APPENDIX 1

Health and Wellbeing Board Update
Alcohol in Southwark

Last updated 29 December 2015
Prepared for meeting 28 January 2016

SUMMARY

Like much of the country, alcohol and drugs continue to drive inequality in life opportunities and health in Southwark. Alcohol and substance misuse are identified as priority lifestyle risk factors in the Southwark Health and Wellbeing Strategy 2015-2020. Locally, we are taking a system-wide approach that seeks to manage the supply of alcohol, identify and prevent harm where possible, and mitigate and treat those chronically afflicted by alcohol. Drugs too, continue to affect the lives of many of our residents. New so-called 'legal highs', prescription medications and high-strength cannabis present new challenges for services.

On 4 January 2016, the drugs and alcohol treatment service was transferred to a single integrated provider following an extensive procurement exercise in 2015. This year, and following the release of HM Government's national alcohol strategy, we will seek to collaborate more closely with partners across the Council, law enforcement, and our nearby centres of academic and clinical excellence to develop an action plan.

WHERE ARE WE?

1. Alcohol and drug-related substance misuse continue to present challenges to health and other municipal services in Southwark and south-east London. While the national picture suggests a gradual reduction in alcohol consumption at population-level, the advent of so-called 'legal highs' and the ageing cohort of people whose lives have been chronically disadvantaged by substance misuse of all types, pose further hurdles to overcome.

2. Southwark continues to suffer significantly higher chronic morbidity relating to alcohol: alcohol-specific and rates of alcohol-related hospital admission are higher than the London average. Conversely, the rates of people attending hospital with 'intentional self-poisoning with alcohol' – the acute effects – are lower than the London average.

3. Yet children and young people are still adversely affected by the damaging effects of substance misuse in families. Social services estimate that 30% of care proceedings involving children involve alcohol. Young people are continuing to place themselves at risk from high-strength cannabis and novel psychoactive substances (NPS, so-called 'legal highs').

4. Ambulance attendances for the financial year 2014/15 show a reduction of approximately 10% on the previous year. The pressure remains however from the Night Time Economy (1800-0600hrs) with more than 60% of calls occurring within this time; more than 20% of all alcohol-related callouts occur between 2200hrs and 0100hrs.

5. There is evidence that street-drinking and antisocial behaviour related to alcohol in Southwark has markedly reduced across the borough over the last two years. Precisely quantifying this is difficult due to changing patterns of data collection and coverage.

POLICY LANDSCAPE

6. Public Health is now reviewing all alcohol licensing applications. Since 2011, the Director of Public Health has held 'responsible authority' status that grants powers to make representation to any alcohol licensing application (under the Licensing Act 2003). Between March 2015 and December 2015, the public health team received and reviewed 88 applications. We made representations against 23 (26%). Quantifying 'success' is methodologically challenging; however, additional conditions and restrictions upon retail hours are now being regularly achieved.

7. We are working to foster relationships across the Council and beyond including with trading standards, environmental protection and the Metropolitan Police. The advantages to taking a collaborative approach include better intelligence sharing, capacity to enforce decision and the potential to align the ambition of public health more comprehensively across the organisation and wider.

8. Public Health has contributed to the Council's newly published statement of licensing policy for 2015-2020 (effective 1 January 2016) and is working with other stakeholders to establish what effect "saturation zones" (formally termed cumulative impact zones, CIZ) have had thus far, and whether additional CIZ may be introduced.

9. LB Southwark is exploring the potential of a Public Spaces Protection Order (PSPO) that would take over from the existing Designated Public Places Order (DPPO) due to expire in 2017. The PSPO would offer additional powers to Police and wardens to prohibit and respond to antisocial behaviour caused related to alcohol and / or drugs.

10. Southwark is working with crime and disorder partners. Alcohol Abstinence Monitoring Requirements (AMMR, referred to as compulsory sobriety orders) are being piloted with The Mayor's office. Operating across several boroughs, an overall compliance rate of 93% has been observed for offenders enrolled in the programme.

HEALTH SERVICES

11. A range of services have been provided to Southwark's residents in 2015. Tier I activity includes Identification and Brief Advice (IBA) spanning the community and hospitals (with a CQUIN at King's College Hospital operated by the CCG). So-called Tier II self-referral and outreach work is also on-going with drop in visits to schools and cross-disciplinary working with sexual health; for 2015 Q2, there were 1064 contacts recorded.

12. Southwark's substance misuse treatment services have, until recently, been provided by a number of different providers including South London and Maudsley NHS Foundation Trust. In 2014, the proportion of patients successfully completing drug treatment have been similar to the London and national averages. Data for 2015 are not yet available.

13. From 4 January 2016, LifeLine Project has become the single integrated provider of substance misuse services (spanning alcohol and drugs) across Southwark. LifeLine takes over from a multiplicity of substance misuse provision that has organically arisen over past years.

14. Careful transition planning has taken place to mitigate the inherent risks of transferring clients to the new provider; the results of this transition will become apparent over the next several weeks.

PLANS FOR 2016/17

15. We are appraising the wide range of epidemiological and treatment-centric indicators to determine a more coherent and streamlined approach to measuring progress and performance. At present we are appraising the comparative benefits of the following five indicators:

Progress (Outcomes)

i. Alcohol-specific mortality (persons); *24-monthly data; Source, Public Health England and ONS.*

ii. Percentage of successful treatment completions (opiates and non-opiates); *12-monthly data; Source, National Drug Treatment Monitoring System, Public Health England*.

Performance (Process)

iii. Tier I and Tier II activity; *quarterly-reported; locally sourced.*

iv. Admission episodes for alcohol related conditions (narrow); *12-monthly data; Source, Public Health England and HES.*

v. People entering prison with substance misuse dependence issues not previously known to treatment; *12-monthly data; Source, National Drug Treatment Monitoring System, Public Health England*.

16. A national strategy on alcohol is to be published by HM Government in 2016, and this will form a starting point for a local action plan to be created over the course of the next year.

17. Drugs and alcohol are identified as priority lifestyle factors for improvement within the current Health and Wellbeing Strategy 2015-2020. Alcohol (with tobacco) are identified as ‘deep-dive’ topics. Both drugs and alcohol will be specifically appraised as part of the Joint Strategic Needs Assessment process in 2016.

18. In respect of local licensing policy, public health faces a level of uncertainty regarding resource as the shared specialist team is split into two borough specific teams. However, resources-allowing, we have an ambition to create a licensing environment that prevents the retail of high strength beers, lagers, ciders and similar alcohol beverages for newly licensed premises.

19. We aim to collaborate more closely with a range of partners across the Council, law enforcement, and our nearby centres of academic and clinical excellence.

Briefing Author

Richard Pinder, Consultant in Public Health Medicine
London Borough of Southwark
richard.pinder@southwark.gov.uk

29 December 2015

TABLE 1: ACTIONS SUMMARY

	PROGRESS IN 2015	ACTIONS FOR 2016
POLICY	• Review of Statement of Licensing (Licensing Team led) completed. Best practice approaches incorporated including defined saturation zones, closing times and model conditions.	• Substance misuse (including alcohol) will be included in the next round of the Joint Strategic Needs Assessment • Public health will be appraising the potential of new saturation zones for alcohol licensing in Southwark • Work will be taking place to refresh the alcohol strategy (2013 – 16)
REGULATORY (LICENSING)	▪ A toolkit has been developed which supports the identification of alcohol license applications where there may be concerns. The use of this tool has supported the review of applications and representations on 23 new applications, variations and reviews of licensed premises in Southwark. Conditions imposed include for example earlier closing times, minimum unit pricing and sales of single cans of high strength beers.	• With licensing colleagues, public health will continue to review licensing applications. • Further work will take place to reduce the supply of high strength beers, lagers and ciders from off-licenses, the effectiveness of minimum unit pricing and to learn from the London prevention devolution pilot.
PREVENTION	• A wide range of outreach activities have been undertaken on behalf of Southwark by the services commissioned by the drugs and alcohol commissioning team (DAT)	• With DAT, public health look to extract maximum value from the new integrated service (provided by LifeLine Project) which went-live 4 January 2016 • Public health be fostering links with CCG, acute and academic partners so that we can prevent, identify, treat and mitigate the effects of alcohol across Southwark
TREATMENT	▪ DAT have led the re-procurement of a new integrated prevention and treatment service taking over from the numerous services (including those provided by Foundation 66 and South London and Maudsley NHS Foundation Trust)	

TABLE 2: INDICATOR OVERVIEW

	Indicator	Southwark (most recent value)	London comparator	Comment
i.	**Alcohol-specific mortality (persons)**	**12.1** DSR per 100k people Data from 2011-13	**9.0** DSR per 100k people Data from 2011-13	Southwark mortality is 34% higher, but not significantly* different from the London average.
ii.	**Percentage of successful treatment completions (opiates and non-opiates)**	Opiates: **6%** Non-opiates: **34%** Data from 2013	Opiates: **9%** Non-opiates: **37%** Data from 2013	Southwark's treatment success for opiate-users is significantly* below London's average; success for non-opiate users is lower but not significantly* different.
iii.	**Tier I and Tier II alcohol activity**	*To be discussed in light of new provider contract; data reported quarterly.*		
iv.	**Admission episodes for alcohol-related conditions (narrow)**	**601** DSR per 100k people Data from 2013/14	**541** DSR per 100k people Data from 2013/14	Southwark's admission rate is 12% higher than the London average – a statistically significant* difference. These data are collected annually.
v.	**People entering prison with substance misuse dependence issues not previously known to treatment**	**58.6%** *equivalent to 242 people per year* Data from 2012/13	**57.1%** *equivalent to 4966 people per year* Data from 2012/13	A marginally higher (but statistically insignificant) proportion of Southwark residents entering prison with dependence were not known to treatment services previously. Nationally, 46.7% of offenders are not known to services prior to prison enrolment. We are currently investigating how these indicators (or proxy thereof) may be accessed in a more timely fashion.

DSR – directly standardised rate; interpretation – the calculation adjusts for age differences between populations enabling comparisons to be drawn between Southwark, other boroughs and the region.

* – a statistically significant difference implies that there is a 95% chance that the difference is real; put another way, the difference cannot be attributed to chance alone.