Strategic Framework for Alcohol Harm Reduction in Lancashire

2014 to 2015
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Working in Partnership to Address Alcohol Harm Reduction

Addressing alcohol related harm is a complex issue involving a range of partners and partnership working is crucial to success in delivering change and many different organisations have an important role to play. For some, such as the NHS, the Police, Licensing and Councils representing their local communities, tackling alcohol-related harm is part of their core business; for others, there is an important role to play in designated areas of their own work. This approach has the potential to deliver added value and ultimately to reduce alcohol related harm and health inequalities across the County.

The Lancashire Alcohol Network (LAN) was established in September 2009 with the aim of providing strategic leadership to reduce alcohol related harm in Lancashire. This partnership continued under a different guise since the NHS changes which became effective in April 2013. At that time Public Health moved from the NHS (PCTs) into the three upper tier local government structures.

With the LAN now ceasing to exist there is a potential gap in. Over 20 organisations including Lancashire Constabulary, Lancashire County Council, the Unitary Authorities in Blackpool and Blackburn with Darwen, 12 district authorities, the newly established Clinical Commissioning Groups Lancashire health and wellbeing Partnerships (Lancashire only), Community Safety Partnerships, Childrens' trusts, Safeguarding Boards, local Community Alcohol Networks (CAN's), licensing, probation, voluntary sector and other alcohol harm reduction partnerships (including DAATs) make up a virtual network addressing alcohol related harm. The strategic action plan below is an attempt to introduce a high level strategic lead to influence these organisations' priorities, allowing them to concentrate on the areas that are most needed in their localities and by their audiences. This gives the potential for sharing good practice, developing work that would be better delivered on a sub-regional level and co-ordinating work to prevent duplication. It also ensures that there is a focus on alcohol related issues and associated harm across all age groups and across the pan Lancashire footprint and enhance and increase the effectiveness of prevention and public health initiatives.

This can be done by addressing the evidence based 7 High Impact Changes as key priority areas. These high impact changes are used across the NHS and local government to highlight practical measures that can be implemented at a
local level and have been calculated to have the greatest impact on tackling alcohol related harm when used in conjunction with each other.

The areas of activity are:

1. Working in Partnership
2. Developing activities to control the impact of alcohol misuse in the community
3. Influence change through advocacy
4. Improve the effectiveness and capacity of specialist treatment
5. Appoint an alcohol health worker
6. IBA – Provide more help to encourage people to drink less
7. Amplify national social marketing priorities

There is also a need to ensure that we work towards incorporating the NICE Guidance and recommendations into an action plan and other locality action plans.

1. Price
2. Availability
3. Marketing
4. Licensing
5. Resources for screening and brief interventions
6. Supporting children and young people aged 10 to 15 years
7. Screening young people aged 16 and 17 years
8. Extended brief interventions with young people aged 16 and 17 years
9. Supporting Students at our local Universities
10. Screening Adults
11. Brief advice for adults
12. Extended brief interventions for adults
13. Referral

Our aim is to - work together to minimise the health harms, violence and anti-social behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly. (Adapted from Safe, Sensible and Social 2007)

And our vision is to - To create healthier, resilient and safer communities for Lancashire citizens free from alcohol harm
This vision echo’s the WHO 2010 vision “Improved health and social outcomes for individuals, families and communities, with considerably reduced morbidity and mortality due to harmful use of alcohol and their ensuing social consequences”
**ACTION PLAN SUMMARY 2014/15**

Agencies and Partnerships may consider sign up to the actions that are pertinent and prioritised for the community which they serve.

ACC Bates has agreed to create a ‘virtual’ governance approach to progress on actions relevant to each partner and to call people together if needed only

<table>
<thead>
<tr>
<th>Reduce alcohol related ill-health and crime</th>
<th>What</th>
<th>Lead Organisation</th>
<th>When</th>
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<tbody>
<tr>
<td>Increase hospital support/alcohol liaison nurses?</td>
<td>CCG's</td>
<td>May - Dec 2014</td>
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<tr>
<td>Make treatment available in more locations</td>
<td>Public health/CCG's</td>
<td>May – Dec 2015</td>
<td></td>
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<tr>
<td>Provide a wider range of treatment pathways</td>
<td>Public health/CCG's</td>
<td>May – Dec 2015</td>
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<td>Expand night safe haven type facilities</td>
<td>Community Safety Partnerships (CSP's)</td>
<td>Dec 2014</td>
<td></td>
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<tr>
<td>Raise awareness of dual diagnosis and FASD</td>
<td>Public health Commissioners</td>
<td>Sep 2014</td>
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<thead>
<tr>
<th>Reduce alcohol related anti-social behaviour and crime</th>
<th>What</th>
<th>Lead Organisation</th>
<th>When</th>
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<tbody>
<tr>
<td>Lancashire Community Safety Strategy Group</td>
<td>Local Authorities (LA's)/CSP's</td>
<td>Mar 2014</td>
<td></td>
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<tr>
<td>Carry out multi-agency enforcement activity</td>
<td>Responsible authorities/CSP's</td>
<td>Mar 2015</td>
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<tr>
<td>Consider the use of EMRO's and evaluate, late night levies, saturation policies</td>
<td>Local Authorities/CSP's</td>
<td>Mar 2015</td>
<td></td>
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<tr>
<td>Develop the use of education as an intervention or alternative to prosecution for alcohol related offenders where appropriate</td>
<td>Police</td>
<td>Jun 2015</td>
<td></td>
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<tr>
<td>Provide treatment and advice for offenders and ensure all partners are aware of and use all available services and pathways</td>
<td>Public health Commissioners</td>
<td>Apr 2015</td>
<td></td>
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<tr>
<td>Develop appropriate alcohol domestic abuse services</td>
<td>DA teams and LA Commissioners</td>
<td>Apr 2015</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Provide a safe, enjoyable, sustainable environment for visitors and residents to improve the local economy</th>
<th>What</th>
<th>Lead Organisation</th>
<th>When</th>
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</thead>
<tbody>
<tr>
<td>Support national, develop local marketing campaigns</td>
<td>All</td>
<td>Dec 2014</td>
<td></td>
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<tr>
<td>Effectively police our night time economy areas and public spaces</td>
<td>Police</td>
<td>Mar 2015</td>
<td></td>
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<tr>
<td>Implement an alcohol settings approach</td>
<td>HR/Public health teams</td>
<td>Mar 2015</td>
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<tr>
<td>Develop alcohol champions</td>
<td>All</td>
<td>Mar 2015</td>
<td></td>
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<tr>
<td>Support and enhance community alcohol partnerships/networks</td>
<td>Public health Commissioners</td>
<td>Mar 2015</td>
<td></td>
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<tr>
<td>Support the introduction of MUP and multi-by deals ban</td>
<td>All</td>
<td>Mar 2015</td>
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Section 1  Purpose of the strategic framework

The purpose of this framework is to provide a clear, overarching context and direction for a co-ordinated approach to tackling alcohol-related harm across Greater Lancashire. The Framework will support the different activities undertaken in Lancashire at county, district and organisational levels, both within partnerships and by individual organisations.

The Public Health departments aims to direct and strengthen the positive work being carried out across Lancashire, providing co-ordination, advice and guidance to localities within a framework of best practice evidence to assist in addressing alcohol-related harm at both individual and population levels.

Section 2  Alcohol-Related Harm – Context

There is a strong case for focusing on alcohol-related harm. Nationally, the estimated cost of alcohol misuse is estimated to be around £20 billion a year. These costs are made up of alcohol related health disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace, and problems for those who misuse alcohol and their families, including domestic violence. For the NHS alone, the estimated financial burden of alcohol harm is £2.7 billion per year.¹ The estimated cost for alcohol related crime and anti-social behaviour each year is £7.3 billion, and £6.4 billion in lost productivity of workers in their work place which may result in shorter working lives. The human and emotional impact of victims of alcohol related crime costs around £4.7 billion per year for example, there are between 780,000 and 1.3 million children affected by parental alcohol problems.²

In Lancashire the total cost burden of alcohol in 2010/11 was £458 per person, 18% above the national average of £387. A breakdown of costs for Lancashire 14 can be found in the Lancashire alcohol JSNA ( www.lancashire.gov.uk/jsna/lifestyle/Alcohol/The Cost of Alcohol to the North West economy )

² Statistics on alcohol. Rachael Harker House of Commons Library 30 December 2010
The impact of alcohol misuse is so widespread in local communities that large-scale action to reduce alcohol-related harm is likely to also have a positive effect on other priorities and targets for instance:

- improving liver health
- reducing the incidence of CVD, liver disease, hypertension and some cancers
- reducing teenage pregnancy and STI incidence
- reducing the incidence of domestic violence
- reducing crime
- reducing health inequalities.

Health inequalities associated with alcohol are clearly evident, alcohol-related death rates and deprivation in England and Wales have shown a strong association, with alcohol-related death rates more than five times higher in males and more than three times higher in females for those living in the most deprived areas compared to those in the least deprived areas.\(^3\)

Since the second National strategy "Safe Sensible Social: The Next Steps in the Alcohol Harm Reduction Strategy" 2007 and "Safe Sensible Social: Further Consultation" 2008 there has been an increased focus nationally on the need to enhance the knowledge and capacity of local partnerships to tackle alcohol-related harm. As part of the Healthy Lives, Healthy People NHS reforms a proposed framework for public health outcomes and other relevant frameworks will provide the vehicle for developing outcome indicators and performance indicators for the future. This is likely to still include the rate of hospital admissions per 100,000 for alcohol-related conditions, and the mortality rate from chronic liver diseases in persons under 75 years.

Until then, some of the existing measures will still be used as an indicator of performance. In the longer term, this Strategic Partnership and the Health and Wellbeing Board's will determine the most effective way to performance manage alcohol improvement, in line with new guidance and policies.

**National Drivers**

There are a number of National Drivers for Alcohol which include:

- Alcohol: Can the NHS afford it? (RCP 2001)
- Safe, Sensible, Social: The next steps in the National Alcohol Strategy (DH 2007)
- Reducing Alcohol Related Harm – Health Services in England for Alcohol misuse (NAO 2008)
- Cutting Crime – A New Partnership 2008-11
- The Licensing Act 2003
- Police Reform and Social Responsibility Bill - March 2011
- Drug Strategy 2010
- Signs for Improvement: Commissioning interventions to reduce alcohol-related harm (DH 2009)
- Healthy lives, healthy people: strategy for public health in England (DH 2010)

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3 Health Statistics Quarterly 33 Spring 2007 Office of National Statistics
• Models of care for alcohol misusers (MoCAM) (DH 2006)
• The National Institute of Health and Clinical Excellence (NICE) has produced a set of harmful alcohol use guidelines.

  o Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence
  o Alcohol-use disorders: preventing the development of hazardous and harmful drinking
  o Alcohol-Use Disorders Clinical Management Physical Conditions
  o Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications

A number of the above drivers are either being superseded or currently undergoing change to reflect the on-going changes within the public sector. The strategy will however, put in place an outcomes-centred performance management framework that will assist us to evaluate progress against objectives and identify current gaps in alcohol improvement interventions.

**Section 3 Why alcohol-related harm reduction is important in Lancashire**

Whilst the picture is a varied one across the County, Lancashire with the rest of the UK shares a deep and increasing concern about the levels and patterns of drinking and the subsequent harms caused. At the launch of [Drinkwise North West](#), Dr Ruth Hussey commented that;

"Alcohol is having a significant impact on life across the North West. It is costing people their jobs, their health and their lives. Enough is enough. It's time to act - to work together to create a healthier, safer North West, free from alcohol harm."

**Dr Ruth Hussey, Regional Director of Public Health, North West**

**The evidence base for alcohol harm in Lancashire**

A range of evidence and information can be found within:

• The Lancashire Joint Strategic Needs Assessment (JSNA)
• Local Alcohol Profiles produced by the Public health England,
• The findings of the Big Drink Debate 2008.
• Trading standards and young people survey 2009
• British Crime Surveys
• Strategic Assessment of Crime and Disorder 2012 (refresh 2013)

The link between alcohol and crime is well established. According to the 2009/10 British Crime Survey, victims believed the offender(s) to be under the influence of alcohol in 50% of all violent incidents. Alcohol also increases the likelihood of becoming a victim of crime.

Lancashire County Council have made a commitment to help adults who are misusing alcohol to make positive life choices and to safeguard children in homes where alcohol misuse impacts on the care they received. From the health perspective, the Joint Strategic Needs Assessment identified liver disease as
one of ten goals for health equity in Lancashire\(^4\). Alcohol abuse and alcohol related violence has been identified as a top five priority or cross-cutting issue by all 14 Community Safety Partnerships.\(^5\)

The **Big Drink Debate** was an anonymous online survey which ran from May to August 2008. It was the largest survey of its type undertaken in the North West with 6,782 people responding from across Lancashire. In terms of alcohol consumption more than a quarter (26\%) of Lancashire respondents stated that they drank more that the recognised sensible levels the previous week (21 units for males and 14 units for females). 17\% of Lancashire respondents drank hazardous levels (high risk) of alcohol in the previous week and 6.2\% respondents stated that they drank harmful levels (increasing risk) of alcohol in the previous week, which is consistent with the North West. There was concern about alcohol use in the community with the biggest concerns about children drinking in the street and parks (76.7\%) and the drunken behaviour of others (73\%). More Lancashire respondents avoid town centres at night because of the drunken behaviour of others (53\%) than was average for the North West (47\%). They also perceived that there is an increase of alcohol related crime in the county compared to the rest of the North West.

The Lancashire Safeguarding Children Board in 2010 noted that the most prevalent issues in Lancashire Serious Case Reviews are alcohol abuse and domestic abuse, along with mental health. In most of the Serious Case Reviews, there was more than one issue present, and alcohol abuse, domestic abuse and mental illness were often found together.\(^6\)

**Children and Young People**

The new 2011-2013 Lancashire Children and Young People’s Plan identifies one of its priorities as ‘Resilience to risk taking behaviours’ which includes smoking, substance misuse (alcohol and drugs) and sexual health. There are 63,000 children of secondary age living in Lancashire. If we look at this in a microcosm it means that if Lancashire where made up of 100 secondary children then 80 would drink alcohol, 71 of which would binge drink and 40 of which would drink alcohol at least once a week.\(^7\)

**Alcohol and health in Lancashire**

The North West had amongst the highest alcohol-related death rates for both males and females in England for the decade 2000–09. The region currently has the second highest rate of alcohol related hospital admissions in England, and it continues to rise faster than in other regions. When comparing Lancashire with the North West, Lancashire is significantly better than the regional average for hospital stays for alcohol related harm, however when compared to the England average Lancashire is significantly worse. (LAPE Profiles)

In relation to binge drinking (adults) Lancashire is not significantly different from the regional average but again is significantly worse than the England average. However there are wide variations between

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\(^4\) Health Inequalities across the Lancashire sub-region. Part of the Lancashire Joint Strategic Needs Assessment (JSNA) Health & wellbeing of children, adults and older people

\(^5\) Lancashire Community Safety Partnership Strategic Assessment 2010/2011

\(^6\) Lancashire Safeguarding Children Board Newsletter Volume 1, Issue 1 JUNE 2010 : SERIOUS CASE REVIEWS

\(^7\) Lancashire Children and Young People’s Plan consultation report 2011 Children’s Trusts in Lancashire
and within individual districts. The most recent ‘Local Alcohol Profiles for England’ show that Lancashire is significantly worse on a number of indicators of alcohol harm than the England average.

- All local authorities in Lancashire are worse than the England average death rates for chronic liver disease. Burnley being significantly worse for both the male and female indicators with Preston and Hyndburn being significantly worse for the male indicator.
- 3 local authorities in Lancashire are worse than the England average alcohol specific mortality rates for males (Burnley, Preston and Hyndburn) with Burnley being significantly worse for female mortality rates.
- 9 local authorities in Lancashire are significantly worse than England average alcohol-related harm hospital admissions (NI39) however, Wyre, Fylde and Ribble Valley are significantly better than England average alcohol-related harm hospital admissions.
- 7 local authorities in Lancashire are significantly worse than England average admission rates for alcohol problems in under 18’s.
- All authorities in Lancashire are worse than England average for synthetic estimates of binge drinking, with 4 authorities being significantly worse (Chorley, Ribble Valley, Rossendale, and South Ribble).

**Minimum Unit Pricing (MUP)**

When the Government published its Alcohol Strategy in March 2012, minimum unit pricing was central to the objective of reducing alcohol-related disorder and health harms. This policy announcement was welcomed by charities and frontline professionals, including police and doctors, who see the devastating effects of alcohol, day in, day out. However, this was one element of the draft strategy which was dropped in the Queen’s Speech, replaced instead by a ban below cost sales of alcohol.

Minimum unit pricing is the only pricing policy tool which is evidence based and proven to be effective at a population level. Studies from Canada and the University of Sheffield verify that minimum unit pricing:

- Reduces health harms, crime and disorder and improve economic outputs
- Does not unfairly target the poorest in society. A moderate drinker would only pay 28p/week more for alcohol with a minimum unit price of 50p – and drinks bought in local pubs would not be affected as average prices are well above 50p per unit.
- A 10 per cent increase in the average minimum price of all alcoholic beverages was associated with an 8.95% decrease in acute alcohol-attributable admissions and a 9.22% reduction in chronic alcohol-attributable admissions two years later.

Additional plans to introduce alternative measures, such as voluntary local partnerships with retailers, are not supported by evidence showing that they will be effective in tackling the unacceptable alcohol harm we face.

Lancashire County Council has recently changed its position in relation to MUP, and supports its introduction as do Blackpool and Blackburn with Darwen Councils.

Appendix 1 provides further facts on MUP.

**Summary of key issues for Lancashire**

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9 LAPE Local Alcohol Profiles For England downloaded 9/2/11 www.lape.org.uk
Alcohol-related harm makes an increasing contribution to reduced life expectancy across much of Lancashire;

Hospital Admissions for alcohol related harm continue to increase

NW amongst the highest alcohol related deaths for the decade 2000-09

Silent majority - those who in their own homes, are quietly opening a bottle of wine or having a few cans each evening and over the week unknowingly drinking well above the recommended limits storing up problems for the future

Ease of access to alcohol

Some alcohol is being sold at too low a unit price

Number of crimes with an alcohol related qualifier

Accidental dwelling fires as a result of cooking whilst under the influence of alcohol

Impact of parental alcohol misuse on children is significant

Section 4  Addressing alcohol related harm in Lancashire

Context

Lancashire, incorporates the 12 districts of Lancashire County Council and the two unitary authorities of Blackburn with Darwen and Blackpool. The area is very diverse containing some of the most and least deprived areas in England.

There is a multi-layered system of delivery to address alcohol related harm in Lancashire, which is currently undergoing a number of changes, due to the public sector reorganisation.

Opportunities within the new system

Opportunities to address alcohol related harm more effectively present themselves in the new landscape which came into effect on 1st April 2013, with Public Health making the journey from the NHS to Local authority.

The approach will be local determination of work focused on what works within a national outcomes framework. Individual responsibility and community lead approaches determined by what is important to and within local communities will also be key.

These are the opportunities for a much more integrated approach:

- Across tiers of local government
- Health and Wellbeing Boards) will identify priorities for their area to include alcohol harm reduction
- The life course approach contained within government policies on health outline a holistic approach to tackling alcohol related harm; Lancashire public health service will co-ordinate health improvement services
- Work via the Health and Wellbeing Boards which have a statutory function joining up all the partners efforts and for producing a high level Health & Well Being Strategy within which alcohol harm reduction is prioritised
- CCG’s to take a more holistic approach and a responsibility for prevention
- Joining up agendas: links to sexual health, domestic violence, illicit tobacco, substance misuse, work via new Public Health Service
Population level approaches are important because they can help reduce the overall level of alcohol consumed and therefore lower the population’s risk of alcohol related harm. However, it is also important that interventions are targeted at an individual level making them aware of risks/harm of alcohol at an early stage as they are more likely to change their behaviour if it is tackled early.

**What more needs to be done?**

We need a more scaled up and systematic approach to reducing alcohol related harm in Lancashire. This includes continuing to work on the high impact changes as they are evidence based interventions.

There needs to be more work on modelling interventions and developing programmes on alcohol liaison nurses, detoxification and diversion from A&E, which aim to increase efficiency and reduce demand for health services and therefore costs to the NHS through the QIPP programme (Quality, Innovation, Productivity and Prevention).

Better community engagement is required to allow the general public and elected members to understand the issues, particularly around Minimum Unit Pricing, much more clearly.
Section 5  Action Plan

The focus of the action plan which is provided as a separate document is to bring together relevant organisations and operate a multi-agency approach to reduce the harm caused by alcohol to individuals, families and communities. By taking a collaborative approach we can all actively promote sensible drinking, lessen the harms, and make Lancashire a safer and healthier place to live.

The Action Plan, a summary above contains a range of activities, projects and tasks and is designed to address the national evidence based High Impact Changes (HIC) and incorporate the NICE guidance to ensure that activity across the County focuses on the achievement of these aims, coordinating action to maximise the impact on alcohol-related harm.

The collaborative approach will need to be taken at both Lancashire wide and local partnership levels. Local partnerships should be able to tailor their approaches to meet the particular needs and priorities of their communities in line with resources available.
Appendices

Appendix 1

Minimum Unit Price and Alcohol Factsheet

Minimum Unit Price Evidence:
Research into the effects of minimum pricing in Canada found that a 10 per cent increase in the average minimum price of all alcoholic beverages was associated with an 8.95% decrease in acute alcohol-attributable admissions and a 9.22% reduction in chronic alcohol-attributable admissions two years later. A recent paper from the same team demonstrated that a 10% increase in minimum price results in a fall in alcohol related deaths of over 30%.

University of Sheffield researchers (Sheffield Alcohol Policy Model v.2.5) found a minimum unit price of 50p in England would reduce crimes by 50,700, and after 10 years, reduce deaths by over 960 and hospital admissions by 35,100 each year.

The Alcohol Burden:

- In 2012 alcohol was 61% more affordable than in 1980 (Health and Social Care Information Centre, 2013)
- Alcohol-related crimes in the North West for 2011/12 stand at 46,700 (Local Alcohol Profiles for England, 2013)
- Alcohol related alcohol admissions in England are 1.22million (Health and Social Care Information Centre, 2013)
- Alcohol related admissions in the North West were 200,000 in 2011/12 (Health and Social Care Information Centre, 2013)
- Alcohol costs the North West over £3 billion. £644 million of these costs are to the NHS alone (Cost of Alcohol to the North West, 2012)
- These alcohol costs average £439 for each man, woman and child in the North West – the national average is only £387/head (The Cost of Alcohol to the North West Economy, 2012)
- Alcoholic liver disease admissions in the North West have risen by 85% between 2002 and 2012 (Balance, the North East Alcohol Office, 2013)
- Alcohol related alcohol admissions in England are 1.22million (Health and Social Care Information Centre, 2013)
- Alcohol related admissions in the North West were 200,000 in 2011/12 (Health and Social Care Information Centre, 2013)
- Alcohol related hospital admissions for the three former Lancashire PCT’s areas were 32,000 (2011/12) (North: 8,100; East: 11,500; Central: 12,400) (Health and Social Care Information Centre, 2013)
- In 2012 alcohol was 61% more affordable than in 1980 (Health and Social Care Information Centre, 2013)
- Alcohol costs the North West over £3billion - £644million to the NHS (Cost of Alcohol to the North West 2012)
Alcohol costs to Lancashire (county level, inc BwD and Blackpool) have been calculated at £663,610,000 (NHS: £141,920,000; Crime and Licensing: £207,140,000; Workforce and economy: £272,330,000; Social Services: £42,220,000) (The Cost of Alcohol to the North West Economy, 2012)

Alcoholic liver disease admissions in the North West have risen by 85% between 2002 and 2012 (Balance North East, 2013)