Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

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<tr><td colspan="2">Development of Bristol Alcohol Harm Reduction Strategy and Action Plan</td></tr>
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1. Purpose of this Paper: the board is asked to consider their priorities for actions to inform a refreshed Bristol Alcohol Harm Reduction Strategy and action plan.

2. Executive Summary: national guidance and strategy recommend high impact changes that can be put in place to reduce alcohol harm. These include setting up alcohol liaison teams in hospitals; consideration of national minimum unit pricing of alcohol to reduce availability and affordability; and to ensure that good partnership work exists locally.

3. Context: The National Alcohol Strategy 2012 states: -

> 'In moderation, alcohol consumption can have a positive impact on adults' wellbeing, especially where this encourages sociability. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in our local communities. And a profitable alcohol industry enhances the UK economy. The majority of people who drink do so in an entirely responsible way, but too many people still drink alcohol to excess. The effects of such excess – on crime and health; and on communities, children and young people – are clear.'

It is estimated that alcohol misuse costs the economy in England up to £21 billion per year. Health, social care services, and criminal justice agencies in Bristol all have to invest significant amounts of money in providing services to respond to the effects of alcohol misuse. Alcohol issues affect many people in Bristol, but our most deprived neighbourhoods are likely to suffer most, and benefit least, from the impact of alcohol on our city.

Partners in Bristol agreed an alcohol harm reduction strategy and action plan in 2007, this was refreshed in 2010. The Alcohol Strategic Needs Assessment of 2012 resulted in a new partnership action plan being developed; many of the actions have now been completed. The partners need to refresh the strategy and action plan, and clarify reporting structures.

In Bristol alcohol-related admissions (using both the 'narrow' and 'broad' definitions) rose exponentially between 2000 and 2010; they peaked in 2011-12, and since then have reduced slightly. They are significantly worse than the national average.

Nationally the deaths from liver disease rose 40% between 2001 and 2012, and it is the only big killer disease where annual deaths are still rising. Liver disease is mainly caused by alcohol misuse. The position in Bristol is similar to the national average, although for males it is worse which is moderated by a much lower rate for women. See appendix 1.

Alcohol use also contributes to disability adjusted life years (see appendix 2) through drinkers developing cancers, mental health disorders and other diseases. It is linked to more than half the cases of high blood pressure as well as obesity and heart disease.

Much work has been undertaken to address alcohol misuse in Bristol and this has been embedded as standard work, for instance policing of the night time economy, and providing training for GPs to manage alcohol misuse in primary care.

4. Important issues.

- the continuing rise in liver disease (see appendix 1).
- the progress we have made is likely to be undermined by the widespread availability of alcohol in the off-trade.
- The last year has been very difficult for partners. We need to join up better to reduce alcohol harm.
- Hospital discharges of homeless dependent drinkers with complex issues and chaotic lives are challenging. How do we avoid readmissions?

5. Possible subjects for HWB discussion:

The HWB is asked to consider priorities for actions for the Bristol Alcohol Harm Reduction Strategy. Possible subjects for discussion are included below, however the HWB may have others it wants to explore.

Public Health policy: the most effective way to reduce the harm caused by alcohol misuse in society is for national policy to control availability and affordability. The government consulted the public about introducing a national minimum unit price (MUP) for alcohol. This policy has excellent evidence for effectiveness in reducing mortality and hospital admissions caused by alcohol misuse. The evidence is based on MUP policies in many provinces in Canada where they have been in place for at least eight years.

Critics of this type of policy have speculated that low income groups suffer disproportionately, that families suffer as food money is diverted to buy alcohol, and that shoplifting increases. However there is little evidence of this in practice.

There is also speculation that the policy would impact on the licensed trade. The on-trade sells alcohol at more than 50 pence a unit so they should not be affected. The off-trade sells the most low cost alcohol; however the price increase would benefit the off- trade as the increased profit would be theirs which could off-set the reduction of sales of very inexpensive alcohol.

Another potential adverse outcome of implementing this policy is that severely dependent drinkers would be unlike to be unable to procure as much alcohol as they currently do and may suffer involuntary detoxification. Plans would need to be made in the health system for this eventuality.

The government has indicated that it will not implement an MUP policy in this administration. In order for Bristol Public Health to advocate for this change in national law in the future it would be helpful if the board could indicate its support for national policy change.

Licensing policy: this is the responsibility of the council and decisions about conditions are legally the remit of the licensing committee. The council's Head of Regulatory Services has been in discussion with councillors to seek agreement on a refreshed licensing policy and conditions. It is not expected that a local MUP byelaw would be put in place due to practicalities.

Healthcare based alcohol workers: hospital based alcohol liaison teams are recommended by national guidance. They reduce hospital admissions, readmissions, and length of stay in hospital. They are recommended as an NHS quality improvement.

The commissioning guidance for Clinical Commissioning Groups (CCGs) and Public Health is not entirely clear around commissioning responsibilities, which are as follows:-

- Local Authority: commissions alcohol misuse services, prevention and treatment

- Clinical Commissioning Group: commissions alcohol health workers in a variety of health care settings

- NHS England: commissions: brief interventions in primary care

It is recommended that district hospitals should have a lead consultant, with six nurses and administrative support. University Hospitals Bristol has two alcohol nurses (one funded by Bristol Public Health, one by Bristol Clinical Commissioning Group). North Bristol Hospital Trust has two alcohol nurses (one funded by Bristol Public Health, one funded for a year by South Gloucestershire Council). Both hospitals need more alcohol staff in order to deliver interventions to alcohol dependent patients. Many of these patients are unknown to substance misuse treatment services and are not identified as dependent drinkers before admission to ward or attendance at the Accident and Emergency Department.

A lead from the HWB would be welcome in making the resourcing of these teams a priority for commissioners.

Partnership working arrangements: the respective governance roles of the HWB and the Safer Bristol Board for the alcohol harm reduction strategy need to be clarified. Previously the Alcohol Harm Reduction Strategy was under the governance of the Violent Crime and Substance Misuse Strategy Group, now defunct, who answered to the Safer Bristol Board.

It is proposed that the Bristol Alcohol Harm Reduction Strategy and action plan will be overseen by a partnership group; the Alcohol Harm Reduction Group. This group could report to the HWB.

6. Key risks and Opportunities

Key risk: To do nothing more to address alcohol harm would lead to increasing mortality from liver disease and alcohol related diseases, it would also lead to no reduction in alcohol related societal harm. The burden of disease on our most vulnerable population would be increased leading to increased health inequalities.

Opportunities for Bristol include: integrated work between Bristol Public Health and Bristol CCG to commission alcohol teams in hospitals to tackle the rise in liver disease and alcohol misuse, would enhance the coordinated approach to health across the city.

Bristol Public Health advocacy of a national minimum unit price would enable government to cite core city support to implement a national policy. Many other core cities have stated their support for national MUP legislation.

Setting up an Alcohol Harm Reduction Group would greatly assist partnership working arrangements, and ensure that tackling alcohol misuse is a priority for the city.

7. Implications (Financial and Legal if appropriate)

The resourcing of hospital alcohol teams will incur costs and cost savings for the Bristol CCG and costs for Bristol Public Health. These can be estimated from other areas where teams have been established.

Action on advocacy would not incur expenditure.

8. Conclusions

The board is asked to consider their priorities for actions to address alcohol harm in Bristol**.**

9. Appendix 1

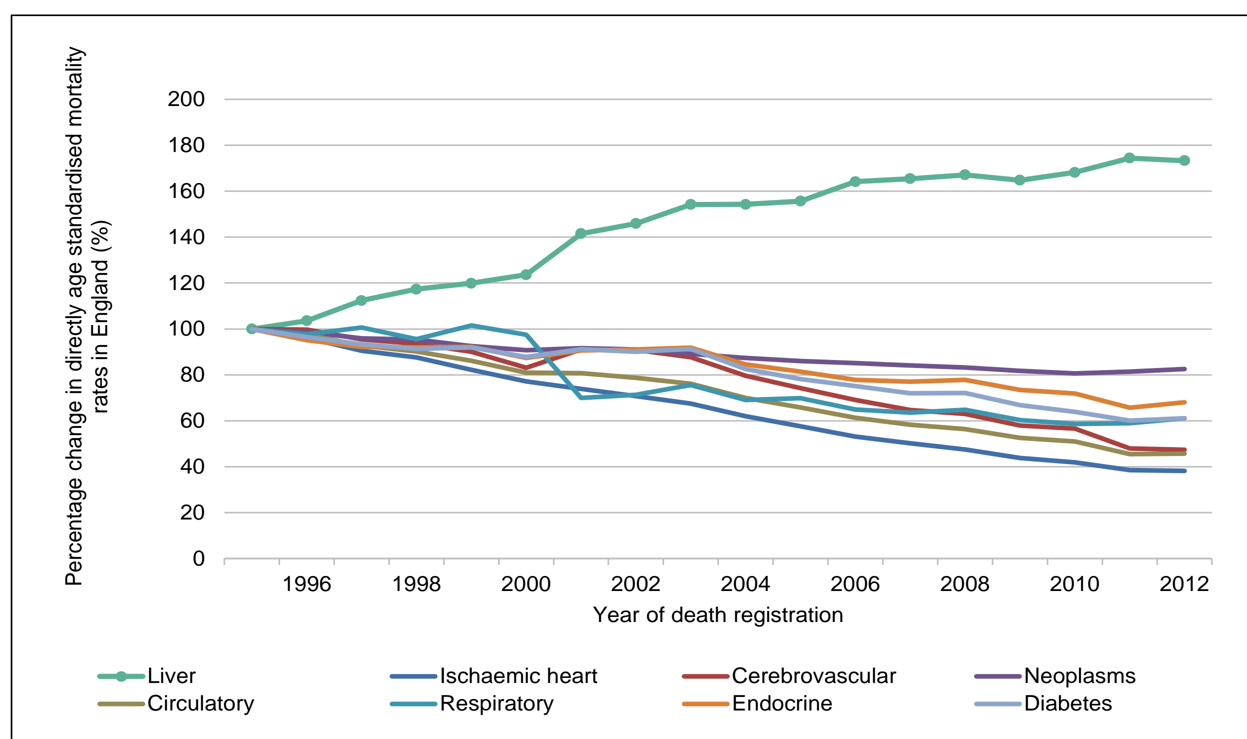

Figure 1: Trend percentage change for the main preventable causes of mortality in England 1995-2012 (directly age standardised rates, %)

Appendix 2