Alcohol, Drugs and Tobacco in Lancashire
Section 1: Alcohol

November 2012

Intelligence for Healthy Lancashire (JSNA)

Contents

Introduction

There is substantial evidence to show that people who use and misuse alcohol, drugs and tobacco experience poorer social, economic and health outcomes than those who do not. Increased use and misuse of alcohol, drugs and tobacco is strongly associated with deprivation and poverty[1] [2].

This joint strategic needs assessment (JSNA) is designed to provide intelligence for commissioners from a variety of organisations to inform their services.

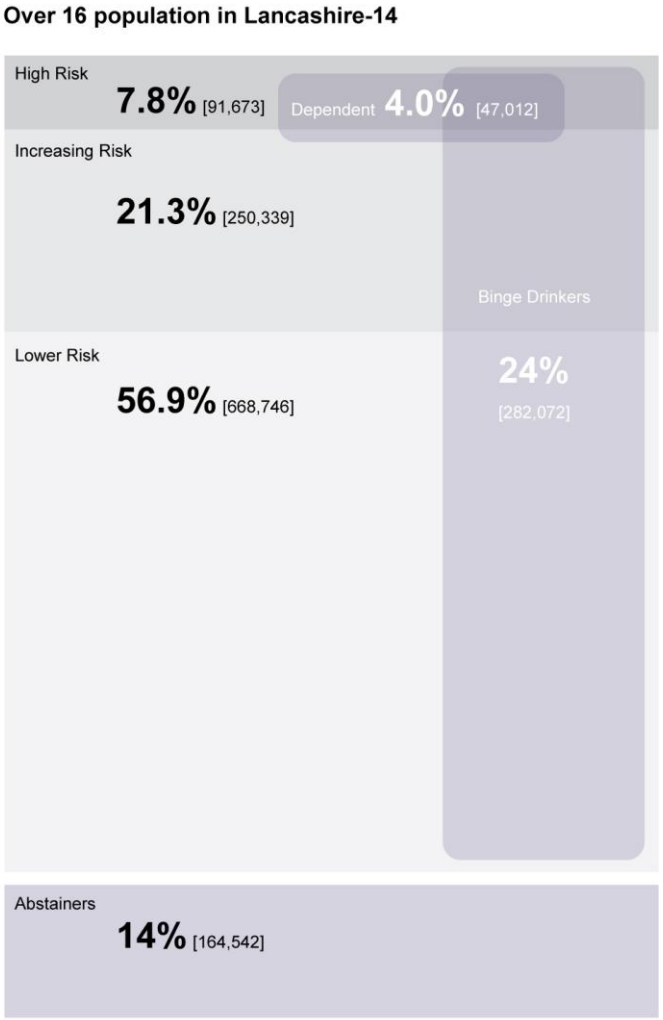
[1] Jarvis and Wardle (2006) 'Social patterning of individual health behaviours: the case of cigarette smoking,' p.224 in Marmot and Wilkinson (eds), *Social Determinants of Health* (2nd edn). Oxford: Oxford University Press.
[2] Marmot and Wilkinson (2003) *Social Determinants of Health: the Solid Facts* (2nd edn), p. 24. World Health Organisation.

Alcohol Consumption

When consumed in moderation, alcohol can provide enjoyment and encourage social cohesion. However, excessive consumption is viewed as a serious problem with a range of health, social and economic consequences. The figure right summarises the percentage and number of people aged 16 and over who abstain from alcohol or are lower risk, increasing risk, or higher risk drinkers in Lancashire, as well as binge drinkers and dependent drinkers.

There is no statistically significant difference between the 14 districts in Lancashire, or between the Lancashire figures and the England average. However:

- Fylde had the lowest proportion of abstainers at 9.7%, while Blackburn with Darwen had the highest at 20.9%.
- Ribble valley has the highest proportion of higher risk drinkers at 11.1%, while Rossendale had the lowest at 5.3%.
- The level of binge drinking in the districts of Blackpool, Burnley, Chorley, Ribble Valley and Rossendale is statistically significantly higher than the England average.



Estimates derived from the Dept of Health publication "Signs for Improvement: Commissioning interventions to reduce alcohol-related harm".

Demographics

Ethnicity

Very little data is available at a Lancashire level for alcohol consumption by ethnic group. However, recent national research[3] suggests:

- Most minority ethnic groups have higher rates of abstinence and lower levels of drinking compared to people from white backgrounds, particularly those from Pakistani, Bangladeshi and Muslim backgrounds.
- Pakistani men and Muslim men and women are more likely to abstain, but those who do drink tend to drink more.
- People from Indian, Chinese, Irish and Pakistani backgrounds on higher incomes tend to drink above recommended limits.
- Minority ethnic populations have similar levels of alcohol dependence compared to the general population, despite having lower levels of consumption than the general population.
- Services are not responsive enough for minority ethnic groups and are under-represented in seeking treatment. Additionally, problem drinking may be hidden, particularly with women and young people from South Asian ethnic groups.
- Some research shows that patterns of drinking in second generation minority ethnic groups may start to resemble the drinking habits of the general population.

Recommendation: community engagement should be used as a method of reaching hidden drinkers. Involving local agencies and stakeholders in consultations is key in developing services for such groups.

[3] Joseph Rowntree Foundation (2010) *Ethnicity and Alcohol: A Review of the UK Literature*, p. 1. Available online: http://www.jrf.org.uk/sites/files/jrf/ethnicity-alcohol-literature-review-summary.pdf [accessed October 2011].

Deprivation

There are strong links between alcohol consumption and deprivation[4]. People who live in the most deprived areas nationally are nearly three times more likely to be dependent on alcohol than those from the least deprived areas.

Age – Older People

Older age groups tend to consume less alcohol overall[5] [6], but this masks the number of 'hidden drinkers.' Recent research suggests a third of men and a fifth of women aged 65 and over drink more than the guideline amounts[7]. With an ageing population trends in alcohol-related falls and hospital admissions suggest that increasing numbers of older people are at risk from alcohol-related problems.

A report by Age UK[8] highlighted the following issues with current policy and interventions:

- Current social marketing campaigns reinforce older peoples' belief that alcohol dependence or problems do not relate to them.
- The perception of some older people is that alcohol is medicinal, for example it will help them sleep or cure a cold.
- Sources of advice regarding alcohol consumption are unconvincing to older people as they have heard so many conflicting pieces of advice from 'professionals' that they no longer believe them.
- Older people assign a great deal of stigma to over-consumption of alcohol which has an impact on all aspects of its management.
- Service providers feel uncomfortable raising issues around drinking with older people and are unsure as to how to deal with concerns. They noted that they find it difficult to identify the point at which a 'pleasure changes into a problem.'

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[4] Marmot and Wilkinson (2003) *Social Determinants of Health: The Solid Facts*, p. 25. Available online: http://www.euro.who.int/en/what-we-publish/abstracts/social-determinants-of-health.-the-solid-facts [accessed October 2011].
[5] Institute of Alcohol Studies (2010) *Alcohol & the Elderly*, p.3. Available online: http://www.ias.org.uk/resources/factsheets/elderly.pdf [accessed November 2011].
[6] Royal College of Psychiatrists (2011) *Our Invisible Addicts: First Report of the Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists*, p. 7. Available online: www.rcpsych.ac.uk/files/pdfversion/CR165.pdf [accessed June 2011].
[7] Alcohol Concern (2011) *Hidden Harm?: Alcohol and Older People in Wales*, p.1. Available online: http://www.alcoholconcern.org.uk/publications/other-publications/hidden-harm [accessed November 2011]
[8] Ibid.

- Current alcohol services are not relevant or suitable for the needs of older people.
- Older people are increasingly drinking in their own homes due to the changing pub culture and the way pubs now focus on people in younger age groups.
- The increasing number of older people taking early retirement seems to add to the problem of over-consumption as people can find themselves disengaged from one set of activities but still feel too young for the next set.

Recommendations for older people:

- **Ensure specific social marketing campaigns are designed with older people as the target audience.**
- **Involve older people in the design of treatment services to ensure they are accessible and appropriate for their needs.**
- **Focus on providing training for all care staff on alcohol brief interventions.**
- **Routinely include advice about the potential dangers of increasing alcohol consumption in pre-retirement courses.**

Age – Children and Young People

A recent survey by Trading Standards North West (2011) revealed that the proportion of 14-17 year olds claiming to:

- Drink alcohol once a week or more has continued to decline.
- Binge drink regularly (five or more alcoholic drinks at least once a week) has reduced.
- Purchase their own alcohol has fallen significantly.

Although these are significant improvements, Lancashire is still above the North West average for young people drinking alcohol. Of the 14-17 year olds surveyed in Lancashire, 80% drink alcohol and 65% binge drink. Of these, 17% drink twice a week or more and a fifth

binge drink at least once a week; a fifth said they mostly drink outside; a quarter had been violent or in a fight whilst drunk; and 15% regretted having sex after drinking[9].

Most 14-17 year olds in Lancashire claim to get alcohol from their friends and family, and the percentage claiming to buy alcohol themselves has remained consistent or fallen for most local authorities.

Enforcement Strategies

Evidence suggests that strict enforcement of the Licensing Act, which bans the sale of alcohol to minors, only has a limited impact on the general access and availability of alcohol to young people. Therefore the focus in Lancashire has been to break the link between alcohol and anti-social behaviour and reduce the availability of alcohol to young people through a combination of education, training and enforcement, involving children, parents, support agencies and retailers.

To supplement formal enforcement action a retailer due diligence resource (AgeCheck) has been produced by Lancashire Trading Standards and distributed to over 7,000 retailers across Lancashire that sell age restricted products like alcohol and tobacco. The award-winning resource is designed to provide retailers with skills and knowledge to assist them in preventing illegal underage sales. The resource is currently being updated to include more specific information around proxy sales for a further distribution run to retailers.

Community Alcohol Networks

A pilot community alcohol network was established in Accrington. Over the six month period from June 2011 until November 2011 juvenile anti-social behaviour was reduced by 53% (170 down to 80) and total anti-social behaviour has reduced by 32% (859 down to 580) when compared to the same period in 2010. Compliance rates for licensed premises during subsequent test purchasing operations improved.

Recommendation: Identify funding to expand the community alcohol networks.

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[9] North West Child Matters intelligence briefing: "*Young people's lifestyle choices and related health indicators: local area profile for Lancashire"*; November 2011.

Adverse Effects of Alcohol

Alcohol-Related Admissions and Alcohol-Specific Admissions

In 2010/11 there were 41,988 admissions to hospital due to alcohol within Lancashire-14. In the Lancashire-14 admissions for conditions that are wholly attributable to alcohol make up 27% of all alcohol-attributable hospital admissions.

There is a strong association between deprivation and alcohol-related admissions in Lancashire, particularly employment deprivation and health deprivation. In all of the 14 local authorities alcohol-attributable hospital admission rates are higher for males than females. Alcohol-attributable hospital admissions rates also increase significantly with age and are highest in individuals aged over 75 years. Blackburn with Darwen and Burnley have the highest rates of alcohol-attributable hospital admissions in 2009/10, and Fylde and Ribble Valley have the lowest rates.

Recommendation: Further investigate and highlight employment and health deprivation as risk conditions for alcohol-attributable hospital admissions.

Recommendation: Examine opportunities for early identification of those facing employment or health issues.

Hypertensive diseases, mental and behaviour diseases due to the use of alcohol, and cardiac arrhythmias alone are responsible for over 71% of all alcohol-attributable hospital admissions. Hypertensive diseases alone equate to 37.5% of all alcohol-attributable admissions.

Recommendation – Improve effective prevention and management of hypertensive diseases in order to make a significant contribution to reducing alcohol-related hospital admissions.

Admitted to Hospital with Conditions that are Wholly Attributable to Alcohol

In all of the 14 local authorities admissions to hospital for conditions that are wholly attributable to alcohol are higher for males than females, and highest for individuals in the 35 to 65 year old age group. This is notably different to the age profile of individuals admitted to

hospital for alcohol attributable conditions. Blackburn with Darwen and Blackpool have the highest rates of admissions to hospital for conditions that are wholly attributable alcohol in 2009/10, and Fylde and Ribble Valley have the lowest rates.

Mental and behavioural disorders due to use of alcohol is the most significant condition that is wholly attributable to alcohol. They account for 18% of all alcohol-attributable hospital admissions and 66% of all conditions that are wholly attributable to alcohol. Mental and behavioural disorders due to use of alcohol include alcohol withdrawal; alcohol dependence; and acute intoxication.

Recommendation: Identify and examine how quality of life and life expectancy can be increased in patients admitted to hospital for conditions that are wholly attributable to alcohol.

Recommendation: Improve prevention, treatment and management of alcohol dependent individuals to reduce levels of dependent drinkers being admitted to hospital.

Hospital Admissions Time Series Analysis

Admissions to hospital for conditions that are attributable to alcohol have increased consistently over the period 2002/03 to 2010/11. In all Lancashire-14 local authorities we have seen an overall increase in alcohol-attributable hospital admissions, but there are variations in the rates of increase.

Recommendation: an important observation to note is the significant increase in 2009/10 in admissions to East Lancashire NHS Trust. This is relevant to local authorities in the east of Lancashire and requires further investigation.

Mortality

Months of life lost due to alcohol varies considerably between districts in Lancashire. For males it ranges from 7.5 months to 20.8 months; for females it ranges from 3.9 months to 9.1 months. For males the districts of Blackburn with Darwen, Blackpool, Preston and Rossendale; and for females Blackpool and Burnley perform significantly poorer than the England average. In the districts of Blackburn

with Darwen, Blackpool, Preston, and Rossendale there are statistically significant inequalities in mortality between males and females, with poorer outcomes for males.

The North West has the highest average annual rate of deaths from alcoholic liver disease in the country with a rate of 14.9 per 100,000 average over 2001-09, compared to just 6.4 per 100,000 in the east of England[10]. Additionally, the number of deaths overall has been steadily increasing across England (9,231 deaths from all liver disease in 2001, to 11,575 in 2009)[11].

Safeguarding

Obtaining safeguarding data where alcohol is a factor is difficult since this information is not routinely coded. Typically, Lancashire County Council receive approximately 3,440 safeguarding alerts per year[12]. It is believed a significant proportion have alcohol as a contributory factor, but it is not possible to say with any certainty what proportion this is.

Recommendation: Implement systematic coding of safeguarding incidents where alcohol is a contributory factor.

Child Deaths

The Lancashire, Blackburn with Darwen and Blackpool Child Death Overview Panel (CDOP) reviewed a total of 298 child deaths in Lancashire-14 between April 2008 and April 2009. Of these, 74 had a 'modifiable factor' relating to the death (n=74). 8 cases (10.8%) identified alcohol use or misuse in the parent as a factor in the child's death; and in 2 cases (3%) alcohol use or misuse in the child was a factor in the child's death.

Recommendation: ensure effective dissemination and implementation of recommendations from lessons learned reports.

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[10] NHS National End of Life Care Programme (2012) *Deaths from Liver Disease: Implications for End of Life Care in England,* p. 11. Available from: http://www.endoflifecare-intelligence.org.uk/resources/publications/deaths_from_liver_disease.aspx

[11] Ibid, p. 8.

[12] Lancashire County Council Adult and Community Services

Recommendation: ensure all commissioned services have policies to address 'hidden harm.'

Incapacity

Nationally the number of people claiming incapacity benefit or severe disablement allowance (IB/SDA) for reasons of alcoholism is 103.7 per 100,000. However, this is likely to understate the impact that alcohol has as unemployment due to indirect impacts on mental ill health and musculoskeletal disorders. This is significantly higher in the North West where 173.4 per 100,000 people claim these benefits for reasons of alcoholism.

The districts of Blackburn with Darwen, Blackpool, Burnley and Lancaster are statistically significantly worse than the North West rate, suggesting significant problems of alcoholism in these areas. Conversely, the districts of Chorley, Fylde, Ribble Valley, South Ribble West Lancashire and Wyre have a statistically significantly lower rate than the North West rate.

Similarly, Blackburn with Darwen, Blackpool, Burnley, Hyndburn, Lancaster, Pendle, Preston, and Rossendale are statistically significantly worse than the England rate. It is worth noting that the rate of benefits claimants for reasons of alcoholism is approximately three times higher than the England rate in Blackburn with Darwen, Blackpool and Burnley, and approximately twice the England rate in Lancaster and Preston.

The rate in Ribble Valley, South Ribble, and West Lancashire are statistically significantly lower than the England rate.

Community Safety

The negative impact of alcohol misuse has been reported as a significant issue in all local area community safety strategic assessments in 2011. In Lancashire, about a third of all violence crimes are given an alcohol marker but this is likely to be an under-recording of the real issue. A large proportion of violence against the person is either centred around the night-time economy or is domestic abuse. Victims and offenders tend to be typically males aged between 15 and 25, although this age group is also the most prolific for females. The weekend is when most incidents occur and incidents are centred around night-time economy locations such as central Preston, central Burnley,

central Lancaster and central Blackpool. Blackpool accounts for almost a quarter of recorded violence with injury across Lancashire and a higher proportion of these crimes (38%) have an alcohol marker than the Lancashire average. Central Blackpool also has the highest density of licensed premises in the county.

A quarter of all sexual offences and 35% of serious sexual offences were alcohol-related between April 2010 and March 2011, and these are of particular issue in Blackpool and Burnley, followed by Preston. Alcohol is also an influencing factor, along with drugs, in the enticement of victims for child sexual exploitation.

Between April 2010 and March 2011, 12% of all ASB incidents and 17% of rowdy and inconsiderate behaviour ASB incidents had an alcohol marker recorded against them. This is likely to be an under-recording of the true involvement of alcohol. There were 2,230 incidents of street drinking in Lancashire between April 2010 and March 2011, a reduction of 25% on the previous year. Lancaster and Fleetwood had higher numbers of incidents than other localities in the county.

Drink and drugs is one of the 'fatal four' factors in collisions, along with speeding, use of seatbelts and mobile phone use. The 16-24 age group have been involved in 36% of all road traffic collisions during 2011/12 and 33% of KSI collisions (those leading to fatality or serious injury). Some of these incidences could have been caused by alcohol or drug use. Rossendale, Chorley, Hyndburn South Ribble and Lancaster were significantly worse than the England average.

Between January and December 2011 there were 2,309 attendances at accident and emergency departments (AED) in Preston and Chorley for reason of an assault. Of these, 60% (1,394) had consumed alcohol in the last three hours prior to the assault (Trauma and Injury Intelligence Group). This indicates that up to 33,680 assaults across Lancashire were due to alcohol during this period (56,134 assaults total).

Recommendation: continue funding TIIG to obtain data from other hospital trusts and quality assure the data. This will build a better picture of how many assaults are alcohol related in Lancashire.

14% of offenders in Lancashire have a significant alcohol misuse problem, although this is higher in Lancaster and Preston (16%) and Ribble Valley (20%), and 37% report regularly drinking excessively. 27% of offenders report having had a severe alcohol consumption issue at some point in their lives, although this is significantly higher in Blackpool (35%). The majority of offenders recognise the connection between alcohol misuse and their offending behaviour, and are motivated to address it; only 3% of offenders demonstrate little motivation to address their behaviour.

Lancashire Probation Trust continue to refer offenders into appropriate alcohol treatment based on need and risk and work with the three DAATs to co-commission effective services. The trust provide alcohol brief interventions for low risk alcohol users and deliver alcohol treatment requirements (ATR) for high risk offenders. The aim of the ATR is to reduce violent and other alcohol-related offending, and facilitate improvements in the health, lifestyle and social functioning of individual offenders. Treatment consists of interventions to address those social and community integration issues that are significantly associated with offending, including improving the offender's circumstances in relation to lifestyle, health, accommodation, education and employment. An ATR is usually made for a six month period and is intended to target a relatively small group of offenders whose offending will be alcohol-related, of high seriousness and probably violent in nature. The trust is currently developing a specified activity requirement (SAR) to target low and medium risk offenders which should be available to the courts later this year as a sentencing disposal.

Recommendation: treatment providers continue to invest in and deliver appropriate services for offenders referred with alcohol misuse issues, specifically ATRs and alcohol specified activities.

Fires

Alcohol and substances featured in approximately a quarter of incidents. Some fire services report as many as 47% of their incidents are linked with alcohol or substance use. These incidents incur a considerable cost, not just to the fire service, but to other providers and society, estimated at £11,983,480 during 2009/2010 and 2010/2011.

The fire service have been raising the profile of the risks associated with alcohol through the delivery of brief safety interventions and LFRS staff have received training. Community members that are assessed by professionals as at greater risk are offered a coordinated package that takes account of the needs of the individual.

Recommendation: all organisations engaged in recognising alcohol as a factor that is impacting on an individual to signpost those community members to LFRS, allowing for an assessment of the likelihood and potential severity that a fire-related incident would have on the individual and their family members, and to work with Lancashire Fire and Rescue Service to help improve the safety of these individuals and begin to reduce the economic cost of such incidents to society.

Ambulance Service

The ambulance service do not provide an alcohol marker for the data they collect on callouts, so it is impossible to determine how many ambulance attendances were for reasons of alcohol. However, up to 60% of presentations at accident and emergency departments are related to alcohol consumption, and it is possible this is a similar proportion for ambulance attendances. The Department of Health estimate that ambulance callouts for reasons of alcohol cost the NHS £372.4m nationally in 2008[13].

Recommendation: improve the quality of recorded ambulance callout data.

Perceptions of Alcohol Use

There is a strong association between deprivation and perceptions that drunk and rowdy behaviour is a problem in an area. The percentage of people who think drunk and rowdy behaviour is a problem in their area ranges from 14.9% in Ribble Valley (the least deprived Lancashire district) to 37.9% in Pendle (the third most deprived Lancashire district).

[13] Department of Health (2008) *The Cost of Alcohol Harm to the NHS in England: An Update to the Cabinet Office (2003) Study*, p. 7. [Available online: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_086412?IdcService=GET_FILE&dID=169373&Rendition=Web]

Financial Cost

Harmful use of alcohol is currently ranked as the third leading factor for disease and disability in the world[14]. Nationally, the cost of alcohol misuse is estimated to be around £20billion per year. These costs are made up of alcohol-related health disorders and disease; crime and anti-social behaviour; loss of productivity in the workplace; and problems for the families of those who misuse alcohol, including domestic violence.

The costs of alcohol are broken down into four main areas: NHS costs; crime and licensing costs; workforce and wider economy and social services cost. In Lancashire the total cost burden of alcohol in 2010/11 is £458 per person, which is 18% above the national average of £387 per person[15]. However, these are only the tip of the iceberg. For example, as previously noted fire and rescue service cost would not have been included.

A detailed breakdown of the district costs for Lancashire-14 will be available from late May 2012. See www.lancashire.gov.uk/jsna > Lifestyle > Alcohol > *The Cost of Alcohol to the North West Economy*.

[14] World Health Organisation (2010) *Alcohol.* Online: http://www.who.int/mediacentre/factsheets/fs349/en/index.html [accessed March 2012].
[15] Drinkwise North West (2012) *The Cost of Alcohol to the North West Economy*.

Interventions and Treatment

The Rush model[16] adopted by the Department of Health recommends that PCTs provide at least a 'medium' level of access to alcohol treatment services (i.e. 1 in 7.5 or 15% of estimated alcohol dependent individuals enter treatment per year). The estimated alcohol dependent population in Lancashire-14 in 2010/11 is 47,012, while the number in treatment was approximately 4,052, or only 8.6% of the dependent population.

Recommendation: As a minimum, organisations in Lancashire should be treating 1 in 10, or approximately 4,700, alcohol dependent individuals (a 'low' level of access). Optimally, 1 in 7.5, or approximately 7,050, alcohol dependent individuals should be in treatment (a 'medium' level of access) to bring Lancashire in line with recommendations from the Department of Health.

Recommendation: A consistent way of measuring treatment journeys is needed, especially for tier two. Currently NDTMS data only captures tier three and four figures and outcome measures.

Recommendation: complete equity audit of treatment and intervention services.

Appoint an Alcohol Worker

The Department of Health recommend PCTs and acute providers appoint an alcohol worker to manage patients with alcohol problems within the hospital and liaise with community services. In Lancashire each of the PCTs have developed this recommendation in slightly different ways depending on need and resources.

Recommendation: resources be made available to put the most effective model in place.

[16] Department of Health (2009) *Signs for improvement – commissioning interventions to reduce alcohol related harm*

Identification and Brief Advice (IBA)

The Department of Health recommend PCTs provide more help to encourage people to drink less. There are a number of agencies which provide IBA and IBA training in Lancashire**.**

Pharmacy Interventions

Community pharmacies offer a unique trusted but 'non-establishment' venue where some people may be more responsive to an intervention. Of those offered an IBA and who were followed up four weeks later, all reported to have reduced their alcohol consumption.

Recommendation: findings of the review of community pharmacy IBA are due during July 2012 and these should be used to inform the structure of any Lancashire-wide provision and encourage the implementation of trained healthy living champions in pharmacies across the county to deliver IBA and healthy lifestyle messages which include alcohol.

Recommendation: IBA training to become mandatory in statutory and non-statutory organisations in Lancashire.

Primary Care

Practices are encouraged through the directed enhanced services (DES) to screen all newly registered patients aged 16 and over for alcohol consumption levels. Brief advice is provided or patients are referred to specialist services if necessary.

Recommendation: optimise implementation of the DES across Lancashire and advocate the incorporation of best practice techniques in its delivery.

Recommendation: develop IBA within primary care by developing a consistent approach across Lancashire by developing and implementing a lifestyle identification, brief advice and referral locally enhanced service (LES) that targets at risk populations across primary care practice registers.

Recommendation: establish a register of abstinent, lower, increasing and higher risk patients through the development of appropriate read codes.

Recommendation: maximise opportunities for early intervention by rewarding appropriate referral into substance misuse services.

Amplify National Social Marketing Priorities

Recommendation: develop effective partnership communication networks to develop consistent messages based on social marketing insight work.

Recommendation: implement the seven high impact changes and the 12 NICE recommendations as a minimum to address alcohol related harm.

Recommendations from Alcohol JSNA

Advocacy and Lobbying:

- Advocate for the importance of tackling low cost alcohol. There is a clear relationship between price and consumption of alcohol.
- Lobby for further changes to licensing legislation for public health to be a consideration in the licensing process.
- Lobby to introduce measures to reduce the exposure of children to the marketing of alcohol products.

Interventions:

- Interventions need to be targeted at individuals and on a population level.
- Ensure that treatment services are able to meet the diverse needs of the population.
- Apply good practice learned from the IBA pilot in Blackpool and East Lancashire.
- Ensure each AED in Lancashire has systems in place to reduce alcohol-related hospital admissions.

Communications and Community Engagement:

- Support the development of intelligence-led social marketing approach to reducing levels of alcohol consumption in Lancashire, focusing on issues such as the 'silent majority' – home drinkers, preloading, underage drinking and parents supplying alcohol, older people and dementia as the target audience.
- Community engagement should be used as a method of reaching targeted populations.
- Support and resource the community alcohol networks programme which raises awareness of the dangers of providing alcohol to young people.
- Routinely include advice about the potential dangers of increasing alcohol consumption in pre-retirement courses.

Community Safety:

- Utilise the trauma and injury intelligence group (TIIG) data to identify trouble spots and intervene to reduce harm and anti-social behaviour.
- Explore a co-ordinated approach to the night-time economy.
- Review training of licensing staff.
- All organisations that work with or recognise alcohol as a factor which is impacting on an individual to consider their safety and that of their families.
- To work with Lancashire Fire and Rescue Service to help improve their safety in the home, including home fire safety checks.
- The use of regulatory powers should be maximised.

Data and Intelligence:

- Develop a co-ordinated approach to data collation, analysis and dissemination across Lancashire utilising MADE to its full potential.
- Ensure that data is used appropriately to inform commissioning, target service provision and validate impact.
- Maximise the contribution partners can make through their core business to the alcohol agenda.
- Further investigate and highlight employment as a priority area and examine opportunities for early identification of those facing employment issues.
- Further investigate and highlight health inequality as a priority area.