



Public Health
England

Protecting and improving the nation's health

Adults - alcohol commissioning support pack 2020-21: key data

Planning for alcohol harm prevention, treatment and recovery in adults

Wirral

(using latest available data)

About this commissioning tool

The health harms associated with alcohol consumption in England are widespread, with around 10.4 million adults (Health Survey for England 2015, NHS Digital) drinking at levels that pose some level of risk to their health. Due to the breadth of these problems, this pack provides a range of alcohol-related data. Firstly, in relation to different levels of alcohol-related harm in your local population and secondly data about your local alcohol treatment system.

Indicators in the first section will help you monitor the extent to which alcohol is impacting on the health of the local population. Data in this section has been taken from the Local Alcohol Profiles for England (LAPE) and comparisons to local and national benchmarks are provided. Further information on alcohol-related harm in your local area can be found on the Public Health Profiles (Health Profiles) tool at:

<http://fingertips.phe.org.uk/profile/local-alcohol-profiles>

To understand better how your local alcohol system is responding to these problems, additional local data can be used. Data related to targeted alcohol prevention interventions in local areas, such as Identification and Brief Advice (IBA), are not collected nationally but should be available at a local level. A list of wider data sources is referenced at the end of the pack.

In the second section of this report there is key information about adult alcohol clients in your local alcohol treatment system during 2018-19, alongside national data for comparison. The data is taken from the National Drug Treatment Monitoring System (NDTMS) and reflects activity reported for individuals in structured alcohol treatment.

Detailed information relating to the methods used in calculating all data items in this pack is available in the supporting document 'Technical definitions for the data to support planning for effective alcohol harm prevention, treatment and recovery in 2020-21'.

Data on alcohol related harm in your area

The following section uses data from the LAPE and makes comparisons against national and local benchmarks using a nearest neighbour approach. The nearest neighbour approach groups each local authority with 15 other areas that are similar across a range of demographic, socio-economic and geographic variables. Utilising a nearest neighbour approach allows like-for-like comparisons of areas and can reveal patterns in the data that would not otherwise be seen when making comparisons against a national benchmark. It is therefore important to consider both national and nearest neighbour comparisons when interpreting the data.

There are two types of benchmarks in this data pack. The first is at the local level and demonstrates which quartile the area falls into within its nearest neighbour group, the second is at national level and shows which quartile the area falls into within all Upper Tier Local Authorities (UTLA) in England. Quartile one (shown in dark green) is indicative of lower levels of alcohol-related harm compared to the benchmark. Quartiles two and three indicate increasing levels of harm respectively and areas in quartile four (shown in red), suggest the local authority has the highest levels of harm compared to the benchmark. All data is reported at UTLA, however data for other geographies including Lower Tier Local Authorities (LTLA) can be found on the Public Health Profiles (Fingertips) site.

Where cells appear with an asterisk (*), small numbers have been suppressed to prevent disclosure or values cannot be calculated as the number of cases is too small. Please refer to the technical guidance for further information on this.

The areas identified as the 15 nearest neighbours for Wirral using the CIPFA 2018 Model are:

Sefton, North Tyneside, Redcar and Cleveland, Southend-on-Sea, Northumberland, Dudley, Torbay, Durham, St Helens, Wigan, Rotherham, Bury, Calderdale, Darlington, Kirklees

Hospital admissions due to alcohol

The data below reflects the general impact of alcohol on population health. Alcohol-related hospital admissions can be due to regular alcohol use that is above low risk levels and are most likely to involve increasing risk drinkers, higher risk drinkers, dependent drinkers and binge drinkers. Health conditions in which alcohol plays a causative role can be classified as either 'alcohol-specific' or 'alcohol-related'.

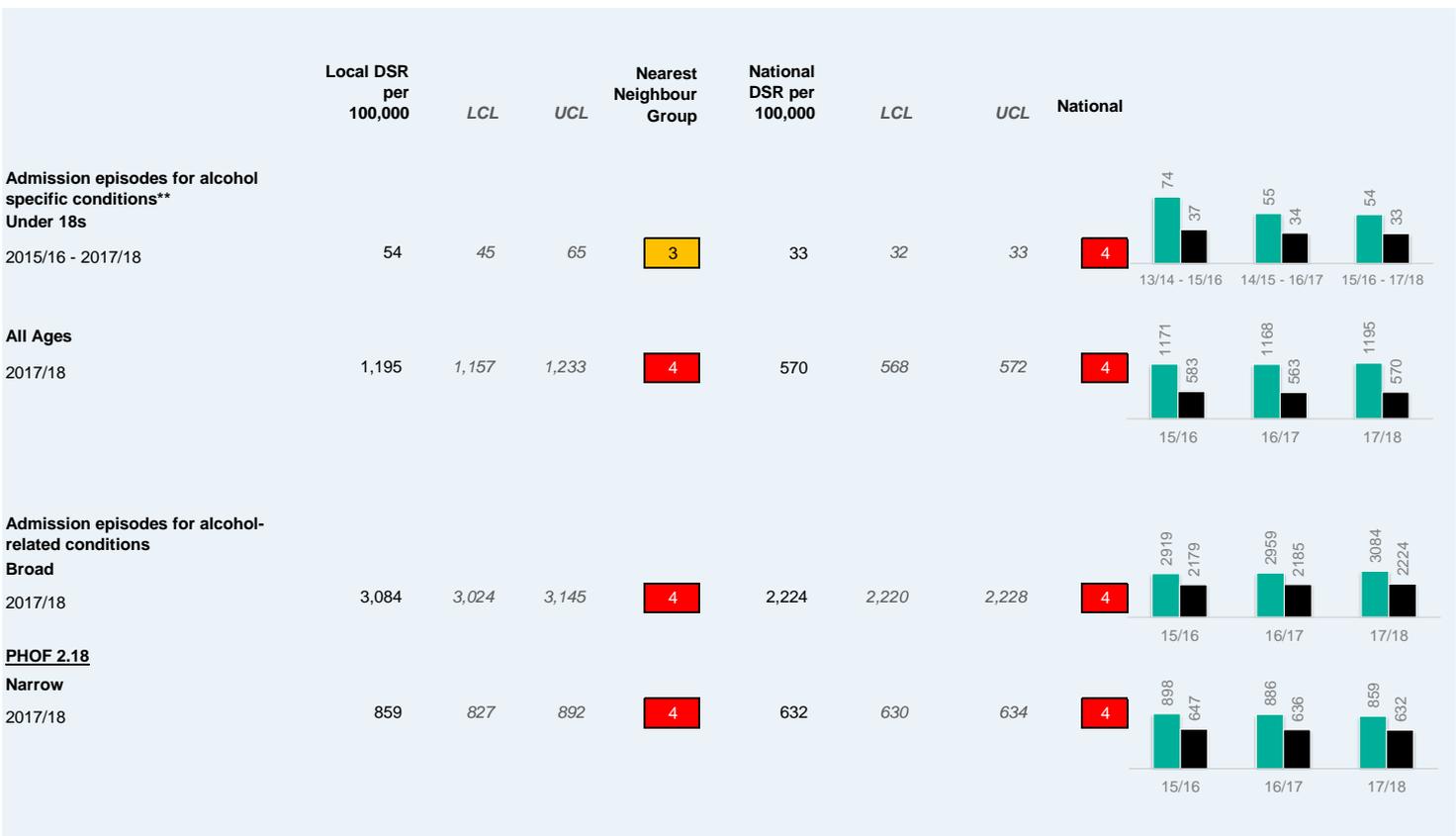
The first two indicators below refer to 'alcohol-specific' conditions, where alcohol is causally implicated in all cases, e.g. alcohol poisoning or alcoholic liver disease. The subsequent two indicators are for 'alcohol-related conditions' which include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases, for example high blood pressure, various cancers and falls.

Admissions episodes for alcohol-specific conditions - under 18s / all ages give a crude indication of the direct health impact of alcohol on the health of that group (includes both male and female).

Admission episodes for alcohol-related conditions was developed as a measure of pressures from alcohol on health systems. For this indicator the alcohol-attributable fractions* are applied in order to estimate the number of admissions, rather than the number of people. Within this there are two types of measure; broad and narrow. 'Broad' is an indication of the totality of alcohol health harm in the local adult population. 'Narrow' shows the number of admissions where an alcohol-related illness was the main reason for admission or was identified as an external cause. This definition is more responsive to change resulting from local action on alcohol and is included as an indicator in the Public Health Outcomes Framework (PHOF).

To address the harm reflected in this data, successful plans will employ what is known to work in terms of: effective prevention; health improvement interventions for those at risk; treatment and recovery services for dependent drinkers; and action to reduce binge drinking and the harms associated with it.

* <https://fingertips.phe.org.uk/documents/alcoholattributablefractions.pdf>



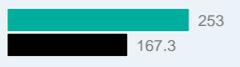
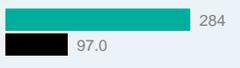
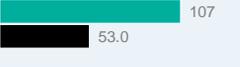
** Crude rate per 100,000

Alcohol-related conditions

Alcohol has been identified as a factor in more than 60 medical conditions, many leading to hospital admission. The conditions below have been selected because of their prevalence or because they are of particular concern for some local areas and may be the focus of wider strategic action. The final indicator looks at the incidence rate of cancer by sex. This is based on data from NCRAS (National Cancer Registration and Analysis Service) as this is more indicative of the incidence of alcohol-related cancer in your area.

Men account for the majority (61%) of alcohol-related admissions. This reflects a higher level of harmful drinking among men compared to women overall (Statistics on alcohol 2019, NHS Digital). The indicators here are provided by sex in order to reflect this differential harm.

1 Lowest amount of harm
 2 Lower harm levels
 3 Higher harm levels
 4 Highest amount of harm

	Local DSR per 100,000	LCL	UCL	Nearest Neighbour Group	National DSR per 100,000	LCL	UCL	National		
Admission episodes for alcohol-related cardiovascular disease conditions (Broad)										
Males 2017/18	1,942	1,873	2,012	4	1,681	1,676	1,687	3	Male	
Females 2017/18	863	820	907	4	739	736	742	3	Female	
Admission episodes for alcoholic liver disease condition (Broad)										
Males 2017/18	252.6	228.5	278.6	4	167.3	165.7	168.9	4	Male	
Females 2017/18	128.4	111.7	146.9	4	76.7	75.6	77.7	4	Female	
Admission episodes for alcohol-related unintentional injuries conditions (Narrow)										
Males 2017/18	301.6	274.4	330.7	4	217.1	215.3	218.9	4	Male	
Females 2017/18	105.9	90.9	122.8	4	77.1	76.1	78.1	4	Female	
Admission episodes for mental and behavioural disorders due to use of alcohol condition (Narrow)										
Males 2017/18	284.3	257.5	313.1	4	97.0	95.9	98.2	4	Male	
Females 2017/18	123.9	107.2	142.4	4	42.3	41.5	43.0	4	Female	
Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow)										
Males 2017/18	90.3	75.5	107.2	4	39.5	38.8	40.3	4	Male	
Females 2017/18	106.8	91.0	124.7	4	53.0	52.2	53.9	4	Female	
Incidence rate of alcohol-related cancer										
Males 2015 - 2017	49.20	42.98	56.06	4	39.33	38.87	39.80	4	Male	
Females 2015 - 2017	41.94	36.66	47.78	4	36.80	36.38	37.22	4	Female	

Frequent hospital admissions

Data on individuals who are admitted to hospital frequently for alcohol-specific conditions have been included to give an indication of the number of drinkers who place a heavy burden on health services and, very often, on social, housing and criminal justice services. The fact that these people are suffering ongoing alcohol-specific ill health suggests that they may not have had contact with treatment services, or if they have, it is likely that services have not engaged with them for long enough for them to achieve sustained abstinence. The data below shows, for those individuals who had an alcohol specific hospital admission in 2018-19, the number of previous alcohol specific admissions they had in the preceding 24 months.

Adults (18+) with alcohol-specific hospital admissions in 2018-19 and number of admissions in the preceding 24 months*

	Local n	Local rate per 100,000	LCL	UCL	National n	National rate per 100,000	LCL	UCL
No previous admission	1,314	515	488	544	114,072	261	259	262
1 previous admission	438	172	156	189	34,800	80	79	80
2 previous admissions	193	76	66	87	17,401	40	39	40
3 or more previous admissions	470	184	168	202	33,916	78	77	78

* Hospital Episode Statistics data (Source: NHS Digital - 2018/19 data is PROVISIONAL) and ONS population data, analysed by PHE, all person crude rate per 100,000

Mortality and years of life lost

Local ● National ●

The data here reflects the level of chronic heavy drinking in the population and is most likely to be found in higher risk drinkers and dependent drinkers.

Years of life lost indicate the contribution of alcohol misuse to premature death. Early death from chronic conditions is disproportionately prevalent in lower socio-economic groups and is likely to place demand on health and social care services prior to death. The death of people of working age will additionally impact on productivity.

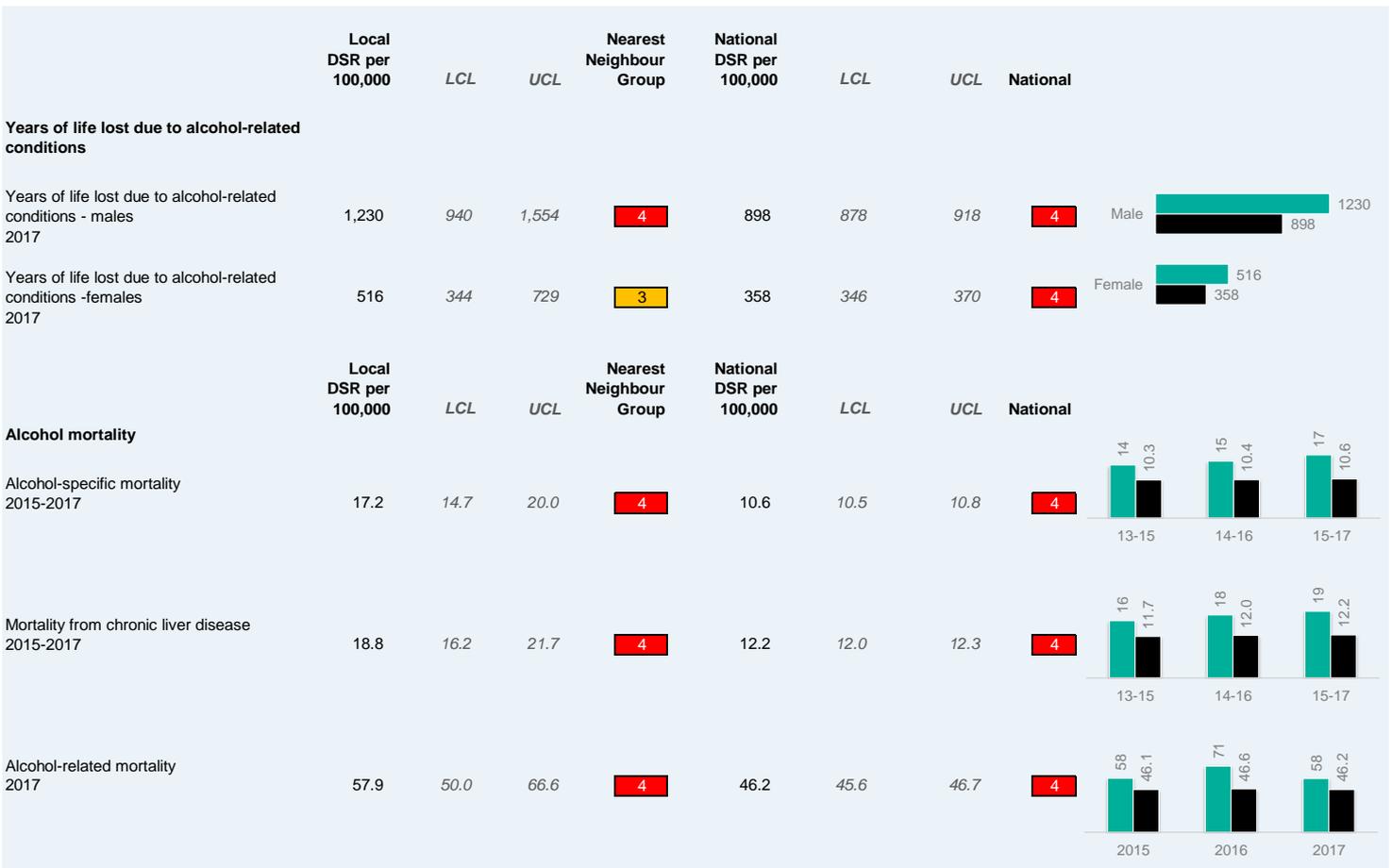
High rates of alcohol-specific mortality and mortality from chronic liver disease are likely to indicate a significant population who have been drinking heavily and persistently over the past 10 - 30 years (obesity is also a key factor for liver disease). Broadly speaking alcohol-related deaths make up around 5% of all deaths (PHE, 2017). Of these, about a quarter are alcohol-specific deaths – e.g. from alcohol poisoning, alcoholic liver disease, alcoholic pancreatitis. The remaining alcohol-related deaths are from conditions partially related to alcohol, roughly two thirds of which are from chronic conditions – e.g. cardiovascular diseases and cancers, with the remainder caused by acute consequences such as road traffic accidents or intentional self-harm. The rate of chronic liver disease mortality in the most deprived quintile (16.9 per 100,000 of the population) is almost double the rate in the least deprived (8.9 - Source: LAPE, PHE).

1 Lowest amount of harm

2 Lower harm levels

3 Higher harm levels

4 Highest amount of harm



Patterns of alcohol consumption

Alcohol-related harm is largely determined by the volume of alcohol consumed and the frequency of drinking occasions. As such, the risk of harm is directly related to levels and patterns of consumption. However there can be a considerable lag between alcohol consumption and alcohol-related harms, particularly for chronic conditions where the lag can be many years. In January 2016 the CMO issued revised guidance on alcohol consumption, which advises that in order to keep to a low level of risk of alcohol-related harm, adults should drink no more than 14 units of alcohol a week.

In England, a quarter of the population are drinking at above low risk levels so may benefit from some level of intervention. However, harm can be short-term and instantaneous, due to intoxication or long-term, from continued exposure to the toxic effect of alcohol or from developing dependence. This requires a multi-component response and pathways will differ from area to area. The data presented here gives an indication of potential local need for some form of alcohol intervention and is a weighted estimate from the Health Survey for England (2011-2014 combined).

2011 - 2014 Health Survey for England data						
	Local %	LCL	UCL	National %	LCL	UCL
Proportion of adults who abstain from drinking alcohol	10.6	7.2	15.3	15.5	15.1	15.9
Proportion of adults drinking less than 14 units a week	63.9	57.5	69.7	59.1	58.6	59.6
Proportion of adults drinking more than 14 units a week	26.3	20.8	32.8	25.7	25.3	26.2

Prevalence estimates and rates of unmet need for alcohol treatment

Set out below are the estimated number of dependent drinkers in your local authority area and rate of unmet need. The prevalence estimate gives an indication of the number of adults in your local area that are in need of specialist alcohol treatment and the rate of unmet need gives the proportion of those not currently in treatment. This data can be used to inform commissioning and any subsequent plans to address unmet treatment need.

Specific rates for addressing unmet need will be determined locally. Effective structured treatment for alcohol dependent adults will be an essential element of a local integrated alcohol harm reduction strategy. Ambition for addressing unmet need for treatment will be based on local need in the context of that strategy.

	Local estimate (2017-18)	Local rate per 1,000	No. in treatment n	Unmet need %	LCL	UCL	National estimate (2017-18)	National rate per 1,000	No. in treatment n	Unmet need %	LCL	UCL
Alcohol only and alcohol & non-opiates	5,033	19.7	1,197	76%	64%	85%	586,780	13.4	104,153	82%	77%	87%

Ambition for addressing unmet need based on previous models should not be used in relation to these rates as different methodologies have been used. Current rates are based on the population of alcohol dependent adults potentially in need of specialist treatment, while previous models used the (much larger) population of harmful drinkers.

Data from your local alcohol treatment system

The following pages provide detailed information on individuals who are receiving structured alcohol treatment. The National Drug Treatment Monitoring System (NDTMS) data presented in this pack covers the period 1 April 2018 to 31 March 2019 and individuals who cited alcohol as their only substance misuse problem, unless otherwise stated. Percentages are rounded and may not sum to 100%. In addition, proportions based on low numbers may also appear as 0%.

Please refer to 'Information disclosure guidelines' at the end of this report for further information on sharing these data.

Client profile

This section describes the characteristics of people who were in treatment in 2018-19. It includes sex and age for all those in treatment and then goes on to describe the characteristics (ethnicity, country of origin, religion, sexuality and disability) of those who started treatment in the year.

Numbers in treatment in 2018-19

	Local		Proportion by sex		National		Proportion by sex	
	n		M	F	n	M	F	
Number of alcohol only clients in treatment	867		62%	38%	75,555	60%	40%	

Age of adults in alcohol treatment in 2018-19

Age group	Local		Proportion of all clients		National		Proportion of all clients		Proportion by sex	
	n	%	M	F	n	%	M	F		
18-29	65	7%	7%	8%	6,538	9%	8%	10%		
30-39	180	21%	20%	22%	16,789	22%	22%	23%		
40-49	282	33%	33%	32%	22,806	30%	30%	30%		
50-59	215	25%	24%	26%	20,275	27%	27%	26%		
60-69	102	12%	12%	11%	7,441	10%	10%	10%		
70-79	■	■	■	■	1,588	2%	2%	2%		
80+	■	■	■	■	118	0%	0%	0%		

This data shows information on demographic groups that presented to treatment in 2018-19. Directly comparable data on the prevalence of each socio-cultural group in your local authority is not currently available. However where it can be sourced locally it should be used to draw comparisons against the data presented here.

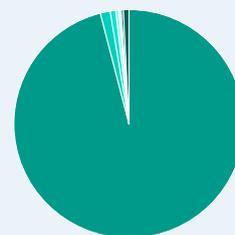
Number and proportion of new presentations to alcohol treatment in 2018-19

	Local		Proportion of all clients		National		Proportion of all clients		Proportion by sex	
	n	%	M	F	n	%	M	F		
New presentations to treatment	649	75%	77%	72%	52,393	69%	70%	68%		

New presentations by ethnicity

Most common ethnic groups in treatment for your local authority	Local		Proportion of new presentations		Proportion by sex	
	n	%	M	F		
White British	623	96%	97%	94%		
Other White	9	1%	0%	3%		
White Irish	■	■	■	■		
White & Black Caribbean	■	■	■	■		
Other Asian	■	■	■	■		
Missing / incomplete	■	■	■	■		

Ethnicity of new presentations

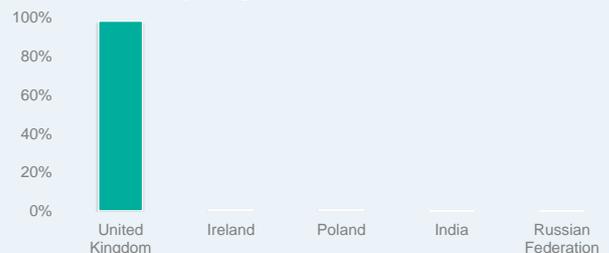


- White British
- Other White
- White Irish
- White & Black Caribbean
- Other Asian
- Missing / incomplete
- All other ethnic groups

New presentations by country of origin

Most common countries of origin groups in treatment for your local authority	Local		Proportion of new presentations		Proportion by sex	
	n	%	M	F		
United Kingdom	637	98%	99%	97%		
Ireland	■	■	■	■		
Poland	■	■	■	■		
India	■	■	■	■		
Russian Federation	■	■	■	■		
Missing / incomplete	■	■	■	■		

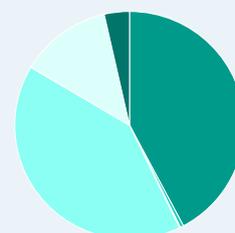
Country of origin of new presentations



New presentations by religion

Most common religious groups in treatment for your local authority	Local		Proportion of new presentations		Proportion by sex	
	n	%	M	F		
Christian	274	42%	42%	42%		
Buddhist	■	■	■	■		
Hindu	■	■	■	■		
No Religion	264	41%	42%	39%		
Missing / incomplete	84	13%	12%	15%		

Religion of new presentations



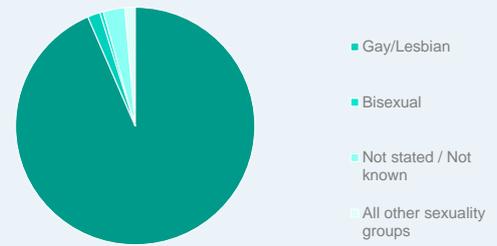
- Christian
- Buddhist
- Hindu
- No Religion
- Missing / incomplete
- All other religions

New presentations by sexuality

	Local n	Proportion of new presentations %	Proportion by sex	
			M %	F %
Heterosexual	607	94%	94%	93%
Gay/Lesbian	11	2%	2%	2%
Bisexual	■	■	■	■
Not stated / Not known	19	3%	3%	3%
Missing / incomplete	■	■	■	■

Individuals that stated "Other" are not displayed.

Sexuality of new presentations

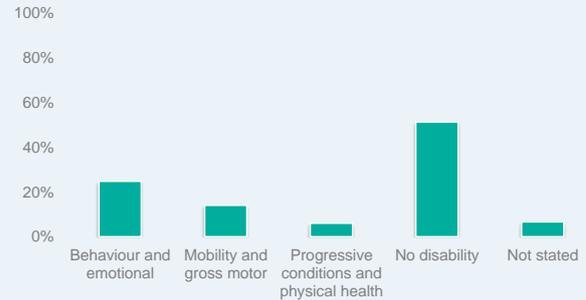


New presentations by disability*

Most common disabilities reported by those in treatment for your local authority

	Local n	Proportion of new presentations %	Proportion by sex	
			M %	F %
Behaviour and emotional	161	25%	22%	29%
Mobility and gross motor	91	14%	14%	15%
Progressive conditions and physical health	39	6%	7%	5%
No disability	333	51%	51%	51%
Not stated	43	7%	6%	8%
Missing / incomplete	0	0%	0%	0%
Number of individuals with at least one disability	288	44%		

Disability of new presentations



* Please note clients may cite multiple disabilities, numbers may sum to greater than number of clients.

Waiting times

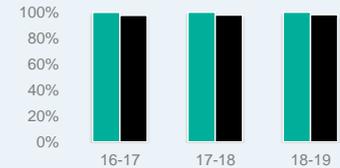
Local ● National ●

This section provides information relating to the length of time clients waited to receive the first intervention in their package of alcohol treatment. People who need alcohol treatment need prompt help if they are to recover from dependence and keeping waiting times short will play a vital role in supporting recovery from alcohol dependence.

Waiting time for the first intervention

	Local n	Proportion of all initial waits %	National n	Proportion of all initial waits %
Initial waits under three weeks to start treatment	683	100%	53,375	98%
Initial waits over six weeks to start treatment	0	0%	329	1%

Proportion of all initial waits waiting under 3 weeks



Treatment engagement

When engaged in treatment, people use alcohol and illegal drugs less, commit less crime, improve their health, and manage their lives better – which also benefits the community. Preventing unplanned drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue. The information below shows the proportion of adults entering treatment in your area in 2018-19 who left treatment in an unplanned way before 12 weeks, but it is important to review any unplanned exits from treatment in order to develop a better understanding of what is happening within the local system.

Early unplanned exits in 2018-19

	Local n	Proportion of new presentations %	Proportion by sex		National n	Proportion of new presentations %	Proportion by sex	
			M	F			M	F
Number of alcohol only clients	84	13%	14%	11%	7,460	14%	15%	13%

Routes into treatment

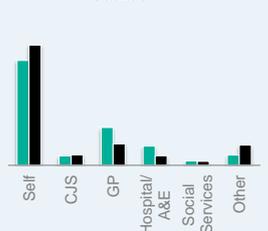
Local ● National ●

The table below shows the routes into alcohol treatment in 2018-19. Understanding these, gives an indication of the level of referrals from various settings into specialist treatment. Criminal Justice System (CJS) means referred through an arrest referral scheme, via an Alcohol Treatment Requirement (ATR), prison or the probation service. Referrals from hospitals includes referrals from alcohol care teams and people identified as potentially dependent through the alcohol and tobacco CQUIN.

Source of referral into treatment

	Local n	Proportion of referrals %	Proportion by sex		National n	Proportion of referrals %	Proportion by sex	
			M	F			M	F
Self-referral	366	56%	56%	57%	33,898	65%	64%	66%
Referred through CJS	33	5%	6%	3%	2,913	6%	7%	3%
Referred by GP	132	20%	22%	18%	6,044	12%	11%	12%
Hospital/A&E	67	10%	10%	11%	2,694	5%	5%	5%
Social Services	15	2%	1%	4%	1,123	2%	1%	3%
All other referral sources*	36	6%	5%	6%	5,721	11%	11%	11%

Proportion of referrals by source



* Please note individuals with a missing or inconsistent referral source are included in other

Clients who are parents/carers and their children

The data below shows the number of alcohol clients who entered treatment in 2018-19 who live with children and the stated number of children who live with them. Alcohol clients who are parents but do not live with children and users for whom there is incomplete data are also included. In addition, the number of pregnant female clients entering treatment in 2018-19 is presented as is the number of clients whose children are involved in the safeguarding process. The data can help you identify the need to engage with social services to ensure appropriate management of families at risk.

Parental status									
	Local		Proportion by sex (M/F)		National	Proportion of new presentations		Proportion by sex (M/F)	
	n	Proportion of new presentations	M	F		n	M	F	
Living with children (own or other)	116	18%	10%	31%	12,750	24%	19%	32%	
Parent not living with children	134	21%	24%	15%	13,270	25%	28%	22%	
Not a parent/no child contact	399	61%	66%	54%	26,190	50%	53%	46%	
Missing / incomplete	0	0%	0%	0%	183	0%	0%	0%	

Living with children							
Number of children living with alcohol clients entering treatment in 2018-19	Local		Proportion of children by client sex		National	Proportion of children by client sex	
	n		M	F		n	M
	220		36%	64%	22,520	49%	51%

Client's children receiving early help or in contact with children's social care									
	Local		Proportion by sex (M/F)		National	Proportion of clients with child contact		Proportion by sex (M/F)	
	n	Proportion of clients with child contact	M	F		n	M	F	
Early Help	9	4%	2%	5%	998	4%	2%	6%	
Child in need	8	3%	1%	5%	936	4%	2%	5%	
Child protection plan in place	18	7%	4%	11%	1,504	6%	3%	9%	
Looked after child	█	█	█	█	624	2%	2%	4%	

Pregnancy data					
	Local		National	Proportion of new female presentations	
	n	Proportion of new female presentations		n	%
New female presentations who were pregnant	█	█	218	1%	
Incomplete data	█	█	207	1%	

Tobacco use

Smoking in people who use drugs and alcohol is highly prevalent and a major cause of illness and death. With the support of treatment services, many people successfully recover from drug and alcohol dependence only to later die of their untreated smoking dependence. Services should offer (or work with stop smoking services to offer) stop smoking support (Nicotine Replacement Therapy and psychosocial), and harm reduction for people unable or unwilling to stop smoking.

Clients identified as smoking tobacco at start of treatment									
	Local		Proportion by sex		National	Proportion of all in treatment		Proportion by sex	
	n	Proportion of all in treatment	M	F		n	M	F	
Number of clients identified as smoking tobacco	276 / 481	57%	59%	55%	15,651	44%	45%	43%	

Clients smoking status at treatment outcome review									
Number of clients identified as abstinent from tobacco at review	Local		Proportion by sex		National	Proportion of reviewed clients smoking at start of treatment		Proportion by sex	
	n	Proportion of reviewed clients smoking at start of treatment	M	F		n	M	F	
	106 / 276	38%	34%	46%	4,919	31%	31%	32%	

Number of clients identified as starting to smoke tobacco at review who were abstinent from tobacco at start of treatment	Local		Proportion by sex		National	Proportion of reviewed clients abstinent at start of treatment		Proportion by sex	
	n	Proportion of reviewed clients abstinent at start of treatment	M	F		n	M	F	
	22 / 205	11%	11%	10%	2,415	12%	13%	12%	

Smoking cessation interventions provided to clients who smoke tobacco									
Overall number of clients receiving smoking cessation interventions	Local		Proportion by sex		National	Proportion of all in treatment		Proportion by sex	
	n	Proportion of clients identified	M	F		n	M	F	
	█	█	█	█	509	3%	3%	4%	

Drinking levels

This section shows the number of units consumed by people in treatment in the 28 days prior to commencing treatment. Most people who require structured treatment for alcohol dependence will be drinking at higher risk levels. Drinking levels can be used as a rough proxy for level of dependence and levels of alcohol health risk. An indication of drinking levels in treatment may be useful in understanding which groups of clients are receiving treatment and whether those with the highest levels of harm are receiving effective interventions.

There is a strong association between levels of consumption and severity of dependence but they are not equivalent. In general, women are likely to become dependent at lower levels of consumption than men for example.

Consumption is based on drinking levels over the 28 days prior to assessment. There will be some moderately or severely dependent adults who have stopped or reduced consumption prior to treatment (for example in hospital or prison) so will appear in the lowest category.

A number of areas are recording scores taken from the Severity of Alcohol Dependence Questionnaire (SADQ) assessment tool and in those areas local data on levels of dependence within the treatment population will be available.

Units consumed in the 28 days prior to entering treatment by sex

	Male		Female		0 units		1-199		200-399		400-599		600-799		800-999		1000+	
	n	n	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Local	535	332	1%	1%	7%	16%	18%	25%	29%	27%	14%	13%	10%	9%	20%	10%		
National	44,811	30,040	7%	7%	18%	23%	21%	26%	22%	23%	12%	9%	9%	6%	12%	6%		

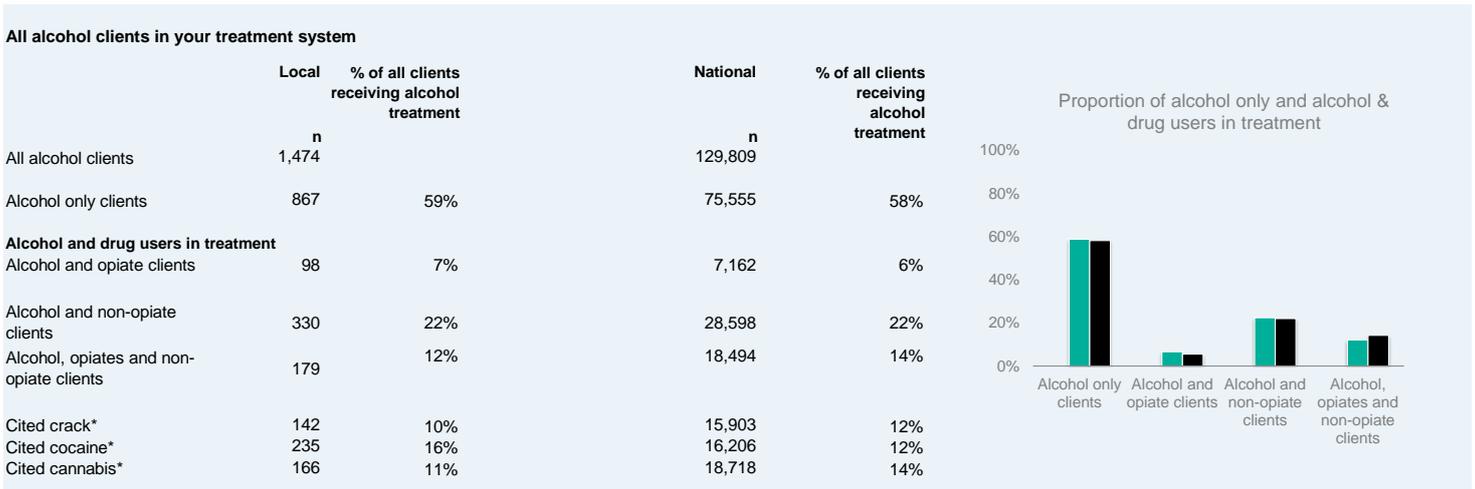
Please note individuals with missing units data are not included in this section

Severity of alcohol dependence questionnaire (SADQ)

	Male		Female		0-15: Mild dependence		16-30: Moderate dependence		31+: Severe dependence		Declined to answer		Not stated / Not known		Missing / incomplete	
	n	n	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Local	410	239	51%	56%	19%	23%	29%	18%	0%	0%	1%	3%	0%	0%		
National	31,708	20,685	29%	31%	16%	16%	18%	15%	0%	0%	19%	19%	17%	18%		

Whilst the NDTMS data in this pack focuses specifically on those individuals who are in treatment for alcohol misuse only, it is important to take into account the wider cohort of alcohol users who also have drug misuse problems. The needs of these clients are particularly complex and extra consideration needs to be given to what additional support they may require.

Presented first here is the number and proportion of clients in your treatment system who have a problem with alcohol only. This is followed by the number and proportion of individuals who have a problem with both alcohol and drugs and then the most commonly cited drugs by these individuals; crack, cocaine and cannabis.



* Please note clients may cite more than one additional substance and are counted once under each relevant category

Interventions

We know that the types of intervention delivered to service users will have an impact on their achievement of recovery outcomes. The table below shows what interventions are delivered locally and in what setting. The last item focuses on those who receive pharmacological intervention and whether it was for withdrawal or relapse prevention. This has been separated in this way so as to distinguish between prescription for initial medically assisted withdrawal and that to reduce craving and maintain sustained abstinence.

Local high level interventions

Setting	Pharmacological		Psychosocial		Recovery Support		Total Individuals**	
	n	%	n	%	n	%	n	%
Community	89	61%	852	98%	764	97%	852	98%
Inpatient unit	94	64%	93	11%	93	12%	94	11%
Primary care	■	■	■	■	■	■	■	■
Residential	■	■	■	■	■	■	■	■
Recovery house	■	■	■	■	■	■	■	■
Young person setting	■	■	■	■	■	■	■	■
Missing / incomplete	■	■	■	■	■	■	■	■
Total individuals*	146		866		789		867	

	Local		National	
	n	%	n	%
Pharmacological Intervention Type (sub intervention):				
Individuals with a pharmacological intervention where the intention is withdrawal	64	44%	5,297	38%
Individuals with a pharmacological intervention where the intention is relapse prevention	19	13%	5,352	38%

* This is the total number of individuals receiving each intervention type and not a summation of the setting the intervention was delivered in.

** This is the total number of individuals receiving any intervention type in each setting and not a summation of the pharmacological, psychosocial and recovery support columns.

Residential rehabilitation

The data below shows the number of adult alcohol users in the local area who have been to residential rehabilitation during their latest period of treatment (as a proportion of the local alcohol treatment population and against the national proportion). Structured alcohol treatment mostly takes place in the community, near to users' families and support networks. However, in line with NICE recommendations, a stay in residential rehabilitation is appropriate for those with the most complex needs, and local areas are encouraged to provide this option as part of an integrated recovery-orientated system.

Numbers and proportion of alcohol only clients in residential treatment

	Local	Proportion of treatment population	National	Proportion of treatment population
	n		n	
Number of alcohol only clients	■	■	2,054	3%

This new data shows the number of alcohol clients who started treatment in 2018-19 who were identified as having a mental health treatment need and, of those, the number who were receiving treatment from mental health services. Comparing prevalence with treatment received can help you assess whether need is being met.

Adults who entered treatment in 2018-19 and were identified as having a mental health treatment need								
	Local	Proportion of new presentations	Proportion by sex		National n	Proportion of new presentations	Proportion by sex	
	n		M	F			M	F
Client identified a mental health treatment need	419	65%	63%	68%	28,166	54%	49%	61%

Client identified a mental health treatment need and receiving treatment for their mental health									
	Local n	Proportion of clients identified	Proportion by sex		National n	Proportion of clients	Proportion by sex		
			M	F			M	F	
Already engaged with the Community Mental Health Team/Other mental health services	25	6%	6%	6%	5,054	18%	18%	18%	
Engaged with IAPT	595	2%	2%	2%	595	2%	2%	2%	
Receiving mental health treatment from GP	328	78%	74%	85%	16,622	59%	57%	62%	
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	462	2%	2%	2%	462	2%	2%	2%	
Has an identified space in a health-based place of safety for mental health crises	140	0%	1%	0%	140	0%	1%	0%	
Total individuals receiving mental health treatment	353	84%	81%	90%	22,621	80%	78%	83%	

Employment

The data below shows self-reported employment status at the start of treatment in 2018-19 along with exit status from the Treatment Outcomes Profile (TOP). Improving job outcomes is key to sustaining recovery and requires improved multi-agency responses with Jobcentre Plus and the Work and Health Programme providers.

Employment status at the start of treatment					Employment status at the start of treatment by proportion			
	Local	Proportion of new presentations	National		Proportion of new presentations			
	n		n					
Regular employment	205	32%	18,409		35%	Regular employment		
Unemployed/economically inactive	230	35%	18,614		36%	Unemployed/economically inactive		
Unpaid voluntary work	108	17%	218		0%	Unpaid voluntary work		
Long term sick or disabled	52	8%	11,489		22%	Long term sick or disabled		
In education	47	7%	360		1%	In education		
Other			973		2%	Other		
Missing / incomplete			2,330		4%	Not stated/missing		

Employment outcomes									
	Local		Planned exit		Start		Unplanned exit		
	n	%	n	%	n	%	n	%	
Irregular (1-7 days)	0	0%	1	1%	0	0%	0	0%	
Part-time (8-15 days)	22	7%	24	7%	0	0%	0	0%	
Full time (16+ days)	57	17%	83	25%	0	0%	0	0%	
Not working	257	76%	228	68%	21	81%	21	81%	

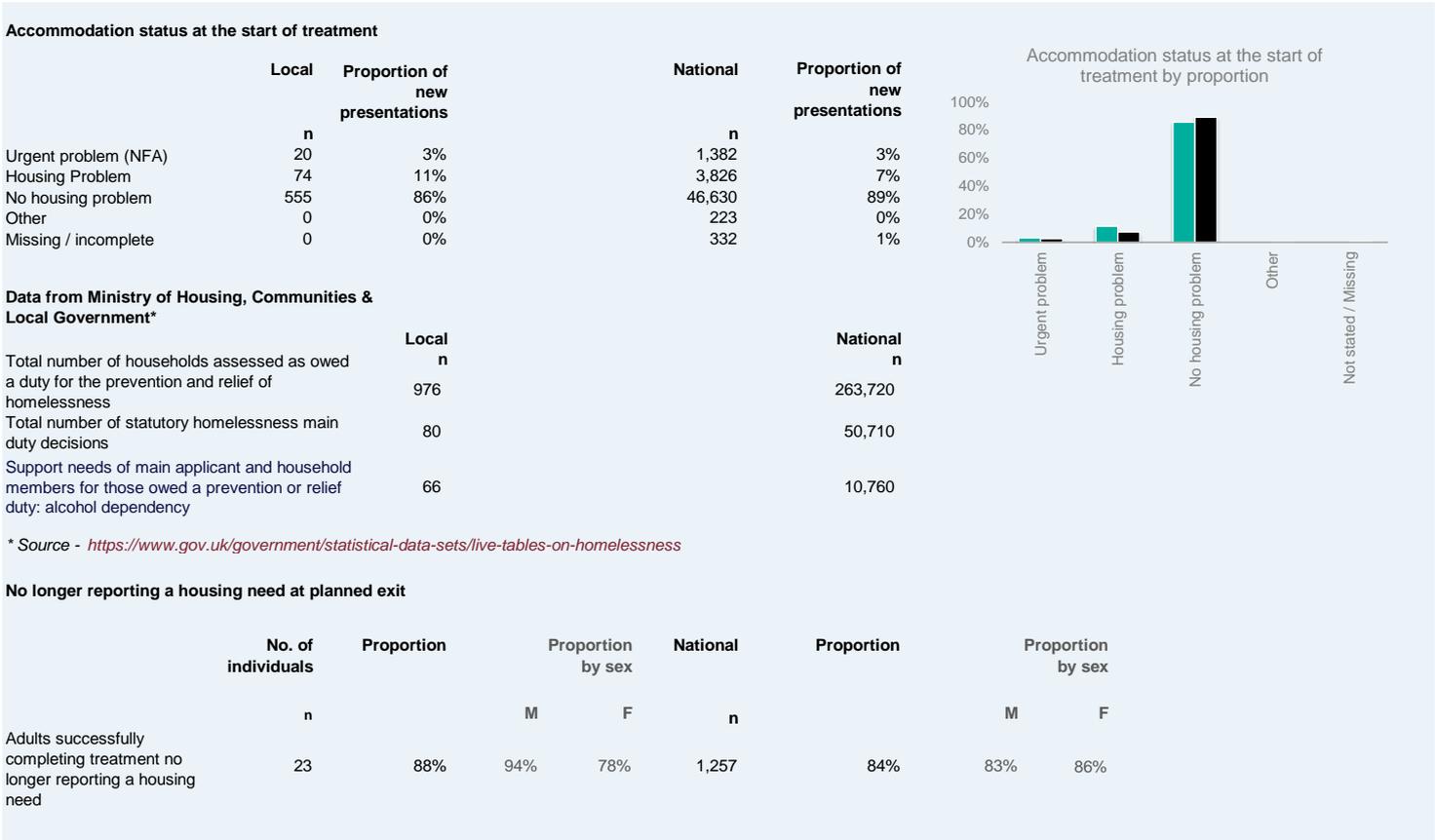
National									
	Start		Planned exit		Start		Unplanned exit		
	n	%	n	%	n	%	n	%	
Irregular (1-7 days)	665	3%	502	2%	49	2%	26	1%	
Part-time (8-15 days)	1,733	7%	1,489	6%	102	4%	92	4%	
Full time (16+ days)	6,689	25%	7,414	28%	440	18%	399	17%	
Not working	17,349	66%	17,031	64%	1,791	75%	1,865	78%	

Please note that all data is displayed here, regardless of TOP/AOR compliance in the local area

Housing and homelessness

The first part of 'Accommodation status' below shows self-reported housing status of adults when they started in your treatment services. The second presents key data from MHCLG on the overall homelessness decisions made and gives a wider sense of housing need in your area. This includes the numbers owed a prevention or relief duty with a support need of alcohol dependency. The final section, 'No longer reported a housing need', shows those clients who successfully completed treatment with no housing problem reported.

A safe, stable home environment enables people to sustain their recovery. Engaging with local housing and homelessness agencies can help ensure that the full spectrum of homelessness is understood and picked up: from statutory homeless, single homeless people, rough sleepers to those at risk of homelessness.

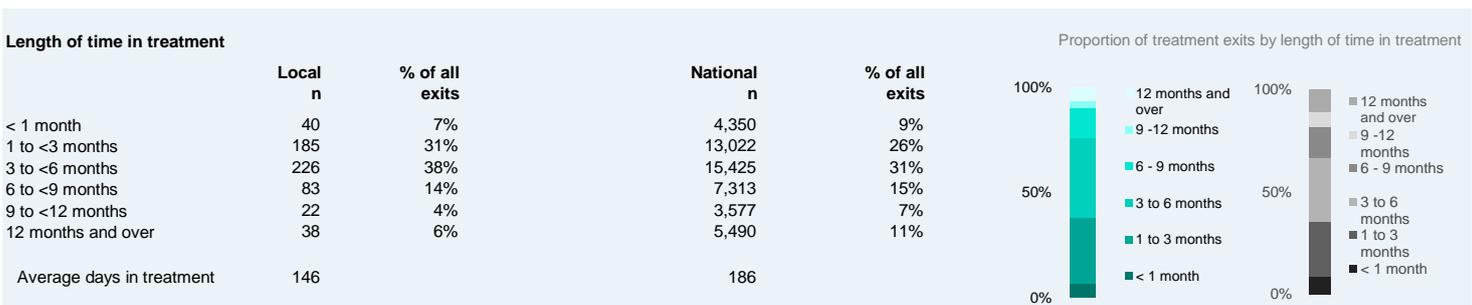


Please note that outcome data is displayed here regardless of local area TOP compliance

Length of time in treatment

NICE Clinical Guideline CG115 recommends harmful and mildly dependent drinkers receive a treatment intervention lasting three months, those with moderate and severe dependence should receive treatment for a minimum of six months while those with higher or complex needs may need longer in specialist treatment.

The length of a typical treatment period is just over 6 months, although nationally 11% of clients remained in treatment for at least a year. Retaining clients for their full course of treatment is important in order to increase the chances of recovery and reduce rates of early treatment drop out. Conversely, having a high proportion of clients in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.



The data below is drawn from the Treatment Outcomes Profile (TOP) and Alcohol Outcomes Record (AOR), which track the progress alcohol users make in treatment. This includes information on rates of abstinence from alcohol and changes in average days use. This is useful as these recovery assets are predictors of continued recovery.



Please note that all data is displayed here, regardless of TOP/AOR compliance in the local area

Successful completions

The following section relates to clients completing their period of treatment in 2018-19, and shows whether they completed successfully and did not return within 6 months.

The PHE alcohol evidence review indicates that treatment is effective and cost-effective and is a necessary part of any overall approach to reduce alcohol related harm. Although there is no single measure of effective treatment for alcohol dependence, the following data gives an indication of how well the current system is working in treating those who are receiving structured treatment. A high proportion of successful completions and a low number of re-presentations to treatment indicate that treatment services are responding well to the needs of those in treatment.



Please note that the percentages given in this pack are rounded to the nearest per cent. Totals may not add up to 100 due to rounding.

Additional data to reduce wider alcohol related harm

The following links provide information regarding additional data sources relating to wider alcohol-related harm which may be available to you either locally or via national surveys or data collection systems.

Primary and Secondary Care Data

NHS Health Check

Everyone in England between the ages of 40 and 74, who has not already been diagnosed with one of a set of chronic conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes. An alcohol risk assessment is included as part of a standard NHS Health Check. People receiving a check will receive personalised advice to lower risk, which could include lifestyle information, referral to other services and prescribing medication. Data is available on a quarterly basis on the number of people eligible for the NHS health check, and on appointments offered and received by local authorities since 2011-12.

http://www.healthcheck.nhs.uk/commissioners_and_providers/data/

Alcohol-related risk reduction in primary care

The GP Extraction Service (GPES) can be used to monitor how many newly registered patients in a practice have been offered alcohol-related risk reduction screening and interventions or referral. To find out how to access data in your area, contact your local CCG, or NHS England area team. For a list of relevant read codes to extract, please refer to the 2013-14 Enhanced Services guidance.

<https://www.nhsemployers.org/~media/Employers/Publications/2013-14-GMS-contract-Guidance-audit-requirements.pdf>

Hospital Episodes Statistics (HES)

HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances (provisional dataset) at NHS hospitals in England. It contains admitted patient care data from 1989 onwards, outpatient attendance data from 2003 onwards and A&E provisional data from 2007 onwards. To find out how to access data in your area contact your local CCG.

<http://content.digital.nhs.uk/hes>

Wider Public Health Data

Public Health Outcomes Framework

A collection of outcomes indicators covering the full spectrum of public health. Data is presented under four domains: 'wider determinants of health', 'health improvement', 'health protection' and 'healthcare and premature mortality'. Comparisons with a benchmark and trend data are provided and information is updated on a quarterly basis.

<http://www.phoutcomes.info/>

Statistics on Alcohol in England 2019 (NHS Digital)

An annual report acting as a reference point for health issues relating to alcohol use and misuse. Combines the results from several national surveys including: the Opinions and Lifestyle Survey (OPN) and Smoking drinking and drug use (SDD).

<https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2019>

Health Profiles

Contained within the Fingertips data tool. These present summary health information to support local authority members, officers and community partners to improve health and reduce health inequalities. Intended as 'conversation starters' to highlight local issues and priorities for members, and for discussion at Health and Wellbeing Boards. Updated annually and available in a data tool or as a summary PIG document.

<http://fingertips.phe.org.uk/profile/health-profiles>

Local Alcohol Profiles for England (LAPE)

Contained within the Fingertips data tool. Profiles containing 31 alcohol-related indicators for every local authority. The majority are also available for all Public Health England (PHE) centres in England and former government office regions.

<http://fingertips.phe.org.uk/profile/local-alcohol-profiles>

ONS Alcohol-related deaths in the United Kingdom 2017

Latest figures for alcohol-related deaths in the UK, its four constituent countries and regions of England for 2016.

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/alcoholrelateddeathsintheunitedkingdomreferencetable1>

Estimates of alcohol dependence in England based on APMS 2014, including estimates of children living in a household with an adult with alcohol dependence, Price et al; University of Sheffield 2017

The full report on prevalence estimates for alcohol dependent adults potentially in need of specialist treatment, including estimates of parental alcohol dependence and numbers of children living with an alcohol dependent adult published by the University of Sheffield at the request of PHE.

Characteristics of children in need: 2015 to 2016, DoE/ONS Nov 2016

Annual data on the numbers of Children in Need including numbers of Children in Need where alcohol or drug use is a factor. Data in this pack uses updated estimates that are unpublished.

<https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england>

Further Alcohol Treatment Data

National Drug Treatment Monitoring System Performance Reports

A collection of reports available on a monthly, quarterly and annual basis, providing detailed information on clients in structured alcohol and drug treatment from the NDTMS. Access is partially restricted and granted to PHE staff, commissioners and local authorities.

<https://www.ndtms.net/Monthly/Adults>

Social Return on Investment (SROI) of Adult Alcohol and Drug Interventions and the Adult Alcohol and Drug Treatment Commissioning Tool

The commissioning tool comprises a cost calculator and cost effectiveness analysis (CEA) to support areas in estimating local spend on treatment interventions and cost-effectiveness. The SROI tool estimates the crime, health and social care benefits of investing in drug and alcohol services at a local level.

<https://www.ndtms.net/VFM>

INFORMATION DISCLOSURE GUIDELINES

Please prevent inappropriate use by treating this information as restricted. Refrain from passing information on to others who have not been given prior access and use it only for the purposes for which it has been provided. If you intend to publish figures from this data support pack you must restrict all figures under 5 and any associated figures to prevent deductive disclosure. For further information please refer to the data disclosure control document entitled "How to apply disclosure control to restricted statistics from NDTMS" available on the NDTMS.Net Report Viewer.

<https://www.ndtms.net/ReportViewer>

For additional guidance please refer to the NHS Digital Anonymisation standard, ISB 1523 entitled "Anonymisation Standard for Publishing Health and Social Care Data".

<http://content.digital.nhs.uk/isce/publication/isb1523>

The restricted status of this data will be lifted after the release of the annual report planned for 7th November 2019.