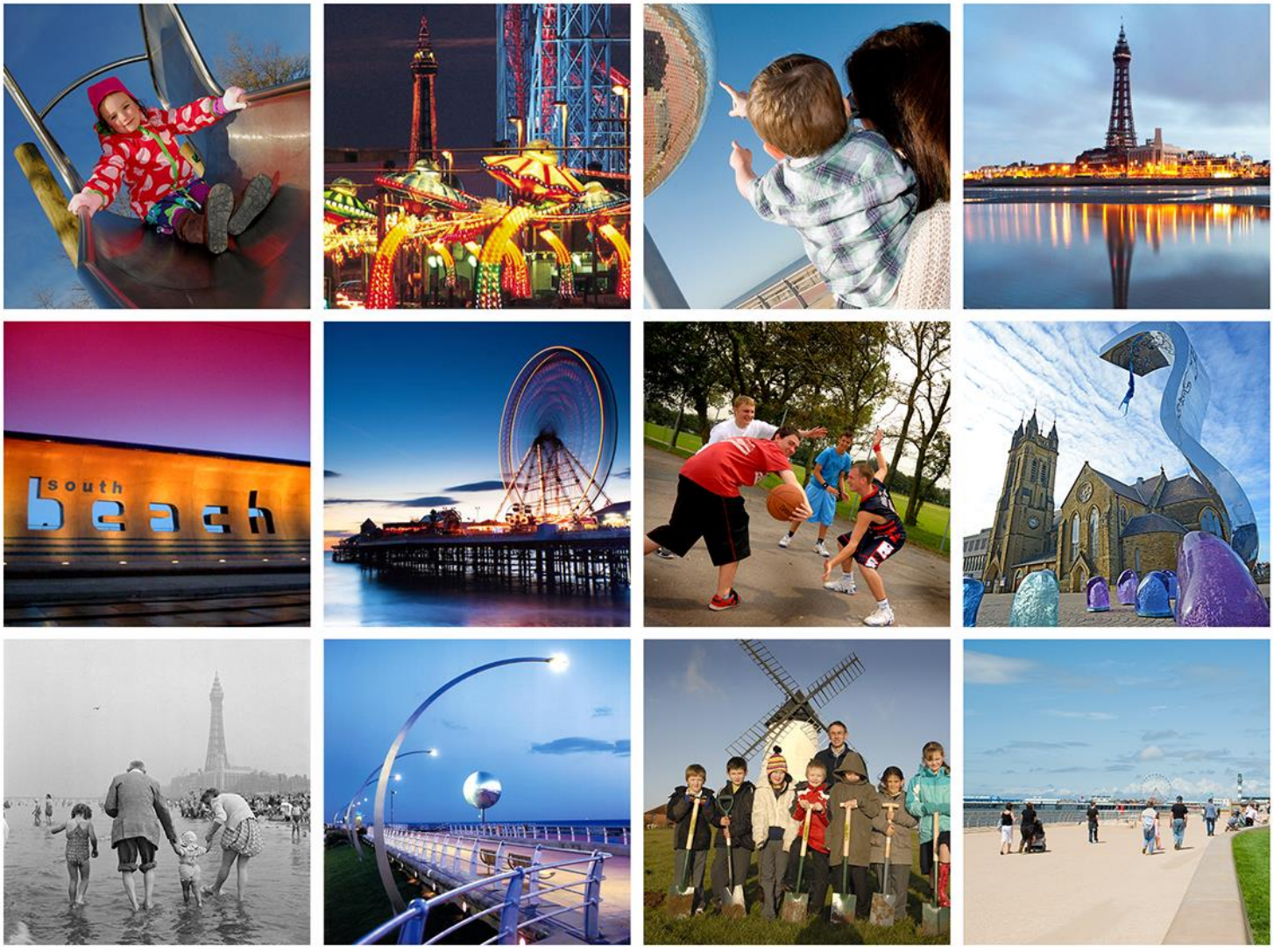
Blackpool Alcohol Prevention and Harm Reduction Strategy

2024 - 2027

Blackpool Council



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1. Executive Summary

People across Blackpool have worked hard, in the local authority, health services, other public services and across third sector and peer support groups to reduce the impact of alcohol harm on individuals and communities. There are many successes to be built on and lessons to be learned from projects and interventions which have been implemented in Blackpool over a significant period of time. We will use our resources, and seek support from partners to continue to deliver effective treatment and interventions that prevent people from becoming alcohol dependent and help those who have developed dependency to make sustainable change that reduces the harm and impact on themselves and others.

Without a new national strategy and the continued impact of alcohol on crime, health, domestic abuse, individuals and families, we need a clear plan to move forward with businesses and people of Blackpool. This will adhere to the current draft document: UK Clinical guidelines for Alcohol Treatment from OHID.

We have an ageing population with higher drinking levels, a population impacted by COVID with unmet need in particular groups, for example women.

Historically we have seen a reduction in alcohol treatment referrals, but we are now starting to see improvement with the launch of the separate alcohol treatment service, the Lighthouse.

To achieve the changes we want to see across Blackpool and improve people's lives we will:-

- Lobby to overcome the legislative barrier that blocks population level change in relation to harmful alcohol consumption.
- Better inform the population and in particular children, young people and parents about the potential harm of alcohol use.
- Encourage intervention at an early stage where alcohol harm may be highlighted as a risk
- Stop stigma to improve access to services when people need them and to maintain recovery
- Improve treatment, recovery and aftercare support options for people facing challenges with their alcohol use
- Effectively address co-occurring mental health and alcohol issues
- Reduce the impact of alcohol misuse on families, the public sector resources and the whole community

The full Delivery Plan can be found as Appendix 2.

2. Foreword from the Director of Public Health

Welcome to this, our new alcohol harm reduction strategy for Blackpool. As with our previous strategy, I want to use this introduction as an opportunity to reflect on the key successes achieved through the last strategy and also the challenges and opportunities ahead of us. These include:

- The launch of the Lighthouse Alcohol Service.
- Successful blocking of new applications in the cumulative impact area.
- Being advocates for Minimum Unit Pricing.

We now have a newly established Combating Drugs and Alcohol Partnership Board as a result of the new national drug strategy – From Harm to Hope. Unfortunately, we have not had a national alcohol strategy since 2012 and this is now very overdue as the harm from alcohol misuse continues to grow, demonstrated by the numbers of alcohol-related deaths.

We are closely watching the work of the Scottish system who have implemented significant policy level choices such as the implementation of MUP for alcohol, to make large scale positive change for their population.

Where we can implement these actions locally we will and where national political will is required, we will continue to lobby for change to benefit our residents and the whole country.

With this strategy, we want to reduce the prevalence of harmful drinking in Blackpool and reduce its impact on our communities. We particularly want to ensure we reduce harmful drinking by women and older people whilst continuing to educate young people.

Even with our challenges, we know that if we continue to work with and for our residents, we can make a difference to people's lives.

This strategy has been developed by the Combating Drugs and Alcohol Partnership Board in conjunction with the Health and Wellbeing Board and BSafe, the Community Safety Partnership for Blackpool.

3. Our Vision

The overall aim of Blackpool's approach is to prevent and reduce harmful impact of alcohol,, alcohol-related deaths and alcohol-related specific deaths :

- Ensuring that international evidence is used to generate an environment to reduce the harm caused by alcohol
- Ensuring that young people understand the impact of alcohol on their bodies and lives and can make informed decisions
- Identifying people at higher risk of alcohol harm earlier, including people with caring responsibilities
- Reducing barriers to treatment and support by removing stigma associated with problematic and harmful drinking
- Ensuring that treatment services are delivered in a way that meets the different needs of the population
- Providing a better integrated approach with primary and secondary care, to wrap help and support around those people who are facing harm to their health and are being admitted to hospital
- Working with partners to deliver a family safeguarding approach where caring responsibilities for children are impacted by alcohol use
- Reducing alcohol-related crime and anti-social behaviour through integrated work between police, probation, treatment services and prisons

4. The National Context

The National Alcohol Strategy was published in 2012. It highlighted that 50 years ago, the United Kingdom had one of the lowest drinking levels in Europe but it is now one of the few European countries whose consumption has increased over that period. This is reflected in national crime and health statistics.

Nationally there are almost 1 million alcohol-related violent crimes and 1.2 million alcohol-related hospital admissions each year. Alcohol is one of the three biggest lifestyle risk factors for disease and death in the United Kingdom after smoking and obesity. Society is paying the costs – alcohol-related harm is now estimated to cost society £21 billion annually in the UK.

No commitment to implementing the international evidence for setting a Minimum Unit Price or including health as a licensing objective was made in this strategy. The Scottish government have implemented this earlier, their 2008 strategy and the 2018 updated Alcohol Framework, gave rise to legislation on setting a Minimum Unit Price for alcohol across Scotland.

This has been subject to evaluation which has been positive and is included in the evidence review section of this strategy.

5. What are the Issues? – The Blackpool Context

Blackpool, like much of the North of England, faces particular challenges. Blackpool has the lowest life expectancy for men and the second lowest for women of all upper tier local authorities. Men in the least deprived areas of the town can expect to live 13 years longer than men in the most deprived areas. Similarly, for women this difference is 7 years. Not only do people in Blackpool live shorter lives, but they also spend a smaller proportion of their lifespan in good health. Alcohol misuse and related problems play a significant part in maintaining this differential.

The Blackpool Joint Strategic Needs Assessment identifies that though the number of residents who drink in Blackpool is average, the quantity and health impacts are much greater than England and the North West, resulting in higher hospital admissions and early deaths due to alcohol-related conditions.

Alcohol misuse does not just impact on an individual's health but also on violent crime, accidents, on communities feeling safe, but also on the local health care system and even Children's and Adult Social Care, with strong links between alcohol misuse, domestic violence and children's safeguarding.

Poverty levels in Blackpool are such that the alcohol harm paradox, whereby less affluent, moderate alcohol drinkers have a higher risk of harm than more affluent, heavy drinkers; results in even greater impact of alcohol on early death.

When understanding the alcohol harm paradox in Blackpool we must consider poverty and barriers to change. Interlinked factors such as mental health, physical health and exercise, sleep disorders, nutrition, accommodation, isolation, literacy/numeracy, finances and prejudice.

6. Progress against Actions from Blackpool Alcohol Strategy – 2019-22

Action	Achieved
We will improve our population's awareness of the Chief Medical Officer's alcohol guidelines, alcohol-related harm and harm reduction.	• Monitored and promoted the 'Lower My Drinking' App • Comms support for Alcohol Awareness Week and Dry January • PSHE alcohol education has been delivered and shared to all primary, secondary, SEND and PRU school staff and the resources are available for review on a free website and via PSHE Association membership.
We will provide evidence-based targeted interventions to prevent alcohol misuse in those populations particularly at risk.	• The SHEU survey was completed in 2022 looking at health and wellbeing behaviours in children and young people inclusive of alcohol. These results were incorporated into the restarted PSHE forum for providing continued targeted interventions. • The AUDIT-C/IBA in primary care audit was completed with the outcomes recommending targeted work with GP Practices and including developing a training offer. • The ASSIST-Lite screening tool has been adapted so it complements the Blackpool Families Rock model of practice and has been branded as a 'Health Check- In', to try and normalise its use and help remove any stigma associated with substance misuse. Ongoing work is still needed to complete the roll-out of the training to Children Social Care. • A community-based 'crisis café' was developed to ensure that those experiencing or at-risk of a mental health crisis have access to acceptable and timely support.
We will provide early help and interventions for people affected by harmful drinking.	• The 'Lower My Drinking' app was promoted as an early help tool and monitored to assess the impact and trends around harmful drinking in Blackpool. • New digital Drink less graphics were created to produce positive gains for stopping or reducing drinking.
We will provide evidence-based effective treatment for alcohol misuse that is accessible to all.	• We have worked collaboratively with Housing First and alcohol treatment services to achieve greater behaviour change for alcohol dependent clients by creating an Inpatient Detox fast track. • Creating and implementing OASIS (Multiple Disadvantage focus) to achieve collaborative partnership working among services and seamless pathways for clients with complex needs including alcohol use to receive timely access and support. • Fylde Coast Alcohol Services Pathway delivery group was reinstated in October 2022 to identify opportunities to improve outcomes, identify skills, knowledge and training for all care professionals across the Fylde Coast. • Instigated a systematic review for alcohol specific deaths • An Alcohol Needs Assessment and Service Review was undertaken and the recommendations were devised into an action plan for completion including the requirements of the service specification.

Action	Achieved
	• Developed a separate system of death reviews in addition to the drug-related death/non-fatal overdose panel including making in-treatment deaths an identified standing agenda item to the panel. • Implemented a review of deaths in service that created changes in the treatment provider's structure for the prevention of alcohol related deaths • A coroner's death out of service review was produced that informed our harm reduction practices and advertising. • Created a dual diagnosis expert/practice group to review service users with a co-existing mental health need and substance misuse issues and develop joint care and recovery plans.
We will ensure that alcohol is sold and consumed responsibly.	• We are continuing to submit representations from Public Health on alcohol licensing applications. • We have reviewed the off-license saturation policy to ensure it is evidence-based and considers cumulative impact.
We will advocate for changes in national policy and practice to reduce alcohol-related harm and better protect our population.	• Ongoing advocacy to make changes to national policy • We reviewed and continue to review evidence from Scotland who have implemented MUP

7. Blackpool's Strategic Approach to Reducing the Harm Caused by Alcohol

Though the greatest impact on reducing drinking levels and associated harm can be delivered from national policy change. Local government can still influence population level impact not just through lobbying for national legislation, from local economic growth strategies but also how it influences and implements its own legal powers, policies and procedures. Blackpool has led the way to control the availability of new licences in high prevalence areas, even without public health being a licensing priority.

Cumulative Impact Policy

The number, type and density of premises selling alcohol in a particular area can lead to serious problems adversely impacting the Licensing Objectives. In these circumstances the cumulative impact of premises in a problematic area can be far greater than specific problems or issues arising from individual premises. On the 11th February 2021 Blackpool Published its first Cumulative Impact Assessment effectively identifying parts of the town where it is evidenced cumulative impact exists - **Blackpool Cumulative Impact Assessment 2021**. The area covered by the town centre saturation area is shown in Figure 1.

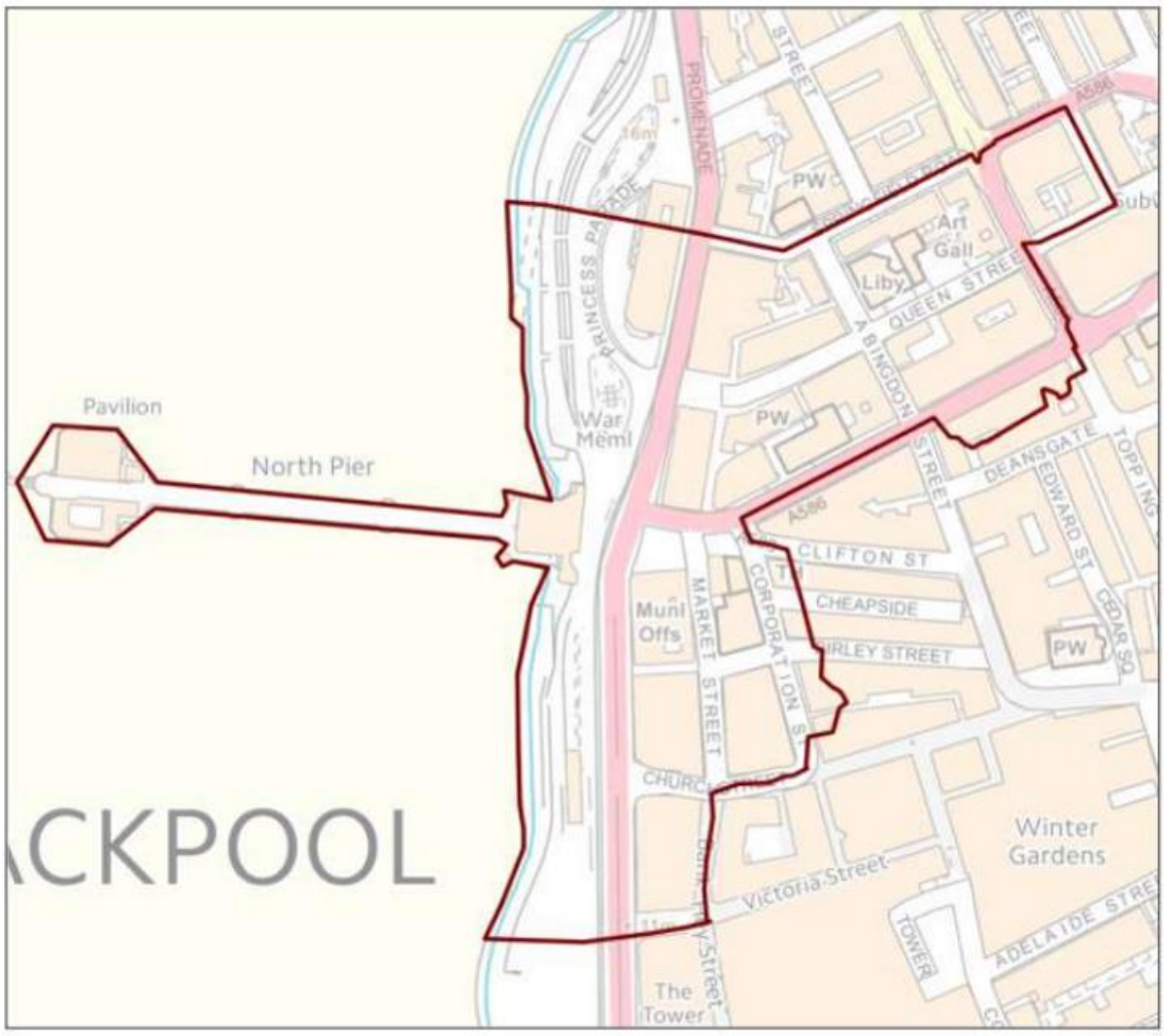
The policy applies to applications including the sale or supply of alcohol on and off the premises. The effect of the policy is to create a rebuttable presumption that applications will be refused. To rebut this presumption an applicant would be expected to show that the operation of the premises will not add to the cumulative impact already being experienced.

This policy does not act as an absolute prohibition on the granting of new licences. However the policy will only be overridden in genuinely exceptional cases where the applicant can demonstrate that the granting of the application will not undermine the policy and the reasons for it. An application is not likely to be classed as exceptional merely on the grounds that the premises have been or will be operated within the terms of its licence or that they are/will be well managed. This is to be expected of any application.

Despite the adoption of such a policy, if no representations are received from responsible authorities, the application must be granted in terms consistent with the operating schedule.

We also have measures to stop the sale of single cans and bottles of alcohol from the off-licenses within the town centre area. This is to assist with the number of street drinkers and young people problematic drinking.

Figure 1: Town Centre Assessment Area



Off-Licence Saturation Policy

The off-licence saturation policy intends to promote a saturation zone within Blackpool in areas where crime and disorder is more prevalent and alcohol-related health statistics are high. The areas to which this off-licence saturation policy will apply include Claremont, Bloomfield and Talbot wards in their entirety as well as part of Brunswick ward and Waterloo ward. For the avoidance of any doubt, premises located along both sides of the highway where the boundary line is drawn are considered to be included in the saturation area.

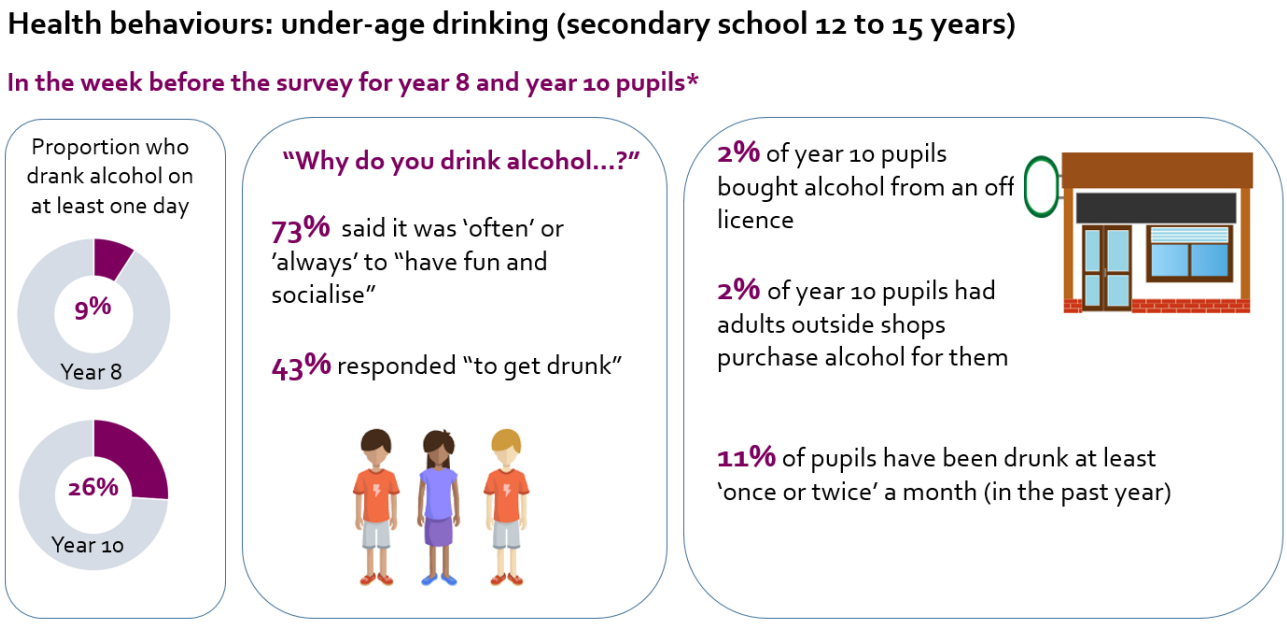
8. What are the Statistics telling us about Alcohol use in Blackpool?

Blackpool regularly undertakes its own needs assessments and analysis using local and national data. The most recent needs assessments can be found here (Alcohol (blackpooljsna.org.uk)), providing a current picture, identifying gaps in information and service provision, enabling goal setting and measuring progress and impact. The impact of COVID and its long term consequences on alcohol consumption, harm and access to treatment is still subject to much research.

8.1 Prevalence Estimates

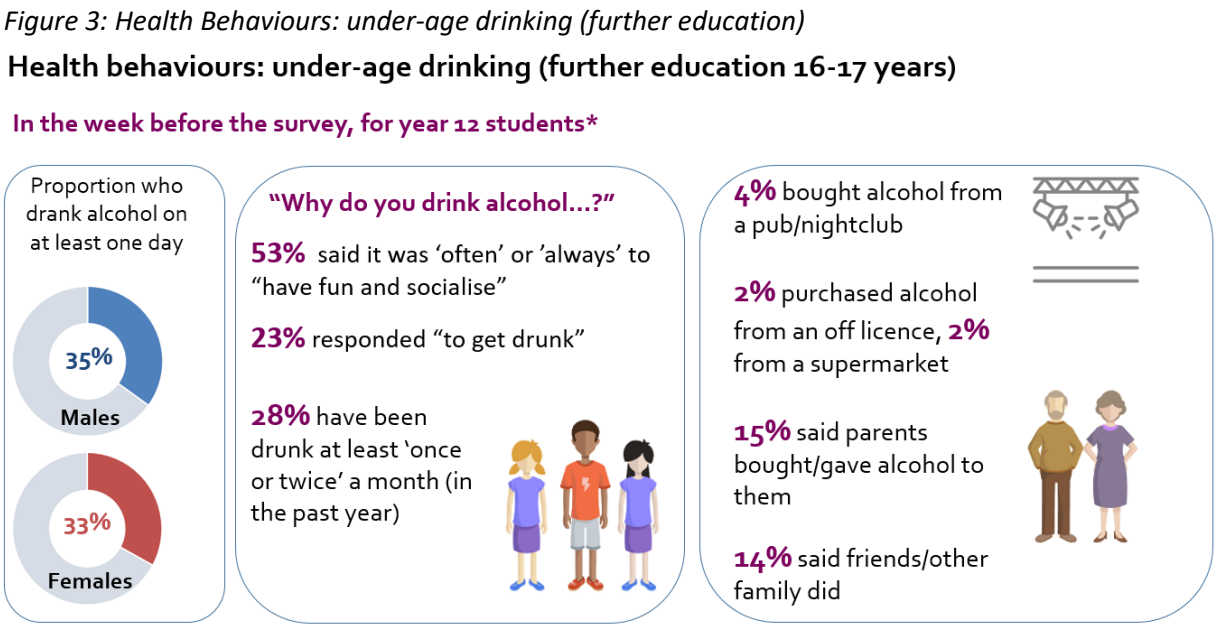
Through the bi-annual Blackpool Schools' Health Surveys we can monitor the evidence of alcohol use in young people. Alcohol consumption by young people 12 – 15 in Blackpool has remained fairly constant with 11% of young people under 16 reporting that they have been drunk at least once or twice each month in the last year, rising to 28% of 16 and 17 year olds.

Figure 2: Health Behaviours: under-age drinking (secondary school)



*There were no significant differences in the alcohol responses between the survey results from 2019 to 2022 ('before' and 'after' COVID-19). *Health Related Behaviour Survey, 2022, Blackpool secondary school pupils in years 8 and 10.*

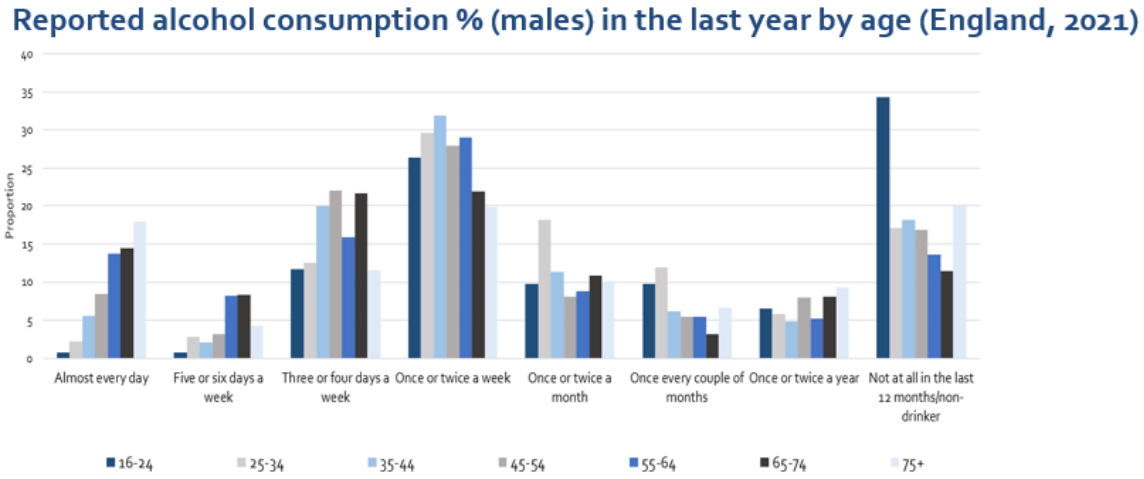
Figure 3: Health Behaviours: under-age drinking (further education)



*There were no significant differences in the alcohol responses between the survey results from 2019 to 2022 ('before' and 'after' COVID-19). *Health Related Behaviour Survey, 2022, Blackpool secondary school pupils in years 8 and 10.*

Unfortunately a similar survey is not available for adults and therefore we use nationally available estimates. In the adult population of England almost 10% of men and 5% of women report drinking alcohol almost every day.

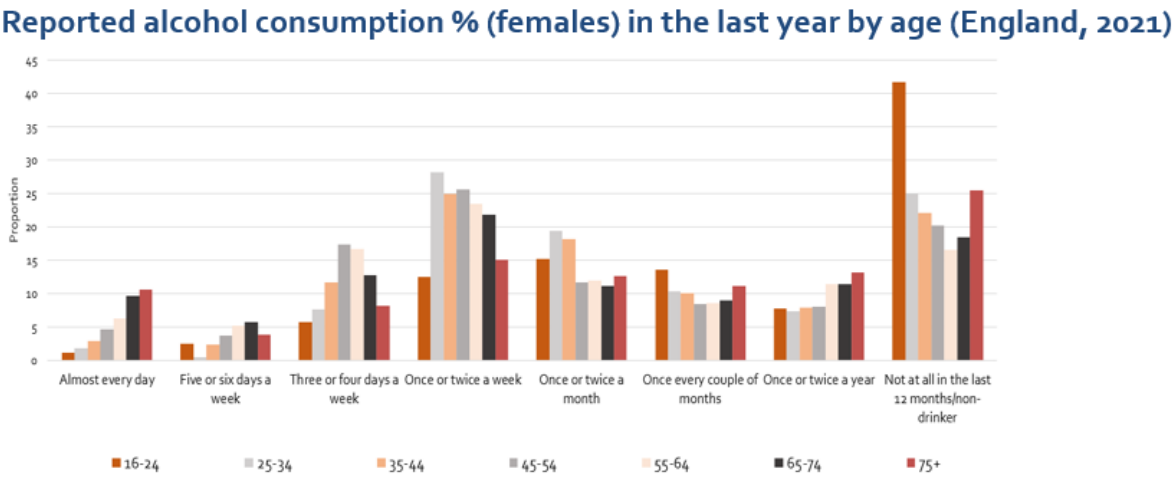
Figure 4: Reported Alcohol Consumption in Males



Men (16 and over)	%
Almost every day	8.4
Five or six days a week	4.2
Three or four days a week	16.8
Once or twice a week	27.4
Once or twice a month	11.2
Once every couple of months	7.1
Once or twice a year	6.6
Not at all in the last 12 months/non-drinker	18.3
Drank alcohol in the last year	*81.7*
At least once a week	*56.7*

Source: Health Survey for England 2021

Figure 5: Reported Alcohol Consumption in Females

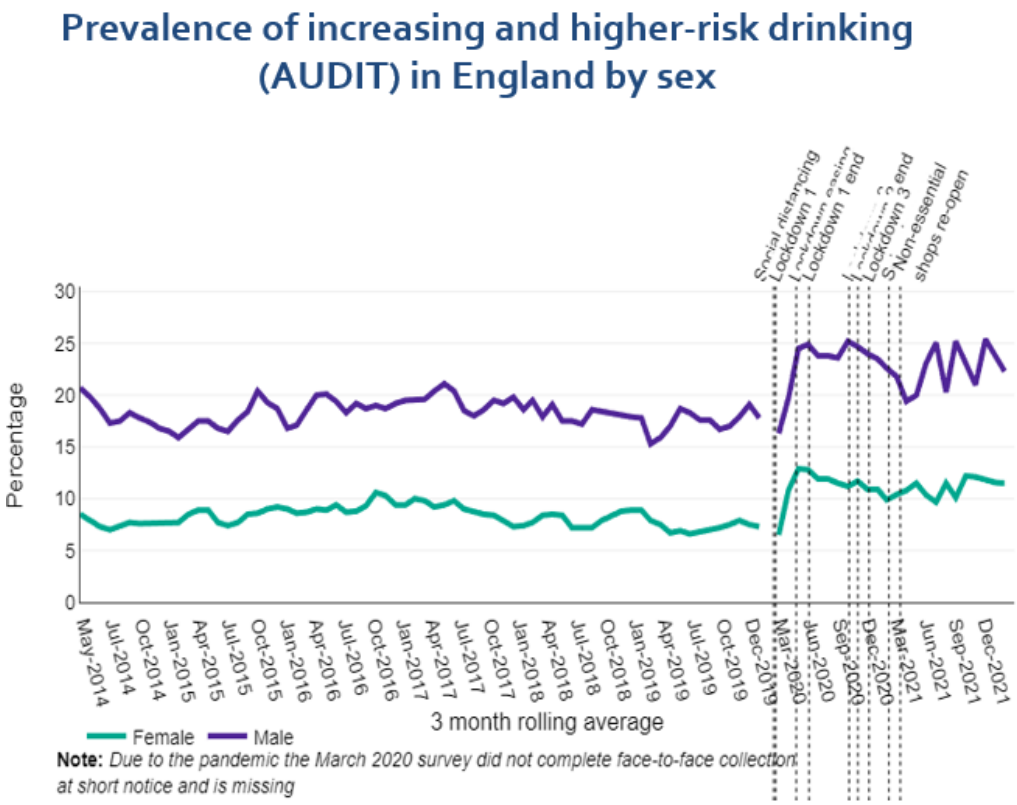


Women (16 and over)	%
Almost every day	5.1
Five or six days a week	3.3
Three or four days a week	11.8
Once or twice a week	22.4
Once or twice a month	14.5
Once every couple of months	10.0
Once or twice a year	9.4
Not at all in the last 12 months/non-drinker	23.6
Drank alcohol in the last year	*76.4*
At least once a week	*42.6*

Source: Health Survey for England 2021

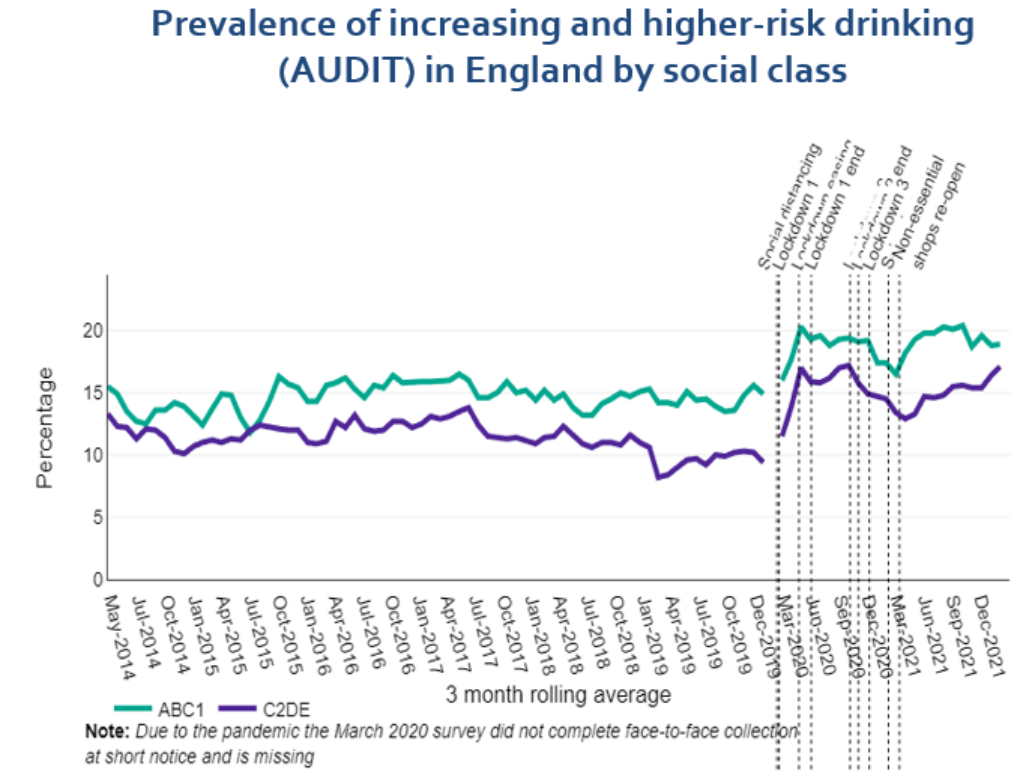
COVID has seen an increase in higher risk drinking levels. The level spiked during COVID lock downs and whilst it has fallen it has not returned to pre-pandemic levels. This information is not available at Local Authority level.

Figure 6: Prevalence of increasing and higher risk drinking in England by sex



Source: Wider Impacts of Covid on Health, Office for Health Improvement and Disparities

Figure 7: Prevalence of increasing and high risk drinking in England by social class



Source: Wider Impacts of Covid on Health, Office for Health Improvement and Disparities

Although alcohol consumption levels are not available for Blackpool, only at national level, there are indicators that would suggest that Blackpool is higher than the national average.

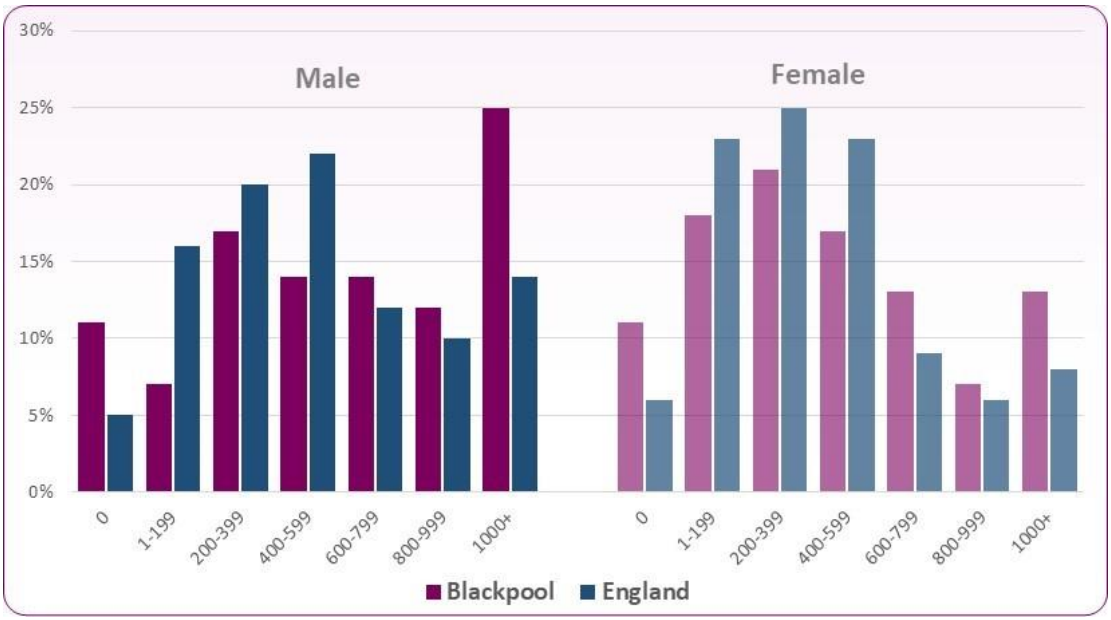
8.2 Drinking Levels

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 adults 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. For example, women are likely to become dependent at lower levels of consumption than men.

Figure 8 shows that for those entering treatment in **Blackpool**, they are drinking at significantly higher levels in the 28 days prior to commencing treatment than is seen nationally.

Figure 8: Units consumed in the 28 days prior to entering treatment, Blackpool and England 2020/2021



Source: PHE/NDTMS, Adults - alcohol commissioning support pack 2022-23: key data

Figure 9: Hospital admissions (all ages) for alcohol-specific conditions 2021/2022

Hospital admissions (all ages) for alcohol-specific conditions, 2021/22

1,220 admission episodes, equating to **1,708** per 100,000 (England **879**) (males)

545 admission episodes equating to **763** per 100,000 (England **390**) (females)

1,765 admission episodes equating to **1,230** per 100,000 (England **626**) (all persons)

All three indicators for Blackpool are significantly higher than England.

Admissions to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-specific (wholly attributable) condition. Directly age standardised rate per 100,000 population (standardised to the European standard population). Source: Local Alcohol Profiles for England

Figure 10: Alcohol-related and alcohol-specific mortality

Alcohol-related and alcohol-specific mortality

Under-75 mortality from alcoholic liver disease, 2021

36 deaths (**27.6** per 100,000) (England **11.5**)

Mortality from chronic liver disease (all ages), 2021

52 deaths (**35.4** per 100,000) (England **14.5**)

Potential years of life lost due to alcohol-related conditions (2020)

2,436 per 100,000 (males) (England **1,116**)

1,093 per 100,000 (females) (England **500**)

Alcohol-specific mortality (all ages), 2017-19

116 deaths (**27.3** per 100,000) (England **10.9**)

Alcoholic-related mortality (all ages) 2021

88 deaths equating to **124.0** per 100,000 (England **58.3**) (males)

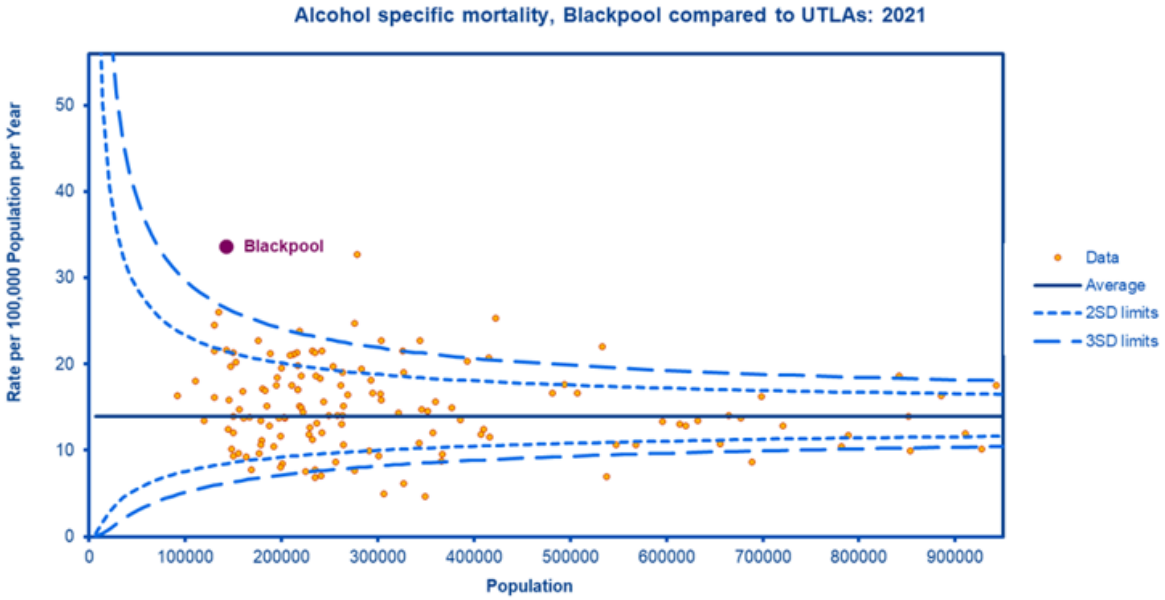
25 deaths equating to **33.7** per 100,000 (England **21.3** (females)

Alcohol-specific mortality (all ages), 2021

48 deaths (**33.7** per 100,000) (England **13.9**)

Source: Local Alcohol Profiles for England

Figure 11: Alcohol specific mortality, Blackpool compared to UTLAs 2021



Though population drinking levels are not available at Blackpool level, indicators such as units consumed before entering treatment and hospital admissions would suggest that Blackpool has a significantly higher rate of drinking, including at harmful and dependent levels, than seen nationally. As noted earlier in this strategy poverty levels in Blackpool are such that the alcohol harm paradox, whereby less affluent, moderate alcohol drinkers have a higher risk of harm than more affluent, heavy drinkers, results in even greater impact of alcohol on early death.

When understanding the alcohol harm paradox we must consider many wider determinants of health inclusive of poverty and barriers to change. Issues such as mental health, physical health and exercise, sleep disorders, nutrition, accommodation, isolation, literacy/numeracy, finances and prejudice. Therefore high drinking levels may be slightly above average, the harm is significantly greater.

8.3 Mental Health and Alcohol Use Conditions

Mental health problems are amongst the most common forms of ill health. People in Blackpool are more likely to experience mental health issues than in other areas.

The prevalence of depression, both identified by GPs and self-reported within the GP patient survey, is significantly higher in Blackpool than the England average. Blackpool's 2021/22 prevalence of GP diagnosed depression is the highest in the country at 20.6% (up from 19.8% in

2020/21), significantly higher than the national average of 12.7%. Blackpool has some of the highest antidepressant prescribing rates in England.

Problematic alcohol use can often occur with mental ill health - people may use alcohol to manage symptoms of anxiety, depression and other mental health issues, which may lead to a cycle of dependence. There are higher levels of substance misuse amongst people with psychosis. Approximately 40% of people with psychosis are reported to have misused substances at some point in their life and this is approximately double the rate seen in the general population. Alcohol use itself is also associated with psychosis e.g. occurrence of psychosis during acute intoxication. Problematic alcohol use can increase risk of self-harm, suicidal thoughts and attempts and deaths from suicide.

People with co-occurring mental health and alcohol use conditions can struggle to get the care they need from both mental health and alcohol treatment services. They may be asked to access treatment for alcohol use before accessing mental health care or the reverse. Intoxication in those experiencing a mental health crisis can also make it more difficult to access help, even though there is a higher risk of harm. National guidance outlines unmet need in people with co-occurring conditions with several recommendations for better care (PHE, 2017).

8.4 Parental Alcohol Misuse

A recent local audit by drug and alcohol services into clients in treatment showed that 286 clients (25%) had some form of parental responsibility, with 163 clients having children under 18 living with them. Not all of these clients were key worked by the drug and alcohol treatment Family Team – with their work focusing on cases where there was already some form of involvement with children's services (e.g. child in need, child protection plan) which has resulted in some duplication of responsibilities. A review into the Family Team offer has demonstrated the need to ensure extra support is offered to families at the early help stage, to prevent escalation, making better use of this resource.

Blackpool Council has a new Family Safeguarding Model and substance misuse workers will be a key part of this new multidisciplinary approach for families in need of child protection support.

8.5 Numbers in Treatment

The number of people in Blackpool accessing alcohol treatment has fallen over the last 10 years.

Figure 12: Numbers in Treatment

Alcohol treatment

394 were in treatment at specialist alcohol misuse services (people aged 18 and over, 2020/21). No comparison with England

No people were waiting for more than three weeks for alcohol treatment (England **2.0%**) (2020/21)$

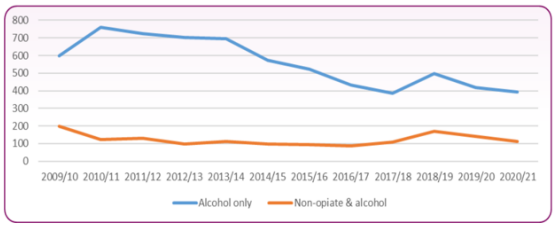
33.6% were considered to have successfully completed alcohol treatment (2021). England **36.6%**)^

13 deaths in alcohol treatment (2018/19-20/21), giving a mortality ratio of **0.88**^

38.0% of adults (18 years and over) admitted to treatment for substance misuse (alcohol) are smokers (2019/20). England **43.9%**)^

Trend in number of 'alcohol only' and 'non-opiate and alcohol' clients in treatment - Blackpool residents.

Source: JSNA



Source: PHE, Adults - alcohol commissioning support pack 2022-23: key data

Source: Local Alcohol Profiles for England

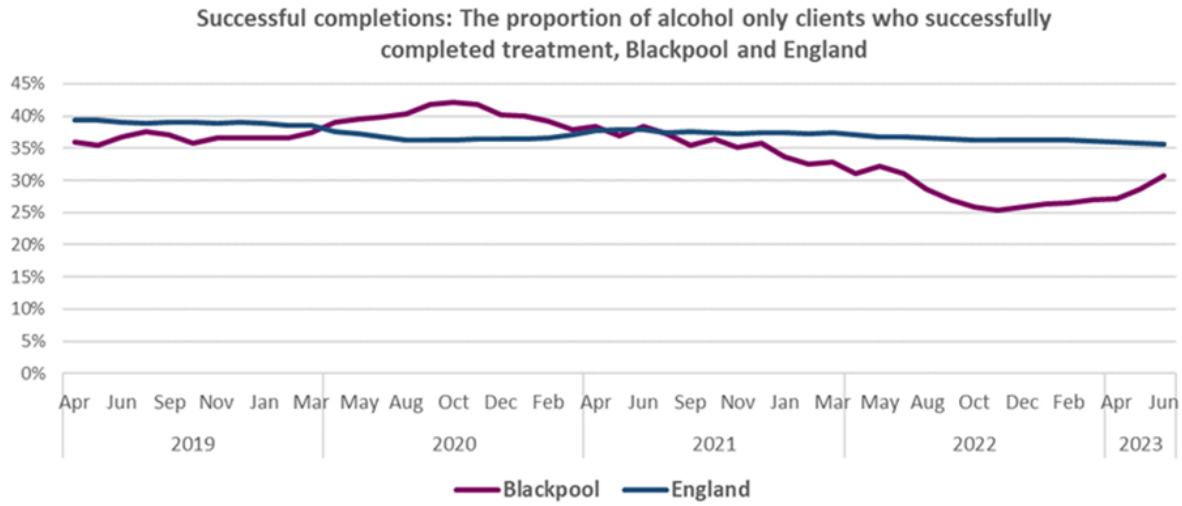
In the face of high rates of hospital admissions and deaths, Blackpool needs to see an increase in those accessing the treatment they need.

8.6 Treatment Outcomes

Treatment outcomes are the changes in condition (psychological, somatic, physical, social, and cultural) reflecting favourable effects on the patient's wellbeing.

Treatment outcomes from the local service have fallen over the past decade and dropped significantly in 2022. These are starting to improve. This may be due to the development of the standalone dedicated alcohol treatment service and also on an emphasis on improved data collection.

Figure 13: Treatment Outcomes



Treatment outcomes through evidence based mechanisms to retain patients in effective treatment, thereby improving outcomes further will be included in the action plan for this strategy.

8.7 Crime Statistics

There is a well-established complex link between drugs, alcohol and crime. Alcohol is a factor in violent crime as well as contributing to public disorder and anti-social behaviour in our communities.

In Blackpool 4.3% of road traffic collisions that resulted in casualties involved people who failed or refused a breath test. This compares to 3.6% in England.

Alcohol significantly impacts on crime levels in Blackpool.

Across Lancashire there were 9.7 alcohol related crimes per 100 000 population in 22/23. This compares to 100.2 per 100 000 people for the Claremont ward, 94.1 per 100 000 for Talbot and 66 per 100 000 for Bloomfield. Demonstrating that Blackpool wards, particularly central Blackpool,face massive harm caused by alcohol related crime.

8.8 Licensed premises (at December 2022)

Blackpool has by far the most licensed premises of any district in Lancashire-14. A fifth (1,315) of over 6,700 licensed premises in Lancashire are located within the town. Blackpool is a tourist town which can account for some of this.

- Almost half (47%) of Blackpool's full licences are held by hotels.
- There are 142 (11%) off-licences and 119 (9%) pubs.
- Almost two thirds (850) of Blackpool's licensed premises are located within Bloomfield, Claremont and Talbot.
- Excluding the three town centre wards, numbers of licensed premises range from 138 in Waterloo to 6 in Highfield.

Figure 14: Licensed Premises

	Hotel	Off License	Restaurant*	Pub	Late night refreshment house/ Takeaway	Members Clubs	Night Clubs	Convenience Store/Super market	Other	Total	% in ward
Anchorsholme	2	4	1		1			2	2	12	0.9%
Bispham	8	3	9	4	2	1		3	2	32	2.4%
Bloomfield	201	17	11	19	25	3		3	10	289	22.0%
Brunswick		6		3	2	2			1	14	1.1%
Claremont	95	17	18	18	24	3	12	1	7	195	14.8%
Clifton		9	2	3	3			2	1	20	1.5%
Greenlands		4	1	1	2			2	1	11	0.8%
Hawes Side		7	1	1	4	2		1		16	1.2%
Highfield		4		2						6	0.5%
Ingthorpe		3	3	2	1			2	5	16	1.2%
Layton		6	1	2	1	2		2	2	16	1.2%
Marton	2	5	4	3		2			6	22	1.7%
Norbreck	1	1	1	2		4				9	0.7%
Park		1						1	5	7	0.5%
Squires Gate	5	4	14	3	2	2		2	2	34	2.6%
Stanley		5	2	3		6		3	4	23	1.7%
Talbot	173	14	61	35	24	6	8	5	13	339	25.8%
Tyldesley		6	1	1	2		1	2		13	1.0%
Victoria		10	2	1	5	2		1	2	23	1.7%
Warbreck	51	7	2	5	8			4	3	80	6.1%
Waterloo	89	9	13	11	5	2		1	8	138	10.5%
Blackpool	**627**	**142**	**147**	**119**	**111**	**37**	**21**	**37**	**74**	**1,315**	

*includes Restaurant/Takaway, Restaurant/Bar, Restaurant/Café and Café Bar

Source: LCC MADE Partners Area, November 2023

9. Equality Analysis

Equality analysis allows us to consider where the need is greatest in the population and then compare this to access to services. So we can see where barriers may be faced by certain subgroups of the population. This analysis is supported by a number of surveys and research studies.

NHS Digital, Health Survey for England, 2021

https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021/part-3-drinking-alcohol#estimated-weekly-alcohol-consumption-by-sex-and-age

9.1 Age and Sex

Prevalence of drinking alcohol by age and sex

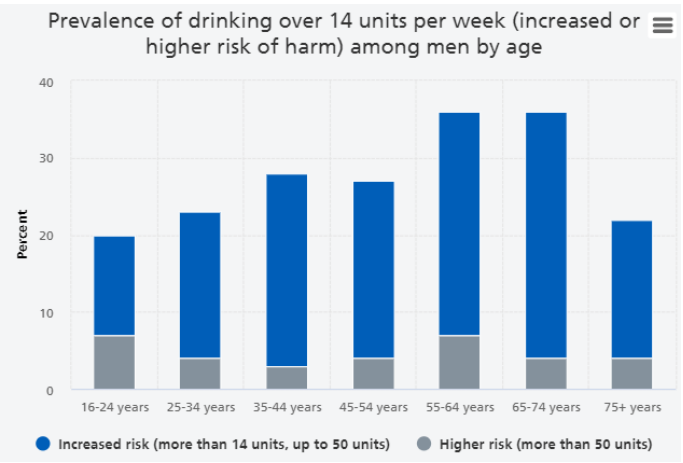
- 79% of participants reported that they had drunk alcohol in the last 12 months.
- 49% reported that they drank alcohol at least once a week.
- 57% of men and 43% of women drank alcohol at least once a week.
- The proportion who drank alcohol in the last 12 months increases with age, from 62% of 16 to 24 year olds to 85% of 55 to 74 year olds.
- The proportion who drank alcohol in the last 12 months was lower in the oldest age group (77% of those aged 75 and over).
- Those aged 16 to 24 were least likely to drink at least once a week (31%) and those aged between 55 and 64 years old were the most likely to do so (59%).

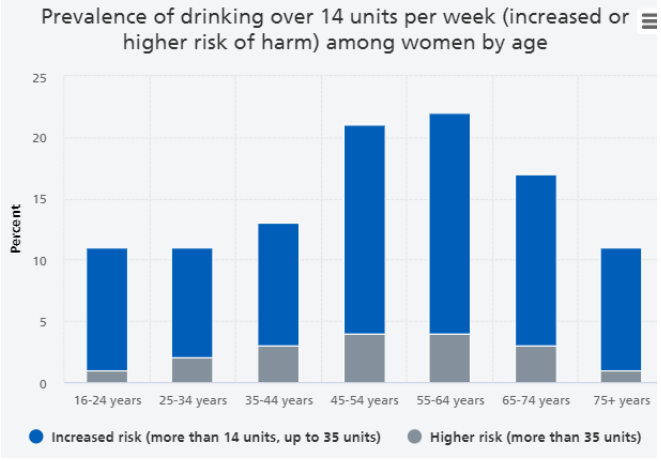
Figure 15: Prevalence of having drunk alcohol in the past 12 months by age and sex

Estimated weekly alcohol consumption, by sex and age

- 57% of adults drank at levels which put them at lower risk of alcohol-related harm, that is 14 units or less each week.
- 21% of adults drank at increasing or higher risk of alcohol-related harm (more than 14 units per week).
- Among those adults that drank alcohol, the average amount drunk was 11.6 units of alcohol in a typical week (14.7 units for men and 8.5 units for women).
- 54% of men and 61% of women drank at levels that put them at lower risk of alcohol-related harm.
- A higher proportion of men (28%) than women (15%) drank at increasing or higher risk levels (over 14 units in the last week for both men and women.
- Men were more likely than women to drink at increasing risk levels (23% and 13% respectively).
- 5% of men drank over 50 units a week and 2% of women usually drank over 35 units a week (higher risk levels) in a week.
- The proportions of men and women who usually drank more than 14 units in a week varied across age groups, increasing up to the age of 55 to 64 (28% of all adults, 36% and 21% of men and women respectively).
- The proportions drinking at these levels then declined among both sexes, from the age of 75 and above for men and age 65 and above for women. Across all age groups, men were more likely than women to drink at increasing or higher risk levels.

Figure 16: Prevalence of drinking over 14 units per week in men and women



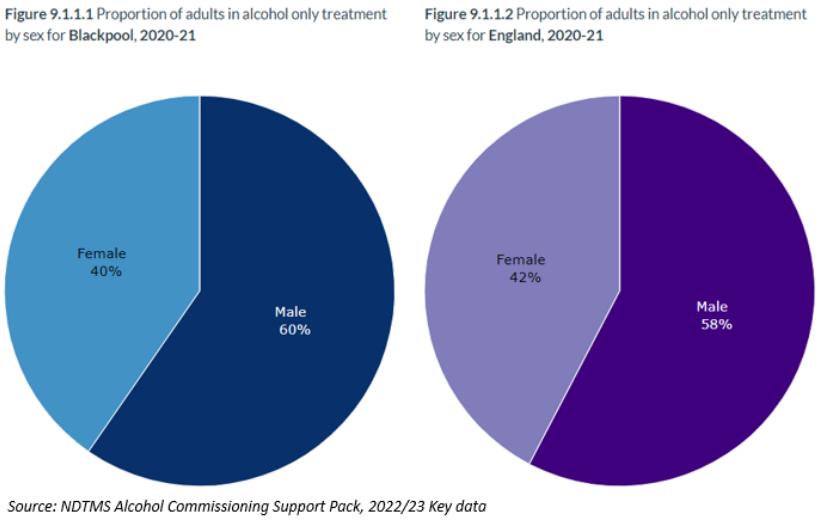


OHID, Adult substance misuse treatment report statistics 2021 to 2022 report, October 2023

https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2021-to-2022/adult-substance-misuse-treatment-statistics-2021-to-2022-report#people-in-treatment-substance-sex-age

- There were 289,215 people in contact with drug and alcohol services between 1 April 2021 and 31 March 2022.
- Over a quarter (29%) had problems with alcohol only. These proportions are similar to previous years
- More than two-thirds of people in treatment were men and less than one-third were women (67% men to 33% women).
- This proportion varies greatly by substance group. For the drug groupings, men make up just over two-thirds
- But in the alcohol only group the divide is smaller with men making up 58% and women 42%.
- Data for Blackpool shows similar proportions, men 60% and women 40%

Figure 17: Proportion of adults in alcohol only treatment by sex



- The proportion of adults in 'alcohol only' treatment is highest in the 40-49 age group for males and females.
- This is the case for Blackpool and England
- Blackpool shows more people in treatment aged under 50 years (66%) compared to England (58%)

Figure 18: Age of adults in alcohol only treatment by sex

Figure 9.1.1.3 Age of adults in alcohol only treatment by sex for **Blackpool, 2020-21**

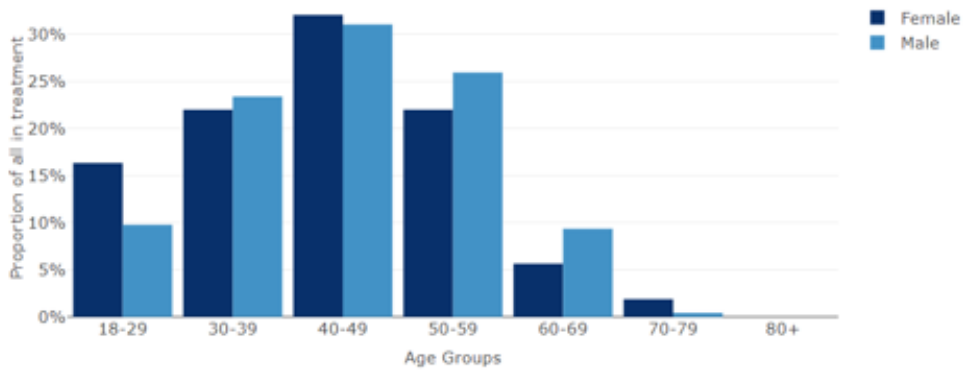
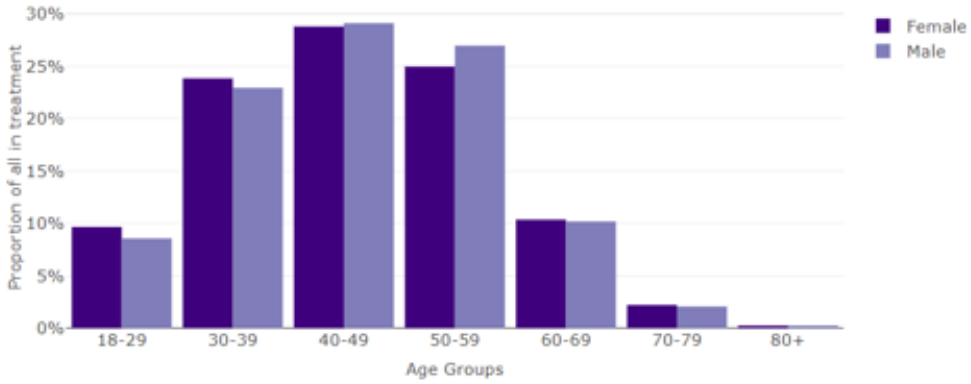


Figure 9.1.1.4 Age of adults in alcohol only treatment by sex for **England, 2020-21**



Source: NDTMS Alcohol Commissioning Support Pack, 2022/23 Key data

9.2 LGBTQ+ People and Alcohol

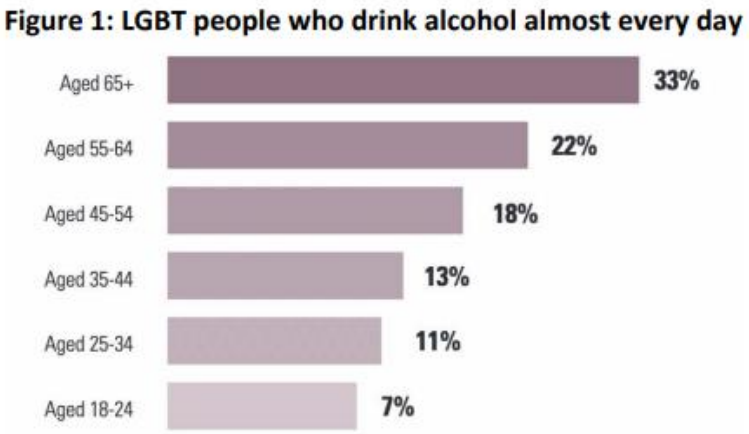
Institute of Alcohol Studies: LGBTQ+ People and Alcohol

https://www.ias.org.uk/wp-content/uploads/2021/07/LGBTQ-Briefing-Final.pdf

- Patterns in alcohol use vary among different orientations and gender identities, but overall there is a higher prevalence of hazardous drinking among the LGBTQ+ population compared to the general population, particularly among women.
- LGBTQ+ people experience around double the odds of alcohol dependence compared to the general population, and also experience a higher prevalence of mental illnesses that can co-occur with alcohol use.
- 3% of people in alcohol treatment identified as gay or lesbian in 2019-2020. Significant barriers to receiving healthcare exist for LGBTQ+ people.

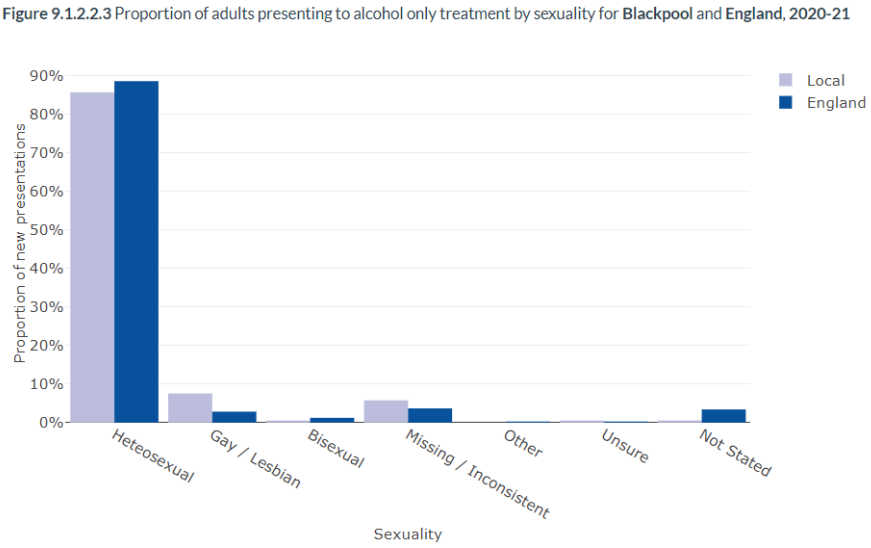
- The 2021 census shows Blackpool has 4.9% of people who identify as LGBTQ+ compared to 3.2% across England
- National data suggests LGBTQ+ women in particular have higher risk drinking patterns than heterosexual women and we have a higher LGBTQ+ population.
- Gay men were twice as likely to engage in hazardous drinking compared to heterosexual men, whereas bisexual women were three times as likely as heterosexual women to engage in hazardous drinking, indicating that LGBTQ+ women may have a greater risk experiencing alcohol harm compared to heterosexual women.

Figure 19: LGBT people who drink alcohol almost every day



- Data from NDTMS shows Blackpool has higher proportions of LGBTQ+ people accessing alcohol treatment than is seen nationally, 8% identify as gay/lesbian compared to 3% nationally

Figure 20: Proportion of adults presenting to alcohol only treatment by sexuality for Blackpool and England 2020/2021



In summary the equality analysis suggests that drinking levels increase with age peaking at 55 to 74 years. Though harmful drinking levels are higher in men, they are still significant in women. Access to treatment services does not reflect the drinking levels in the older age groups, as the largest demographic group is 40 to 49. Therefore work is needed to encourage older people into treatment.

Though access to treatment services in Blackpool is similar to the national picture it has a high prevalence of alcohol misuse along with high levels of units consumed. Although 60% of people in treatment here in Blackpool are male, recent data from our 'Lower my Drinking' app showed more women than men seeking support and advice, potentially showing that services are not as accessible and focused on the needs of women as they should be. We also have a larger than average LGBTQ+ community which also needs consideration when designing services equitably.

Overall there is a higher prevalence in hazardous drinking among LGBTQ+ populations, compared to the general population.

10. What Research and Guidance Says

A review of national and international research has been undertaken and the following summarises the evidence of who and what works in terms of alcohol policy. We have reviewed this evidence, also whether or not it was already being fully implemented in Blackpool and therefore has informed the development and prioritisation of the action plan.

Education of the Population

The Alcohol Public Health Burden Evidence Review 2016 states that although education plays an important role in increasing knowledge and awareness, there is little evidence to suggest that providing information, education and labels is sufficient to lead to substantial and lasting reductions in alcohol-related harm.

Though a popular strategy, education programmes are not cost-effective. Nonetheless, these policies increase public support and a consumer right to be better informed.

Identification and Brief Intervention

The Alcohol Public Health Burden Evidence Review 2016 states that 'Health interventions aimed at drinkers who are already at risk (e.g. Identification and Brief Advice), and specialist treatment for people with harmful drinking patterns and dependence, are effective approaches to reducing consumption and harm in these groups'.

It also summarises the settings where there is evidence for use of Identification and Brief Advice such as primary care, emergency departments and criminal justice settings, there is also some potential for workplace settings.

It goes on to say 'typically, these interventions show favourable returns on investment. However, their success depends on large-scale implementation and dedicated treatment staffing and funding streams, without which they are less effective.'

A Cochrane Review 2011 'Brief Interventions for Heavy Alcohol Users Admitted to General Hospital Wards' found that brief interventions with admitted heavy alcohol users was associated with significant reductions in alcohol consumption up to 9 months but this was not maintained at 12 months.

The interventions were also associated with a significant reduction in deaths and there were a wide variety of types and lengths of brief interventions used.

Treatment

In term of interventions to maintain abstinence a recent evidence review found that everything was in keeping with NICE guidance i.e. offering a choice of a range of psychosocial interventions and the option of combining these with pharmacological intervention.

Public Health England (now OHID) have produced a detailed examination of the effectiveness of psychological and pharmacological interventions which is essentially in keeping with NICE's recommendations.

New national treatment guidance is currently out for consultation at the time of writing this strategy.

Repeat Admissions

A qualitative study on access to alcohol treatment in England and the relationship with alcohol related conditions (2020) found that stigma around both alcohol use and around treatment services and venues were barriers to accessing treatment alongside fear of participation in groups, a lack of recognition of having a problem with alcohol and cuts to services. Outreach hubs in the community and in reach services into hospitals were facilitators.

Early intervention with YP

With regards to the overview of the Impact of PSHE Education the PSHE Association review of impact of effective practice March 2015 states that the evidence shows that personal, social, health and economic (PSHE) education (inclusive of alcohol education) can improve the physical and psychosocial well-being of pupils. A virtuous cycle can be achieved, whereby pupils with better health and well-being can achieve better academically, which in turn leads to greater success.

Women

The National Library of Medicine 2019 paper 'Alcohol and Women a Brief Overview' says there is compelling evidence that rates of alcohol use and binge drinking are increasing among women.

Also that many of the harmful health effects of alcohol use occur more rapidly and severely for women than men, 'addiction pathophysiology in stress, reward and immune pathways is sex-specific'.

They also note that while women and men appear to have equivalent outcomes in traditional mixed-gender alcohol treatment programs, treatment in specialized, women-only settings or

treatments that target women-specific issues may improve outcomes for women with alcohol use disorder and their treatment needs.

Mental Health

The NICE guidance around alcohol use disorders and interventions for conditions comorbid with alcohol is that 'for people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety.

If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, undertake an assessment of the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder'

Stigma

The Lancet Commission on Ending Stigma and Discrimination in Mental Health from October 9 2022 states:-

- Interventions based on social contact effective
- Lived experience co production effective
- Media plays a powerful role

The October 23 Government consultation on UK clinical guidelines for alcohol treatment notes that 'The World Health Organization European framework for action on alcohol 2022 to 2025 (PDF, 2.2MB) includes a priority action for healthcare services to reduce social stigma and discrimination that prevent people from accessing alcohol treatment. Services and practitioners should address policies, practices and attitudes that can contribute to experiences of stigma, ensuring people feel respected, heard, and not judged or treated differently because of their alcohol use. Physical and mental health services and social care services should not exclude people from care that they need on the basis that they have an alcohol problem.'

Regulating Availability and Marketing

The Alcohol Public Health Burden Evidence Review 2016 states that the strongest evidence for the impact of marketing comes from reviews of longitudinal and cohort studies of children, which consistently report that exposure to alcohol marketing increases the risk that children will start to drink alcohol, or if they already drink, will consume greater quantities.

While the relationship between marketing and child alcohol consumption does not directly provide evidence that limiting marketing will reduce consumption, the evidence is sufficient to support policies that reduce children's exposure to marketing.

Policies that sufficiently reduce the hours during which alcohol is available for sale such as our cumulative impact area – particularly late night on-trade sale – can substantially reduce alcohol-related harm in the night-time economy.

When simultaneously enforced and targeted at the most densely populated areas this policy is cost-effective. While there is a clear relationship between the density of alcohol outlets and social disorder, the research is more mixed for other outcomes and causation is unclear.

Tax and Price Regulation

The Alcohol Public Health Burden Evidence Review 2016 goes on to say 'taxation and price regulation policies affect consumer demand by increasing the cost of alcohol relative to alternative spending choices. Policies that reduce the affordability of alcohol are the most effective, and cost-effective, approaches to prevention and health improvement. Increased Tax and Minimum Unit Price.

The Minimum Unit Pricing Public Health Scotland conclusion is that the overall evidence supports that MUP has had a positive impact on health outcomes, including alcohol-related health inequalities.

There was no clear evidence of substantial negative impacts on the alcohol drinks industry or social harms at the population level. However MUP in Scotland reduced deaths directly caused by alcohol consumption by 13.4% and hospital admissions by 4.1%. MUP reduced consumption by 3%. There are now calls to increase the MUP to match inflation in order to continue this success.

11. Delivering this Strategy – Our Priorities

The strategy will be delivered by the Combating Drugs and Alcohol Partnership Board, a partnership of the following organisations:

- Public Health
- Licensing services
- Blackpool Business Community
- Children's Services
- Adult Social Care
- Community Safety
- Police
- Violence Reduction Network
- Probation
- Elected members
- Integrated Care Board
- Lived Experience
- Drug and Alcohol Treatment services
- Police and Crime Commissioner's Office
- Youth Justice Board
- Blackpool Teaching Hospital, NHS Foundation Trust
- Lancashire Care, NHS Foundation Trust

The stakeholder workshops held in the summer of 2023 included a prioritisation exercise. This exercise was considered by the Drugs and Alcohol Partnership Board in identifying the following strategic priorities for the Strategy:

Strategic Priority 1

Overcome the legislative barriers, such as MUP and licencing objections, that block population level change in relation to harmful alcohol consumption

What - Lobby Government to take national policy decisions that impact most on alcohol harm reduction

Why - Evidence from Scotland and from around the world demonstrates that population change can be achieved from the right legislation

How - Through harnessing the power of local politicians, Local Government Association and Faculty of Public Health to encourage Government and Civil Service to recognise the impact of alcohol across Government departments and to introduce the necessary legislation.

Strategic Priority 2

Better inform children, young people and parents about the potential harm of alcohol use in childhood.

What - Work with schools and colleges to ensure that children, young people and families receive accurate information on the potential harm caused by alcohol.

Why - To reduce the levels of drinking alcohol in our young people.

How - Provide professional expert support in the development of the curriculum delivered by our schools and colleges, along with educating parents and family members.

Strategic Priority 3

Ensure we intervene early to reduce alcohol harm in children, young people and their families.

What - More children and young people, have a childhood that is not only free form alcohol but where foundations are set for a healthier future life.

Why - So children have better childhoods and fulfil their potential.

How - By ensuring that we implement high quality evidence-based interventions in maternity, antenatal education, health visiting, early years, educational settings and the broader community.

Strategic Priority 4

Stop stigma to improve access to services when people need it and to maintain recovery.

What - We will reduce the stigma faced by people fighting alcohol dependency and those along their recovery journey.

Why - So that more people ask for help, particularly early help, increasing the numbers in treatment and helping people to achieve a sustained recovery.

How - Develop a trauma informed anti stigma campaign for substance misuse.

Strategic Priority 5

Improve the options and take up by people facing challenges in their use of alcohol for treatment, recovery and aftercare.

What - Expand the options for accessing evidence-based treatment to increase the number of people asking for and receiving help, especially amongst under-represented groups such as women.

Why - The numbers in treatment is an under representation of residents of Blackpool facing problematic or dependent alcohol use and is significantly lower than the turn of the century. Successful outcomes from alcohol treatment have fallen. We need to reverse this trend.

How - Get a better understanding through equality analysis of the take-up of services, this will involve seeking the opinion of underrepresented subgroups of the population and then co-designing service delivery.

Strategic Priority 6

Effectively identify and address co-occurring mental health and alcohol issues.

What - Ensure that the co-existence of mental health and alcohol misuse are effectively addressed after years of passing referrals backwards and forwards between services.

Why - We know that mental health and substance misuse issues frequently go hand-in-hand and both need to be addressed.

How - Agree trauma informed pathways between alcohol and mental health services, train both to effectively address the issues.

Strategic Priority 7

Reduce repeat admissions for hospital and prison.

What - To identify those in a revolving door of hospital and prison admissions and ensure we intervene proactively with them to support access to effective treatment and recovery.

Why - To reduce alcohol harm to the individual and the community, thereby reducing hospital admissions, crime and early death.

How - Review national best practice and work with stakeholders to implement new ways of working.

Strategic Priority 8

Reduce the impact of alcohol on families and the outcomes for children.

What - Ensure that support for families exposed to alcohol misuse is available and the impact of interventions are monitored.

Why - To reduce the rate of children in care and subject to safeguarding processes. Ensuring that we support the aim of families being able to stay together and safeguard their children.

How - Through the development of a shared understanding of the impact of alcohol misuse between organisations and the development of a new multidisciplinary approach.

12. Links to other Blackpool Strategies

The impact of alcohol harm is greater in disadvantaged areas than in more affluent areas, even taking account of the similar drinking levels. This is known as the Alcohol Paradox. Therefore strategies and measures to reduce disadvantage and poverty will lead to a reduction in alcohol harm.

Blackpool has a number of key strategies to promote economic development and build the resilience of Blackpool communities.

For example,

- The Levelling Up Strategy
- The Housing Strategy
- The Town Centre Strategy
- Blackpool Town Investment Plan, the Blackpool Town Deal
- Financial Inclusion Strategy

This is not an exhaustive list but is indicative of the work Blackpool is undertaking to reduce deprivation and disadvantage through economic growth.

High drinking levels are linked to wider physical and social harm. Therefore reduced alcohol misuse will then impact to positively support a range of other Blackpool Strategies.

For example,

- The Neglect Strategy
- Early Help Strategy
- Blackpool Children, Young People and Families partnership plan
- Domestic Violence Strategy
- Community Safety Strategy
- Serious Violence Action Plan
- Violence against Women and Girls Strategy
- Health and wellbeing Strategy
- Healthy Weight Strategy
- Homelessness Strategy

Again, this is not a comprehensive list but does reflect the impact that alcohol misuse has across the town and all Council directorates.

13. Key Performance Indicators

The following indicators have been agreed by the Combating Drugs and Alcohol Partnership Board as a measure of performance against the strategy:

- Age standardised rate of hospital admissions attributable to alcohol.
- Number of adults in treatment for alcohol only and non-opiates and alcohol.
- Successful completions for alcohol only and non-opiates and alcohol.
- Increase of percentage of referrals converting to registrations for treatment.

These indicators include 3 that are nationally monitored and one that uses only locally available data. The rationale in the choice of indicators is as follows.

They are short and medium term indicators and therefore appropriate to monitor within a 3 year plan.

The hospital admission indicator demonstrates if we are having an impact, not only on ensuring dependent drinkers are successfully referred to service but also that pre dependent but high risk patients are being identified earlier by the hospital and motivated to attend treatment services. Thereby reducing the burden on the hospital from repeat admissions but also improving the likely success rate of alcohol treatment. This in the much longer term would reduce deaths.

The number of adults in treatment indicator is a measure of our success in reducing barriers to accessing treatment and encouraging greater take up of help by people who are pre dependent but at increasing risk of harm. This is a key national target particularly ensuring referral and take up of services by people involved in the criminal justice system.

The percentage of successful completion of treatment (rather than drop out or death) has reduced over the past decade as fewer and more dependent drinkers access services. Therefore, increasing successful completions will demonstrate that measures to reduce drop out are working and that more pre dependent people are accessing the help they need.

The final measure depends on local data without national comparison. The increase in percentage of referrals that result in people actually registering for treatment is the key indicator that demonstrates if we are ensuring that front line workers making referrals have effectively motivated the client and that the service is responding quickly to those referrals and providing a flexible service model that people wish to access.

14. Governance

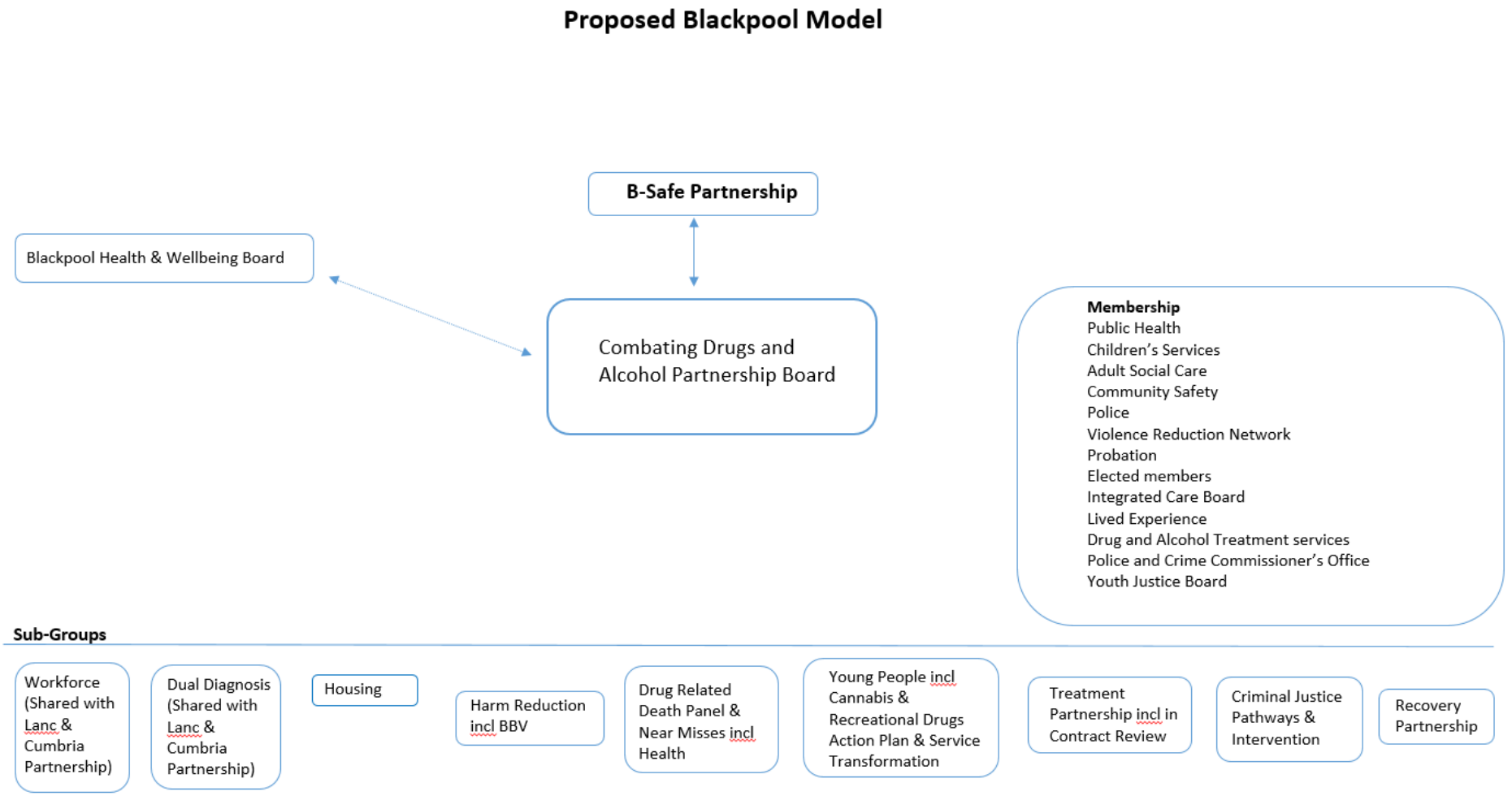
The Strategy, including outcomes, will be monitored by the Combating Drugs and Alcohol Partnership Board. This Board reports to both the Health and Wellbeing Board in relation to health improvement and Blackpool Community Safety Partnership (BSafe) for reducing the impact of crime including violent crime.

The Combating Drugs and Alcohol Partnership Board works in partnership with a number of other Committees and Boards with shared representation. Wherever possible, the Combating Drugs and Alcohol Partnership Board aims to add value to the work of these other Committees rather than duplicate work.

There are a number of existing groups that will report into the Combating Drugs and Alcohol Partnership Board and a small number of new sub-groups that will need to be established. These are outlined in Appendix 1.

The Combating Drugs and Alcohol Partnership Board will review progress against agreed metrics on a quarterly and annual basis. Key metrics will also be reported and monitored nationally by The Office of Health Improvement and Disparities (OHID) who are responsible for approving the Combating Drugs and Alcohol Partnership Board Spending Plans.

Appendix 1: Governance



Appendix 2: Alcohol Reduction Delivery Plan

Strategic Priority	Actions	To be Achieved by
Strategic Priority 1 **Overcome the legislative barrier that block population level change in relation to harmful alcohol consumption**	Continue to submit representations from Public Health on licensing applications, inclusive of new licenses and variations	On-going Public Health
	Lobby for Public Health to become a fifth licensing objective	On-going Public Health
	Advocate for minimum unit pricing across the North West and Nationally, in line with Scotland's evidence based findings	On-going Public Health
	Lobby for a ban on alcohol on TV in relation to programmes children watch, and football matches/sporting events	On-going Public health
	Support the selective licencing scheme within the 8 wards in Blackpool	On-going Licensing Trading Standards / Public Health
Strategic Priority 2	Establish a PSHE website that includes resources and guidance for schools and parents. Ensuring that this is marketed through social media. Work with Blackburn council on this approach as a similar request has been made to their Public health team.	March 2025 Public Health/PSHE Schools Forum

Better inform children, young people and parents/adults about the potential harm of alcohol use in childhood and throughout life	To create bespoke resource for alcohol education front-line workers and teachers	March 2025 Public Health
	After piloting our own a local Blackpool 'Lower My Drinking App' and evaluating its low take up. There is a need to work with other Local Authorities and OHID to explore technology to support behaviour change in pre dependent but harmful drinkers on a wider geographical footprint, with economies of scale for marketing	March 2026 OHID
Strategic Priority 3 **Ensure we intervene early to reduce alcohol harm in children and young people**	Review the evidence base for effective early help for young people	March 2026 Public Health/Young people's service
	Ensure staff involved in alcohol intervention with young people are trained in-line with the new UK clinical guidance for alcohol treatment: core elements of alcohol treatment	March 2026 Young People's service
	Develop wider workforce training, competence and skills at intervening in alcohol use with parents and young people	March 2025 Public Health Training Team
	Implement pilot group programmes in schools to tackle alcohol misuse at an early stage. Keep programmes under regular review	March 2025 Young People's service
Strategic Priority 4	All organisations to adopt a trauma informed practice approach to interventions grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development	March 2026 VRN

Stop stigma and reduce barriers to improve access to services when people need it and to help them maintain recovery	Development of a Blackpool Trauma Informed Charter Mark for all organisations to adopt	June 2024 Public health
	Undertake market research with women, older drinkers and LGBTQ+ to understand attitudes to accessing services and potential barriers which need to be addressed	December 2024 Public Health
	Following on from the market research, explore the possibility of a campaign to encourage more women, older drinkers, LGBTQ+ to access services without fear of judgement	March 2025 Public Health
	Undertake an Equity Audit re: uptake of services and successful completions, and to identify where the demographic successes lie	March 2025 Delphi Medical
Strategic Priority 5 **Improve the options and take up by people facing challenges in their use of alcohol for treatment, recovery and aftercare, adults and young people**	**Identification of people who need support to reduce their drinking:**	
	Promote the use of Audit C within Primary Care and Adult Social Care partners to identify people whose drinking levels may be reaching a level of risk	March 2026 Delphi Medical
	Work with the commissioners of Health Checks to improve the questions in relation to alcohol and improve pathway in to treatment	March 2026 Public Health
	Modernise treatment:	
	Services to be delivered in neighbourhoods, in addition to the Lighthouse	March 2025
	Increase in retention from referral to treatment through sending welcome reminders, text message touch points during the treatment journey, with a strong focus on	March 2025 Delphi Medical

	increasing successful outcomes and the people lost between referral and first appointment	
	Provide remote access treatment to help people with different needs, engage in different ways	March 2025 Delphi Medical
	Establish a Webchat system to reach people not in treatment but want to consider options	March 2026 Horizon including young people's services
	Ensure assessment processes are phased with only as much information gathered as is needed at the beginning of the treatment journey	March 2025 Delphi Medical
	Review the environment of the Lighthouse building to ensure it is a psychologically informed environment and make improvements	March 2025 Public Health/Delphi Medical
	Train all keyworkers in CBT and appoint CBT therapists within the alcohol treatment service	December 2024 Delphi Medical and Young People's Service
	Embed regular service user feedback processes to support continuous improvement	March 2025

		Horizon including young people's services
	Harm Reduction for those who are not ready to enter treatment:	
	Alcohol treatment service to provide on-going outreach work with individuals who are not at this point hoping to become abstinent or reduce drinking levels to promote harm reduction	March 2026 Horizon including young people's services
	Primary Care to consider prescribing Thiamine (B-1), to reduce the risk of Wernick-Korsakoff syndrome and other neurological consequences of harmful alcohol use	March 2026 ICB
	Ensure that the Smoking Cessation Service is effectively used as a Harm Reduction tool for drinkers	March 2025 Public Health
	Explore 'wet area' where street drinkers can gather safely, reducing antisocial behaviour, as part of the town centre re-development.	March 2026 Public Health/BID
	Supporting life-long Recovery:	
	Implement the new Recovery Model for Blackpool, including the development for a Recovery Hub	March 2025 Recovery Partnership
	Further expand peer-led and peer-delivered buddying systems	March 2025

		Recovery Partnership
Strategic Priority 6 **Effectively identify and address co-occurring mental health and alcohol issues**	Train Talking Therapies team in Assist Lite	March 2026 Public Health
	In-line with new National UK Guidelines for Alcohol Treatment, explore the potential options for providing frontline staff and volunteers in alcohol and mental health services with training on Alcohol Related Brain damage and neurodivergency.	March 2026 To Be confirmed through national guidance
	Ensure patients receiving a Severe Mental Illness health check are referred into the alcohol treatment service if alcohol issues are identified.	March 2026 ICB
	Develop a comprehensive training offer to support better care for people with co-occurring mental health and alcohol use conditions.	March 2026 Public Health
Strategic Priority 7 **Reduce repeat admissions for hospital and prison**	**Hospital:**	
	The ICB will review the role, function and effectiveness of Alcohol Nurse Liaison Service across Lancashire and South Cumbria	September 2024 ICB
	Map and improve pathways in to community treatment for people with alcohol related hospital admissions in line with recommendations from both the Peer Review and the ICB review	March 2025 ICB

	For the Alcohol Liaison Team to train all hospital staff to do identification, brief advice, and referral to ALNs when appropriate	March 2025 ICB/Alcohol Liaison team
	Criminal Justice:	
	Develop a drug intervention programme alert, to include alcohol for the police to notify to partner agencies.	March 2025 Public Health
	Development of a criminal justice prison pathway to include alcohol.	March 2025 Public Health
	Development of a criminal justice community pathway to include alcohol.	March 2025 Public Health
Strategic Priority 8 **Reduce the impact of alcohol on families and the outcomes for children**	ASSIST-Lite (Alcohol, Smoking, Substance Misuse involvement screening tool) to be rolled out to Children and Young Peoples Services	March 2026 Public Health
	Review the delivery model for Family Recovery Workers, ensuring that they target parents where early intervention and parenting support will benefit the development of children	March 2026 Delphi Medical
	Implement family safeguarding model which is a multidisciplinary approach for parents where children are subject to safeguarding support	March 2026 Children's Social care