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Tackling Health Inequalities in Wirral: Reducing Premature Mortality Resulting from Drug and Alcohol Use

Authors: Caryl Beynon, Adam Marr, Sacha Wyke, Jim McVeigh and Mark Whitfield

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Introduction

In 2012 the UK Government published its Public Health Outcomes Framework, which sets out their public health priorities over the forthcoming three years. At the heart of this commitment are two overarching targets: increasing healthy life expectancy and reducing differences in life expectancy and healthy life expectancy between different communities. Commissioners of services therefore require data in order to identify which behaviours and diseases contribute most to ill health in their areas and also how these differ among different groups of the population. Under 'health improvement', the framework recognises the harm caused by the use of alcohol and illicit drugs and sets key indicators that local partnerships should monitor and work towards improving (Department of Health, 2012).

In relation to deaths from drug use, the Office for National Statistics reported that there were 1,192 male deaths and 413 female deaths registered in 2011 in England and Wales (Office for National Statistics, 2012a). Such deaths are from the acute effects of drug use, typically poisoning and mental and behavioural disorders associated with the use of a drug controlled under the Misuse of Drugs Act (1971; for a full definition see: Office for National Statistics, 2012a). Figure 1 describes the trends in such deaths in England and Wales from drug use between 2007 and 2011; deaths among males have fallen since 2007 but deaths among females have risen from 340 in 2007 to 413 in 2011 (Office for National Statistics, 2012a).

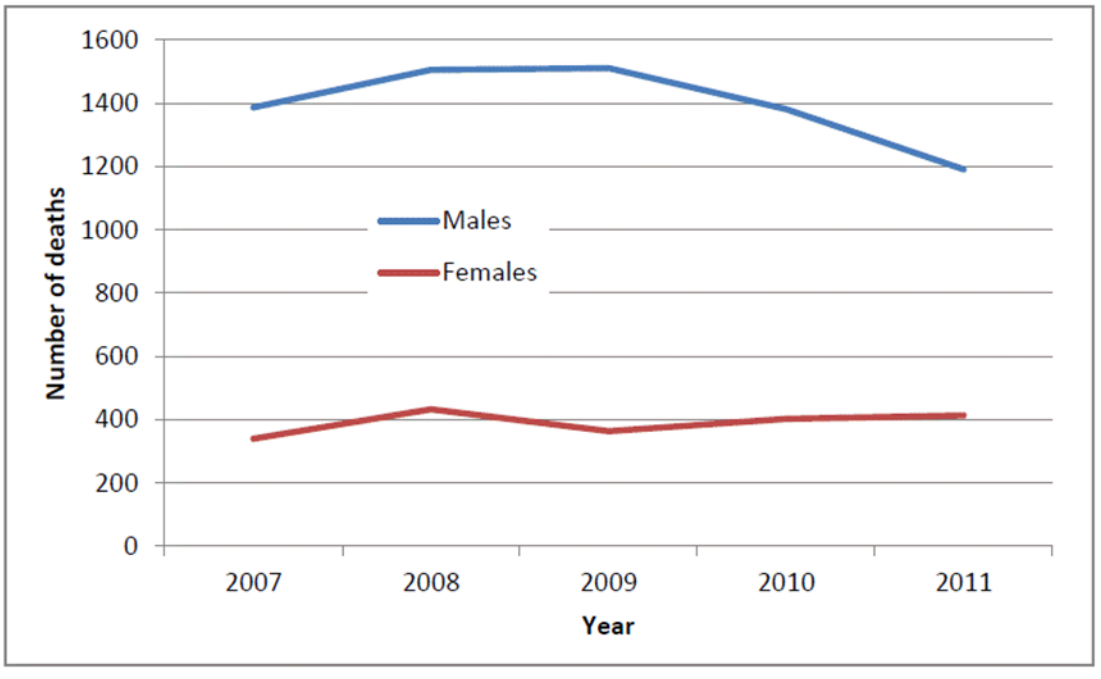

Figure 1: Deaths from drug misuse in England and Wales (Office for National Statistics, 2012a)

A recent study demonstrated that the median[1] age at death of drug users in contact with drug treatment services in the North West of England was 41.4 years (interquartile range, 36.6–48.7; Beynon et al., 2010). In comparison, the most common age at death in England and Wales in 2010 for the whole population was 85 for men and 89 for women (Office for National Statistics, 2012b), highlighting the contribution of illicit drug use to premature mortality. However, deaths of drug users are not solely from the acute effects of drug use. Indeed an analysis of the causes of death of people in contact with structured drug treatment services in the North West of England between 2003 and 2008 demonstrated that the likelihood of a person aged 40 and over dying from a cause officially defined as non-drug-related was 3.27 times the likelihood of a person aged less than 40 dying from a non-drug-related death (95% confidence interval 2.16-5.11). For drug users aged 40 and over, the main causes of premature death recorded in this study were liver diseases, neoplasm, chronic lower respiratory infections and viral hepatitis (Beynon et al., 2010). In at least some of these deaths, drug use is a likely contributor, despite such deaths not featuring in official drug-related death statistics (Beynon and McVeigh, 2007; Beynon et al., 2010).

Alcohol consumption in the UK has risen considerably over the last 50 years (HM Government, 2012), and has driven an increase in liver disease (Beynon et al., 2012). Between 2001 and 2009 the number of people dying from liver disease in England increased by 25% in contrast to declines in other major causes of death (National end of life care intelligence network, 2012). Premature deaths from liver disease are higher in the North West than in England and are increasing at a faster rate than the rest of the country, with alcohol-related liver disease accounting for the greatest proportion of such deaths (47% of male liver disease deaths and 43% of female liver disease deaths; Beynon et al., 2012).

According to the 2012 Health Profile, Wirral scores relatively poorly compared to the rest of England in relation to drug- and alcohol-related harm. Wirral is higher than the England average for alcohol-specific hospital stays for people aged under 18; hospital stays for alcohol-related harm among adults; and the estimated number of users of opiates and/or crack cocaine aged 15 to 64 years (Wirral's Health Profile is available at: http://www.apho.org.uk/default.aspx?RID=49802).

Together these data highlight the need for local partnerships to continue to focus on reducing drug- and alcohol-related mortality among Wirral residents. The responsibility for preventing such deaths falls across all tiers of the treatment system (National Treatment Agency for Substance Misuse, 2004). The aims of the work presented in this report were set by the Public Health team at Wirral Council. More specifically, the Public Health team requested an evaluation of specific aspects of drug- and alcohol-related mortality in order to support the development of the Wirral's Action Plan to reduce such deaths.

[1] Median is an average and is used when data are not normally distributed (i.e. the data do not follow a 'bell curve' shape).

Methods

Study 1: Deaths in drug treatment

Using the Centre for Public Health's database which links data from the National Drug Treatment Monitoring System (NDTMS) to cause of death data provided by the Office for National Statistics, data were extracted on drug users who died while in contact with Wirral-based drug treatment services. The data relate to people who were reported to the NDTMS system as being in contact with drug treatment between 1st April 2003 and 31st March 2012. For each deceased person, four pieces of information were extracted:

1. The age of the individual when they first entered the drug treatment system.[2]
2. The length of each individual's most recent treatment episode (in days) prior to death.
3. The age of each individual at death.
4. The most recently recorded residential postcode (area and district sections) of each individual.

Data were not normally distributed (i.e. did not follow a 'bell curve' shape) so medians are presented here and compared. The median age of individuals when they first entered the treatment system, the median length of the most recent treatment episode prior to death and the median age at death were calculated; comparisons by sex and by the type of death (drug-related/non-drug-related) were made using Mann-Whitney U tests. The level of significance was set at 0.05.

Study 2: Alcohol-related deaths

The mortality dataset, held by the North West Public Health Observatory (now Public Health England), was used to identify Wirral residents that had died from an alcohol-specific cause and whose death was registered between 1st January 2007 and 31st December 2011. Alcohol-specific causes are diseases/health outcomes that are wholly attributable to alcohol use and are detailed in Box 1.

[2] The NDTMS system began operation in 2001/02; treatment contact before this would not necessarily be captured by the research presented here.

Box 1: Alcohol-specific causes (Jones et al., 2008)

Disease/Related Health Problem	**ICD-10 code**
Alcohol-induced pseudo-Cushing's syndrome	E24.4
Mental and behavioural disorders due to use of alcohol	F10
Degeneration of nervous system due to alcohol	G31.2
Alcoholic polyneuropathy	G62.1
Alcoholic myopathy	G72.1
Alcoholic cardiomyopathy	I42.6
Alcoholic gastritis	K29.2
Alcoholic liver disease	K70
Chronic pancreatitis (alcohol induced)	K86.0
Ethanol poisoning	T51.0
Methanol poisoning	T51.1
Toxic effect of alcohol, unspecified	T51.9
Accidental poisoning by and exposure to alcohol	X45

The data on age at death were investigated. Because age at death was normally distributed (i.e. follows a 'bell curve' shape) independent t tests were used to compare the age at death between males and females. For consistency across this report, the median age at death, rather than the mean age at death, is reported. Chi square was used to test differences in the cause of death between males and females. The level of significance was set at 0.05.

For the second alcohol-related analysis, the mortality file was again used to identify Wirral residents that had died between 1st January 2007 and 31st December 2011 from the following causes: assaults, falls, intentional self-harm and road traffic deaths. Separately for each of these four categories, the number of deaths which featured an alcohol-specific (see Box 1) contributory cause was quantified.

Results

Study 1: Deaths in drug treatment

There were 95 people recorded in the NDTMS system as being in contact with a Wirral-based service and confirmed dead. Table 1 gives summary details of each person's age at first presentation to the treatment system. Table 2 gives summary details of the number of days in their most recent treatment episode prior to death. Table 3 describes the median age at death. There were no significant differences by sex for the median age at first presentation, the median number of days in the treatment episode prior to death and the median age at death.

Table 1: Age at first presentation to drug treatment (as measured by the NDTMS) by sex, Wirral drug treatment clients confirmed as dead, 2003/04 – 2011/12

	All	Male	Female
Number of deaths	95	75	20
Median age at presentation	35.00	36.00	32.50
Interquartile range	31.00 – 40.00	30.00 – 41.00	31.00 – 38.25
Minimum age at presentation	20	20	20
Maximum age at presentation	57	51	57

Table 2: Number of days in treatment episode prior to death (as measured by the NDTMS) by sex, Wirral drug treatment clients confirmed as dead, 2003/04 – 2011/12

	All	Male	Female
Number of deaths	95	75	20
Median number of days	2023.00	2120.00	1291.50
Interquartile range	640.00 – 4258.00	770.00 – 5213.00	607.00 – 3234.25
Minimum number of days	31	31	49
Maximum number of days	7624	7624	7481

Table 3: Age at death by sex, Wirral drug treatment clients confirmed as dead, 2003/04 – 2011/12

	All	Male	Female
Number of deaths	95	75	20
Median age at death	44.25	45.25	42.50
Interquartile range	39.75 – 49.75	40.25 – 50.25	37.50 – 45.25
Minimum age at death	27	27	35
Maximum age at death	63	63	59

Summary details for the age at first presentation, the number of days in the treatment episode prior to death and age at death by type of death (drug-related and non-drug-related) are given in Tables 4, 5 and 6 respectively. None of these three measures differed significantly according to the type of death.

Table 4: Age at first presentation to drug treatment (as measured by the NDTMS) by type of death, Wirral drug treatment clients confirmed as dead, 2003/04 – 2011/12

	Drug-related death	Non-drug-related death
Number of deaths	14	81
Median age at presentation	35.50	35.00
Interquartile range	29.75 – 39.25	31.00 – 41.00
Minimum age at presentation	26	20
Maximum age at presentation	46	57

Table 5: Number of days in treatment episode prior to death (as measured by the NDTMS) by type of death, Wirral drug treatment clients confirmed as dead, 2003/04 – 2011/12

	Drug-related death	Non-drug-related death
Number of deaths	14	81
Median number of days	1937.00	2195.00
Interquartile range	1174.25 – 3510.00	609.50 – 4409.50
Minimum number of days	113	31
Maximum number of days	6753	7624

Table 6: Age at death by type of death, Wirral clients confirmed as dead, 2003/04 – 2011/12

	Drug-related death	Non-drug-related death
Number of deaths	14	81
Median age at death	43.75	44.25
Interquartile range	38.50 – 47.50	40.25 – 50.00
Minimum age at death	35	27
Maximum age at death	52	63

Details on the number of deaths by postcode of residence are given in Table 7. One quarter of all deceased drug users were living in CH41 when they died, with a further one fifth living in CH42.

Table 7: Postcode of residence, Wirral drug treatment clients confirmed as dead, 2003/04 – 2011/12

First part postcode of residence	Number of deaths	
CH41	24	25.3%
CH42	20	21.1%
CH43	12	12.6%
CH44	10	10.5%
CH45	7	7.4%
CH46	*	5.3%
CH49	7	7.4%
CH60	*	1.1%
CH61	*	1.1%
CH62	6	6.3%
CH63	*	1.1%

The postcode refers to the last postcode recorded for each person in NDTMS. There are 94 deaths in this table because postcode data was missing for one person.

Table 8 describes the underlying causes of death for the 81 people whose death was categorised as non-drug-related. Causes of death were grouped into International Classification of Disease (ICD version 10) code chapters. Seven of the neoplasm deaths were bronchus- or lung-related, while eight of the respiratory deaths were from chronic obstructive pulmonary disease; these deaths highlight the likely contribution of smoking. Of the 18 deaths related to the digestive system, 13 were from alcohol-related liver damage, highlighting the contribution of alcohol use to deaths of people in drug treatment.

Table 8: Underlying causes of non-drug-related death, Wirral drug treatment clients confirmed as dead, 2003/04 – 2011/12

Cause of death	Number	%
Certain infectious and parasitic diseases	8	9.9
Neoplasm	14	17.3
Endocrine, nutritional and metabolic diseases	*	1.2
Diseases of the nervous system	*	1.2
Diseases of the circulatory system	12	14.8
Diseases of the respiratory system	15	18.5
Diseases of the digestive system	18	22.2
Diseases of the genitourinary system	*	1.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	*	1.2
Codes for special purposes	*	2.5
External causes of morbidity and mortality	8	9.9

Note: * highlights a number of deaths of 5 or less to minimise identification of any individual

Study 2: Alcohol-related deaths

There were 314 deaths of Wirral residents from alcohol-specific underlying causes over the five year study period, an average of 63 per year. Of these deaths, 212 (67.5%) were male and 102 (32.5%) were female. Summary details for the age at death are presented in Table 9; there was no significant difference in age at death between males and females.

Table 9: Age at death, alcohol-specific causes, Wirral residents, 2007-2011

	All	Male	Female
Number of deaths	314	212	102
Median age at death	53.00	53.00	54.50
Interquartile range	44.00 – 61.00	44.00 – 61.75	43.00 – 61.00
Minimum age at death	21	21	25
Maximum age at death	88	88	80

Table 10 details the causes of death. The biggest contributor to alcohol-specific deaths in Wirral was the various forms of alcoholic liver disease (ICD-10 K70) which accounted for 275 (87.6%) of all deaths. There was no significant difference between males and females in the cause of death.

Table 10: Frequency of alcohol-specific deaths, Wirral residents, 2007-2011

Cause of death	Number	%
Mental and behavioural disorders due to use of alcohol (acute intoxication)	6	1.9
Mental and behavioural disorders due to use of alcohol (dependence syndrome)	11	3.5
Mental and behavioural disorders due to use of alcohol (unspecified mental and behavioural disorder)	*	0.3
Alcoholic cardiomyopathy	*	1.0
Alcoholic fatty liver	26	8.3
Alcoholic hepatitis	10	3.2
Alcoholic cirrhosis of the liver	64	20.4
Alcoholic hepatic failure	52	16.6
Alcoholic liver disease unspecified	123	39.2
Alcohol-induced chronic pancreatitis	*	0.6
Accidental poisoning by and exposure to alcohol	16	5.1

Note: * highlights a number of deaths of 5 or less to minimise identification of any individual

Table 11 describes the number and crude rate of alcohol-specific deaths by ward. The rate of alcohol-specific deaths in Rock Ferry was 19 fold higher than the rate of alcohol-specific deaths in Wallasey.

Table 11: Alcohol-specific deaths by ward, Wirral residents, 2007-2011

Ward	Alcohol-specific deaths (N)	Crude rate per 100,000 of population[1]
Wallasey	*	17.33
Heswall	*	29.41
West Kirby and Thurstaston	*	30.89
Greasby, Frankby and Irby	*	45.83
Oxton	6	56.88
Claughton	7	63.71
Eastham	9	85.52
Pensby and Thingwall	9	89.31
Bebington	12	105.64
Clatterbridge	12	108.20
Prenton	12	112.50
Moreton West and Saughall Massie	12	113.34
Leasowe and Moreton East	13	120.56
Hoylake and Meols	12	120.66
Upton	18	154.03
New Brighton	17	159.91
Bromborough	18	168.59
Liscard	25	226.20
Seacombe	24	228.01
Bidston and St. James	30	294.99
Birkenhead and Tranmere	31	297.56
Rock Ferry	34	332.81

[1] Mid-2010 ward population estimates (experimental statistics available from the Office for National Statistics).
Note: * highlights a number of deaths of 5 or less to minimise identification of any individual

There were 133 deaths from falls registered during 2007 to 2011 and of these, 12 deaths (9.0%) had an alcohol-specific contributory cause of death. There were no deaths from assault among Wirral residents during this 5-year period. There were 132 deaths from intentional self-harm, 11 (8.3%) of which had an alcohol-specific contributory cause of death. Finally, of the 49 deaths due to road traffic deaths, 4.1% had an alcohol-specific contributory cause recorded on the death certificate.

Summary of Key Findings

1. People who died while in contact with Wirral-based drug treatment services were relatively old (median age: 35 years) at first presentation to the NDTMS system. However, it is important to note that the NDTMS system became operational in 2001/02 and treatment contact before this date will not be captured by the research presented here.
2. People who died while in contact with Wirral-based drug treatment services were in contact with that service for a relatively long time before death (median number of days in treatment at their last episode: 2023).
3. The median age at death of drug users in contact with Wirral-based drug treatment services was 44.25 years.
4. Almost half of deceased drug users lived in either CH41 or CH42 when they died.
5. 85% of people that died while in contact with Wirral-based drug treatment services died from a non-drug-related death.
6. The main causes of non-drug-related deaths were: diseases of the digestive system, diseases of the respiratory system, diseases of the circulatory system and neoplasm. While not officially classified as 'drug-related', many of these deaths are likely to be associated with substance use (including the use of tobacco and alcohol).
7. On average, 63 Wirral residents died from an alcohol-specific underlying cause each year.
8. The median age at death of Wirral residents that died from an alcohol-specific underlying cause was 53 years, highlighting the contribution of alcohol use to premature mortality.
9. The rate of alcohol-specific deaths varies considerably across wards from 17.33 per 100,000 of population in Wallasey to 332.81 per 100,000 of population in Rock Ferry.
10. Nearly 38% of all alcohol deaths were attributable to residents within the Seacombe, Bidston & St James, Birkenhead & Tranmere and Rock Ferry wards.
11. Alcohol use contributed to 9% of falls, 8% of deaths from intentional self-harm and 4% of road traffic deaths.

Development of Wirral's Action Plan to Reduce Drug- and Alcohol-Related Deaths

This current report is accompanied by an Action Plan which describes a list of actions that are considered necessary in order to reduce drug- and alcohol-related harm. The actions have been developed in line with current guidance from a range of organisations. The list includes actions targeting both the acute effects of drug and alcohol use and actions focusing on reducing longer-term harms. It is clear from the action plan that Wirral has a number of systems already in place to reduce drug- and alcohol-related harm and details of these are given in the 'current status' column. The other columns of the plan describe what action is required and the priority status of these actions. This action plan has been finalised in consultation with stakeholders from the following organisations:

- Public Health, Wirral Council.
- CYPD, PH
- CWP
- Response
- Sefton Council
- COPD & Home Oxygen Team
- CYPD Response
- Wirral Community NHS
- The Social Partnership

LJMU would like thank the individuals who attended and contributed on the day.

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Centre for Public Health
Liverpool John Moores University
Henry Cotton Building
15-21 Webster Street
Liverpool
L3 2ET

Telephone: 0151 231 4314
Email: m.whitfield@ljmu.ac.uk

Priority 1: Reduce Overdose Deaths					
Recommendation	**Current Status**	**Action Required**	**RAG Priority (High, Med, Low)**	**Lead(s)**	**By When**
Provide Overdose Training for drug users.	Naloxone/Overdose Prevention Training commissioned (100 of 200 places have already been delivered). To date, **34** drug users have accessed this training.				
Provide Overdose Training for staff (including prisons).	Naloxone/Overdose Prevention Training commissioned (100 of 200 places have already been delivered). To date, **71** staff have accessed this training.				
Provide Overdose Training for family members and friends of drug users.	Naloxone/Overdose Prevention Training commissioned (100 of 200 places have already been delivered). To date, **0** family members and friends have access this training.				
Provide drug users with take home naloxone.	**17** drug users have been issued with naloxone.				
Ensure paramedic staff are provided with naloxone.	All NWAS paramedic ambulances are provided with Naloxone. Confirmed by NWAS.				
Develop strategies for persuading overdose victims revived by naloxone to stay in A&E until appropriately discharged.	It is WUTH's current position that we would discuss with patients the need to stay within the department should they have been given naloxone post overdose.				

Priority 1: Reduce Overdose Deaths					
Recommendation	**Current Status**	**Action Required**	**RAG Priority (High, Med, Low)**	**Lead(s)**	**By When**
Provide literature on preventing/ responding to overdose in services, hostels, etc.	Historic literature campaign concerning overdose but present coverage is likely to be sporadic across local system.				
Develop a local overdose awareness raising campaign	No overdose awareness campaign presently.				
Raise local awareness with regard to cocaine deaths.	Specialist Stimulant Workers at ARCH and CWP. Key work addresses risk factors of cocaine use (including death) but no specific campaign.				
Not all overdoses are accidental; routine screening for mental health disorders.	No routine careening for mental health disorders. Individuals with diagnoses are managed by Dual Diagnosis Team and there are joint Care Notes across MHT and CWP Substance Misuse Service. Additionally, there are referral pathways into the MHT for individuals who are a concern.				
Develop strategies to support a reduction in the prevalence of injecting	Long-standing, local strategy in place. Evidence of its effectiveness can be found in very low (local) hepatitis C prevalence estimates and declining number of injectors.				

Priority 2: Reduce Impact of Longitudinal Substance Misuse-related Harm					
Recommendation	**Current Status**	**Action Required**	**RAG Priority (High, Med, Low)**	**Lead(s)**	**By When**
Involve Public Health to ensure substance misuse services address wider health needs of drug and alcohol users	Public Health currently commission drug and alcohol services, with an increasing focus being placed upon the wider health needs of individuals.				
Conduct Winter Health Checks for all drug users, particularly those in poor health .e.g. homeless.	Annual Winter Health Check Programme now in place, incorporating a flu vaccine programme. **140** vaccines targeted for Winter 2013.				
Provide spirometry to test for Chronic Obstructive Pulmonary Disorder (COPD).	CWP conducted viability study re provision of spirometry but considered unfeasible. Service has access to COPD team but latter is set up to manage COPD cases but not diagnose. Issues with direct referral into primary care services. Leaves only route for diagnosis via GP but potential barrier for those clients who have no/poor relationship with GP.				
Provide ECG Screening Programme for drug and alcohol users.	Pathway established between CWP and Heart Support Team. Need to review access across the drug/alcohol user population.				

Priority 2: Reduce Impact of Longitudinal Substance Misuse-related Harm					
Recommendation	**Current Status**	**Action Required**	**RAG Priority (High, Med, Low)**	**Lead(s)**	**By When**
Provide blood borne virus (BBV) screening and vaccination.	Comprehensive BBV screening programme in place for hepatitis B/C & HIV. Includes vaccination for hepatitis B. 73% of previous current IDUs now tested for hepatitis C. Recent DBS results seem to suggest local hepatitis C prevalence among IDUs is as low as 23%				
Develop local campaign to raise awareness about longitudinal substance misuse-related harm.	No campaign presently in place.				
Speedy referral to treatment for ulcers, endocarditis, TB, thrombosis, etc.	Comprehensive programme of nursing clinics established across treatment system. Referral pathways into treatment for these conditions are established.				
Advice and information given about general physical health needs.	Routinely undertaken within key work sessions. Links established with treatment services and Health Action Areas, providing access to Community Health Programme.				
Provide dietary advice for all drug and alcohol users	Links established with Health Action Areas, providing access to healthy eating and dietary services.				
Link substance misuse treatment with smoking cessation services.	Links established with smoking cessation services. Some treatment providers commissioned to deliver smoking cessation alongside substance misuse treatment.				

Priority 2: Reduce Impact of Longitudinal Substance Misuse-related Harm					
Recommendation	**Current Status**	**Action Required**	**RAG Priority (High, Med, Low)**	**Lead(s)**	**By When**
Discourage the use of 'blue lighting' in public places e.g. public toilets.	Current status is unknown. Number of public places using 'blue lighting' is thought to be minimal. Noted as an area of non/partial compliance in PH18 NICE NSP Audit.				
Develop appropriate training to specifically reduce the impact of longitudinal harm caused by substance misuse.	Range of health-related training courses available which cover some aspects but nothing bespoke to reducing longitudinal harm.				
A&E to routinely offer hepatitis B vaccination to injectors.	*Awaiting response from WUTH*				
Supply injecting equipment in line with guidance (PH18 NICE NSP Provision)	PH18 Audit completed in 2009. Local provision was considered to be mostly compliant.				

Priority 3: Alcohol					
Recommendation	**Current Status**	**Action Required**	**RAG Priority (High, Med, Low)**	**Lead(s)**	**By When**
Work in partnership so that action is coordinated at the local level; the emphasis should be on policy-based interventions not individually orientated interventions	All alcohol treatment interventions are commissioned in line with the local Alcohol Strategy which is informed by national policy and underpinned by all current and emerging best practice/guidance.				
Develop activities to control the impact of alcohol misuse in the community; make use of all existing laws, regulations and controls available (e.g. Licensing Act, 2003).	Recent Alcohol Strategy (2013-16) and associated action plan developed, which is due for launch on 3rd October 2013.				
Find high-profile champions to provide leadership within partner organisations and a focus for action to reduce alcohol harm. Every acute hospital should have a named consultant as their 'Alcohol Lead' from whatever acute specialty that is pragmatic for that hospital	Four Alcohol Strategy Leads/'Champions' from various organisations across the local partnership have been appointed. Their role is to promote and oversee the implementation of the local Alcohol Strategy with a view to reducing alcohol harm. It is unknown whether there is a specific Alcohol Lead attached to acute services.				
Develop a local alcohol treatment pathway.	Comprehensive review of all alcohol treatment pathways undertaken and work in final stages of completion.				
Improve the effectiveness and capacity of specialist alcohol treatment. Reviewing care pathways, access times and blockages into treatment offer opportunities to improve the local treatment system.	Public Health is currently reviewing the cost-effectiveness and service delivery model in place for Wirral's current alcohol treatment programme and considering the case for re-modelling.				

Priority 3: Alcohol					
Recommendation	**Current Status**	**Action Required**	**RAG Priority (High, Med, Low)**	**Lead(s)**	**By When**
Appoint a dedicated Alcohol Health Worker or an Alcohol Liaison Nurse in each major acute hospital, to work with a named Consultant/ Senior Nurse Alcohol Lead	Public Health-commissioned Substance Misuse Liaison Nurse post in place. This post provides link between acute setting and community services.				
Opportunistic brief interventions are useful. Staff need guidance on how to conduct informal assessment. These can be undertaken in a number of settings (primary care, A&E, criminal justice settings such as probation).	Ambitious programme of IBA in place and ongoing. Work is ongoing to improve the quality of delivery of the alcohol screening And brief advice programme, to ensure that the right people are identified in the right places.				
Commission local social marketing activity which builds on the evidence, strategic frame work and tools emerging from the national social marketing programme.	'What?' Campaign continues with dedicated website and helpline number. Full programme of social marketing activities for 2013-14 to be implemented.				
Drug service staff to screen for alcohol as part of substance misuse profile.	Currently being implemented as part of an integrated substance misuse service.				

Priority 4: Young People					
Recommendation	**Current Status**	**Action Required**	**RAG Priority (High, Med, Low)**	**Lead(s)**	**By When**
Follow the framework in NTA's guidance for an integrated and comprehensive service for young people with substance misuse problems.	All young people who access specialist services receive a comprehensive assessment, which includes a risk assessment and an individually agreed care plan. Approximately half the young people engaging with the service are involved in a multi-disciplinary approach, including section 20, TAC or Placement Recovery Conference. Workers are trained to work within a multi-disciplinary setting including the role of lead professional. The team is fully compliant with Wirral's safeguarding procedures. Young people are always encouraged to involve parents and/or carers in the treatment plan. When consent is not given the staff will use a competency assessment for those under 16. Young people's views are taken into account and they are allowed to decide on gender of worker, time & place of appointment, length of session, development of care plan and when finishing with the service they complete an evaluation.				

Priority 4: Young People					
Recommendation	**Current Status**	**Action Required**	**RAG Priority (High, Med, Low)**	**Lead(s)**	**By When**
Provide psychosocial interventions such as CBT, as recommended by NICE Guidance.	Staff are trained to use a variety of interventions including CBT, motivational interviewing and relapse prevention. All service users are supported to build resilience, increase confidence and build self-esteem. The team support young people to develop coping strategies to deal with crisis enabling them manage their substance misuse. Young people are supported into engaging in positive activities, including entering employment education or training and diversionary activities provided through Positive Futures				
Ensure targeted interventions are directed at vulnerable young people such as those who began drinking regularly before the age of 15 years.	A large number of our clients are at TAC, or section 20. We have a number of clients who have been removed from their families and are living in supported housing. Nearly all of our clients have been using drugs or alcohol from a very early age.				

Priority 5: Miscellaneous					
Recommendation	**Current Status**	**Action Required**	**RAG Priority (High, Med, Low)**	**Lead(s)**	**By When**
Organised plan for staff training around drug-related death.	Some training available about drug-related deaths, as far as signs/symptoms of overdose and what to do in the event. No current training about the links between substance misuse, treatment and associated longitudinal harms, nor the importance of an holistic approach to drug treatment to develop effective mitigating action.				
Mechanism for cascading credible alerts about contaminated drugs	Very effective alert system in place				
Safe storage of medicines.	Safe storage of medicine protocols at CWP/ARCH. Medicine safes made available by Public Health				
Local awareness raising campaigns targeted at a key risk (in 'hotspots').	No campaign presently in place.				
Rigorous monitoring and evaluation in order to support an assessment of the impact of interventions.	Current monitoring system in place is fairly robust but reservations about how this can measure/ demonstrate the impact of mitigating action(s).				
Use monitoring system to select case studies for in-depth reviews.	Reviews currently undertaken through Death Surveillance Group but not a 'deep dive' audit.				