numbers are backed up by data from National Insurance registrations that show 2,070 people from Poland registered to work in Sandwell in the last two years. These new residents are predominantly of working age although there are substantial proportions of younger people (Figure 5).

Table 2: Country of Birth of people registered with a GP, 2008

Country of Birth	% of Population
United Kingdom	86.7
India	5.1
Pakistan	2.0
Poland	1.3
Bangladesh	1.1
Zimbabwe	0.4
Afghanistan	0.4
Iraq	0.4
Somalia	0.3
Iran	0.2
china	0.2
Philippines	0.2
Nigeria	0.2
Latvia	0.2

Source: M-Connect 2008

Figure 5: Age of those registering with a GP by country of Birth, 2008

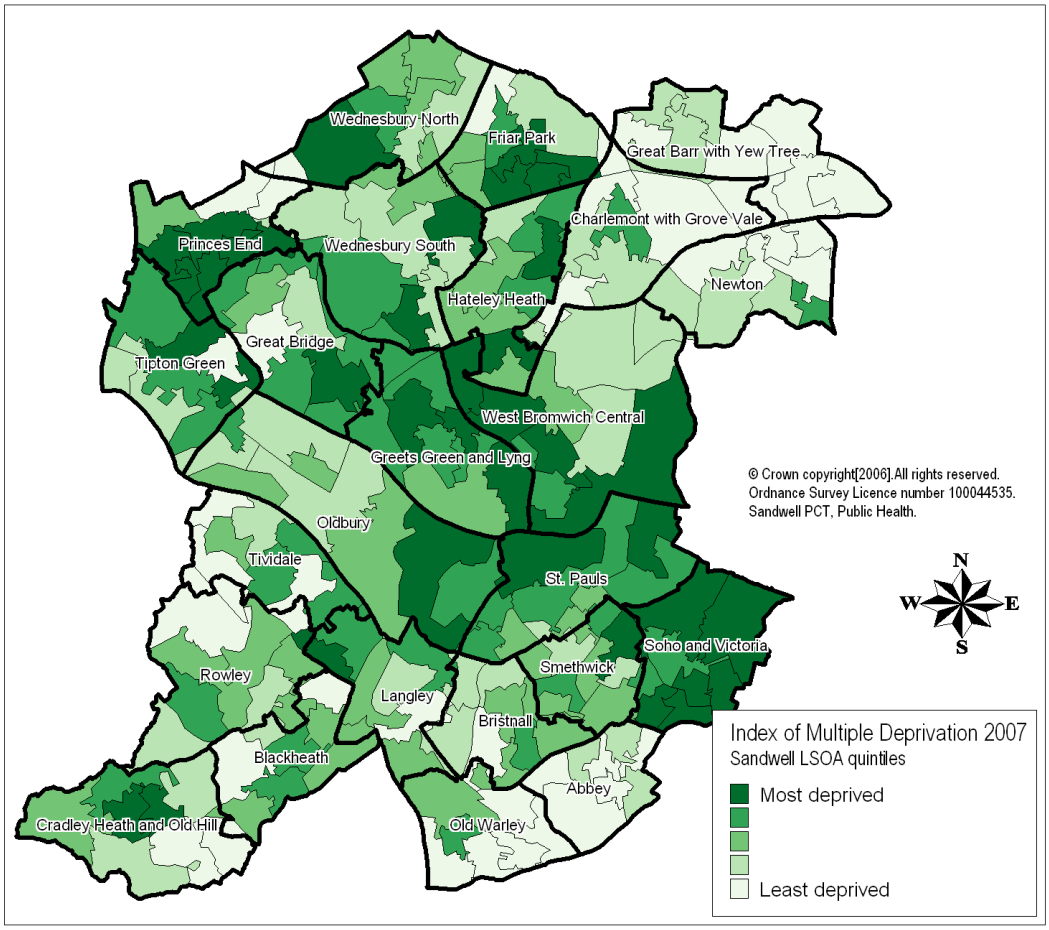


Source: M-Connect 2008

1.1 Deprivation

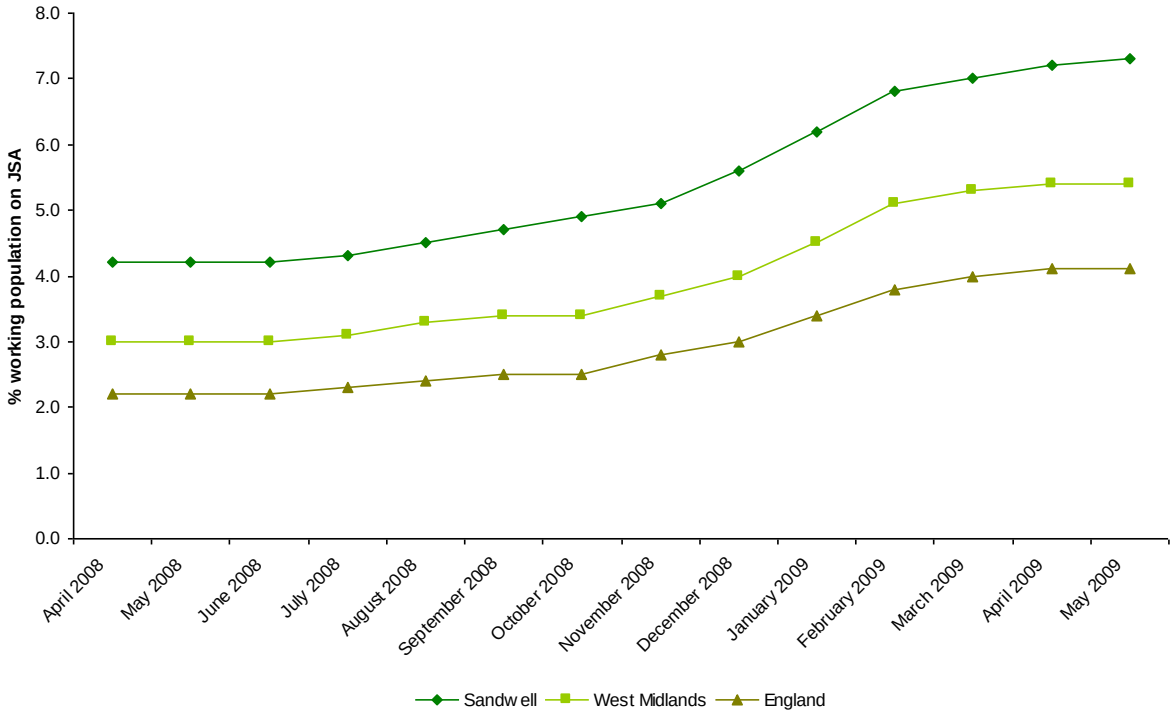
The Indices of Multiple Deprivation 2007 (IMD 2007) are measures of deprivation of local communities (known as Super Output Areas). The indices fall into seven categories of indicators of deprivation, known as domains, for each of which individual Super Output Areas (SOAs) are given scores and national rankings. Sandwell is the 14th most deprived local authority in England. 15 of our wards fall into the most deprived 10% nationally. The eastern side of Sandwell is the most deprived (Figure 6).

Figure 6: Deprivation across Sandwell, IMD 2007



The impact of the recession will however deepen the inequality between Sandwell and the rest of England primarily because of the size of our manufacturing sector in which 25% work. Sandwell is the 4th hardest hit local authority in terms of unemployment across England. It is unclear how this will impact on the health and well-being in Sandwell, it is possible that the demand for mental health support will increase in the short to medium term but the significant impact will be felt in the longer term if those made newly unemployed fail to regain work: continued unemployment curtails life expectancy. Jobseeker Allowance claimants went up 73% in the year up to May 2009, from 4.2% of the working age population to 7.3%.

Figure 7: Percentage of working age population on Job Seekers Allowance, April 2008 to May 2009.



Source: ONS claimant count, Crown copyright material is reproduced with the permission of the Controller of HMSO

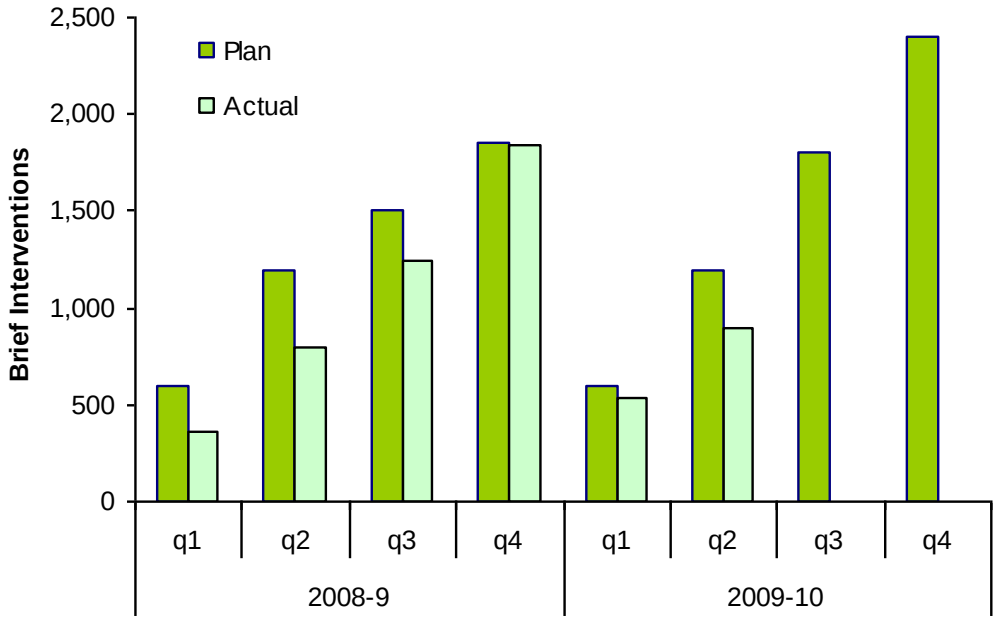
2 Targets

Reducing alcohol related harm is a priority area for both the Local Area Agreement and for World Class Commissioning.

2.1 LAA

There is an LAA target for alcohol to achieve 2,400 brief interventions in the year 2009/10, growing from a milestone of 1,200 in 2007/8 (Figure 8**Error! Reference source not found.**).

Figure 8 LAA target achievement: Brief Interventions



Source: Aquarius

2.2 World Class Commissioning

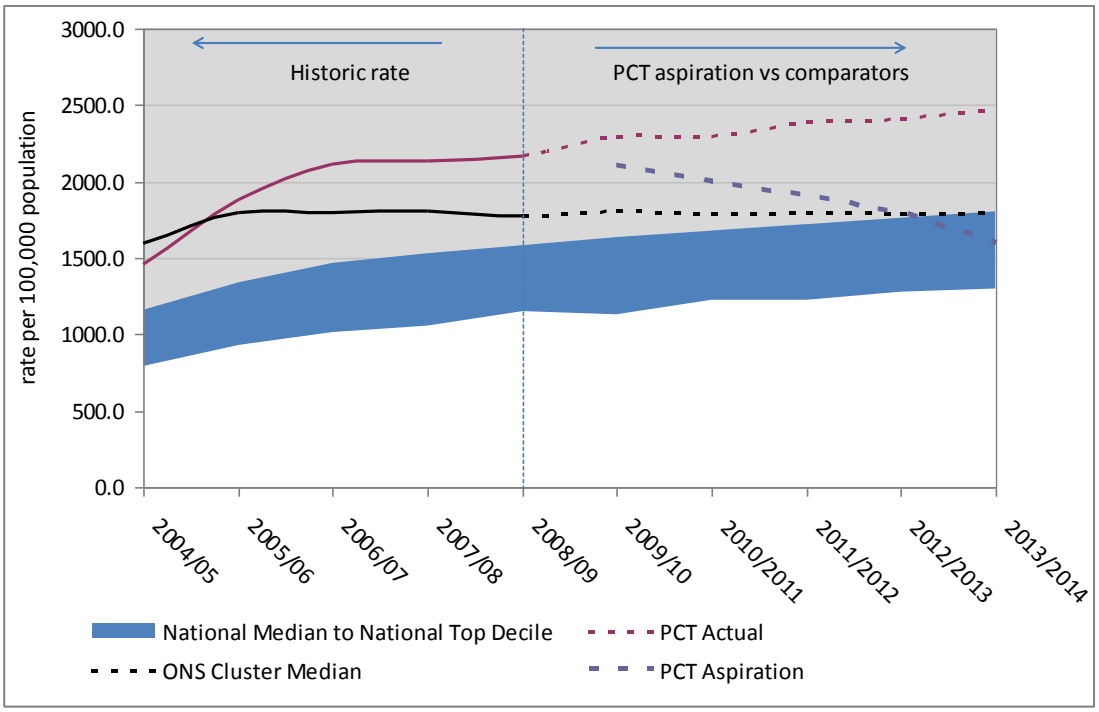
The World Class Commissioning (WCC) process required the PCT to compare its position with the best in the country and our cluster group to set an aspirational target. The aspiration agreed on is to reduce admission rate due to alcohol related harm down from 2,080 per 100,000 to 1,600 per 100,000 by 2013/14. This would bring the PCT in line with the national average and out perform the cluster median (Figure 9), and has been recognised as ambitious by the SHA demonstrating how seriously the Local Strategic Partnership take the issue.

Table 3: WCC benchmarking for alcohol related harm

		2005	2006	2007	2008	2009
	Best performing decile	794.8	924.3	1019	1057.7	1155.8
	England Median	1157.5	1343.5	1465	1533.5	1582
All PCTs	England lowest	451	656	570	640	369
Peer Group	Median	1586	1854	1989	2104	2080
	Lowest	1235	1419	1667	1732	1480
	Sandwell PCT	1455	1879	2112	2132	2167
	Rank (0ut of 152)	116	139	141	139	133

Source: NHS Information Centre WCC Data packs

Figure 9: Aspirational target for alcohol related admissions



Source: West Midlands SHA

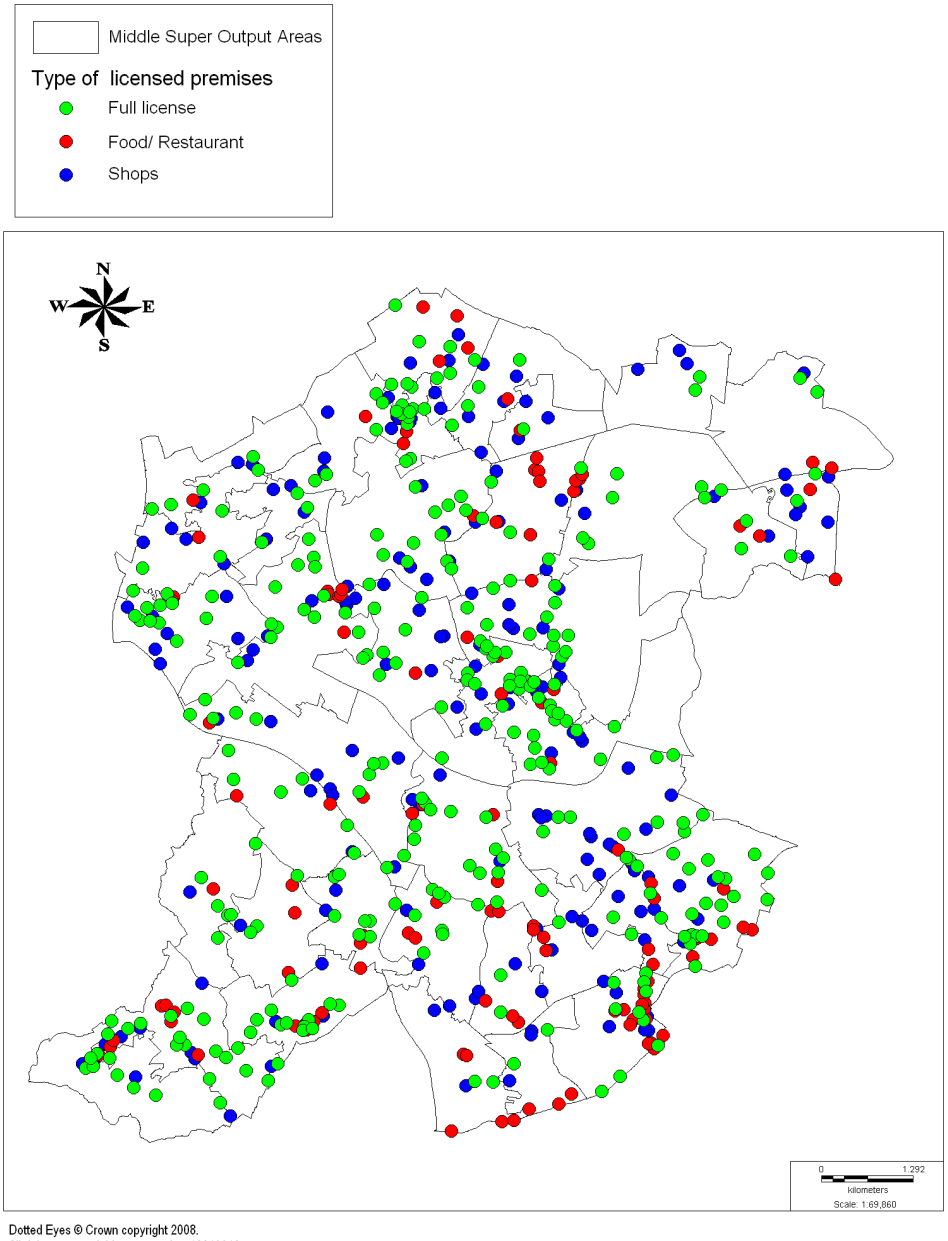
3 Prevalence

3.1 Risk factors

3.1.1 Availability of alcohol

Alcohol is widely available both for consumption in a premises (full licence) and from off-licence retail units across Sandwell (Figure 10)

Figure 10: Map showing the location of retail venues selling alcohol, 2009



Source: Sandwell MBC

3.1.2 Drinking patterns

There is a lack of good lifestyle data available on drinking behaviours at a local level. The only data available nationally against which we can benchmark the population are the synthetic estimates produced by Association of Public Health Observatories. These show that Sandwell appears to not have an alcohol problem as the percentage of the population engaging in either hazardous, harmful or binge drinking is either below or no different to the England average (Table 4). The levels in Sandwell are estimated to be lower than most of our comparator PCTs.

Table 4: Estimates of drinking patterns for Sandwell and its peers

	Hazardous Drinking %		Harmful Drinking %		Binge Drinking %	
England	20.1	(18.4) to (21.8)	5.0	(4.5) to (5.6)	18.0	(17.4) to (18.6)
West Midlands	18.3	(16.8) to (19.8)	4.9	(4.4) to (5.4)	17.9	(16.3) to (19.6)
Sandwell	16.5	(15.2) to (17.8)	5.2	(4.7) to (5.7)	17.3	(15.1) to (19.7)
Blackburn with Darwent	17.6	(16.2) to (19)	5.5	(5) to (6.1)	20.7	(17.8) to (23.9)
Blackpool	18.9	(17.3) to (20.4)	5.7	(5.1) to (6.3)	24.6	(22.1) to (27.3)
Islington	21.4	(19.3) to (23.5)	6.1	(5.4) to (6.8)	15.3	(13.1) to (17.8)
Knowsley	21.3	(19.4) to (23.1)	7.4	(6.6) to (8.2)	23.8	(20.9) to (27)
Liverpool	22.6	(20.6) to (24.6)	8.1	(7.2) to (9)	26.9	(23.6) to (30.4)
Manchester	22.5	(20.5) to (24.6)	8.8	(7.7) to (9.8)	28.4	(24.9) to (32.1)
Middlesbrough	22.3	(20.4) to (24.2)	6.3	(5.6) to (7)	27.8	(24.5) to (31.5)
Newham	14.1	(13) to (15.2)	5.1	(4.5) to (5.6)	12.3	(10) to (15)
Nottingham City	18.7	(16.9) to (20.5)	6.5	(5.6) to (7.3)	23.0	(19.6) to (26.7)
Salford	22.9	(21) to (24.9)	7.5	(6.7) to (8.4)	26.4	(23.6) to (29.5)
Tower Hamlets	15.9	(14.3) to (17.5)	6.0	(5.3) to (6.7)	14.8	(12.5) to (17.3)

Source: APHO

Young people

The Lifestyles survey of children in Sandwell aged between 12 – 15 years found that 32% of boys and 33% of girls state that they have had an alcoholic drink at least once. They reported drinking recently with their last drink being "in the last week". They described their drinking "for fun", and only a small number recognised they had a drink problem; 2.6% of boys and 2.8% of girls. The TellUs survey of children in schools report that between 2007 and 2008 there was a fall in numbers of young people who had never had an alcoholic drink, but also an improvement in the number of young people who have been drunk which has fallen.

4 Service description

4.1 Licensing and legislative interventions

The current legislation provides powers to tackle most of the issues arising from alcohol disorder in and around licensed premises but the appropriate authorities need to be encouraged to use those powers. The Police have a wide range of closure powers under the 2003 Act and, in addition to prosecuting licence holders for offences which may be committed under the Act there are also review powers which means action can be taken against known 'problem' premises. In fact Sandwell had more review Hearings than any other Licensing Authority in the country, primarily as a result of under-age sales test purchasing exercises by our own Trading Standards officers as well as the Police. Licensing Authority Committees have been recommended by Government to take a much tougher stance against premises which continue to sell alcohol to those who are under the age of 18, which would include the power to suspend or, ultimately, revoke a premises licence.

Certain conditions of the Policing and Crime Act 2009 (OPSI, 2009) will come into effect on the 29th January 2010, namely:

- section 28 (persistent sales to children - "three strikes to two strikes")
- section 29 (confiscation of alcohol from under 18's);
- section 30 (new offence of persistently possessing alcohol in a public place by under 18's);
- section 31 (extending directions to leave to those aged 10 or over),
- section 33 (allowing councillors to act as interested parties)

Also, there are five conditions proposed by the government in response to the mandatory licensing code. These are:

- banning irresponsible promotions, such as ‘all you can drink for £10’ or ‘women drink free’ deals, that encourage people to drink quickly or irresponsibly
- banning ‘dentist’s chairs’ where drink is poured directly into the mouths of customers, making it impossible for them to control the amount they are drinking
- ensuring free tap water is available for customers, allowing people to space out their drinks
- ensuring all those who sell alcohol have an age-verification policy in place, requiring them to check the ID of anyone who looks under-18
- ensuring small measures of beers, wine and spirits are made available to customers

Local consultation at the Alcohol Visioning Day held in October 2009 shows that there is vigorous local support for measures to tackle all the problems

caused by irresponsible licensing, sales and pricing and local solutions will be sought to address the issues.

In England and Wales we have do have a particular problem about 'availability' which needs to be addressed at some stage, either at Government level through amended legislation or by Licensing Authorities themselves introducing more 'cumulative impact' areas based on evidence from the Police, which could effectively reduce the number of premises selling alcohol within a given area. Blackpool Council are one particular Licensing Authority to have successfully introduced cumulative impact areas for both 'on' and 'off' licensed premises. Oldham Council have also brought in fairly stringent measures to tackle 'binge' drinking, affecting 'on' and 'off' licensed premises recently, including 'queuing' systems in bars and a ban on purchasing more than 2 drinks at a time.

4.2 Community/voluntary sector

This sector is underutilised currently due to the lack of local knowledge, the DAAT is addressing through a investigative piece of work. The aim of which is to identify the capacity within this sector to be trained in alcohol awareness and identification and brief advice. This work is due to be completed by July 2010.

Sandwell voluntary sector comprises some 430+ separate organisations, each of which needs to be assessed and categorised according to their suitability, interest and capacity to identify issues, deliver information, advice, brief intervention and appropriate referral. We also need to identify organisations that have the capacity to benefit from staff training, those able to deliver training internally and those able to deliver training to organisations which are external to their own.

4.3 Primary care Primary care activity and initiatives (Tier 1)

We have an alcohol Local Enhanced Service to which 20 practices have signed up. The service actively promotes practices searching for alcohol problems within the practice population and administering a brief assessment tool (the Alcohol Use Disorders Identification Tool - AUDIT) to ascertain usage. From the scoring of the AUDIT tool either a brief intervention is given in the surgery or a referral is made to tier 2 services (Aquarius specialist alcohol counselling). There were 8 more canvassed to find out what measures may make them yet take up the LES. However to date the engagement with practices has been poor with only 3 practices taking up the LES and activity levels very low (Table 5)

Table 5: LES activity, 2009-2010 first 3 quarters

Levels	Patients

1. Number of patients who have had an AUDIT score of >15 and who have been referred to Sandwell Aquarius.	13
2. Number of patients who have had an AUDIT score of 9 to 15 and have undergone brief intervention	21
3. the number where intervention has resulted in a reduction in alcohol consumption when the patient has been followed up (as measured by AUDIT score)	1

Source: Sandwell PCT

4.4 Tier 2 activity (specialist alcohol interventions delivered by Aquarius)

The purpose of identification and brief intervention (IBA) is to engage professionals from as many different backgrounds as possible in order to identify people who are drinking at harmful levels and to deliver brief advice to them to help reduce their consumption. IBA is one of the most effective interventions for reducing people's alcohol consumption and therefore harm. IBA is particularly effective amongst harmful and hazardous drinkers i.e. drinking at levels that could cause them significant physical or mental health or may cause significant harm to others such as through domestic abuse. IBA has been consistently shown in randomised controlled trials to reduce the amount of alcohol that an individual consumes whether it is delivered in a primary or secondary healthcare setting.

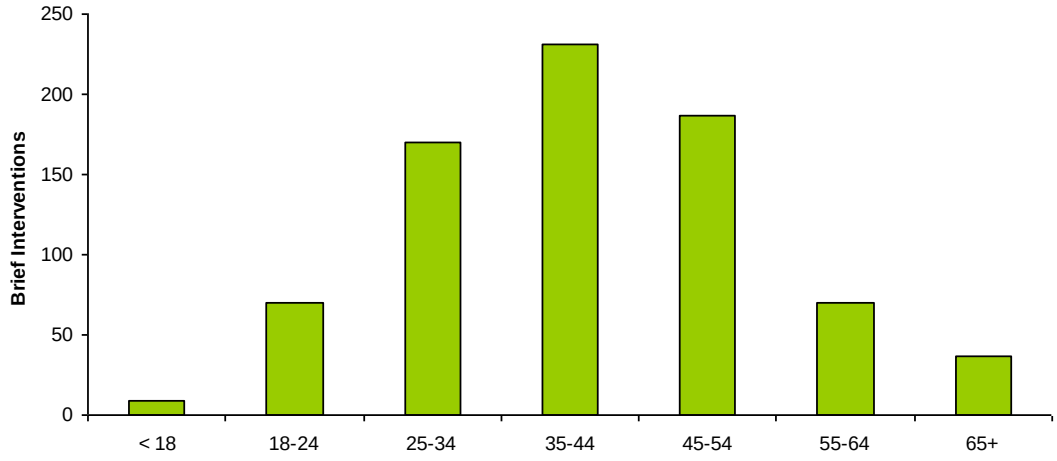
As mentioned above IBA is the LAA target. The people being given a brief intervention are aged between 25-54, and male (73.4%) (Figure 11). Aquarius also delivers services in primary care and in Sandwell hospital. They offer an arrest referral service and an Asian specialist service. They have extended their role to also do outreach work with Sikh males. They also co-ordinate pre and post detoxification services with the tier 3 provider (Anchor) and operate an open referral service.

The treatment pathways for adults in for tier 2 to tier 3 are included in the appendix.

For young people DECCA provide Tier 1 education in schools and outreach and education in communities and with professionals. Tier 2 and 3 treatment services including counselling, psychosocial intervention, GP prescribing, specialist pharmacological invention. Decca have specialist workers for Looked After Young People, providing direct support to young people and their carers and further with young offenders.

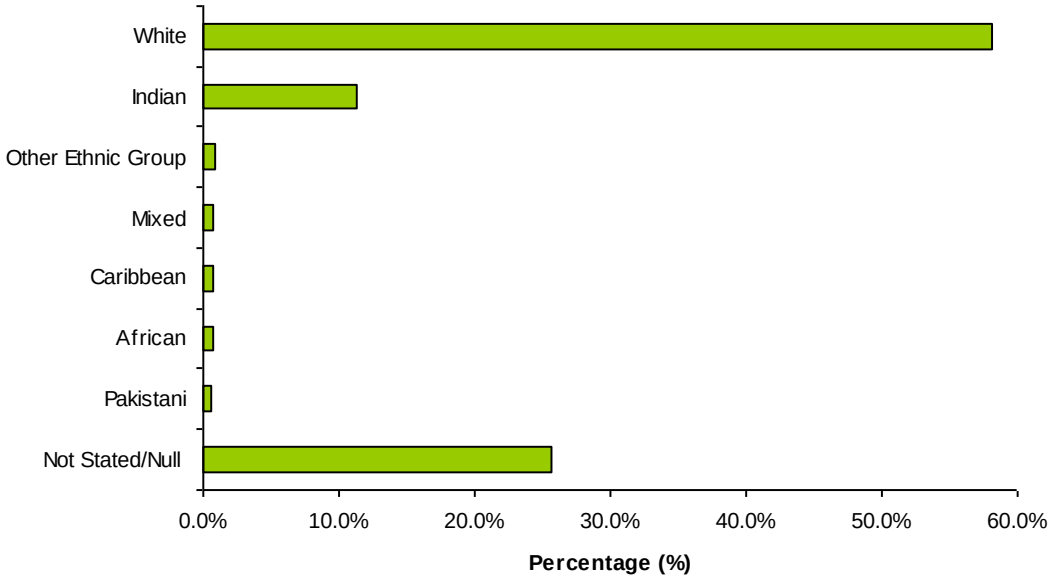
Aquarius deliver family support services working with parents/carers and siblings of young people misusing substances.

Figure 11 Age profile of those receiving brief interventions



Source: Aquarius

Figure 12: Ethnic profile of those receiving brief interventions

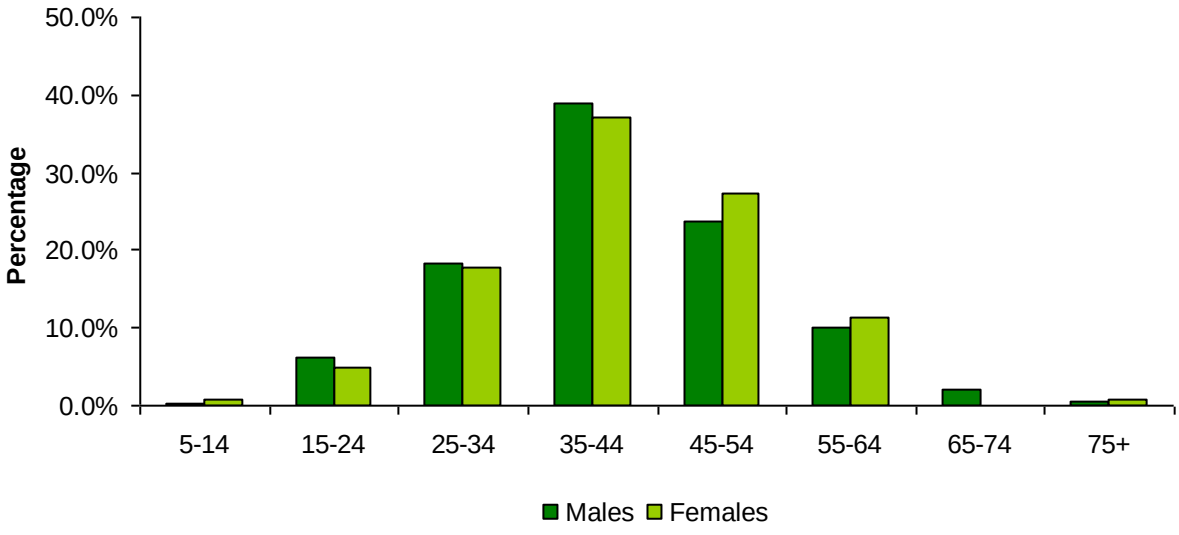


Source: Aquarius

4.5 Tier 3 provision

Anchor treated 648 clients in the last two financial years (2007/8 and 2008/9) (Figure 13). The vast majority of clients were white 68.6%, with 10% being Indian. There were 17.9% of records with no recorded ethnicity that might be masking access by other ethnic minority groups.

Figure 13 Anchor clients 2006/7 to 2008/9



Source: Anchor

4.6 Tier 4 and supportive services

Tier 4 services could include hostel provision (both wet and dry), support services for people in need of hospital admission that prevent the admission, step down or floating support for those discharged from hospital (with a focus on the prevention of re-admission) and low level maintenance for those at risk of serious health problems and those who need to focus on abstinence. There has been some very limited take up for residential placements over the last few years for both people with alcohol problems and problematic drug use. This level of need would be more efficiently and successfully addressed with increased local provision and choice

5 Impact

5.1 Morbidity

Table 6: Admissions to hospital from Alcohol related conditions, Sandwell compared to its peers, 2006/7

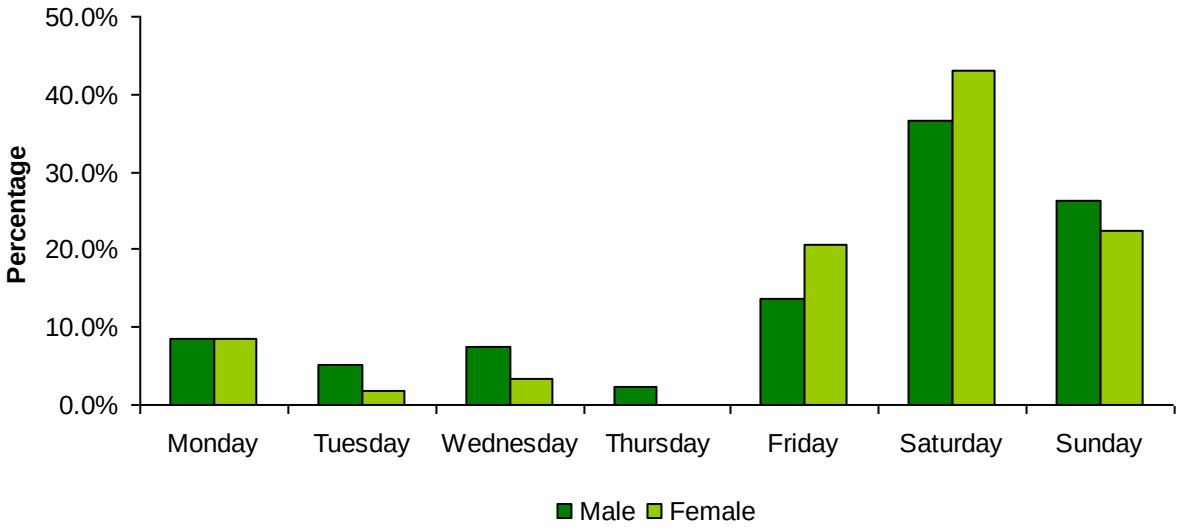
	Number of admissions	Rate per 100,000
Dudley	5,126	1,412
Walsall Teaching	5,113	1,775
Wolverhampton City	3,979	1,480
Bolton	5,150	1,806
Gateshead	5,101	2,338
Coventry Teaching	3,246	1,003
Derby City	4,966	1,877
Stoke on Trent	6,779	2,413
Sandwell	**6,741**	**2,129**

Source: DH, 2008

5.1.1 Accident and Emergency

Data on A&E attendees is poorly recorded across the NHS, especially with regard to why people and attend and even worse with regard to the involvement of alcohol. In the West Midlands the police are working with many of the A&E departments to record data on assault attendances and in this they record whether the injured person had been drinking. This system is the LINXs system. This data collection has only been in place since the summer of 2009 and data is less than complete. However, it does provide a window into what is happening at least for one group of patients. Not unsurprisingly most assault victims presented over the weekend (Friday, Saturday or Sunday).

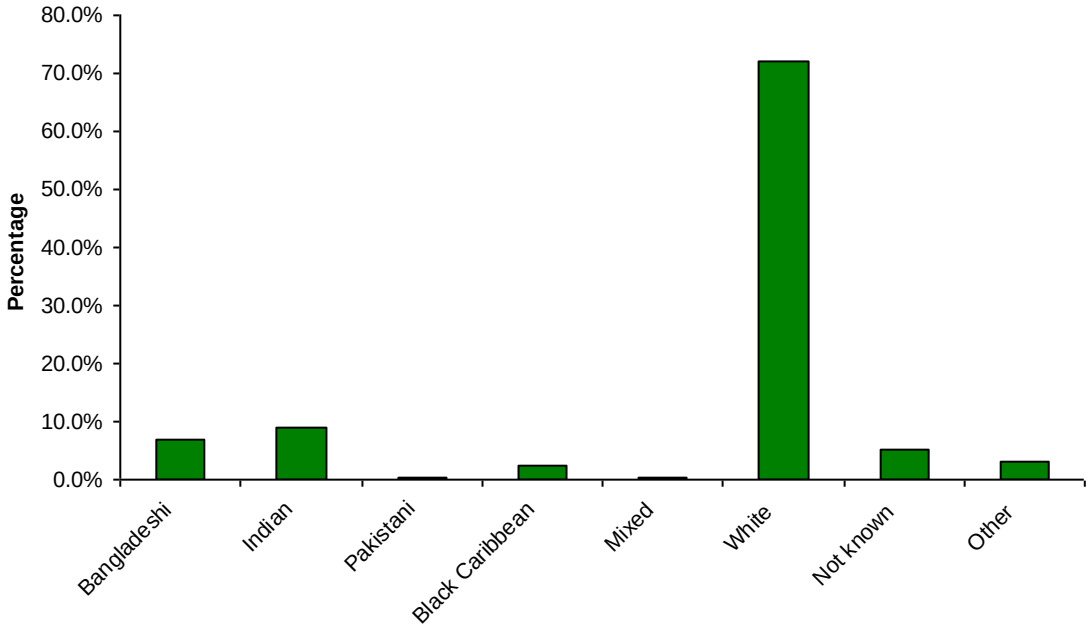
Figure 14: Daily variation in alcohol related assaults, Autumn 2009



Source: LINX A&E departments, West Midlands Police

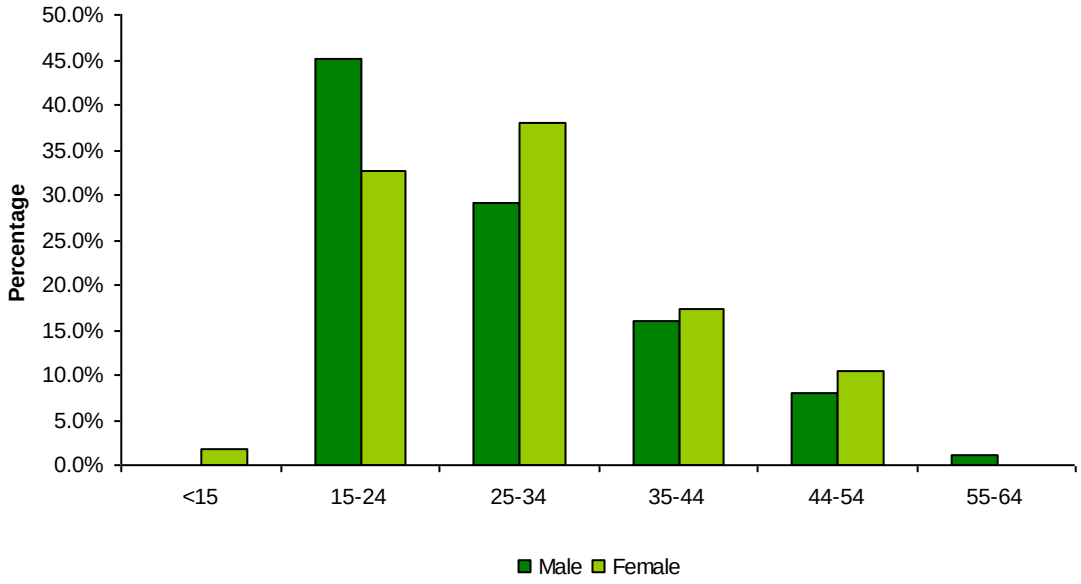
There is a surprisingly high level of Bangladeshi being recorded as having been assaulted after drinking.

Figure 15 Ethnic variations in alcohol related assaults



Source: LINX A&E departments, West Midlands Police

Figure 16 Age and sex variation in alcohol related assaults

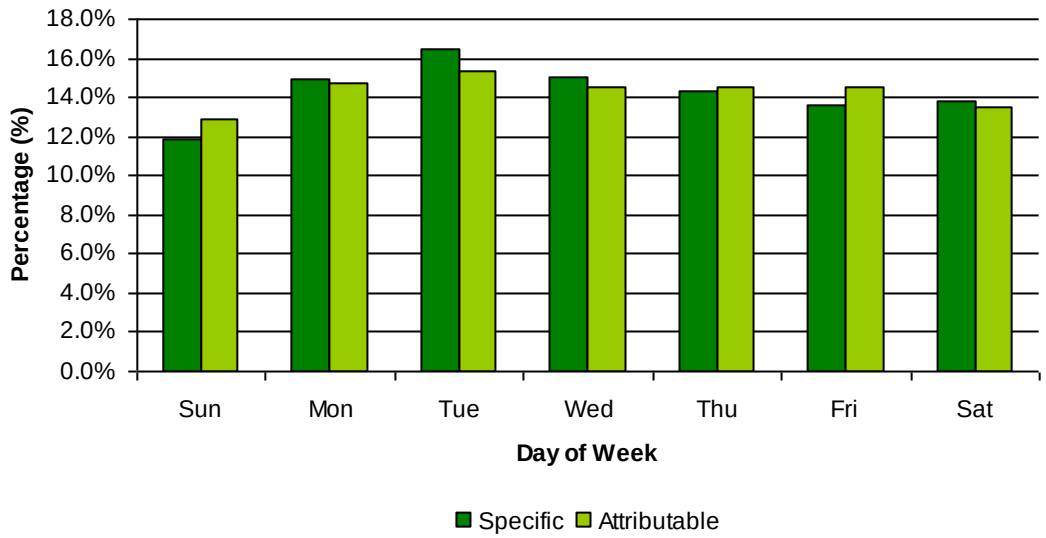


Source: LINX A&E departments, West Midlands Police

Other than the LINXs data the only way to ascertain the involvement of alcohol is to look back for those people admitted into hospital. Using the NHS number of those admitted we can look at both the attendance that lead to admission and more importantly their history of attendance prior to and after admission. Looking at attendances prior to admission gives an insight into opportunities to refer for non-inpatient treatments and looking at attendances after admission the recurrence or poor management of the condition.

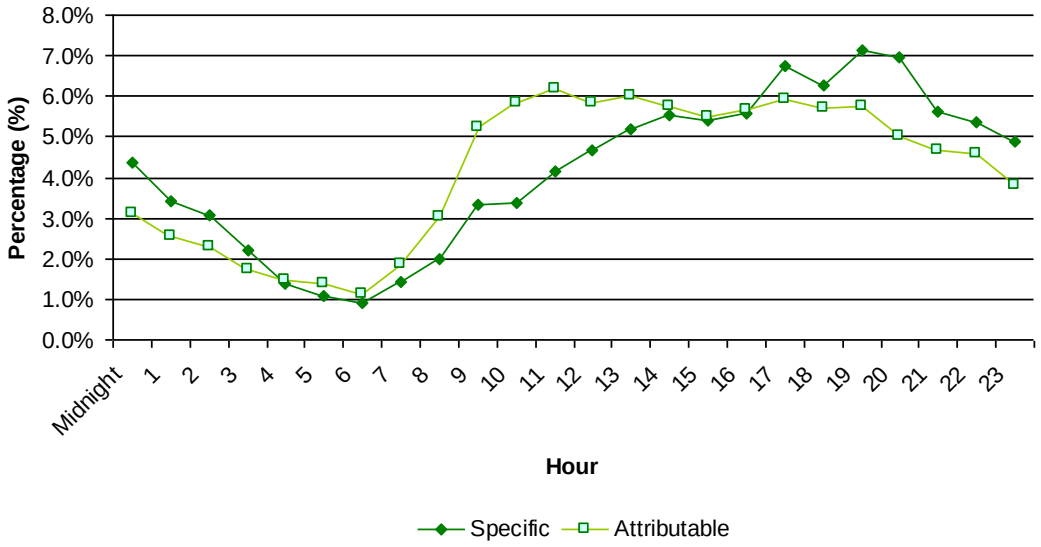
Using this data it is possible to identify a temporal pattern for admissions.

Figure 17: Daily variation in alcohol attributable attendances



Source: A&E MDS and Inpatient MDS 2007/8 to 2008/9

Figure 18: Hourly variation in alcohol attributable attendances



Source: A&E MDS and Inpatient MDS 2007/8 to 2008/9

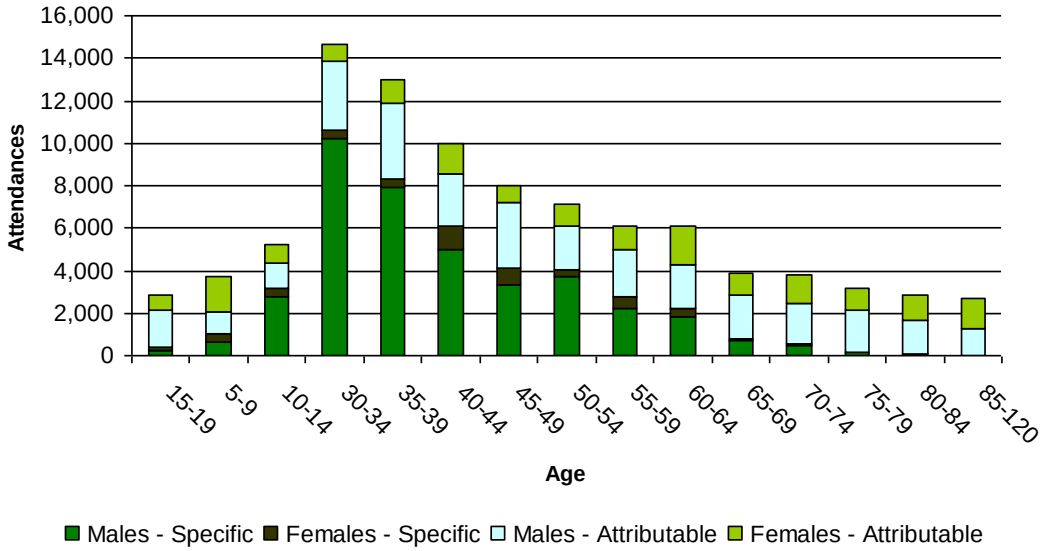
However it must be born in mind looking at these data that they only indicate where a condition could not be resolved in A&E. The most common reasons for admission after attendance is mental and behavioural disorders, epilepsy and arrhythmias (Table 7).

Table 7 Alcohol attributable condition after attendance at A&E, 2007/8 to 2008/9

Condition	Male		Females	
Specific				
Mental and behavioural disorders due to use of alcohol	29875	41.7%	3960	17.2%
Alcoholic liver disease	6926	9.7%	911	4.0%
Chronic pancreatitis (alcohol induced)	1774	2.5%	79	0.3%
Ethanol poisoning	265	0.4%	113	0.5%
Alcoholic gastritis	225	0.3%	29	0.1%
Toxic effect of alcohol, unspecified	52	0.1%	48	0.2%
Grand Total	39285	54.9%	5181	22.5%
Attributable				
Hypertensive diseases	12019	16.8%	5306	23.1%
Epilepsy and Status epilepticus	7539	10.5%	5080	22.1%
Intentional self-harm/Event of undetermined intent	4106	5.7%	2478	10.8%
Cardiac arrhythmias	3275	4.6%	2738	11.9%
Fall injuries	1330	1.9%	583	2.5%
Assault	1164	1.6%	164	0.7%
Acute and chronic pancreatitis	949	1.3%	196	0.9%
Spontaneous abortion		0.0%	618	2.7%
Liver cirrhosis	310	0.4%	155	0.7%
Oesophageal varices	292	0.4%	32	0.1%
Gastro-oesophageal laceration-haemorrhage syndrome	187	0.3%	89	0.4%
Road traffic accidents (driver/rider)	207	0.3%	40	0.2%
Ischaemic stroke	205	0.3%	1	0.0%
Psoriasis	87	0.1%	112	0.5%
Pedestrian traffic accidents	161	0.2%	14	0.1%
Haemorrhagic stroke	112	0.2%	29	0.1%
Work/machine injuries	102	0.1%	22	0.1%
Malignant neoplasm of lip, oral cavity and pharynx	81	0.1%	9	0.0%
Fire injuries	44	0.1%	36	0.2%
Grand Total	32295	45.1%	17807	77.5%
Overall	71580	100.0%	22988	100.0%

Source: A&E MDS and Inpatient MDS 2007/8 to 2008/9

Figure 19 Demographic variation in age and sex of attendances prior to admission

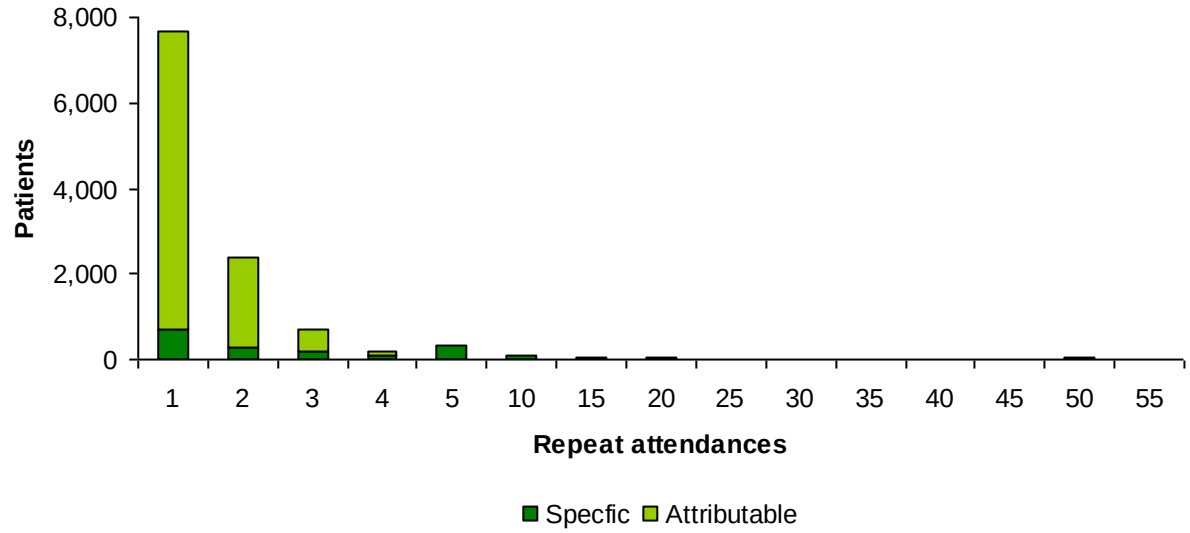


Source: A&E MDS and Inpatient MDS 2007/8 to 2008/9

5.1.2 Frequent attenders

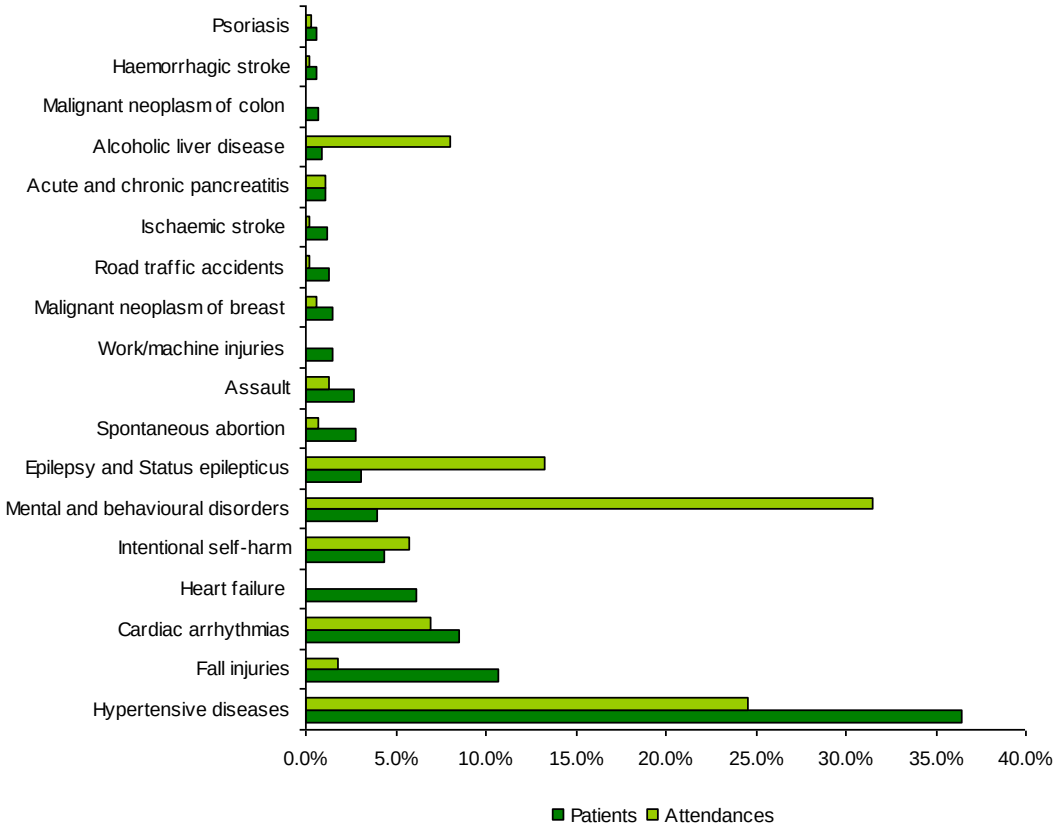
There are 1,026 patients who have attended more than 5 times in the last two years for alcohol attributable reasons. 333 of these patients have attended more than 55 times in the last two years, or at an average of once every fortnight. Of these about half of them, 159 patients, attended on average once a week.

Figure 20 Frequent attenders at A&E, in the 2 years, 2007/8 to 2008/9



Source: A&E MDS and Inpatient MDS 2007/8 to 2008/9

Figure 21 Attendance volume compared to patient numbers, at A&E

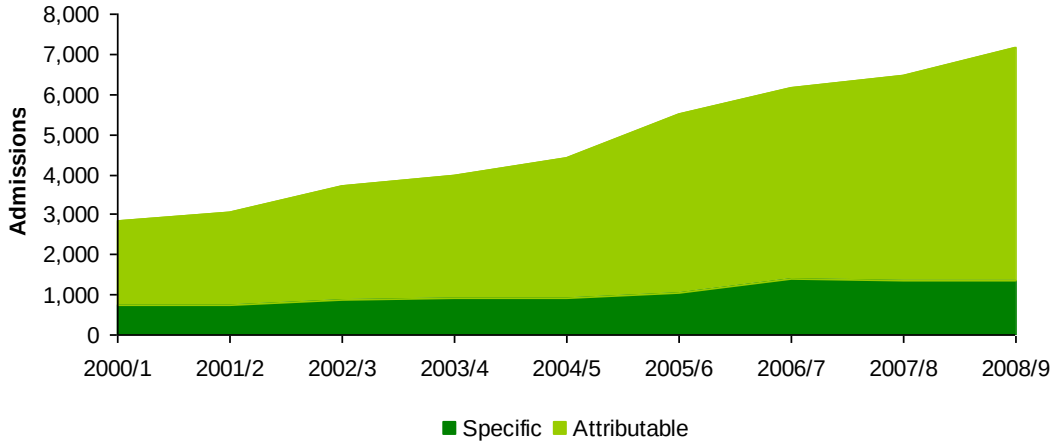


Source: A&E MDS and Inpatient MDS 2007/8 to 2008/9

5.1.3 Admissions

There has been an increased trend in alcohol related admissions for at least nine years (Figure 22), however there is a data capture issue that may be exaggerating the rate of increase. The greatest increase in the underlying condition has been in hypertensive disease, up 448%. The rise in this condition has coincided with the introduction of the payment by results and the improvement in data completeness in the hospital. This compares with only a 31% rise in alcoholic liver disease in the same time period, which is perhaps a more accurate marker for alcohol related harm than elevated blood pressure (Table 8).

Figure 22 Admission trend, 2000/1 to 2008/9



Source: Sandwell MDS

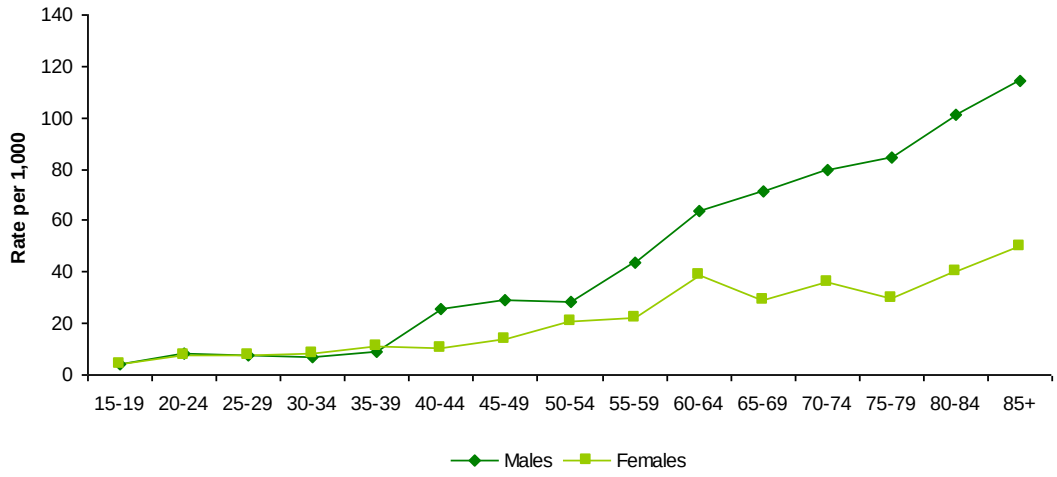
Table 8 Admissions by condition

Condition	2000/1	2001/2	2002/3	2003/4	2004/5	2005/6	2006/7	2007/8	2008/9	% Increase
Attributable										
Hypertensive diseases	581	816	1,037	1,199	1,584	2,269	2,512	2,765	3,183	448%
Cardiac arrhythmias	378	408	503	485	528	656	691	687	755	100%
Epilepsy and Status epilepticus	273	279	354	400	374	486	500	575	697	155%
Intentional self-harm	137	115	177	183	178	182	188	196	230	68%
Fall injuries	127	138	144	154	159	157	148	158	176	38%
Malignant neoplasm of breast	118	112	107	101	111	106	123	138	163	38%
Assault	66	65	63	81	72	72	87	73	73	11%
Liver cirrhosis	43	36	41	32	44	61	44	43	42	-2%
Acute and chronic pancreatitis	32	27	41	41	46	47	50	43	34	7%
Attributable Total	1,756	1,996	2,466	2,677	3,095	4,035	4,344	4,679	5,352	205%
Specific										
Mental and behavioural disorders	463	521	601	631	575	722	949	981	1,002	116%
Alcoholic liver disease	230	181	211	220	290	278	354	292	302	31%
Chronic pancreatitis (alcohol induced)	27	9	20	38	31	41	51	40	29	7%
Specific Total	720	711	832	889	896	1,041	1,354	1,313	1,333	85%
Overall Total	2,476	2,707	3,298	3,566	3,991	5,076	5,698	5,992	6,685	170%

Source: Sandwell MDS

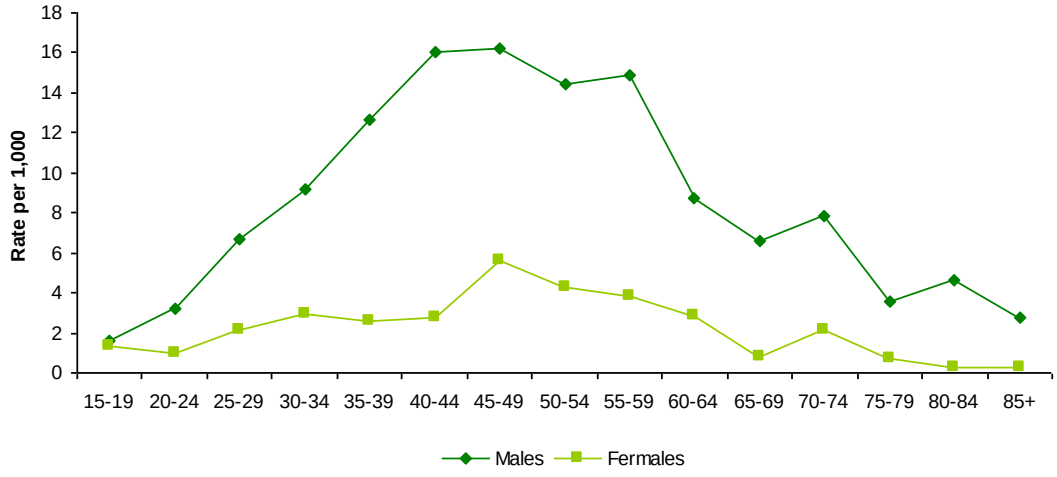
There are not unexpected differences in the age sex profiles of the attributable and specific conditions (Figure 23 & Figure 24). The attributable reflecting many years of chronic exposure to alcohol present in the older age groups, whilst the acute exposure that results in specific harm present predominantly in the 30-64 age groups. For both condition groups males have substantial higher admissions.

Figure 23 Demography of admissions - attributable



Source: Sandwell MDS

Figure 24 Demography of admissions - specific



Source: Sandwell MDS

5.1.3.1 Ethnicity

Table 9 and Table 10 show the breakdown of the admissions by the major ethnic minority population. The Indian population are the largest non-white group admitted with a larger proportion (17%) for mental and behavioural disorders than in the white population (13.7%).

Table 9: Admissions for alcohol related harm, by Ethnic group, 2004/5 to 2008/9 (Numbers)

type	condition	Bangladeshi	Indian	Pakistani	Black Caribbean	All other groups	White	Not stated/missing	Grand Total
Attributable	Hypertensive diseases	59	1140	254	370	316	9121	1052	12312
	Cardiac arrhythmias	3	115	19	21	28	2859	273	3317
	Epilepsy and Status epilepticus	4	111	52	35	152	2022	256	2632
	Intentional self-harm	3	53	23	16	27	645	204	973
	Fall injuries	2	46	9	9	18	613	99	798
	Malignant neoplasm of breast		44	4	14	16	528	36	641
	Spontaneous abortion	11	37	30	11	36	205	77	408
	Assault	2	40	12	13	29	200	80	377
	Malignant neoplasm of oesophagus	1	1	0	3	7	237	14	263
	Liver cirrhosis	12	13	11	10	10	166	11	235
	Acute and chronic pancreatitis	1	23	3	4	4	160	25	220
	Malignant neoplasm of lip	1	3	2	1	5	165	36	212
	Psoriasis	0	12	2	0	2	153	17	187
	Oesophageal varices	1	25	6	7	3	124	8	173
	Road traffic accidents (driver/rider)	0	12	6	2	8	79	23	129
	Haemorrhagic stroke	1	9	2	7	6	78	20	124
	Malignant neoplasm of rectum		7	0	1	0	98	11	118
Attributable Total		102	1691	435	524	669	17455	2244	23121
Specific	Mental and behavioural disorders	2	392	24	45	125	2976	665	4229
	Alcoholic liver disease	1	179	5	19	26	1169	117	1516
	Chronic pancreatitis		39	2	10	6	115	20	192
Specific Total		3	610	31	74	157	4260	802	5937
Total		105	2301	466	598	826	21715	3046	29058

Source: Sandwell MDS

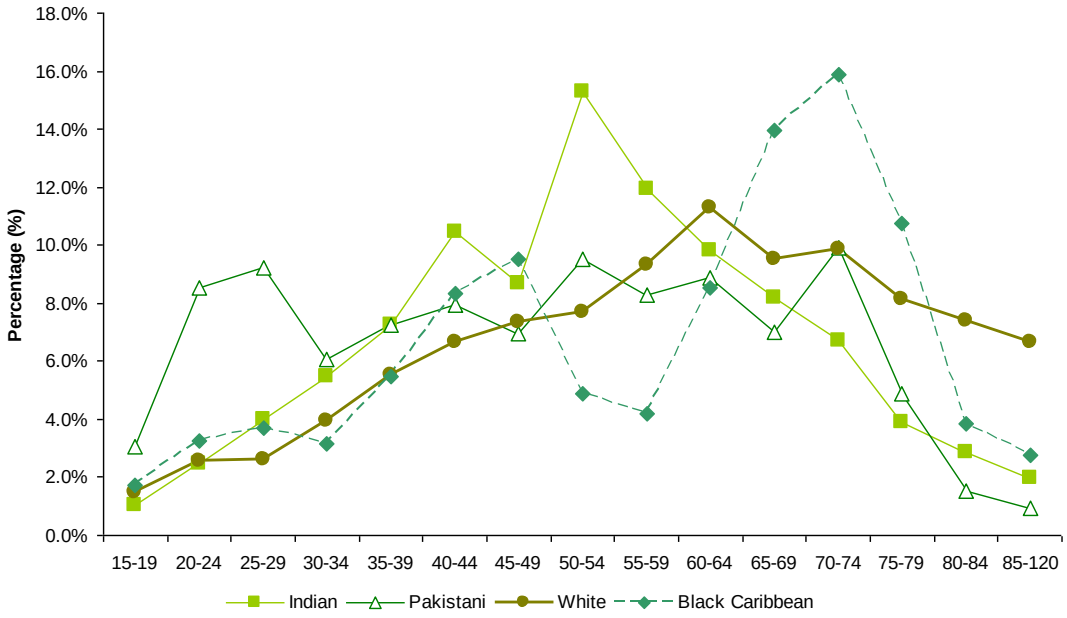
Table 10 Admissions for alcohol related harm, by diagnosis for Ethnic groups, 2004/5 to 2008/9 (Percentages)

Type	condition	Bangladeshi	Indian	Pakistani	Black Caribbean	All other groups	White	Not stated/missing	Grand Total
Attributable	Hypertensive diseases	55.9%	49.6%	54.5%	61.9%	38.3%	42.0%	34.5%	42.4%
	Cardiac arrhythmias	2.9%	5.0%	4.0%	3.4%	3.4%	13.2%	9.0%	11.4%
	Epilepsy and Status epilepticus	3.4%	4.8%	11.2%	5.8%	18.4%	9.3%	8.4%	9.1%
	Intentional self-harm	3.2%	2.3%	5.0%	2.7%	3.3%	3.0%	6.7%	3.3%
	Fall injuries	2.3%	2.0%	1.9%	1.6%	2.2%	2.8%	3.3%	2.7%
	Malignant neoplasm of breast	0.0%	1.9%	0.8%	2.3%	1.9%	2.4%	1.2%	2.2%
	Spontaneous abortion	10.5%	1.6%	6.4%	1.9%	4.4%	0.9%	2.5%	1.4%
	Assault	1.8%	1.7%	2.7%	2.2%	3.6%	0.9%	2.6%	1.3%
	Malignant neoplasm of oesophagus	1.2%	0.1%	0.1%	0.5%	0.8%	1.1%	0.5%	0.9%
	Liver cirrhosis	11.8%	0.6%	2.4%	1.7%	1.3%	0.8%	0.4%	0.8%
	Acute and chronic pancreatitis	1.1%	1.0%	0.6%	0.7%	0.4%	0.7%	0.8%	0.8%
	Malignant neoplasm of lip,	0.5%	0.1%	0.3%	0.1%	0.6%	0.8%	1.2%	0.7%
	Psoriasis	0.3%	0.5%	0.5%	0.0%	0.2%	0.7%	0.6%	0.6%
	Oesophageal varices	0.6%	1.1%	1.2%	1.1%	0.4%	0.6%	0.3%	0.6%
	Road traffic accidents (driver/rider)	0.2%	0.5%	1.2%	0.3%	0.9%	0.4%	0.8%	0.4%
	Haemorrhagic stroke	1.4%	0.4%	0.5%	1.1%	0.8%	0.4%	0.7%	0.4%
	Malignant neoplasm of rectum	0.0%	0.3%	0.1%	0.2%	0.0%	0.5%	0.4%	0.4%
Attributable Total		97.2%	73.5%	93.3%	87.6%	81.0%	80.4%	73.7%	79.6%
specific	Mental and behavioural disorders	1.9%	17.0%	5.2%	7.5%	15.1%	13.7%	21.8%	14.6%
	Alcoholic liver disease	0.9%	7.8%	1.1%	3.2%	3.1%	5.4%	3.8%	5.2%
	Chronic pancreatitis	0.0%	1.7%	0.4%	1.7%	0.7%	0.5%	0.7%	0.7%
Specific Total		2.8%	26.5%	6.7%	12.4%	19.0%	19.6%	26.3%	20.4%
Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Sandwell MDS

The reason for the higher proportion of Indians with mental and behavioural disorders related to alcohol could be related to the age profile of those presenting, as they are centred in the 50-54 age group, where as the white population is an older population (Figure 25).

Figure 25: Admissions for alcohol related harm by ethnic group and age

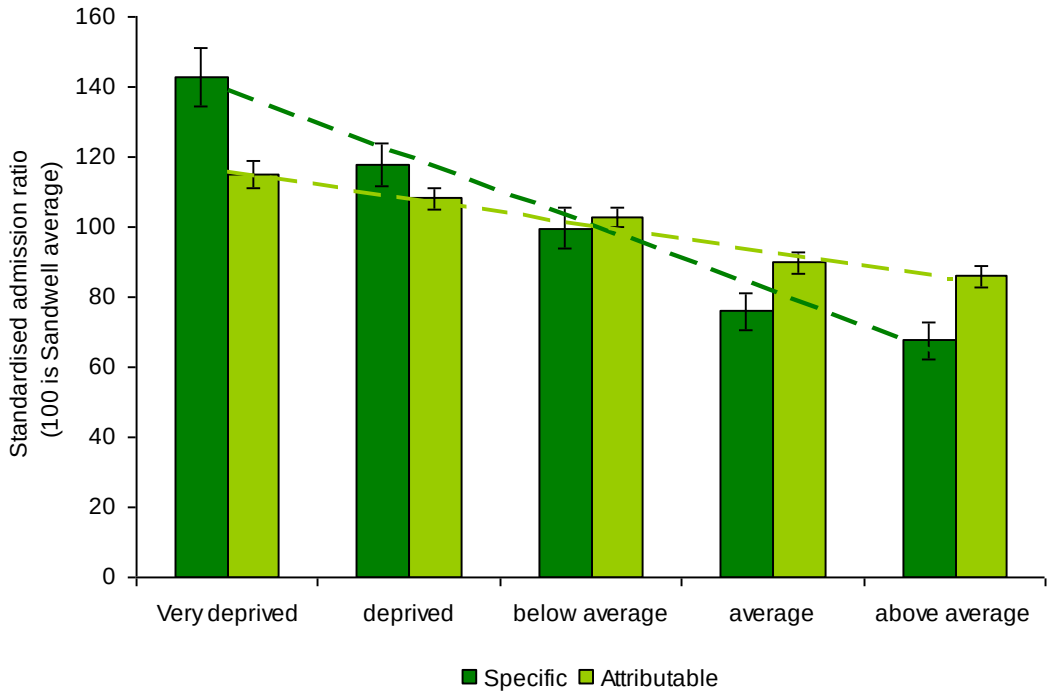


Source: Sandwell MDS

5.1.3.2 Deprivation

Alcohol related harm is significantly related to deprivation. This is especially true for specific conditions with the most deprived quintile of our population having levels of admission over 40% higher than the Sandwell average.

Figure 26: Admissions for alcohol related harm, by qunitile

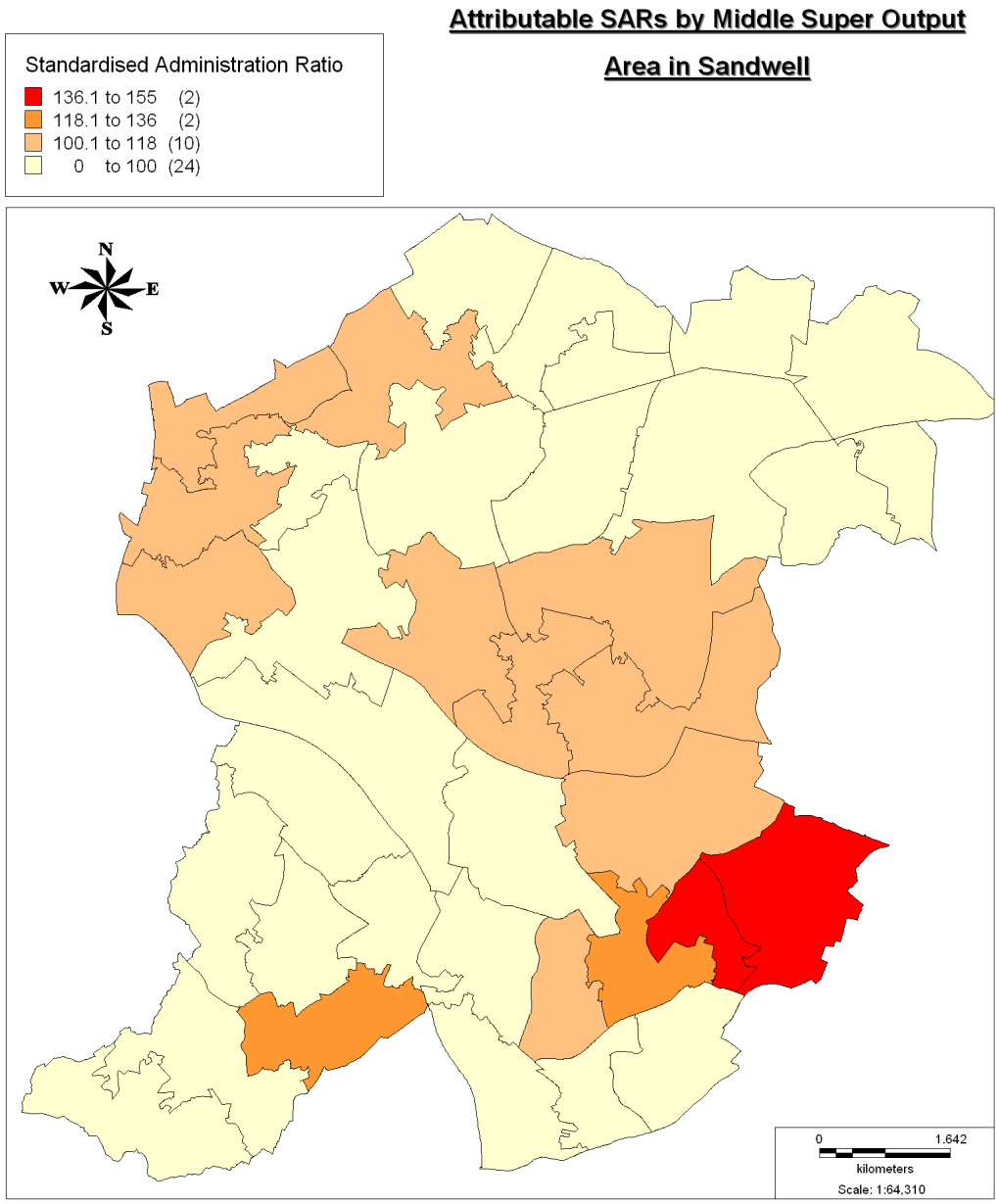


Source: Sandwell MDS

5.1.3.3 Geography

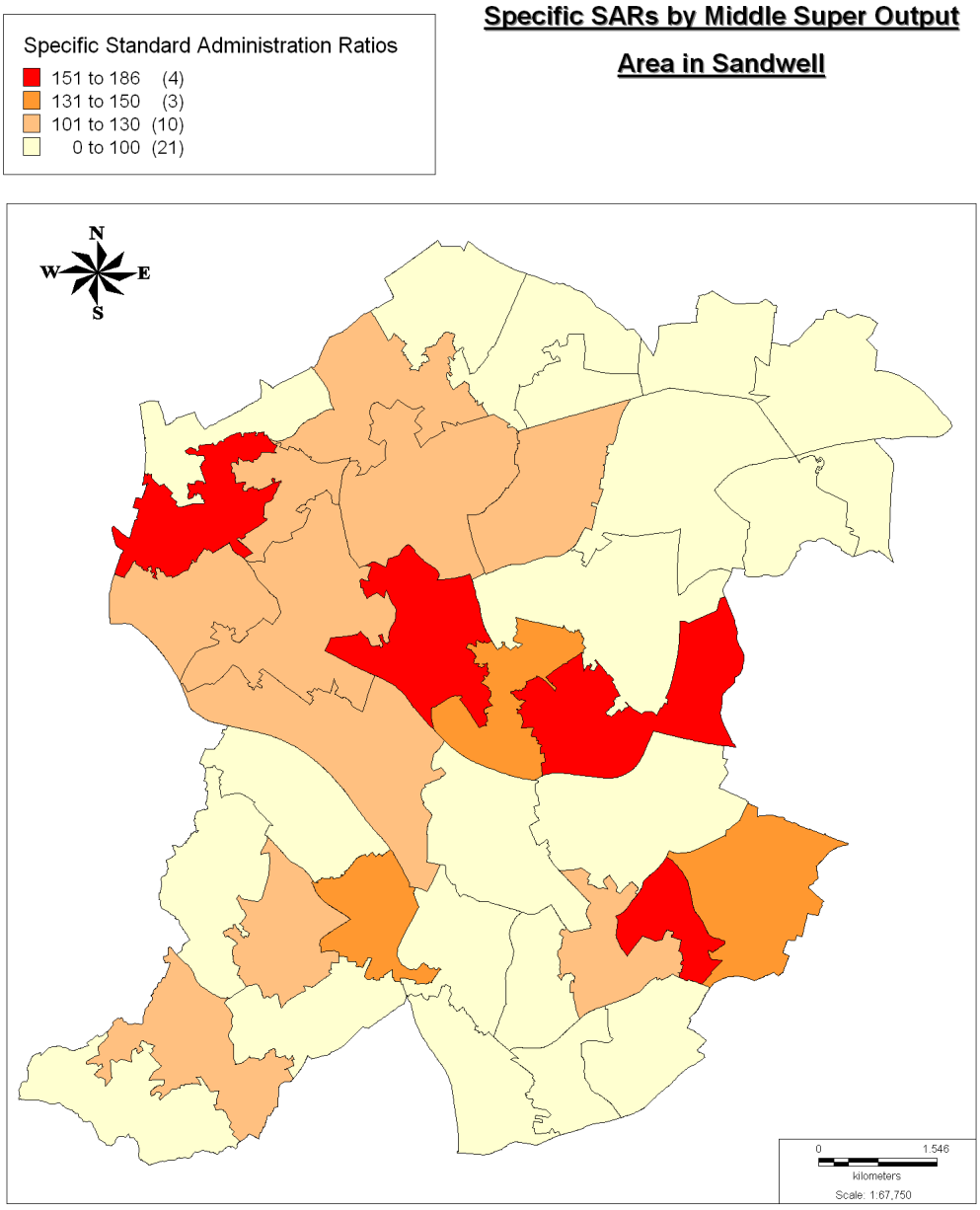
By mapping where people who are admitted for both specific and attributable conditions reveals geographical differences in the spread of those affected (Figure 27, Figure 28). There are a number of areas in the north east of Sandwell where specific harm is more prevalent and towards the south east with attributable harm is more prevalent. Service delivery needs to take this into consideration as the two groups will require very different interventions.

Figure 27: Map of Attributable Standardised Admission Ratios 2004/5 to 2008/9



Source: Sandwell MDS

Figure 28 Map of Specific Standardised Admission Ratios 2004/5 to 2008/9



Source: Sandwell MDS

5.1.3.4 Social Segmentation (MOSAIC)

The MOSAIC data shows where different population segments have a greater likelihood to undertake a specific behaviour compare to the general population and might point to why the data above are under-estimating the numbers drinking. Looking at the largest groups affected by alcohol related harm, a number of the groups appear to not to visit licensed premises nor consume much alcohol. The groups C20, D26 and I50 all have no elevated levels of risky behaviour. Two of the groups have high Asian populations (C20 and D26) and one is an older group and they may not be expected to use licensed establishments, but they also report drinking less frequently. However all three groups experience substantial morbidity related to alcohol.

Table 11 Admissions by mosaic classification

		Specific			Attributable		
label	pop	obs	sar	Confidence interval	obs	sar	Confidence interval
H44: Manual workers, many close to retirement, in low rise houses in ex-manufacturing towns	15.2%	834	93	(87 to 99.7)	3498	97	(94.3 to 100.8)
G43: Older people, many in poor health from work in heavy industry, in low rise social housing	7.3%	658	157	(144.8 to 168.9)	2110	110	(105.8 to 115.3)
D22: Comfortably off manual workers living in spacious but inexpensive private houses	6.9%	158	38	(32.1 to 44.1)	1593	88	(83.3 to 91.9)
C20: Suburbs sought after by the more successful members of the Asian community	6.8%	301	73	(64.6 to 81.3)	1243	88	(83.6 to 93.5)
H45: Older couples, mostly in small towns, who now own houses once rented from the council	6.5%	271	74	(65.4 to 83.3)	1724	93	(88.4 to 97.2)
D26: Communities of lowly paid factory workers, many of them of South Asian descent	6.0%	276	78	(69 to 87.6)	1025	92	(86.4 to 97.7)
G42: Families with school age children, living in very large social housing estates on the outskirts of provincial cities	5.9%	452	133	(120.9 to 145.8)	1140	97	(91.9 to 103.3)
D23: Owners of affordable terraces built to house 19th century heavy industrial workers	5.9%	279	78	(69.1 to 87.7)	1348	100	(94.7 to 105.5)
D24: Low income families living in cramped Victorian terraced housing in inner city locations	4.0%	277	116	(102.9 to 130.7)	723	90	(84 to 97.3)
H47: Social housing, typically in 'new towns', with good job opportunities for the poorly qualified	3.8%	210	94	(81.9 to 107.9)	762	109	(101.6 to 117.3)
C18: Inter war suburbs many with less strong cohesion than they originally had	3.1%	93	51	(40.8 to 61.9)	800	98	(91.1 to 104.7)
F37: Young families living in upper floors of social housing	3.0%	461	262	(238.2 to 286.6)	636	122	(112.8 to 132)
C16: Low density private estates, now with self reliant couples approaching retirement	2.5%	103	72	(59 to 87.7)	724	90	(83.4 to 96.6)
B13: First generation owner occupiers, many with large amounts of consumer debt	2.4%	85	56	(45.1 to 69.8)	258	71	(62.5 to 80.2)
B12: Middle income families with children living in estates of modern private homes	2.3%	78	53	(41.7 to 65.8)	381	78	(70.7 to 86.6)
G41: Families, many single parent, in deprived social housing on the edge of regional centres	1.8%	135	134	(112 to 158.1)	254	97	(85.8 to 110.2)
I49: Low income older couples renting low rise social housing in industrial regions	1.7%	95	96	(77.8 to 117.6)	565	121	(111 to 131.1)
F39: Older people living in crowded apartments in high density social housing	1.7%	275	276	(244.1 to 310.3)	638	132	(121.8 to 142.4)
C15: Senior white collar workers many on the verge of a financially secure retirement	1.6%	31	32	(21.6 to 45.2)	380	89	(80.2 to 98.3)
D21: Mixed communities of urban residents living in well built early 20th century housing	1.5%	25	27	(17.5 to 40.1)	275	82	(72.3 to 92)
I50: Older people receiving care in homes or sheltered accommodation	1.4%	217	308	(268 to 351.3)	885	146	(136.5 to 156)
E31: Well educated singles and childless couples colonising inner areas of provincial cities	1.3%	76	92	(72.7 to 115.5)	208	83	(71.7 to 94.6)
H46: Residents in 1930s and 1950s council estates, typically in London, now mostly owner occupiers	1.1%	35	56	(38.9 to 77.8)	228	97	(84.6 to 110.2)
F38: Singles, childless couples and older people living in high rise social housing	0.7%	152	314	(266.3 to 368.5)	238	150	(131.6 to 170.4)

Red – are significantly eleviated admission levels

Source: Sandwell MDS

Table 12: Understanding our population, MOSAIC Lifestyle segmentation of drinking population

		C16	C18	C20	D22	D23	D24	D25	D26	F37	F39	G42	G43	H44	H45	H47	I50
Visits to Nightclubs	Once/twice a week	55	94	72	106	109	157	132	87	133	107	130	74	112	80	121	17
Visits to Pubs/Wine bars	3 times a week	77	85	68	103	126	138	160	37	82	106	82	88	92	86	86	56
	Almost every day	76	91	45	109	103	144	172	39	94	127	88	102	93	93	86	67
Alcohol	Drink 3 Days a week or more	146	114	44	97	80	82	92	24	48	66	53	78	83	108	61	99
	Drink Once or Twice a Week	141	117	48	119	118	117	71	35	82	100	95	119	128	115	95	71
	Number of Drinks in Last 7 Days -5-6	126	115	40	115	107	69	44	17	41	74	84	90	58	59	71	88
	Number of Drinks in Last 7 Days -6-8	125	126	45	104	110	97	76	30	74	108	97	82	101	108	78	42
	Number of Drinks in Last 7 Days -8+	93	102	32	108	118	153	103	32	96	134	122	147	145	124	110	49
	Going to the pub	73	86	69	99	120	142	127	65	128	116	113	107	106	93	110	67

Key

C16: Low density private estates, now with self reliant couples approaching retirement
C18: Inter war suburbs many with less strong cohesion than they originally had
C20: Suburbs sought after by the more successful members of the Asian community
D22: Comfortably off manual workers living in spacious but inexpensive private houses
D23: Owners of affordable terraces built to house 19th century heavy industrial workers
D24: Low income families living in cramped Victorian terraced housing in inner city locations
D26: Communities of lowly paid factory workers, many of them of South Asian descent
F37: Young families living in upper floors of social housing
G42: Families with school age children, living in very large social housing estates on the outskirts of provincial cities
G43: Older people, many in poor health from work in heavy industry, in low rise social housing
H44: Manual workers, many close to retirement, in low rise houses in ex-manufacturing towns
H45: Older couples, mostly in small towns, who now own houses once rented from the council
H47: Social housing, typically in 'new towns', with good job opportunities for the poorly qualified
I50: Older people receiving care in homes or sheltered accommodation

Source: MOSAIC Public Sector

5.2 Mortality

Knowing what people die of is only half the picture as it focuses our attention on the major killers, however it does not indicate whether these causes of death are different in number or relative importance compared to anywhere else. The standardised mortality ratio (SMR) is a method that compares Sandwell with England and accounts for any age and sex differences in the population. A SMR over 100 means Sandwell has more deaths than England and a SMR under 100 means fewer deaths. The methodology also calculates an expected number of deaths so it is possible to say how many people are additional people are dying compared to rest of England. Every year 393 more people die in Sandwell, as our mortality ratio is 14% higher than England. Almost half of these deaths are due to circulatory disease.

Table 13 Average annual Standardised Mortality Ratios from the major causes of death, Sandwell, 2002-6

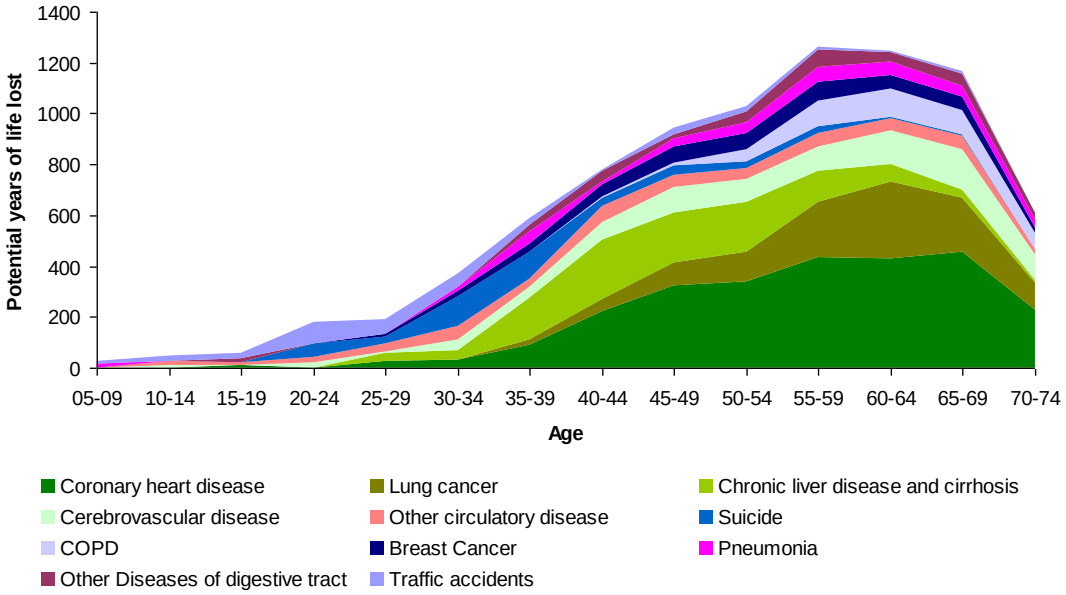
Cause	Deaths	SMR	Additional Deaths
Diseases of the liver	55	154.2	19
All causes, all ages	3,180	114.1	393

Source: ONS Death Extract 2002-2006, August 2007, Sandwell PCT 2008

Another way of looking at pre-mature death is consider the potential years of life lost (PYLL). PYLL makes the assumption that any death that occurs before 75 is premature and that the difference between the person's age at death and what would have been their 75th birthday are lost years. For example, some one dying at 40 would have lost 35 years and someone dying at 65 has lost 10 years.

It is interesting to see when different causes have an impact on years of life lost as that will guide our interventions. In Sandwell, the greatest number of potential years of life lost is for coronary heart disease. Traffic accidents impact most on the 15-24 age range, suicide 25 to 44 year olds, liver disease (in the main the result of alcohol), 35-59 year olds and coronary heart disease 35 up wards (
Figure 29).

Figure 29 Major causes of years of life lost by age for those 1 year and over, Sandwell 2002-6



Source: ONS Death Extract 2002-2006, August 2007, Sandwell PCT 2008

The primary challenge remains coronary heart disease in men (significantly higher than England), as it is responsible for almost three times more lost potential years of life than any other cause. It is also the major concern for women. Second to this is the effect of alcohol (Chronic liver disease and cirrhosis). In the last five years it has been responsible for the loss of 784 years of life even more than lung cancer (Table 14) for men (significantly higher than England) and 299 years for women.

Table 14 Main causes of potential years of life lost by sex for those aged one year and over, Sandwell 2002-6

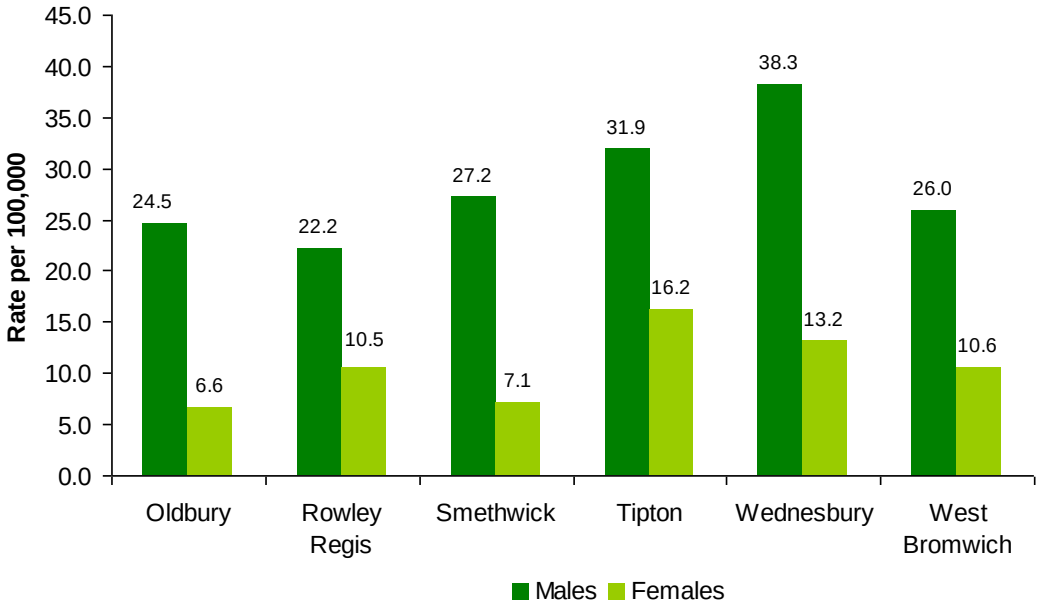
	Men		Women	
	PYLL	%	PYLL	%
Chronic liver disease and cirrhosis	784	7.2	299	4.8

Source: ONS Death Extract 2002-2006, August 2007, Sandwell PCT 2008

5.3 Deaths by area

As mentioned in section 4 “Improving Health” of the JSNA, mortality from alcohol is a significant problem in Sandwell. Alcohol kills almost 1 in 4 men aged 35-45. Overall it kills 2.6% of men. In Tipton and Smethwick, it kills almost 1 in 30 men. It kills 1 in 4 women aged 25-29, overall it kills 1 in 100 women. The highest death rates are in Wednesbury (38.3 per 100,000) for Males and Tipton (16.2 per 100,000) for Females.

Figure 30 Deaths from Alcohol related conditions, rate per 100,000, 2002-6

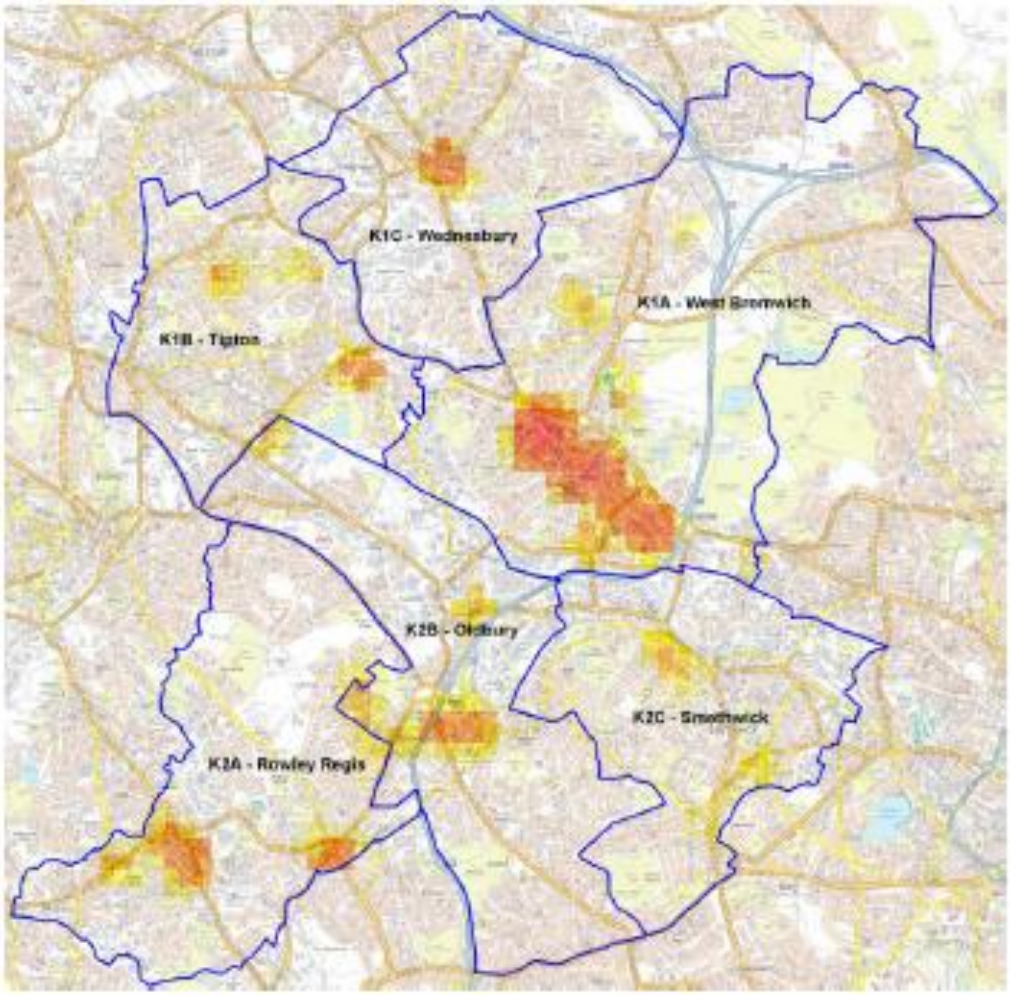


Source: ONS and Sandwell PCT – Public Health,

5.4 Crime

11% of recorded violent crime in Sandwell has an ‘under the influence’ marker attached. The peak neighbourhoods for under the influence violence are West Bromwich Central followed by neighbouring Greets, Green, Guns and Swan Village, which by looking at the hotspot map opposite is an overspill of alcohol related violent incidents from the town centre (Figure 31). Alcohol related incidents from West Bromwich Central and the surrounding streets in the town centre make up 12% of total alcohol related incidents in the borough.

Figure 31: Map of areas with high levels of 'under the influence' violence



Source: West Midlands Police

The time window for alcohol based offending in West Bromwich town centre is between 2300 and 0400 with a peak hour of between 0200 and 0300 with a peak day of Saturday. 55% of the offences have occurred on the street with 23% occurring within licensed premises, with the peak locations being. The Marksman PH and Busby's PH. The high number of offences occurring in the street and the peak times for offences is indicative of when people are leaving nightclubs and pubs and there is a high concentration of people in the street who are intoxicated and are lacking the protection and control offered by SIA registered door supervisors, as well as the natural boundary offered in the confines of a club.

Key Finding- The peak location for alcohol related offences in West Bromwich town centre is in the street.

Inference- People become intoxicated in licensed premises but the majority of violent offences occur outside the confines of a pub or club, either in the street or in the home

Recommendation- Continuation of robust practice of filling in of alcohol proformas and link this intelligence with the reviewing process of licensed premises.
- Continuation of Operation Moregate and Terminate. SSP to consider implementing a Moregate type operation in Wednesbury town centre.

Across the whole Sandwell borough the peak times for incidents were 2200-0100 which is perhaps indicative of earlier closing times in the majority of licensed venues across Sandwell. As above, the peak day is Saturday. 31% of incidents occurred outside, with 22% incidents each occurring in licensed premises. A total of 37% of incidents occurred in a dwelling and 39% of the offences are classed as domestic violence. This compared to 12% of incidents in West Bromwich town centre being classed as domestic assaults which although obviously reflecting the number of dwellings in the area, also reflects the fact that the majority of domestic assaults occur in the home. There may be future implications regarding this fact, as demonstrated below;

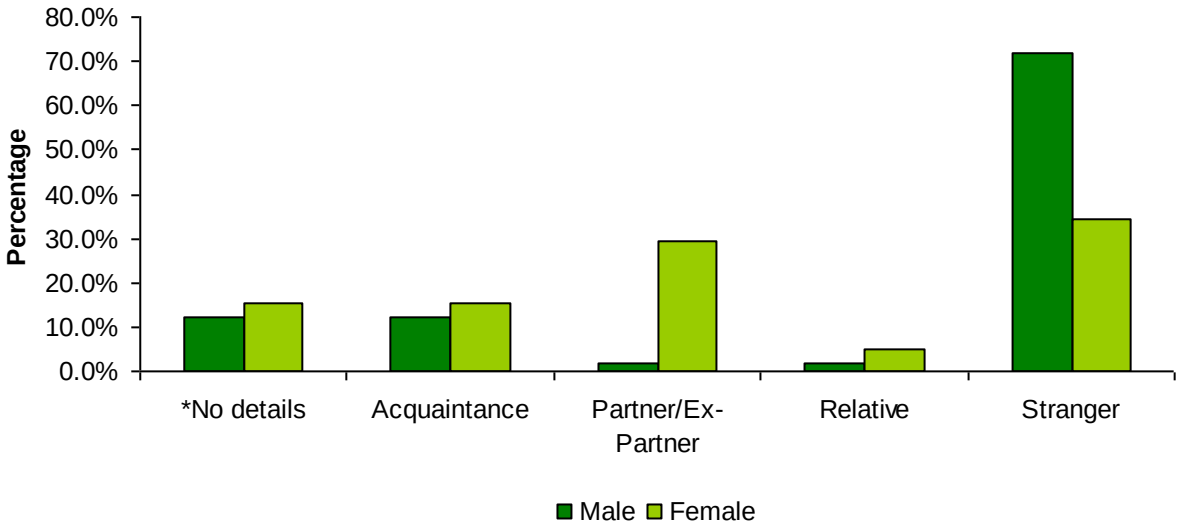
Sandwell's Domestic Abuse Strategy has made pertinent comments about the cross cutting nature of domestic abuse. These are particularly between domestic abuse and safeguarding children, alcohol and drug misuse, welfare benefits and legal issues, decent housing and homelessness, mental health and family breakdown. The strategy also makes comment to the fact that domestic abuse is linked to, and in many cases is the cause of, a wide range of other problems.8

5.4.1 Domestic Abuse Offenders

The majority of domestic abuse offenders were male with a peak age range of between 19 and 32. 54.6% were white, although other peak ethnicities were Asian or Asian British (Indian) and Black or Black British (Caribbean). SOADA's data also shows that 27% of offenders had alcohol issues and 8% had drug issues.

Data from A&E attendance show that for assaults where alcohol had been reported, women were much more likely to have been attacked by a partner or relative than for men (Figure 32).

Figure 32 Perpetrator of the assault, by gender of victim



Source: LINX A&E departments, West Midlands Police

5.4.2 Alcohol and drugs

42% of those who had used illicit drugs in the 4 weeks prior to assessment reported that they had also used alcohol. 72% of those using cocaine as main drug reported that they also drank alcohol, 53% of main drug cannabis users, 35% of main drug crack cocaine users and 25% of main drug heroin users. Combinations of alcohol and drugs, particularly alcohol and Class A drugs, are potentially lethal and can significantly increase the risk of overdose and damage to health. This analysis refers to those who have been arrested and tested in custody suite – (trigger offence) –and is not a general indicator of those non offending drug users.

Recommendation

- Raise awareness of the dangers and risk to health of combining Class A drugs and alcohol.

Those in the 18 - 24 yr old group were less likely to use heroin as their main drug than other age groups and more likely to use cocaine or cannabis. The British Crime Survey 2008/09 found that within this age group cocaine use has increased whilst opiate use has reduced. This profile of drug use amongst younger people is increasingly referred to as ACCE (Alcohol, Cocaine, Cannabis and Ecstasy).

- Ensure services are able to provide support to those who use combinations of different drugs in conjunction with alcohol, for example the "ACCE" cohort. In addition to this ensure brief interventions are available to prevent those individuals whose drug use is its early stages from becoming problematic in the future, particularly in relation to younger age groups.

Those considered to be a risk of accidental dwelling fires in Sandwell were aged 25-44, living alone or who were single parents. Main risk properties were in purpose built and converted flats, and were rented accommodation. Ethnicity alone is not a risk factor in Sandwell. 11% of the accidental dwelling fires in Sandwell were alcohol or drugs related.

6 Insight

6.1 Gathering Insight

There have been two key pieces of work undertaken on the attitude and beliefs the people of Sandwell have on alcohol. However, they only cover two of the cohorts: young people; and men aged 45 and over. These cohorts do though reflect the key groups identified in this assessment as alcohol is now a major killer of those aged under 15-30 years and in men aged 40+ who place the greatest demands on health services.

The collection of insight in the young people was undertaken using peer research. A diverse group of six young people aged 15-21 were trained as Young Researchers. They undertook research with 57 young people asking about the health needs of young people locally, what constitutes a 'healthy' young person, and how services can be made more young people friendly.

The insight on men aged over 40+ years is the result of the work on developing social marketing interventions to reduce admissions to hospital from alcohol. This group was identified by examining the admissions to hospital by MOSAIC type. Using the MOSAIC Grand Index we then looked at the drinking behaviour, in this case we have used frequency of consumption of those adults most 'at risk' by focusing on those who drink most frequently, i.e. more than once a week. This segmentation has enabled us to focus on a specific group and importantly a clearly defined set of individuals from which men were recruited for the qualitative interviewing.

In depth interviews were used explore the attitudes as either a couple or drinking buddies. In this instance we also wanted the drinking buddy to be younger than the main respondent, either a son, nephew or friend to understand the influence on younger drinkers. In total 24 men were interviewed. We also undertook two additional studies: firstly interviews with 5 landlords in pubs across the core geographical areas identified in Sandwell (Oldbury, Cradley Heath, West Bromwich and Wednesbury) to understand their role; and secondly we developed an observation programme to take place in the 5 pubs across Sandwell to record how people used pubs.

6.2 Adolescents and young people

All the respondents talked about alcohol, drugs and smoking as issues for young people locally. For example:

> *"These are big issues for young people in Sandwell – binge drinking, smoking, cannabis and other drugs. And of course they all come*

together for a lot of young people. I know it's a problem across the country, but it's really serious here".

"It comes back to what I said earlier, young people with nothing to do, feeling they've got no prospects. So they drink, do drugs, smoke. The health implications are huge".

"Binge drinking, and drinking regularly, like every day, is a real issue around here".

In addition, several stakeholders talked about how alcohol and drugs were used by young people to relieve stress and anxiety in their lives:

"It's not only boredom and low self-esteem that lead young people around here to drink, or do drugs. It's that, like, they experience a lot of stress in their lives, from school and peers and the like, and drink and drugs are coping mechanisms".

"A lot of the young people they work with, substances help them cope, as they'd see it, helps them get through".

Two interviewees considered that alcohol was the main health problem for young people locally, and that illegal drug use and smoking were often higher up the health agenda:

"I do think we underestimate the impact of alcohol on young people in Sandwell. It's much more damaging on growing bodies that cannabis, smoking or other drugs. Because it's more socially acceptable… we really need to focus on drinking more than anything else"

"For me it's alcohol [the main health issue locally]. Both the impact on health but also risky behaviour, accidents, pregnancy and the like".

6.3 On the condition/behaviour

6.3.1 Consumption

The majority of men are drinking with friends in the pub, during the day and evening; however some of heaviest drinkers are drinking alone or with family at home. There was clear evidence that the consumption of cheap alcohol at home is increasing due to economic pressures. This is having an affect upon their ability to 'belong' or 'connect' with their social group by going to the pub a bit less, which pushes them to drink more at home.

Consumption by ethnic group

From lifestyle survey's undertaken in a number of ethnic minority communities we know that for Sikhs a third (33.1%) stated that they regularly/sometimes

consume alcoholic drinks, of which 95.0% were male. Only 1.2 per cent of Pakistanis stated that they regularly/sometimes consume alcoholic drinks. less than 4% of Black Caribbeans reported drinking every day, with just over half (57%) drinking sometimes or socially. Those who reported drinking alcohol 'socially' or 'sometimes' were most likely to be between 25 and 44 years.

These are lower proportions than the UK average; with 63.0% having consumed alcohol in the last week according to the General Household Survey 2006.

6.3.2 Risk

Alcohol, alcohol abuse, binge drinking: Use of alcohol and alcohol-related problems was mentioned by 33 of the 57 young people. The respondents talked about seeing people drinking in parks and on the street, and very drunk people acting dangerously and causing problems. For example:

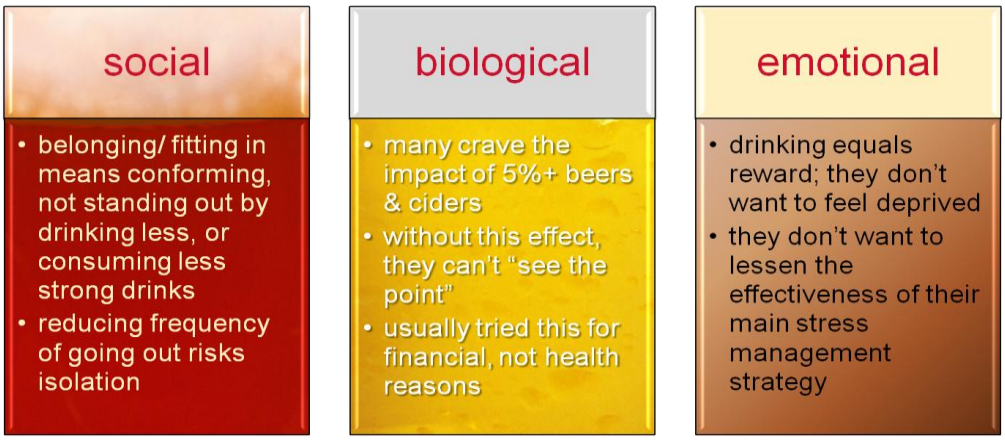
"… alcohol can ruin your life"

"People get addicted to it"

As might be expected, many young people named all three of aspects above as key health issues for young people in Sandwell – so they talked about alcohol, drugs and smoking as problematic for young people locally.

Awareness of risk is not the main barrier that needs to be overcome in changing patterns of consumption. The vast majority of drinkers understand that excessive drinking leads to health problems, however they have little concept of what is "excessive?". Drinking diaries used in the study revealed that these men were recording between 84 and 200 units a week. They know what can happen, they mention liver and kidney damage primarily, also mentioned are diabetes, increased risk of heart disease and damage to health caused by accident or misfortune (example: involved in violence); however, most people distance themselves from the risks, even though they understand them. Primarily, they do this by having a kind of "binary" attitude; i.e. "risk" or "no risk". They have no concept of a graded and continuous connection between consumption and risk. The vast majority put themselves in the "no risk" category, placing only "alcoholics" or "problem drinkers" in the "risk" category. They need to be made aware and to understand that risk to health isn't just either present or absent, but that virtually everyone interviewed knew an "alcoholic" or problem drinker. Many were themselves children of such people. They described a problem drinker as having the shakes, craving a drink first thing in the morning; they lose their jobs and destroy relationships because of drink. But they were resolute that this did not describe them, so in their mind, how can they have a problem?

There are three barriers to controlling consumption:



The key challenges are to help people to realise more accurately just how much they are consuming through increase understanding of the units system and by stressing the continuous relationship between consumption and levels of risk. Social marketing has to take account of the way that alcohol is woven inextricably into the fabric of people's lives and to acknowledge that this challenge exists in a social context. To be successful we need to be aware that the personal cost of the benefit of drinking less, a happy life, will be felt in terms of people feeling less connected, more isolated, more bored, less happy (or more aware of their unhappiness) and more stressed. This is particularly challenging as the drinker do not recognise the benefit as most people already enjoy what they see as reasonable health.

6.3.3 Reducing consumption

The ethnic minority health profiles did ask about reducing consumption or giving up. Only a very small minority (1.4%) of Sikh drinkers stated that they have attempted to give up in the past 6 months. None of the respondents had received any professional advice on ways to give up. One in four Pakistani drinkers (25.0%) stated that they have attempted to give up in the past 6 months none of the respondents had received any professional advice on ways to give up. Only 6% of Black Caribbeans who drank were interested in cutting down with just over 2% reporting having tried to give up in the last six months.

6.4 On the service provided

The **Substance Misuse needs assessment for young people found that:**

- Young people need an individualised response to their needs
- Families need support
- Services need to be better promoted

The Decca service was mentioned by all 10 people interviewed, as a good example of a really excellent local service. For example:

"It's really good, excellent. It's a great model of how to develop and provide a service. It's world class health provision I'd say"

"Decca is a great service, it really makes a difference to young people's views and experiences of drugs, definitely"

"They take a clear and consistent approach, you know, the actions and consequences principle. They have really good links with schools and other organisations locally, and they're respected, which is essential."

Improved alcohol services: Five of the stakeholders said that better alcohol services needed to be provided locally. This included a wider range of services, in a wider range of settings. For example:

"Schools can do more on alcohol, in PSHE, in other lessons. It's a real problem round here as I said, and there needs to be more education"

"I'd like to see a lot more help and advice for young people. Maybe through free educational events, which are tied up with fun things to do, and events in colleges, youth clubs and the like"

Some of this group felt that young people's direct input into alcohol education was needed. Some thought peer education was particularly important, for example:

"… and young people have to be at the heart of it. Whether it's providing the education, like APAUSE does with sex education, or helping to put the policy together. Young people have to be involved"

"I'd like to see young people really actively involved in more educational work around alcohol. You talk to young people and they all say binge drinking, alcohol, it's a big problem. So let's get them involved in the answer".

Men aged over 40+ were aware of only one alcohol service and that was alcoholic anonymous, which was not relevant to them as they did see themselves as alcoholics. They were unaware of primary care or the other services such as Aquarius.

Patient feedback was mentioned in the Black Caribbean survey; however it is not possible to draw any conclusions about the advice given as only 2 individuals had sought professional advice to help them cut down, one found the service good and one adequate.

7 Modelling the future

7.1 Future demand

7.1.1 The Recession

The implications of the recession are wide ranging and have the potential to affect acquisitive crime levels. The longer that the United Kingdom remains in a recession the greater potential for it to cause social problems, such as domestic abuse, alcohol and substance misuse, as well as potentially impacting upon community cohesion.

This was recognised by the Community Safety Partnership who believes there is potential for domestic abuse crimes to increase in proportion with total crime and/or volume in future years as domestic abuse services become more widely publicised and accessible. There is also speculation that the recession may fuel domestic abuse as people will drink more alcohol in the home, although there is currently no quantitative evidence for this as yet in Sandwell. This process has been witnessed in the Birmingham CDRP who have found that violent crime is now reducing in city centres, but has increased in the suburbs. Although this process cannot be strongly applied to Sandwell, there is potential for similar patterns to emerge, particularly a reduction in visitors to West Bromwich town centre's night time establishments and an increase in alcohol abuse in the home. The charity 'Refuge' which supports victims of violence agreed with these comments going further to say that some women would suffer more abuse because the economic climate would make them less likely to leave violent partners due to financial worries about how they will cope.

7.1.2 Changing population

The changing ethnic profile of Sandwell poses a new challenge to Sandwell in two communities:

1. Established Indian (Sikh), Pakistani and Bangladeshi communities
2. New migrant populations

Over the next 20 years the ethnic minority population is set to grow to 30% of our population. These groups have differing relationships with alcohol depending on their cultural backgrounds. The needs assessments in these populations indicated that was perhaps an under reporting in these populations, given the level of admissions seen and the numbers presenting to A&E after assault.

There is anecdotal evidence of problem drinking among migrant communities, particularly young males who are seeking asylum. Coupled with a higher (actual as well as expected) prevalence of mental illness (the milder stress related end of the spectrum) in migrant communities as they attempt to

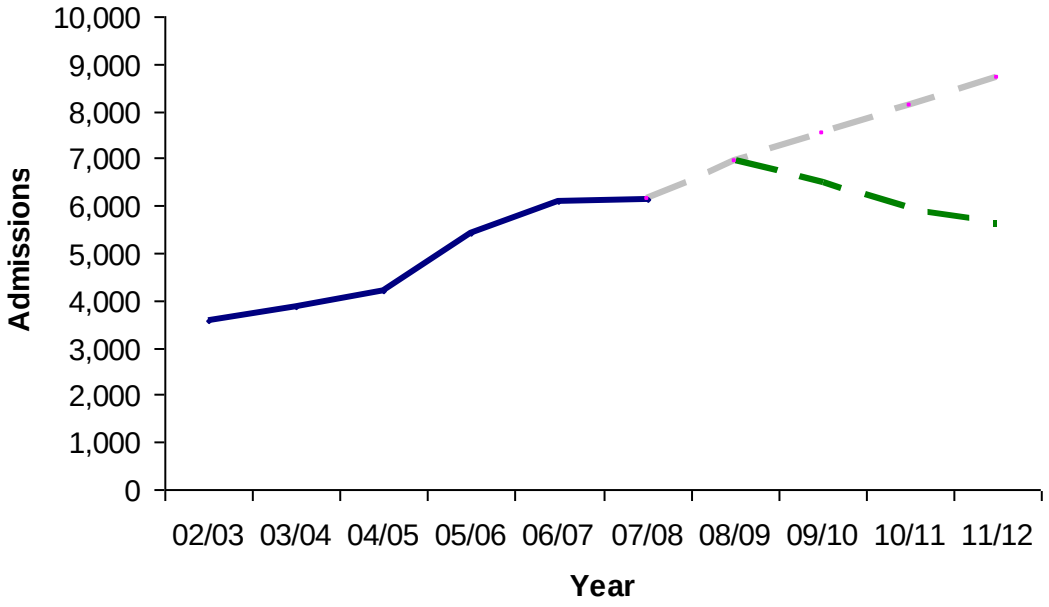
integrate – attitudes to drinking should be explored in order to inform strategy and planning. Current numbers suggest about 10% of the local population is migrant communities so the problem is likely to be sizeable.

7.2 Potential of service changes

7.2.1 Alcohol ready reckoner

The Alcohol ready reckoner gives a prediction for Alcohol related admissions that sees the rate grow from 2,132 per 100,000 in 2007/8 to 3,025 per 100,000 in 2011/12. If we are to achieve the aspirational target of 1,900 per 100,000 in 2011/12 on the way to achieving 1,600 per 100,000 in 2013/4 then the reckoner points to some of the changes that need to occur.

Figure 33: Modelling the future: trends in alcohol related admissions



Source: Alcohol ready reckoner

To deliver this reduction in admissions it is reckoned that changes such as these detailed below are required. The model indicates that the most effective change is through the use of Alcohol health workers, however along with A&E nurses these are also the most expensive resource. In total the additional investment estimated by the ready reckoner is £1.2Million by 2011/12. But that would deliver savings of £2.98Million, by preventing 7,005 A&E attendances and 3,131 admissions.

Table 15: The modelled investments required to deliver the reduction

A&E nurses

Non-dependent drinkers

	Visits/admissions averted					
	Number of nurses wte		A&E	hospital		
					extra cost	benefit
2009/10	1.00		550	37	£60,000	£67,500
2010/11	2.00		1,100	73	£120,000	£135,000
2011/12	3.00		1,650	110	£180,000	£202,500

Alcohol Health Workers

Dependent drinkers

	visits/admissions averted					
	Number of nurses wte		A&E visits saved	hospital		
					extra cost	benefit
2009/10	5.00		1,473	860	£300,000	£726,200
2010/11	10.00		2,945	1,720	£600,000	£1,452,400
2011/12	15.00		4,418	2,580	£900,000	£2,178,600

Treatment-dependent drinkers **Number** **6,226**

Social network group UKATT

Increase in treatment: percentage points of prevalence (ppop)

		extra treated	A&E	hospital	extra cost	benefit
2009/10	2.0	125	22	27	£24,900	£76,100
2010/11	4.0	249	44	55	£49,800	£152,200
2011/12	8.0	498	88	110	£99,600	£304,300

GP screening **Proportion of new registrants AUDITed**

					extra cost	benefit
2009/10	40%		340	133	£40,400	£120,400
2010/11	100%		850	331	£101,000	£301,000
2011/12	100%		850	331	£101,000	£301,000

7.2.2 Behaviour change

The ready reckoner forecast demonstrates that any clinical intervention is only going to slow the pace of morbidity and not slow the underlying rate of incidence. Also clinical interventions will have to continuing growing in a similar scale year on year to sustain the reduction. If the harm from alcohol is to be permanently reduced then change has to happen before physical damage from alcohol occurs and this can only happen through behaviour

change, through either education awareness raising or through restricting access either by further controls on sales or through the making it less affordable.

7.2.3 Legislative interventions

Minimum pricing

A lengthening list of organisations and leaders now support the introduction of minimum pricing of alcohol, a direction that Scotland has already gone down. The Royal Colleges of Physicians, part of the Alliance on Alcohol has stated that:

> *"The most effective and cost effective strategy for reducing alcohol harm is to increase tax and reduce availability. Evidence suggests that increasing tax on alcohol by only 10% could decrease alcohol related deaths of various forms by 10-30%" (Royal College of Physicians, 2010)*

The Chief Medical Officer in his annual report for 2008, called for a minimum price of 50p a unit. He quoted the evidence from the Independent review of the effects of alcohol pricing and promotions, undertaken by the University of Sheffield in 2008 that concluded that this minimum price would result in nationally:

- 3,393 fewer deaths
- 97,900 fewer hospital admissions
- 45,800 fewer crimes
- 296,900 fewer sick days

This would save over £1 billion by 2019, although some of the effects would be more immediate especially in regard to crime and sick days.

8 Recommendations

8.1.1 Service modifications

8.1.1.1 Alcohol QIPP

The PCT is already progressing many of the recommendations of the QUIPP with the work on IBA with the LAA target and Primary care LES. Indeed the LES offered by Sandwell is more comprehensive than the national DES, however the lack of uptake requires the review of the LES to increase its use.

8.1.1.2 Extend Identification and brief advice into more settings:

Despite having more people than ever receiving IBA it is not universally available and there are opportunities to increase access by extending IBA into these areas:

1. Identification and brief advice in primary care (new registrants):
2. Identification and brief advice in primary care (at risk group):
3. Identification and brief advice in A&E and specialist units (e.g. fracture clinics)

8.1.1.3 NI39 –diversion away form hospital care into primary care possible – with provision capable to deal with/divert by type of drinker e.g. low/medium/high risk/violent

8.1.1.4 Scope for wet- dry hostel/post- discharge support/ Supporting People/housing association interventions

8.1.1.5 There needs to be a greater interaction with service users to contribute to treatment pathways and interventions. There also needs to be provision for abstinence based models such as (but not exclusively) those offered by Alcoholics Anonymous

8.1.1.6 Tier 4 provision needs attention and all efforts must be directed towards effective services that reduce hospital admissions

8.1.1.7 Ensure our services are equitable provided through an Equality Impact Assessment (part of WCC governance framework), especially in regard to the Indian population

8.1.2 Behavioural change – Social Marketing

The conclusion of the social marketing is that all future marketing campaigns need to focus on the following messages:

health

- education on limits/units, simple, credible, personal to bridge the gap between their perceived 'safe' levels and their actual behaviour
- clear messages to build awareness of immediate damage to "people like me" – daily fitness and energy, memory loss, mental health,

wealth

- pricing – increases may create more worrying health behaviour for some
- job prospects – workplace programmes to reinforce fear of loss (random testing, education)

happiness

- alternative roles for pubs to retain social factor and/or provision of alternative social activities outside of the pub
- leverage impact on relationships, emotional wellbeing, opportunities to live life
- support when needed avoiding stigma of "alcoholic"

8.1.3 Minimum price

The JSNA recommends that Sandwell LSP support the call for a minimum price for alcohol as without this the valuable work in treating those harmed by alcohol will become rapidly unaffordable.

8.1.4 Community Safety

Hidden harm agenda/ Safeguarding agenda – there are plans to strengthen links with children and young people's commissioning through joint commissioning and pathway development. These links can be further strengthened by links with the acute trust, particularly midwifery services, education services and children's services. Family work has a key part to play in this.

Night time economy & police laws, licensing laws, - balance of two – learning from other areas

Change of focus for local pubs to enhance their community focus, and where responsible drinking can be encouraged

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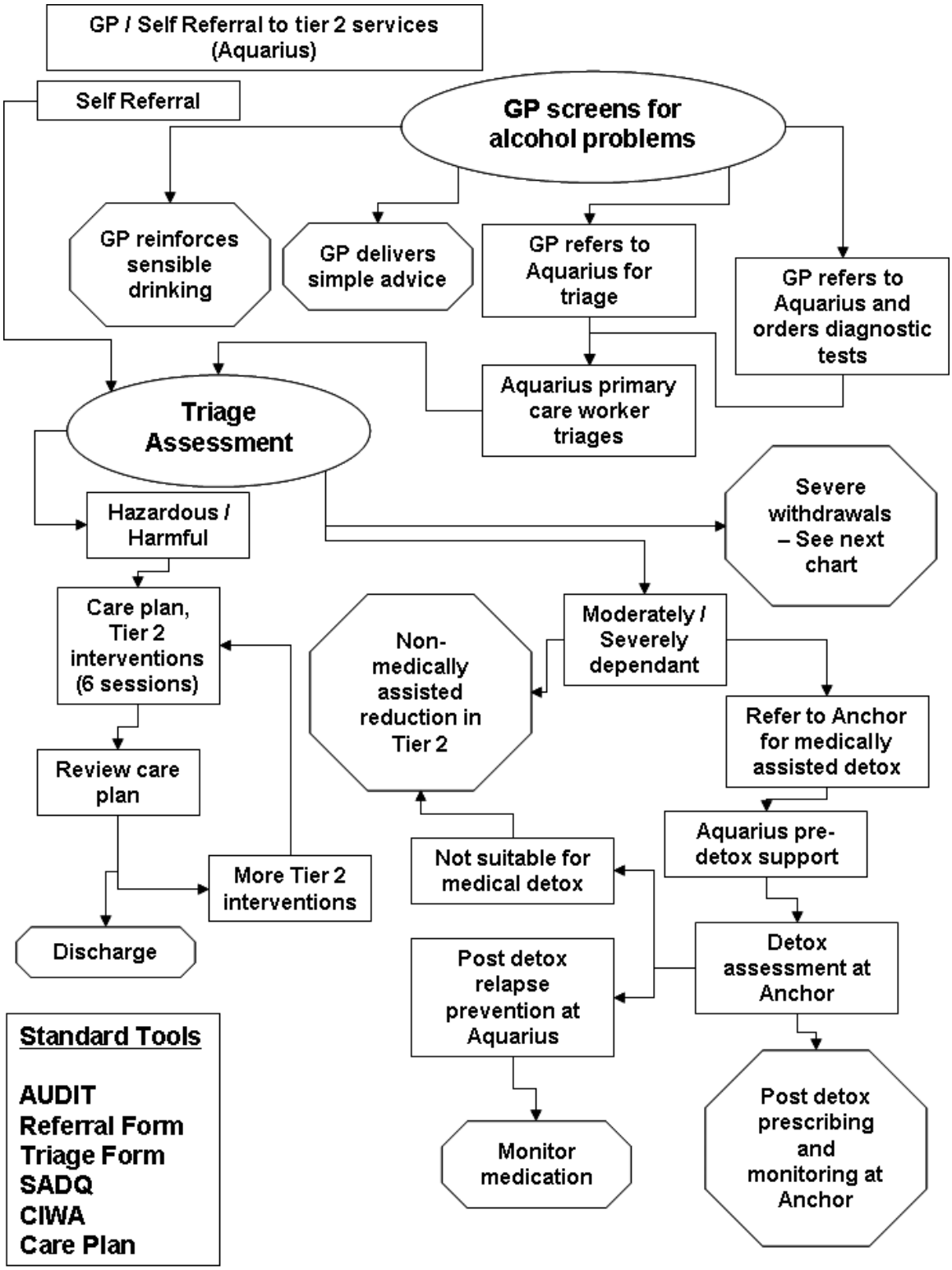
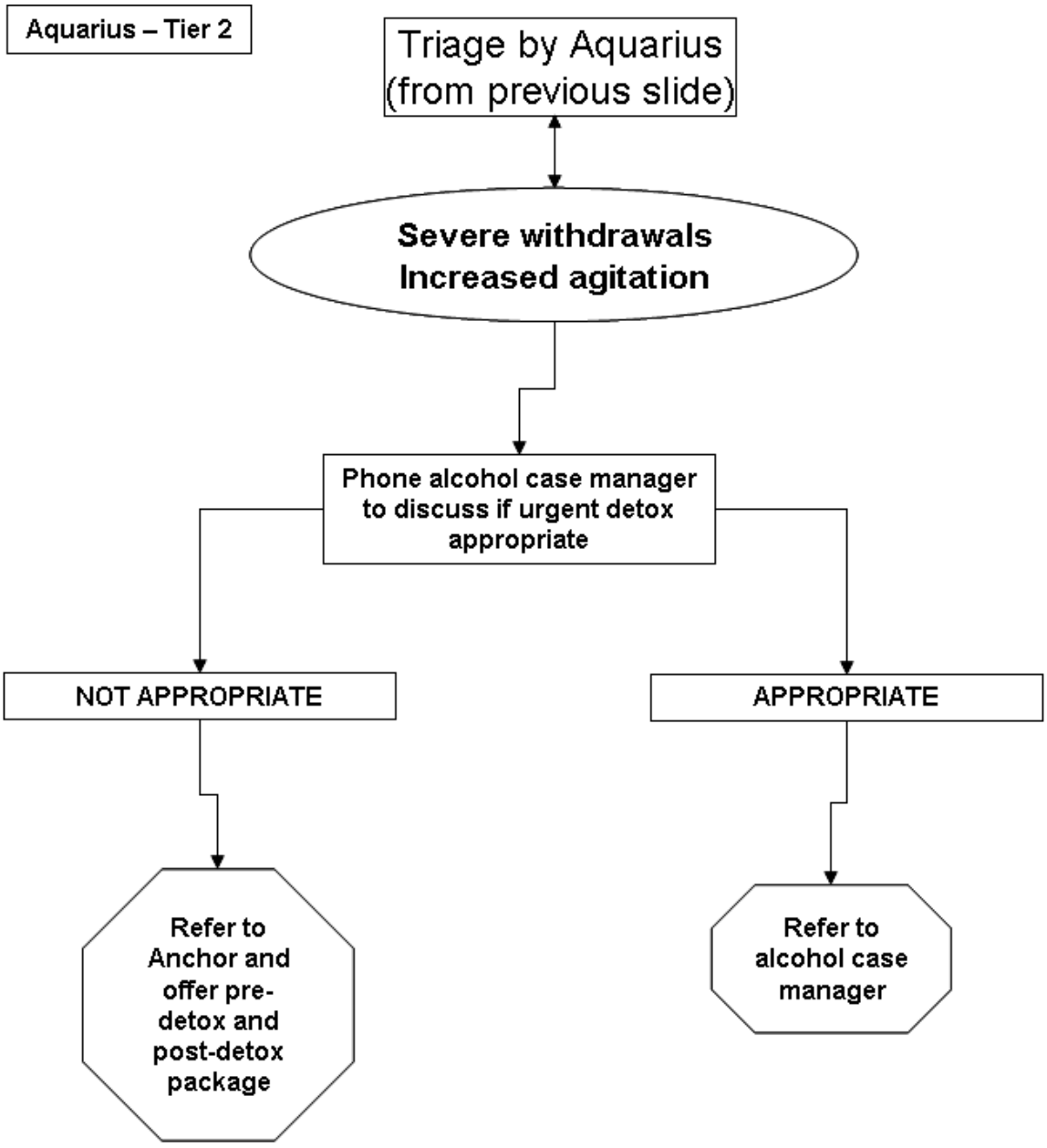
Appendix

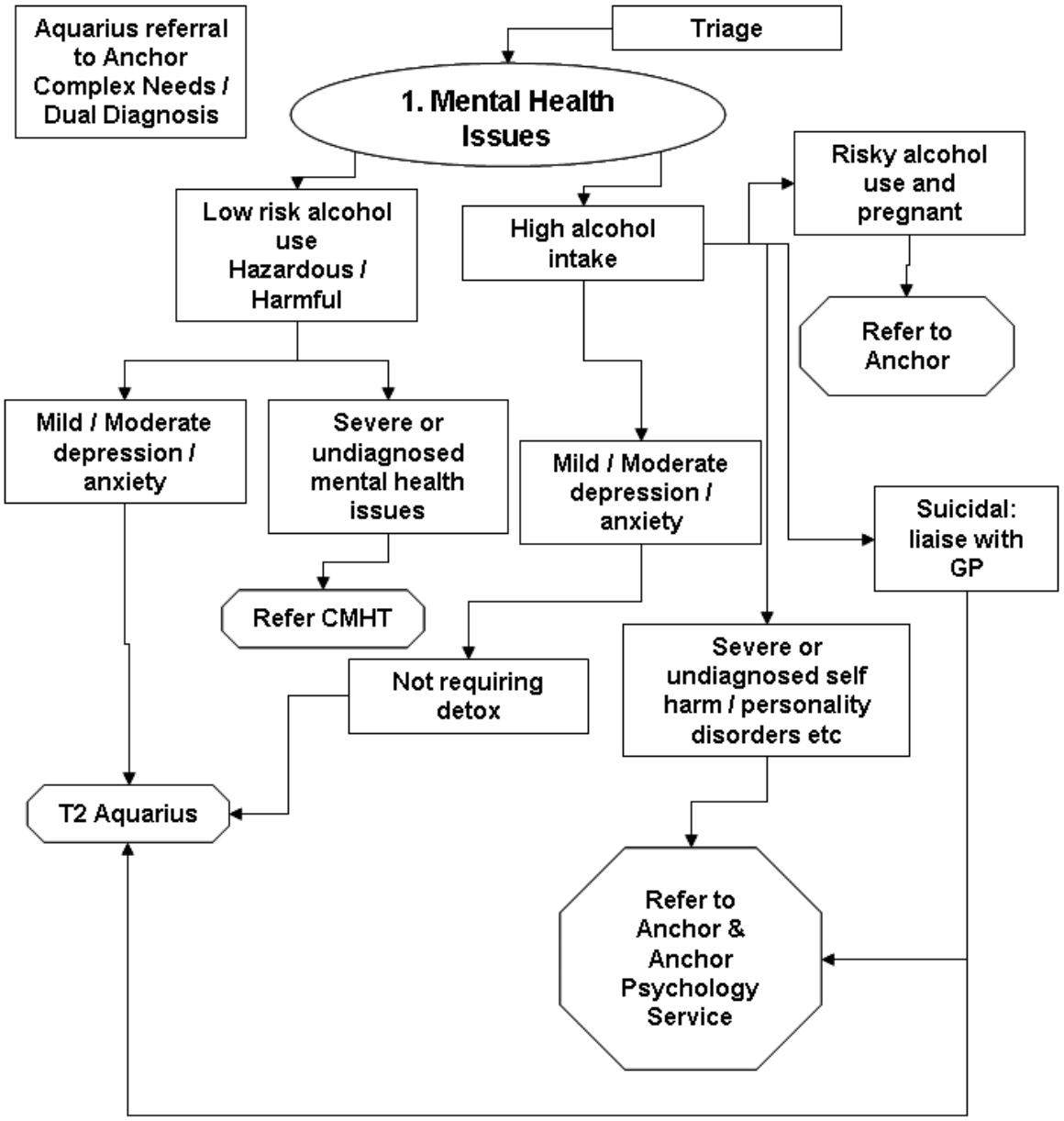
Tier 2 and 3 Care Pathways





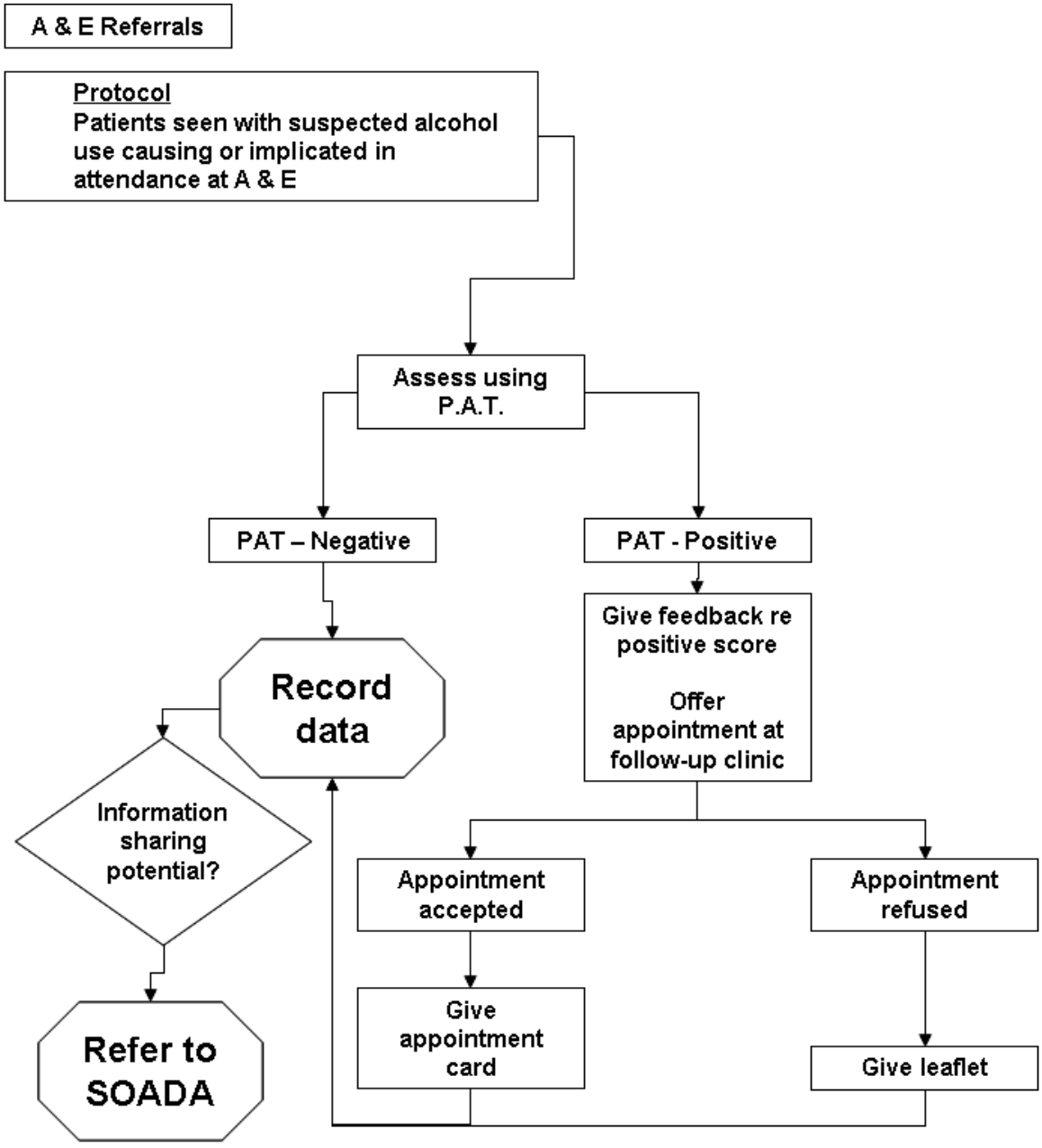
Standard Tools

Triage Assessment
SADQ
CIWA



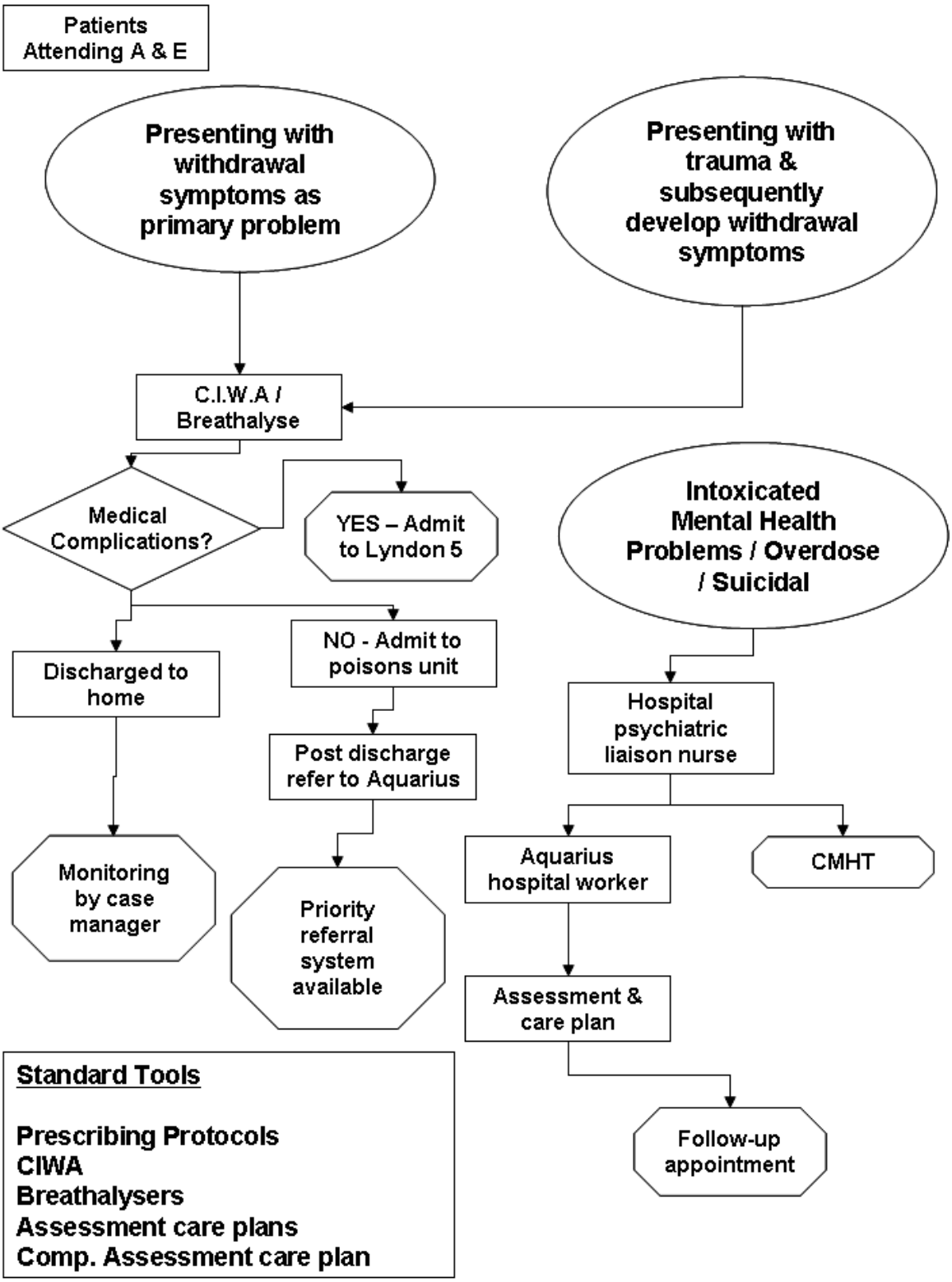
Standard Tools

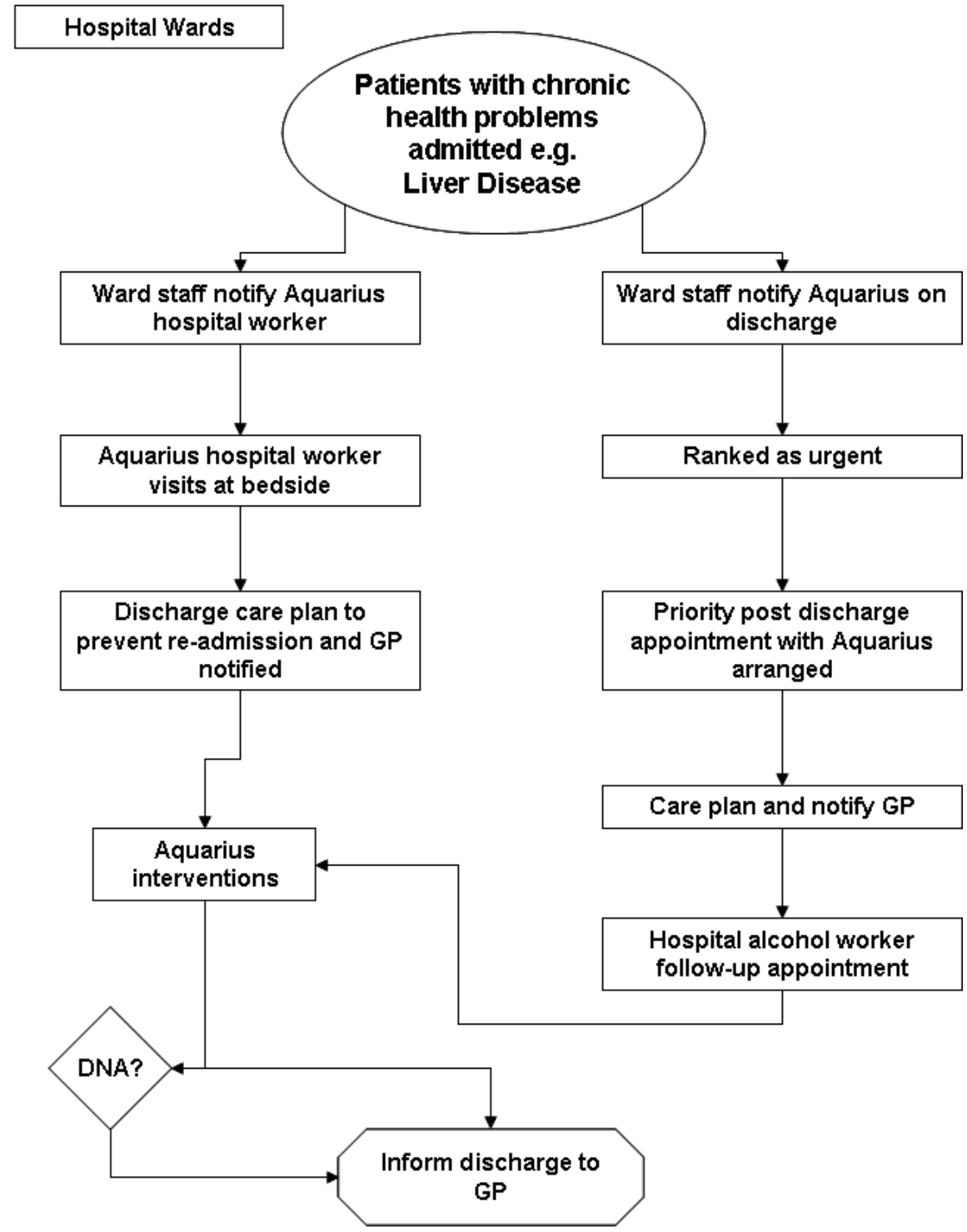
Triage Form
Comprehensive Assessment
Risk Assessment
Risk Management
Care Plan



Standard Tools

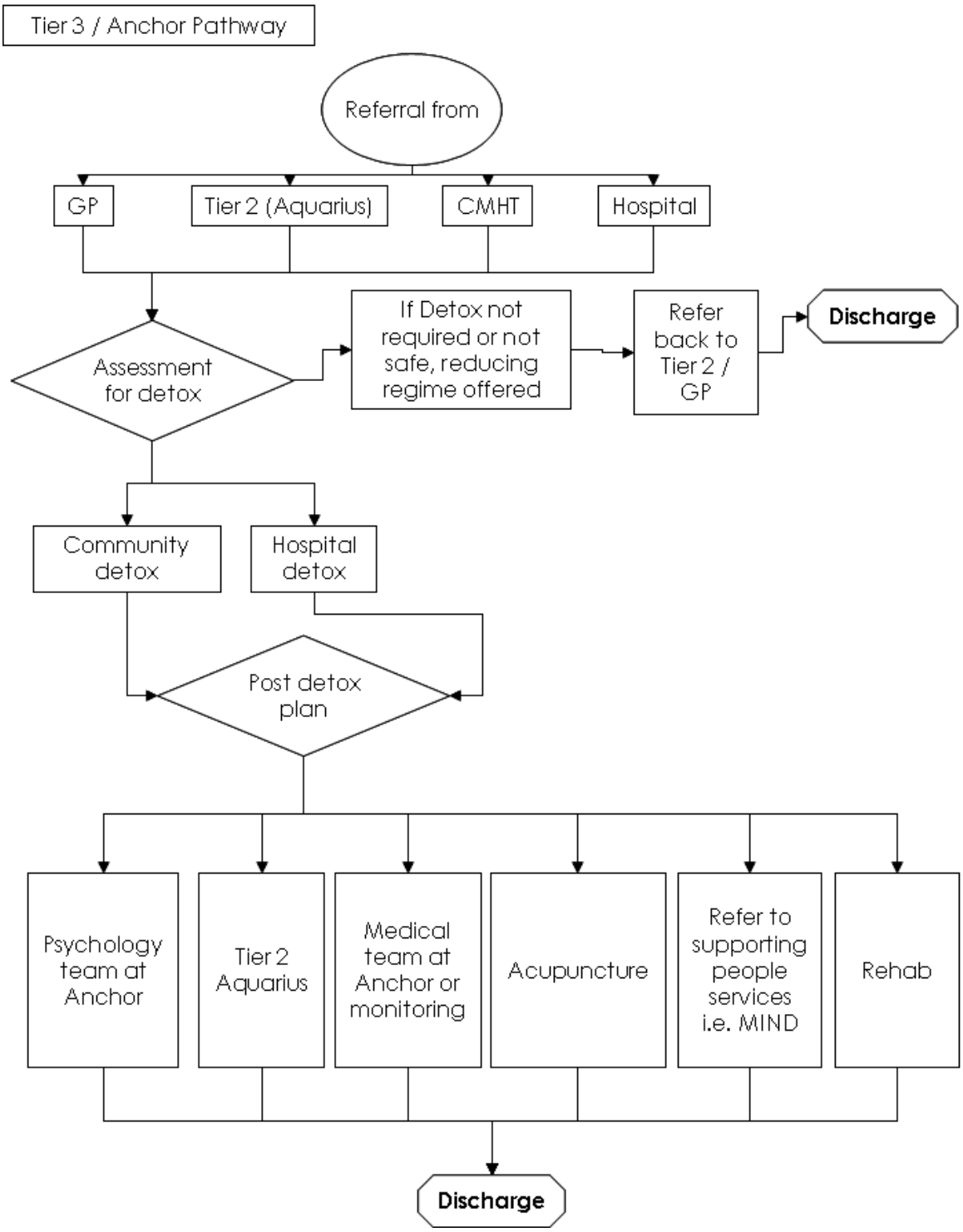
Paddington Alcohol Test
Data Sheet
Follow-up Clinic Appointment Card


Patients Attending A & E
Presenting with withdrawal symptoms as primary problem
Presenting with trauma & subsequently develop withdrawal symptoms
C.I.W.A / Breathalyse
Medical Complications?
YES – Admit to Lyndon 5
Intoxicated Mental Health Problems / Overdose / Suicidal
Discharged to home
NO - Admit to poisons unit
Hospital psychiatric liaison nurse
Post discharge refer to Aquarius
Monitoring by case manager
Priority referral system available
Aquarius hospital worker
CMHT
Assessment & care plan
Follow-up appointment
Standard Tools
Prescribing Protocols
CIWA
Breathalysers
Assessment care plans
Comp. Assessment care plan



Standard Tools

Care Plan


Tier 3 / Anchor Pathway
Referral from
GP
Tier 2 (Aquarius)
CMHT
Hospital
Assessment for detox
If Detox not required or not safe, reducing regime offered
Refer back to Tier 2 / GP
Discharge
Community detox
Hospital detox
Post detox plan
Psychology team at Anchor
Tier 2 Aquarius
Medical team at Anchor or monitoring
Acupuncture
Refer to supporting people services i.e. MIND
Rehab
Discharge