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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Tuesday, 25th January, 2011 at 10.00 am

(A pre-meeting will be held for ALL Members of the Board at 9.30 am)

MEMBERSHIP

Councillors

S Armitage	-	Cross Gates and Whinmoor;
M Dobson (Chair)	-	Garforth and Swillington;
P Ewens	-	Hyde Park and Woodhouse;
P Harrand	-	Alwoodley;
A Hussain	-	Gipton and Harehills;
J Illingworth	-	Kirkstall;
G Kirkland	-	Otley and Yeadon;
G Latty	-	Guiseley and Rawdon;
J Matthews	-	Headingley;
E Taylor	-	Chapel Allerton;

Co-opted Members (Non-Voting)

Arthur Giles - Leeds LINk
Emma Stewart - Leeds LINk

Please note: Certain or all items on this agenda may be recorded

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting.)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:- **No exempt information or items have been identified on this agenda**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATIONS OF INTEREST** To declare any personal / prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES OF THE PREVIOUS MEETING** To confirm as a correct record the minutes of the meeting held on 21st December 2010.	1 - 6
7			**HEALTHY LIVES, HEALTHY PEOPLE: THE PUBLIC HEALTH WHITE PAPER** To consider a report of the Head of Scrutiny and Member Development providing an opportunity for the Scrutiny Board (Health) to understand and comment on the national and local implications of the Government's proposed public health reforms.	7 - 26

Item No	Ward/Equal Opportunities	Item Not Open		Page No
8			**EQUITY AND EXCELLENCE: LIBERATING THE NHS - UPDATE** To consider a report of the Head of Scrutiny and Member Development providing a further update for the Scrutiny Board (Health) around the Government's overall vision for the future of the NHS initially presented in the White Paper, '*Equity and excellence: Liberating the NHS'* by introducing some additional inputs around what is currently understood of the proposals and likely implications.	27 - 48
9			**ECONOMIC AND SOCIAL COST OF ALCOHOL IN LEEDS 2008/09** To consider a report of the Head of Scrutiny and Member Development on the introduction of a paper, commissioned by NHS Leeds, which estimates the wider economic and social costs of alcohol-related harm in Leeds. The report also provides the Board with an opportunity to understand and comment on the national and local implications of the Government's proposed public health reforms.	49 - 126
10			**UPDATED WORK PROGRAMME 2010/11** To consider a report from the Head of Scrutiny and Member Development outlining the Scrutiny Board's work programme for the remainder of the current municipal year.	127 - 138
11			**DATE AND TIME OF NEXT MEETING** To note that the next meeting of the Scrutiny Board will be held on Tuesday 22nd February 2011 at 10.00am (Pre meeting for Board Members at 9.30am)	

SCRUTINY BOARD (HEALTH)

TUESDAY, 21ST DECEMBER, 2010

PRESENT: Councillor M Dobson in the Chair

Councillors P Harrand, A Hussain, J Illingworth, G Kirkland, G Latty and E Taylor.

CO-OPTEE: Mr A Giles, Leeds Local Involvement Network

56 Late Items/Supplementary Information

Reference was made to the following supplementary information circulated at the meeting:-

- Agenda Item 8 (Minute No. 62 refers) – Recommendation Tracking – Kirkstall Joint Service Centre – Update on the recommendations of the Leeds City and Regional Partnerships Scrutiny Board Review.

- Agenda Item 8 (Minute No. 62 refers) – Recommendation Tracking – Update on the recommendations of the Board's Inquiry into Promoting Good Public Health: The role of the Council and its Partners

- Agenda Item 10 (Minute No. 60 refers) – Equity and Excellence: Liberating the NHS – Update on the Government's response to the consultation around the White Paper.

- Agenda Item 10 (Minute No. 60 refers) – Equity and Excellence: Liberating the NHS – Presentation from NICE (National Institute for Health and Clinical Excellence)

None of the documents had been available at the time of agenda despatch.

57 Declarations of Interest

Councillor E Taylor made a general declaration of personal interest in respect of today's agenda, in her capacity as an NHS employee.

58 Apologies for Absence

An apology for absence from the meeting was submitted on behalf of Ms Emma Stewart, Leeds Local Involvement Network.

59 Minutes - 23rd November 2010

RESOLVED – That the minutes of the meeting held on 23rd November 2010 be confirmed as a correct record.

60 Equity and Excellence: Liberating the NHS - Update Report

Further to Minute No. 53, 23rd November 2010, the Board received an update regarding the Government's White Paper, 'Equity and Excellence: Liberating the NHS', which set out the Government's vision of the future of the NHS, and also a briefing paper on the latest White Paper entitled 'Healthy Lives, Healthy People: Our Strategy for Public Health in England'.

In attendance at the meeting, and responding to Members' queries and comments, were:-

- Councillor Lucinda Yeadon, Executive Member (Adult Health and Social Care).

- John England, Deputy Director, Adult Social Care.

- Gill Matthews, Implementation Consultant, National Institute for Health and Clinical Excellence (NICE)

In brief summary, the main points of discussion were:-

- It was reported that many of the Scrutiny Board's previous representations had been picked up in the Government's response to the original White Paper consultation exercise and also in the new White Paper on Public Health. The proposed role of the Health and Wellbeing Boards had been further clarified and strengthened and, locally, work was ongoing to initialise the local Board, including work on proposed Member training, a draft constitution and terms of reference for the Board, and a proposed workshop in February bringing together all key stakeholders. It was intended that a Shadow Board would be in place by April 2011.

- Significant uncertainties remained surrounding several key areas, including the HR implications of the proposed changes, transfers of budgets and commissioning arrangements.

- It was clear that local Health Overview and Scrutiny Committees would remain once the new Health and Wellbeing Boards were operational. It was noted that this represented a significant change to the original proposals.

- As well as representation on the Health and Wellbeing Boards from a broad political spectrum, it was also anticipated that there would be a role for Area Committees and local Member 'Health Champions' in embedding the arrangements locally.

- There was an acknowledgement of the danger of concentrating too much on the new structural and governance arrangements, important as they were, and the need for good communication and liaison with patients and carers was emphasised.

- The need for the Council to review its whole service provision ethos holistically, and to embed its new role and responsibilities, was also referred to.

- Gill Matthews gave a presentation on the role and work of NICE, both in terms of its national role, but also the role it could, and would, play locally in developing, assisting and supporting the new Health and Wellbeing Boards, e.g. the development of best practice guidelines and quality standards.

RESOLVED –

a) That the update report be noted, and a further report be submitted to the January 2011 meeting.

b) That Gill Matthews be thanked for her contribution today, and be invited to attend the proposed local stakeholder seminar planned for February 2011.

61 Health Performance Report Quarter 2 - 2010/11

The Board considered the joint Leeds City Council/NHS Leeds Health Performance Report for Quarter 2, 2010/11.

In attendance at the meeting, and responding to Members' queries and comments, were:-

- Ian Cameron, Joint Director of Public Health, NHS Leeds/Leeds City Council

- Brenda Fullard, Head of Healthy Living and Health Inequalities, NHS Leeds

- Paul Bollom, Priority Outcome Commissioner, Children's Services.

- Graham Brown, Performance Manager, NHS Leeds.

- Councillor Judith Chapman, Chair, Scrutiny Board (Children's Services).

In brief summary, the main points of discussion were:-

- Premature mortality in the most deprived areas – Ian Cameron outlined current initiatives to improve this most challenging key indicator, and responded to Members. It was suggested that the Scrutiny Board

might wish to conduct a review once the Council had assumed its new public health responsibilities, perhaps to assess existing initiatives against new expectations and priorities.

- Improvements in the infant mortality rate, and the underlying reasons for this.

- A request for statistical information to be broken down into Ward level information so that problem or 'hotspot' areas could be more easily identified. The point was made that local Ward Councillors were an invaluable source of information for anyone wanting to know details of what was happening at grass roots level.

- Problems with the former 'alcohol tracker', due primarily to data availability and patient confidentiality issues. This did not mean that tackling alcohol abuse was not an NHS Leeds priority, and a new action plan was due out in April 2011.

- Issues surrounding cancer referral and treatment times (PCT Vital Signs Indicators VSA12 and VSA13 - Page 31 of report refers), e.g. external late referrals from other Trusts, and action being taken to ensure that targets were met in Q3 and Q4.

- Teenage conception rates – Members expressed concern that there had been no improvement in this area over the past 10 years and questioned whether existing strategies were working. Councillor Chapman, on behalf of her Scrutiny Board, requested that a Joint Inquiry be established between the Children's Services and Health Scrutiny Boards, and this was agreed.

RESOLVED –

a) That, subject to the above comments, the report be received and noted.

b) That a Joint Inquiry into teenage conception rates be agreed, and the Board's Principal Scrutiny Adviser prepare a draft Terms of Reference, in consultation with the Chairs of the Health and the Children's Services Scrutiny Boards.

(NB: Councillors G Kirkland and G Latty left the meeting at 3.57 pm at the conclusion of this item.)

62 Recommendation Tracking

The Board reviewed and noted progress on the implementation of its recommendations in respect of the Kirkstall Joint Service Centre proposal and its Inquiry into Promoting Good Public Health.

A Member expressed frustration at what he regarded as the very slow progress of Council Departments and officers in embedding a public health ethos into their service delivery, in particular, in his opinion, the Development Department. He regarded that this was an issue which the Board could usefully address.

RESOLVED – That the progress reports be received and noted.

63 Health Service Direct Discharge

The Head of Scrutiny and Member Development submitted a report regarding the recent request of the Scrutiny Board (Adult Social Care) at its meeting held on 10th November 2010 that the Health Scrutiny Board should review or monitor the current Health Service Direct Discharge arrangements, especially in view of the financial implications for the Council of adults discharged directly into residential or nursing homes.

RESOLVED – That the Board's Principal Scrutiny Adviser make arrangements for this issue to be added to the Board's regular quarterly monitoring reports, in order that the Board can monitor the situation.

64 Children's Cardiac Surgery Services - National Review

The Head of Scrutiny and Member Development submitted a report seeking Board nominations to serve on a Joint Regional Health Overview and Scrutiny Committee to be consulted on a national review of Children's Cardiac Surgery Services.

RESOLVED –

a) That, in line with the Regional Joint Health Scrutiny Protocol, the following Members be nominated as Leeds City Council representatives (as required):-

- Councillors M Dobson, Peter Harrand and Eileen Taylor.

b) That the Board's Principal Scrutiny Adviser contact Board Members absent today to ascertain whether or not there are any further nominations.

65 Updated Work Programme 2010/11

The Head of Scrutiny and Member Development submitted the Board's current work programme, updated to reflect decisions taken at previous meetings.

Reference was made to earlier Minute No. 62, and the best way to address the Member's concerns. It was agreed that the Board's Principal Scrutiny Adviser should arrange a meeting between the Member concerned and the

Chairs of the Health and City Development Scrutiny Boards, and possibly the Director of City Development, to explore the concerns in more detail.

RESOLVED – That, subject to the above comments, the Board's Work Programme be received and noted.

66 Date and Time of Next Meeting

Tuesday, 25th January 2011, at 10.00 am (pre-meeting at 9.30 am).

67 Chair's Closing Remarks

The Chair wished everyone the compliments of the season, and thanked Board Members and officers for all their hard work and dedication throughout the year.

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 25 January 2011

Subject: Healthy Lives, Healthy People: The Public Health White Paper

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose

1.1 The purpose of this report is to provide an opportunity for the Scrutiny Board (Health) to understand the national and local implications of the Government's proposed public health reforms. It also provides an opportunity for the Board to comment on such proposals.

2.0 Background

2.1 In July 2010, the Government published its overall vision for the future of the NHS via its White Paper, '*Equity and excellence: Liberating the NHS'.* The Board has received and considered a number of briefings on these proposals and the likely implications. A further update on the status of these proposals is included elsewhere on the agenda.

2.2 At its meeting in December 2010, the Board was made aware that the Government's proposed public health reforms had been issued for consultation. Since that time, additional consultation papers have been issued, therefore to date, the suite of Government public health papers published can be summarised as:

- **Healthy lives, healthy people White Paper: Our strategy for public health in England** – sets out the Government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service (Public Health England) and to strengthen both national and local leadership.

- **Healthy lives, healthy people: our health and wellbeing** – summary of evidence aimed to set out the state of the nation's health and wellbeing in 2010, which has informed the development of the White Paper.

- **Review of public health professional regulation** – a report on the issue of professional regulation within public health on behalf of the Chief Medical Officers in England, Scotland, Wales and Northern Ireland. The White Paper invites views on the report, and asks a specific consultation question on this report.

- **Healthy Lives, Healthy People: transparency in outcomes - proposals for a public health outcomes framework** – explores the proposed public health outcomes framework. The consultation closes on 31 March, after which a summary of consultation responses received will be published.

- **Healthy lives, healthy people: consultation on the funding and commissioning routes for public health** – explores the proposed funding and commissioning routes for Public Health England, including the ring-fenced budget provided to local authorities. The consultation closes on 31 March, after which a summary of responses received will be published.

3.0 Health Lives, Health People proposals

3.1 A summary of the Government's proposals for Public Health is outlined in Appendix 1. A full copy of the White Paper is available on request, but can also be found at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122347.pdf .

3.2 A Scrutiny Unit briefing on public health proposals is attached at Appendix 2 and a summary produced by the Centre for Public Scrutiny (CfPS) is attached at Appendix 3.

3.3 The Joint Director of Public Health has been invited to the meeting to outline the proposals in more detail and address any questions raised by the Board. A summary of the consultation questions posed is detailed at appendix 4.

4.0 Recommendations

4.1 Members are asked to:

4.1.1 Consider and note the details presented in this report and those discussed at the meeting;
4.1.2 Determine any specific comments to make as part of a stand alone or combined consultation response; and,
4.1.3 Identify any specific matters that require further scrutiny and/or are to be included on the Board's future work programme.

5.0 Background Documents

- Public Health White Paper – *Healthy Lives, Healthy People: Our strategy for public health in England* – 30 November 2010

HM Government

HEALTHY LIVES, HEALTHY PEOPLE: THE GOVERNMENT'S PLANS FOR PUBLIC HEALTH

This leaflet explains our plans for helping people lead healthier lives, and how you can have your say about them.

What is public health?

Public health is about everything society does to prevent people getting ill, rather than treating sickness. We take for granted the huge advances in public health made in the past. Dirty water, hunger and infection are no longer major killers here.

On average, people in England are healthier and live longer than ever before. Nowadays "diseases of lifestyle" like heart disease, obesity and depression are the issue. Smoking, drinking, lack of exercise and poor diet play a big part.

What is the problem?

Poor health is still a big problem. It shortens and damages people's lives, harms our economy and puts a huge burden on the NHS and taxpayers. Much of it can be prevented, and many of the root causes are social.

This is about how we live our lives, but also about our position in society. Rich people live longer and have better health than poor people. Low income, unemployment, loneliness and discrimination are bad for people's physical and mental health. As a society we have focused a lot on cure and not enough on prevention. We need to do better.

Who should do what?

The health of the nation is everyone's responsibility.

The government must make sure we have high quality health services and that we prepare for health emergencies like flu epidemics and chemical spills. The government is also in charge of other policies that affect health such as housing, jobs, welfare benefits, pensions, transport, environment and education.

The government cannot force people to live healthy lives. People can be helped and encouraged to make healthier choices. Local communities working together, and with a good understanding of human behaviour, will achieve more than extra laws and lectures from the government. Local councils have a critical role to play. Business and industry such as the food

and drink industry has a big responsibility to help us make healthier choices by encouraging healthier eating and sensible drinking.

What will change?

A new service called Public Health England will bring together the things that have to be done at national level, such as preparing for emergencies. From 2012, Public Health England as part of the Department of Health will have responsibility for protecting the health of the population.

From 2013, councils will be responsible for public health in local areas. Their job will be to help improve people's health, particularly those with the worst health. Directors of Public Health will be in charge of this work, in partnership with the NHS, local communities, charities and businesses. It makes sense for councils to have this duty as they are already in charge of many things that affect health.

Councils where people's health is worst will receive more money than other areas where health is better as they have more to do. Councils will be rewarded with extra funds for some of the improvements they make in people's health.

Unlike in the past, funding for public health will be identified as a separate budget so that the government and councils will only use this for public health.

Your GP will also be asked to play a bigger part in preventing ill-health, not just treating sickness.

The Government will work with the business and industry (including food, drink, leisure and lifestyle) through a voluntary Public Health Responsibility Deal. The government will look at a range of ways to encourage business and industry to have a more positive impact on health before considering more laws and regulations.

What will this mean for……?

Parents, children and young people

- A good start in life is vital for health. The government aims to end child poverty by 2020. We will increase the number of health visitors, and provide extra support for families most in need, including through Sure Start Children's Centres.
- We will encourage employers to make it easier for mothers to breast-feed at work.
- There will be a new school sports competition linked to the Olympics.

Older people

- We will continue to offer NHS health checks to people aged 40 to 74.
- There will be local schemes to help and encourage older people stay fit and active, enjoy their environment and live independently at home.
- There will be more support for carers.
- We will improve living standards by increasing pensions in line with inflation or average earnings (whichever is the higher).

Local communities and the environment

- There will be local schemes to encourage more walking and cycling
- There will be new protections for public green spaces to encourage recreation, community activities and food growing.

Smoking

- We will keep the current smoke free laws.
- It will be illegal to sell cigarettes and tobacco from vending machines after 1 October 2011.
- The government is looking at other options, including whether cigarettes should be sold in plain packaging. It will publish a tobacco control plan shortly.

Alcohol

- There will be tougher penalties for clubs, bars and pubs and shops that sell alcohol to children or contribute to alcohol related crime and anti social behaviour.
- There will be tougher controls on selling cut price alcohol.

Have your say

This is only a summary of our plans; you can find more detail at

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

We want to hear your views and suggestions. Please make your voice heard and contact us by 8 March 2011.

This leaflet applies to England only. It has been produced by the Department of Health and put into plain English with the help of the health and social care charity National Voices.

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HEALTHY LIVES, HEALTHY PEOPLE – THE PUBLIC HEALTH WHITE PAPER

Leeds CITY COUNCIL

Scrutiny Unit Briefing Note – Scrutiny Board (Health)

Purpose

1. To provide an outline of the most recent NHS reforms set out in the White Paper of public health – *Healthy Lives, Healthy People: our strategy for public health in England* and consider the proposals in the context of the previous health White Paper – *Equity and Excellence: Liberating the NHS* and supporting suite of consultation documents.

Background

2. In July 2010, the Government set out its vision and radical reforms for the NHS through its White Paper – *Equity and Excellence: Liberating the NHS* and supporting suite of consultation documents. The proposals include a significantly enhanced role for local councils in assessing local needs, promoting integration and partnership working, and supporting joint commissioning and pooled budget arrangements. It also proposed a transfer of public health and health promotion responsibilities to local councils.

3. The White Paper – *Healthy Lives, Healthy People: Our strategy for public health in England (30 November 2010)* – expands on the Government's previously outlined proposals around public health responsibilities, which are summarised in more detail below.

Main considerations

Overview

4. The White Paper outlines the government's vision for pubic health being a higher priority area with dedicated resources. It complements another consultation document: *A Vision for Adult Social Care: Capable Communities and Active Citizens,* which emphasises more personalised and preventative services and also forms the government's substantive response to the Marmot Review, outlining a commitment to:

   - protecting the population from serious health threats;
   - helping people live longer, healthier and more fulfilling lives; and,
   - improving the health of the poorest, fastest.

5. In this regard the Government is seeking to build on evidenced base approaches to improving health, with a proposed focus on improving health through the life course, as follows:

   - Starting well – giving children the best start in life
   - Developing well – delivering better outcomes for children and young people
   - Living well – encompassing all of the factors that contribute to heath such as housing, transport, planning and the natural environment
   - Working well – promoting work as providers of good physical and mental health
   - Ageing well – helping people to live longer, more active and healthier

6. The White Paper also proposes a new approach to public health that will aim to address the root causes of poor health and wellbeing, based on being:

   - **Responsive** – owned by communities and shaped by their needs
   - **Resourced** – with ring-fenced funding and incentives to improve
   - **Rigorous** – professionally-led and focused on evidence; efficient and effective
   - **Resilient** – strengthening protection against current and future threats to health

7. The White Paper comments on the achievements of public health services and outlines the overall health inequalities agenda alongside some of the specific current-day public health challenges, including;

   - Maternal health;
   - Children's health and development;
   - Better physical and mental health; and,
   - An increase in emphasis on preventing ill health (preventative services).

8. There is a clear intention for councils to regain a leading role in improving, promoting and protecting the health of local communities. From April 2013, it is proposed that upper-tier and unitary local authorities will have enhanced freedoms and responsibilities to improve the health and wellbeing of communities and reduce health inequalities.

9. Furthermore, aspects of the White Paper suggest an increased emphasis on localism – acknowledging the breath of local government activity that can have a direct influence on public health outcomes. This includes a commitment from the Home Office to overhaul the Licensing Act 2003, to give local authorities and the police stronger powers to remove and refuse licenses.

Partnership Working and Accountability

10. The White Paper builds on the previous proposals to establish statutory local Health and Wellbeing Boards – stating that, subject to Parliament, Health and Wellbeing Boards will be statutory in all upper-tier authorities, with a proposed minimum membership of:

    - Elected representatives
    - GP Consortia
    - Director of Public Health
    - Director of Adult Social Services
    - Director of Children's Services
    - Local HealthWatch; and,
    - NHS Commissioning Board (participation where appropriate).

11. Local Health and Wellbeing Boards are clearly seen as the main vehicles to bring together key elected representatives with NHS, public health and social care leaders: With the main purposes of such Boards being to:

    - Establish a shared local view about the needs of communities; and,
    - Support joint commissioning of NHS, social care and public health services to meet such need.

12. Health and Wellbeing Boards will be responsible for making arrangements for the production of the local Joint Strategic Needs Assessment (JSNA) – with GP consortia and local authorities (including Directors of Public Health) each having equal and explicit obligations for its preparation.

13. As such, and in line with the Government's previous proposals outlining the vision and reforms for the NHS, it appears highly probable that Leeds City Council will be required to establish a local Health and Wellbeing Board. It is likely that this will be required to be established in shadow form for April 2011.

14. In addition, local authorities will be free to take joint approaches to public health where it is believed to offer the best approach to tackle health improvement challenges. Consequently, consideration of appropriate regional and sub-regional arrangements may also be necessary.

15. Nonetheless, it will be important for the Council to be fully accountable to its local population for its record on health improvement and health inequalities. The full and proper involvement of locally elected members will be a key aspect in this regard and it will also be important for all staff working in its public health function, including the Director of Public Health (DPH), to be properly and fully accountable to the Council. As such, the transfer of public health responsibilities and staff to the Council is likely to create a number of complex employment issues, which will need to be managed effectively.

16. However, the full impact of the NHS reforms and the Council's enhanced role on current local partnership arrangements are yet to be finally confirmed and, therefore, the practical implications will need to be worked through. Key considerations associated with the new Health and Wellbeing Board are likely to include:

    - How the new arrangements will complement / replace current partnership arrangements;
    - Support and governance arrangements; and,
    - Decision-making processes.

    Some consideration of the above is outlined in the Executive Board report – xxxx – due to be considered on 15 December 2010.

    National Public Health Service

17. A new national integrated public health service, Public Health England (PHE), is also proposed. The purpose of this service will be to ensure excellence, expertise and responsiveness – particularly around emergency preparedness and health protection, bringing together what is described as a 'fragmented system'. However, it is also unclear how the centralisation of functions into PHE supports the otherwise localist vision of the White Paper.

    Budget allocation

18. The overall Public Health ring-fence budget is suggested to be in the region of £4 billion, however this estimate will be revised as the detailed design of PHE develops and more information is gathered around existing services and spend. Nonetheless, it is unclear how much of the ring-fenced budget will support the work of PHE and how much of that will filter down to local authorities for delivery of this important agenda for which they are going to be held responsible.

19. PHE will be responsible for allocating ring-fenced budgets to upper-tier and unitary authorities, weighted for inequalities and asking the NHS Commissioning Board to commission specific services and elements of GP contract. PHE will also commission or provide services directly – such as national purchasing of vaccines.

20. Within the overall public health budget, a new health premium is also proposed, which will form part of the local public health budget for health improvement. Initially targeted towards areas with the worst health outcomes and most need, the Council will receive an incentive payment (or premium) that will depend on the progress made in improving the health of the local population.

21. Further specific details around public health funding and the outcomes framework are due out before the end of 2010, however it is already clear that to support this enhanced role, it will be vitally important that councils have sufficient financial and human resources, along with the freedom and flexibilities to determine how they are deployed locally.

Summary and conclusion

22. While the most recent White Paper is wide-ranging in its proposals, further details on a number of issues are still outstanding. Without these details it remains difficult to have a completely clear picture of the proposed new public health landscape and the role of the Council within it. The outstanding details include:

- the outcomes framework for public health (covering 5 broad domains of public health);
- more precise details of public health funding; and
- 10 further consultation documents on specific aspects of health improvement and health protection.

23. That said, the details in the White Paper add to what has previously been proposed in terms of NHS reforms. As such, it is perhaps worthwhile to consider and restate some of the identified key milestones:

Key date		**Reform**
During 2011	–	Establish Public Health England (in shadow form) within DH
April 2011	–	Arrangements in place to support Health and Wellbeing boards (in shadow form).
	–	Begin transformation of patient Local Involvement Networks into local HealthWatch
	–	Begin to establish GP commissioning consortia in shadow form
	–	Re-focused carers' strategy
October 2011	–	White Paper on sustainable funding and legislative framework for social care
April 2012	–	new statutory functions of local authorities come into effect: Health and Wellbeing Boards in place
	–	Public Health England in place

Key date		Reform
April 2012	–	local health improvement led by Directors of Public Health in local councils: Ring-fenced budget in place
	–	NHS Commissioning Board fully established
	–	Formally establish GP commissioning consortia
	–	HealthWatch launched (nationally)
Autumn 2012	–	NHS Commissioning Board makes allocations to GP consortia for 2013/14
2012/13	–	Shadow public health grant allocations to local government
April 2013	–	Strategic Health Authorities (SHAs) abolished
	–	Primary Care Trusts (PCTs) abolished
	–	GP consortia take full responsibility for commissioning
	–	Upper-tier and unitary local authorities to have enhanced freedoms and responsibilities to improve the health and wellbeing of communities and reduce health inequalities
2013/14	–	Complete transition of all NHS trusts to Foundation Trust status

24. The above timeline outlines some of the major NHS reforms and provides an indication of some of the significant challenges likely to affect the Council and its partners across the local health economy. As such, local councillors are likely to want to know, and arrangements will need to be put into place to advise, how members will influence:

    - the local transition to the new arrangements?
    - appropriate outcome measures for commissioners and providers?
    - how well GP Commissioners evaluate whether the services they commission meet local needs and change services that don't meet needs?
    - the effectiveness of Health and Wellbeing Boards as co-ordinators of healthcare, social care and health improvement?
    - the NHS Commissioning Board, especially around regional and specialist services?
    - the development and support of an effective local Healthwatch?
    - key relationships: For example, between the Council and the Care Quality Commission and between local Healthwatch and national Healthwatch?
    - the experience of patients and carers and the quality and safety of services?
    - the influence local people have to develop options for changes to services?
    - the process for assessing service reconfigurations?

25. It has recently been reported that the anticipated draft Health and Social Care Bill will be published during January 2011: However, irrespective of the final proposals, it appears clear that greater local public accountability will be a significant feature. As such, continuing to build on existing relationships and developing new ones will be essential – in particular the relationship between locally elected members and the emerging local GP consortia.

Steven Courtney
Principle Scrutiny Adviser

December 2010

APPENDIX 3

The Centre for Public Scrutiny
Healthy Lives, Healthy People – White paper summary

Introduction

A link to the Public Health White Paper 'Healthy Lives, Healthy People' and supporting documentation, published on 30th November 2010, is:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

The White Paper sets out in more detail the Coalitions aspirations for public health, following the announcement of its intentions for healthcare in Equity and Excellence: Liberating the NHS and is published with certain assumptions about the passage of the Health Bill due before the end of the year. This summary is not a critique of every proposal – it is intended to summarise the key issues falling out of the white paper and to identify key themes that will be of interest to councillors serving on overview and scrutiny committees.

The White Paper is wide ranging, however there are some areas that are to be filled with further details and consultation. For example, documents that will set out the proposed public health outcomes framework, and funding and commissioning arrangements will follow in 2011, as too will 10 documents relating to health improvement and protection.

This document sets out:

- A summary of the key proposals
- CfPS initial reaction
- Questions that Councillors might want to ask
- Next steps in the response

Summary of key proposals

Public Health Locally

- For the first time in a generation, local government will be given the responsibility for public health, backed by ring-fenced budgets and new freedoms, to make a major impact on improving people's health and tackling health inequalities in every community.

  Services currently provided by Primary Care Trusts and Strategic Health Authorities will be *transferred to local authorities from 2013.*

- *Directors of Public Health (DsPH) will also transfer to local government* where they can bring together work across education, health, transport, leisure and communities through new health and wellbeing boards (opening the door to more effective tackling of health issues with a focus on the wider social determinants of health). They will be jointly accountable to the LA and Public Health England (a new national public health service).

- DsPH will have a *ring-fenced budget*, and a new *health premium* rewarding progress on key outcomes and tackling health inequalities.

- The White paper describes a radical new approach in improving the health of the population – this new approach will empower individuals to make healthy choices and will give communities the tools to meet their own health needs.

- The Government has reaffirmed its intention to create new Health and Wellbeing boards (H&WB). The comments gathered in the Equity and Excellence White Paper consultation were broadly supportive of the establishment of H&WBs, however what is interesting is the acceptance that more work is needed to develop "clarity of accountability". It proposes that H&WBs will:

    - Be established in every *upper tier or unitary local authority* – but they will also have the flexibility to bring in the local expertise of district councils
    - Will bring together the key NHS, public health and social care leaders in each local authority area to *work in partnership*
    - Have a *proposed minimum membership* of elected representatives, GP consortia, DsPH, Directors of Adult Social Services, Directors of Children's Services, local HealthWatch and, where appropriate, the participation of the NHSCB. However local areas will be able to expand membership to include the voluntary groups, clinicians and providers.
    - *Local authorities*, including DsPH, will each have an *explicit obligation to prepare the Joint Strategic Needs Assessment* (JSNA), and to do so through the arrangements made by the health and wellbeing board**.**
    - Develop a *shared local view* about the needs of the community and support joint commissioning of NHS, social care and public health services in order to meet the needs of the whole local population effectively.

- Local authorities will have *new powers* to remove licenses from bars and clubs to deal with problem drinking cultures.

Addressing health and well being throughout life

- Closely linked to the recommendations within the *Marmot Review 'Fair Society, Healthy Lives'* the Government is seeking to build on evidenced based approaches to improving health. A notable feature is improvement of health through the life course:
    - *Starting well* – giving children the best start in life
    - *Developing well* – delivering better outcomes for children and young people
    - *Living well* – encompassing all of the factors that contribute to heath such as housing, transport, planning and the natural environment
    - *Working well* – promoting work as providers of good physical and mental health
    - *Ageing well* – helping people to live longer, more active and healthier

Public Health Nationally

- The White Papers announces the establishment of a new, dedicated and professional public health service – *Public Health England* (PHE) within the Department of Health. It will bring together parts of the current public health system delivered by the Health Protection Agency, the National Treatment Agency, the regional DsPH and others, which will strengthen the national response on emergency preparedness and health protection, and provide a strong hub for evidence, information and evaluation, supporting local efforts.

  Its role will include:
    - Providing public heath advice, evidence and expertise to the Secretary ofState

- Delivering effective health protection services;
- Commissioning or providing national-level improvement services
- Jointly appointing DsPH and supporting them through professional accountability arrangements:
- Allocating ring-fenced funding to local government and rewarding them (via the Health Premium) for progress made against elements of the proposed public health outcomes framework;
- Commissioning some public health services from the NHS
- Contributing internationally-leading science to the UK and globally.

PHE will be responsible for funding and commissioning of number of health protection, prevention and emergency preparedness services.

- Top-down targets will be replaced by a new *strategic outcomes framework*, focusing effort where it can make the most difference.

- Public Health remains important to Government but it is keen not to tell people what to do. Therefore it proposes a 'ladder' of interventions to determine the least intrusive approach necessary to achieve the desired effect and aim to make voluntary approaches work before resorting to regulation.

- Working in partnership with industry and the voluntary sector through the *'Public Health Responsibility Deal'* to tackle the challenge to public health. This will be launched in 2011 and will include the establishment of five networks on food, alcohol, physical activity, health at work and behaviour change.

Conclusion

The White Paper

- Further develops the Governments commitment to localism by proposing a radical change in the way that Public Health is delivered.
- Begins to describe the new public health world – and this will be developed further with additional consultation papers
- Presents opportunities for Local Authorities to take the public health reigns and are welcomed providing that there is sufficient funding and capacity to help them to deliver the expectations
- Continually refers to transparency and accountability. The Government also seems to have taken notice of the responses it received to the recent consultation on the Health White Paper Liberating the NHS 'Equity and Excellence' – with the new White paper seeking clarity of accountability in the system between local government, GP Consortia and others
- Such a radical change could present a dip in services that are provided as staff work through new structures etc. Local Authorities, will need to be resilient and support a maintained focus on improving health.
- There are opportunities to link together transparency, involvement and accountability at local and national level

APPENDIX 3

CfPS - initial reaction to the white paper

The Centre welcomes the Government's recently published White Paper 'Healthy Lives, Healthy People', which is proposing to hand local councils responsibility for public health, giving them the opportunity to have a major impact on improving local people's health and tackling health inequalities.

There are a number of issues that will affect Overview and Scrutiny functions; however the most important issue for OSCs is the reaffirmation of the intention to create local Health and Wellbeing Boards, and the desire to clarify accountability arrangements.

The White paper described a radical new approach in improving the health of the population – this new approach will empower individuals to make healthy choices and will give local communities the tools to meet their own health needs.

Tim Gilling, Deputy Executive Director, CfPS says:
"It is good to see that transparency and accountability are threaded throughout the white paper. We are delighted that there is an ongoing commitment to these fundamental principles that CfPS holds in high regard.

"It is also pleasing to note that the Government seems to be responding to messages it heard during the recent consultation on 'Equity and Excellence' – with the latest white paper seeking "clarity of accountability" between councils, GP Consortia and other partners.

"Over recent months CfPS has been promoting the role and function of scrutiny, accountability and transparency - I look forward to reviewing how "clarity" will be achieved when the full response to the consultation is published".

For the past 18 months we have been developing a programme looking at creative ways of using scrutiny to tackle Health Inequalities. The 10 Scrutiny Development Areas involved in this programme, have developed imaginative and transferrable models of scrutiny that will be available to other local authorities and their partners when the programme is launched in February 2011. The outputs of the programme chime very well with the proposals within the white paper, and we look forward to working with the Government on this agenda.

Questions that Councillors might want to ask

How will councillors influence:

- The local transition to the new arrangements?
- Appropriate outcome measures – for the new payment by results system proposed?
- How District Councils play an active role?
- The clarity of accountability and transparency arrangements locally and nationally?
- The development and support of an effective Health and Well-being Board?
- The relationship between councils and Public Health England?
- Resilience in the provision of services and health outcomes

Next Steps

The closing date for responses is 8 March 2011. CfPS will be preparing its own response to the proposals and we are seeking your views on the proposals. Please send comments, questions, concerns and views to: su.turner@cfps.org.uk by 4th February 2011.

In addition to this, we will be running a series of discussion topics on our website to gain the views of scrutiny professionals from across the Country.

Healthy lives, healthy people White Paper: The Government's strategy for public health in England

Summary of the Government's Consultation Questions

The White Paper

a) **Role of GPs and GP practices in public health:** Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

b) **Public health evidence:** What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

c) **Public health evidence:** How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

d) **Public health evidence:** What can wider partners nationally and locally contribute to improving the use of evidence in public health?

e) **Regulation of public health professionals:** We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health

1) Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

2) What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

3) How can we best ensure that NHS commissioning is underpinned by the necessary public health advice?

4) Is there a case for Public Health England to have greater flexibility in future on commissioning services currently provided through the GP contract, and if so how might this be achieved?

5) Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

6) Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

7) Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:
   (a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and
   (b) reduce avoidable inequalities in health between population groups and communities?

   If not, what would work better?

8) Which services should be mandatory for local authorities to provide or commission?

9) Which essential conditions should be placed on the grant to ensure the successful transition of responsibility for public health to local authorities?

10) Which approaches to developing an allocation formula should we ask ACAR to consider?

11) Which approach should we take to pace-of-change?

12) Who should be represented in the group developing the formula?

13) Which factors do we need to consider when considering how to apply elements of the Public Health Outcomes Framework to the health premium?

14) How should we design the health premium to ensure that it incentivises reductions in inequalities?

15) Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

16) What are the key issues the group developing the formula will need to consider?

Healthy Lives, Healthy People: Transparency in Outcomes Proposals for a Public Health Outcomes Framework

1) How can we ensure that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, and does not act as a barrier?

2) Do you feel these are the right criteria to use in determining indicators for public health?

3) How can we ensure that the Outcomes Framework and the health premium are designed to ensure they contribute fully to health inequality reduction and advancing equality?

4) Is this the right approach to alignment across the NHS, Adult Social Care and Public Health frameworks?

5) Do you agree with the overall framework and domains?

6) Have we missed out any indicators that you think we should include?

7) We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

8) Are there indicators here that you think we should not include?

9) How can we improve indicators we have proposed here?

10) Which indicators do you think we should incentivise? (consultation on this will be through the accompanying consultation on public health finance and systems)

11) What do you think of the proposal to share a specific domain on preventable mortality between the NHS and Public Health Outcomes Frameworks?

12) How well do the indicators promote a life-course approach to public health?

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Agenda Item 8

Leeds CITY COUNCIL

Originator:	Steven Courtney
Tel:	247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 25 January 2011

Subject: Equity and Excellence: Liberating the NHS – update

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose

1.1 The purpose of this report is to provide a further update around the Government's overall vision for the future of the NHS – initially presented in the White Paper, '*Equity and excellence: Liberating the NHS'* – by introducing some additional inputs around what is currently understood of the proposals and likely implications.

2.0 Background

2.1 In July 2010, the Government published its overall vision for the future of the NHS via its White Paper, '*Equity and excellence: Liberating the NHS'.* This set out key proposals for change and reform for the commissioning and delivery of NHS services and was supported by the following suite of additional consultation papers setting out more specific and detailed proposals:

- Transparency on outcomes – a framework for the NHS
- Liberating the NHS: Local democratic legitimacy in health
- Commissioning for patients
- Regulating healthcare providers

2.2 In October 2010, the following additional consultations were published as part of the Government's overall vision for the NHS and delivery of health care reform:

- *An information revolution: a consultation on proposals* –part of the Government's agenda to create a revolution for patients - "putting patients first" - giving people more information and control and greater choice about their care. The information revolution is about transforming the way information is accessed, collected, analysed and used by the NHS and adult social care services so that people are at the heart of such services.

- *Greater choice and control: consultation on proposals* – explains, in more detail, the proposals which envisage a presumption of greater choice and control over care and treatment, choice of treatment and healthcare provider becoming the reality in the vast majority of NHS-funded services by no later than 2013/14.

2.3 In December 2010, the Government published a further consultation document – Liberating the NHS: developing the healthcare workforce – which sets out proposals to establish a new framework for developing the healthcare workforce and seeks views on the systems and processes that will be needed to support it. The Executive Summary is attached at Appendix 1 for information. The closing date for responding to this consultation is 31 March 2011.

3.0 Proposed NHS reform

3.1 In December 2010, the Government also published its response to the initial consultation around its proposals for NHS change and reform. The response covered the following board areas:

- Putting patients and the public first
- Improving healthcare outcomes
- Commissioning for patients
- Local democratic legitimacy
- Regulating healthcare providers
- Effective implementation and a managed transition

3.2 At the time of writing this report the anticipated draft Health and Social Care Bill has yet to be published, however it is expected that this will be published before the end of January 2011. Nonetheless, as reported at the Board meeting in December 2010, some of the key areas where the Government has modified its initial approach are summarised below:

- a longer and more phased transition period for completing reforms to providers:
- significantly strengthened role for Health and Wellbeing Boards and enhanced joint working arrangements through a new responsibility to develop a "joint health and wellbeing strategy" spanning the NHS, social care, public health and potentially other local services. Local authority and NHS commissioners will be required to have regard to this;
- a clearer, more phased approach to the introduction of GP commissioning, by setting up a programme of GP consortia pathfinders. This will allow those groups of GP practices that are ready, to start exploring the issues and will enable learning to be spread more rapidly;
- accelerating the introduction of Health and Wellbeing Boards through a new programme of early implementers;
- a more distinct identity for Health Watch England, led by a statutory committee within the Care Quality Commission (CQC);
- increasing transparency in commissioning by requiring all GP consortia to have a published constitution;
- maternity services to be the responsibility of GP consortia rather than the NHS Commissioning Board;
- recognising that the original proposal to merge local authorities' scrutiny functions into the health and wellbeing board was flawed. Instead councils' formal scrutiny

powers will be extended to cover all NHS-funded services, and will give local authorities greater freedom in how these are exercised;
- phasing the timetable for giving local authorities responsibility for commissioning NHS complaints advocacy services, and allow flexibility to commission from other organisations as well as from local Health Watch;
- giving GP consortia a stronger role in supporting the NHS Commissioning Board to drive up quality in primary care.

3.3 A summary of the Government's response produced by the Centre for Public Scrutiny (CfPS) is attached at Appendix 2.

3.4 In order to help the Board maintain a broad overview of the proposals, the likely implications for the Council and progress within the local health economy, representatives from NHS Leeds and the City Council have been invited to attend the Board.

4.0 Recommendations

4.1 Members are asked to:

4.1.1 Consider and note the details presented in this report and those discussed at the meeting; and,

4.1.2 Identify any specific matters that require further scrutiny and/or are to be included on the Board's future work programme.

5.0 Background Documents

- The NHS White paper – *Equity and excellence: Liberating the NHS – July 2010*

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NHS

Liberating the NHS:

Developing the Healthcare Workforce

Executive Summary

DH Department of Health

Executive Summary

Chapter 1 – Purpose & Scope

1. The vision set out in the white paper *Equity and Excellence: Liberating the NHS* can only be achieved if healthcare providers employ staff with the skill mix appropriate to deliver a high quality service to patients in every circumstance. That blend of skills will change repeatedly to satisfy the evolving healthcare needs of local communities.

2. Public investment is central to securing high quality services and training. However, we cannot continue to expect top-down workforce planning to respond to the bottom-up changes in patterns of service that will be required by GP consortia. In future the DH will have progressively less direct involvement in planning and development of the healthcare workforce, except for the public health services.

3. So, it is time to give employers greater responsibility for planning and developing the healthcare workforce. Local 'skills networks' of employers will take on many of the workforce functions currently discharged by Strategic Health Authorities, while the quality of education and training will remain under the stewardship of the healthcare professions, working in partnership with universities, colleges and other education and training providers.

4. This consultation document sets out proposals to establish a new framework for developing the healthcare workforce and seeks views on the systems and processes that will be needed to support it. The **final date for responses is 31st March 2011**, but earlier expressions of view would be helpful.

Chapter 2 – Vision

5. The current system of workforce planning has grown in a piecemeal way. There is an opportunity now to fundamentally reshape it.

6. This chapter sets out five objectives the new framework will need to deliver:

   - security of supply, having people with the right skills in the right place at the right time;
   - responsiveness to patient needs and changing service models;
   - high quality education and training that supports safe, high quality care and greater flexibility;

- value for money;
- widening participation.

7. This chapter also proposes 12 principles that should shape the design of the new system. They include:

- doing at national level only what is best done at national level – leaving maximum opportunities for flexible, local implementation and innovation;
- security of supply, having people with the right skills in the right place at the right time;
- ensuring effective professional engagement at local and national levels, with the professions having a leading role on safety and quality issues;
- ensuring strong partnerships with universities and education providers, to make the most effective use of the skills of educators;
- sustainable and transparent investment in education and training.

Chapter 3 – Context

8. About 1.4 million people in over 300 different roles make up the NHS workforce. More than half of them are healthcare professionals, including doctors, nurses, midwives, healthcare scientists, pharmacists and a wide range of Allied Health Professionals.

9. Currently Strategic Health Authorities (SHAs) determine where to invest the £5bn central budget for education and training. Most of the money is spent on developing the skills of the next generation of professionals, including clinical placements and other work-based learning through healthcare providers. The Department of Health will continue to ensure this core investment is available to make the sector more self-sufficient and less reliant on international recruitment.

10. Led by SHAs, the current system has made significant progress, notably in improving security of supply of healthcare professionals. However, there are deficiencies:

- the current system is too top-down;
- service development planning is often poorly integrated with financial and workforce planning;
- medical workforce planning and education is managed by postgraduate deaneries within SHAs, largely in isolation from the planning and commissioning of education for other healthcare professionals;

- there are persistent shortages of particular skills, including insufficient specialist skills in theatre, renal and intensive care nurses, which causes over-reliance on expensive agency staff and recruitment overseas. The agency bill for healthcare staff is more than £1.9bn;

- ways of working often follow a traditional pattern of looking at supply and demand within single professional silos;

- the costs of running the current system are high and vary greatly among SHAs.

11. There is scope to design a more streamlined system that contributes more to delivering better productivity and improved healthcare outcomes.

Chapter 4 – Developing a new system

12. This chapter sets out the core functions of workforce planning and development. It introduces the proposed roles and responsibilities that different organisations will undertake.

Chapter 5 – Increased autonomy & accountability for healthcare providers

13. This chapter makes clear that the responsibilities of planning and developing the workforce will apply to all providers of NHS-funded care, including providers in the independent and voluntary sectors. The consultation asks for views about duties that might be placed on providers, including a duty to consult on workforce plans and a duty to provide data about their future workforce needs. This information would be used to shape decisions about investment in education and training.

14. More than half the NHS's central funding for education and training goes directly to healthcare providers to support clinical placements. This chapter argues these placements are best managed multi-professionally across a network of healthcare providers. It asks for views on whether the providers should have a duty to consult widely and cooperate on education and training.

15. The chapter also asks for views on the workforce planning and management functions that would be undertaken by the local provider networks, including holding and allocating funding for education and training and taking on the deanery functions. The skills networks would include GPs in their role as providers of healthcare, and work in partnership with representatives of local authorities as providers of social care and commissioners of public health, and education providers.

Chapter 6 – Sector-wide oversight and support

16. This chapter explains why the Government intends to create an autonomous statutory board to support healthcare providers in their workforce planning, education and training. Health Education England (HEE) will be a lean and expert organisation, free from day-to-day political interference. It will focus on workforce issues that need to be managed nationally. It will bring together the interests of healthcare providers, the professions, patients and staff. HEE will take on the advisory role of Medical Education England and the professional advisory boards for education and training. Its functions will include championing the greater involvement of patients and local communities in planning and developing the workforce.

17. The chapter discusses how to get the right balance between strategic national oversight and greater freedom for local education commissioning. It looks at the analytical capability that will be needed for longer-term workforce planning in health and asks how the Centre for Workforce Intelligence can develop to make the most effective contribution. The role of the NHS Commissioning Board and healthcare regulators is also considered.

18. The Government intends to reduce significantly the level of central funding for Skills for Health. It supports moves towards a business model in which employers decide how much they need to invest in the services that Skills for Health can provide. The Government supports a much closer working partnership between Skills for Health and Skills for Care.

19. The professions and medical Royal Colleges have an important role to play in devising and delivering education in their specialties. Clinicians should be involved in the skills networks. The new framework provides an opportunity for the Academy of Medical Royal Colleges to give clinical and professional leadership in working across specialty boundaries. Similar support may be forthcoming from the professional bodies and representatives of other healthcare professions and from the education sector.

Chapter 7 – The public health workforce

20. The Government will consult during 2011 on a workforce strategy for public health. This chapter outlines how Public Health England (PHE) will need to work in close partnership with healthcare providers and local authorities. It asks for views about whether PHE and its partners in public health delivery should be represented on the HEE board. Another question is whether local authorities should become members of the NHS healthcare provider skills networks.

Chapter 8 – Funding and incentives

21. This chapter explains why relying solely on market levers to secure sufficient investment in healthcare skills is an unacceptable risk. It would also be unfair if some healthcare providers bore the costs of providing skills to the local labour market while others did not.

22. Current funding of training and development comes from top-slicing the NHS budget. Over time the Government intends to move to a levy on providers to raise the money needed to train the next generation of healthcare professionals. However, it would not be appropriate to apply a national levy to fund local investment to develop the skills of the existing healthcare workforce. HEE will take a strategic overview of the funding priorities and allocate money to different areas as appropriate. It needs an effective strategic relationship with the funding bodies for higher education, taking account of changes to the funding regime following Lord Browne's Review.

23. The chapter discusses how the flow of funding for education and training can be made fairer and more transparent. It notes that the DH has previously negotiated a benchmark price as a national tariff paid to higher education for the tuition costs of most NHS-funded pre-registration education programmes. Tariffs for medical and other clinical placements and tariffs covering other programmes and placements are to be considered as a way to provide a level playing field. Providers should be allowed time to adjust to these arrangements before further changes are made.

24. The Government asks for views on how quickly tariffs and a levy should be introduced and which healthcare providers should pay. Should it apply to healthcare providers who do not treat NHS patients, but do deliver services using staff trained by the public purse?

Chapter 9 – Transitional arrangements

25. There is a challenging timescale to put in place new systems and processes by 2012 to take on functions of Strategic Health Authorities before they are abolished. Providing stability and continuity will be important.

26. SHAs will hold and allocate the Multi-Professional Education and Training Budget for 2011/12. They will work with local health and social care economies to develop coherent plans for the new local framework. Providers are encouraged to take on SHA staff with appropriate knowledge and expertise.

27. Subject to Parliamentary approval, Health Education England will be established in shadow form in 2011 and as a special health authority to go live in April 2012. The chapter discusses how local healthcare provider skills networks will become legally established, and other transitional arrangements.

Chapter 10 – Equality and diversity

28. The DH will conduct an equality impact assessment on these proposals. The initial screening suggests the policy may provide opportunities to make a positive impact on equality and to tackle current inequalities. The consultation seeks to establish if any individuals or groups might be disadvantaged by the proposals.

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APPENDIX 2

The Centre for Public Scrutiny
'Equity and Excellence' – Summary of Consultation Response

Introduction

The Government published its response to the public consultation on the Healthcare White Paper 'Equity and Excellence' on 15 December 2010. A link to the response document is here:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661

This summary is not a critique of every aspect of the response – it is intended to relate to key themes that CfPS initially identified in its original summary of the Healthcare White Paper.

The response document focuses mostly on commissioning, local democratic legitimacy and regulating providers. There will be separate responses to the consultation papers on the NHS Outcomes Framework, the 'Information Revolution' and 'Extending Patient Choice'.

The Health and Social Care Bill is expected to be introduced in Parliament in January.

Changing the structure of the NHS

GP practices will have flexibility to decide how they come together to form consortia and how these consortia evolve over time, subject to being able to demonstrate to the NHS Commissioning Board, when applying to be established, that they have workable arrangements to enable them to carry out their statutory duties. However, there is to be a phased approach by setting up a programme of GP consortia pathfinders. Pathfinder consortia have already been announced, testing the different elements involved in GP-led commissioning and enable emerging consortia to get more rapidly involved in current commissioning decisions. The pathfinders will operate under existing legislation, but they will provide valuable early learning and momentum.

As part of their application to the NHS Commissioning Board for establishment, consortia will have to submit a proposed constitution, and this will be publicly available. The Bill will provide that each consortium's constitution must include, as a minimum: the name and members of the proposed consortium; the geographic area for which the consortium will be responsible (for the purposes of certain prescribed responsibilities such as securing emergency care); arrangements for discharging their statutory functions (which will include public and patient engagement, and multi-disciplinary working);

procedures for decision-making and managing conflicts of interest; and arrangements for securing the effective participation of the consortium's members. To reinforce the requirement that governance arrangements must be robust, the NHS Commissioning Board will also have the power to issue guidance to consortia on the form and content of their proposed constitution, drawing for example on the principles of good governance in public life.

Consortia will have a duty, before the start of each year, to prepare commissioning plans, including proposals for how they intend to use their commissioning budget and how they intend to improve outcomes for patients. Consortia will need to discuss these proposals with local health and wellbeing boards to ensure that they reflect joint strategic assessments of need and joint health and wellbeing commissioning strategies.

The Government considers that requiring there to be a statutory management board for each consortium would be over-prescriptive; and that placing legislative requirements for there to be lay or patient participation in the governance of consortia is unlikely to work. The Government does not wish to discourage consortia from developing arrangements for lay or patient involvement but believes that consortia should make their own decisions on this.

To support public accountability, consortia will also be required to make public their remuneration arrangements, to hold an annual general meeting that is open to anyone, make their commissioning plans available to the public, and publish an annual report which includes consideration of how well they have discharged their new joint arrangements with local authorities. The annual report will also be the place where GP consortia reflect the patient and public consultations that have taken place. This is an aspect that CfPS will continue to lobby on and we will be working with GP Consortia to develop robust non-professional input and to become transparent, inclusive and accountable organisations.

The NHS Commissioning Board will have a vital role in providing national leadership for driving up the quality of care, including safety, effectiveness and patients' experience, promoting patient and public involvement, and the promotion of innovation and integration across the NHS, by supporting consortia in a number of ways. It will be for the shadow NHS Commissioning Board to take forward work on developing the Commissioning Outcomes Framework with the support of NICE. To help maintain momentum, the Department will publish a discussion document early in 2011, seeking more detailed views on possible features of the framework, and we will ask NICE to engage with professional and patient groups on proposals for the design and testing of specific outcome indicators. In response to consultation, commissioning maternity services will sit with GP consortia rather than being commissioned nationally.

The Government accepts that reform of the provider side of the NHS is likely to take time and needs careful staging. Therefore there will be a longer and more phased transition period. The Government will ensure rapid progress is made on the NHS trust pipeline to foundation trust status and in opening up choice and competition, for example in community services.

There was widespread support for retaining the strengths of the current FT governance model, most responses emphasised the benefits of the existing model and identified risks in allowing greater flexibility. Strong, transparent and accountable governance arrangements are vital to the safe and effective operation of an FT. Taking account of responses, the Government has decided to make a number of changes to clarify responsibilities and make the directors and governors of an FT more directly accountable for their decisions and for the performance of the trust. The Bill will make explicit the duty of governors to hold the board of directors to account, through the chair and non-executive directors; give governors power to require some or all of the trust's directors to attend a meeting; extend to FT directors the duties imposed on directors under company law; require FTs to hold an annual general meeting for its membership, at which members would be able to discuss the trust's annual report and accounts. CfPS will be working with stakeholders to help FT governors and non-executives develop their skills in scrutiny and accountability.

Many respondents agreed that foundation trusts should be able to change their constitution without the consent of Monitor. The Bill will remove the need for Monitor's consent, but retain the essential elements governing the requirements for a constitution. The Bill will strengthen the power of the governors by requiring their agreement to any changes to an FT's constitution. As an additional safeguard, the FT's members could overturn any constitutional change concerning the governors' own role within the organisation, if a significant majority of the members voting at an annual meeting opposed it. FTs will be under a new statutory obligation to inform the regulator about amendments to their constitution, but it will be the responsibility of trusts rather than Monitor to assure themselves that changes are compatible with legislation. However, in case the details need to be refined in the light of experience, the Bill will give power to use regulations to amend the precise voting mechanisms and the amount of support required from members, governors and directors for making changes relating to the constitution and governance of an FT.

The Government is pressing ahead with the proposal to give foundation trusts the flexibility to merge, acquire another FT or NHS trust, or de-merge without the approval of Monitor, to allow them to respond quickly to the needs and choices of patients. However, given the potential impacts on patients, commissioners and staff the Bill will require an FT's governors to agree any merger, acquisition, separation, or any other change that the FT's constitution defines as "significant". CfPS will be working with stakeholders to ensure that processes for changing FT constitutions and operational changes are transparent, inclusive and accountable.

Changing the culture of the NHS

There was a consensus for a move away from centrally-dictated process targets. The Government is clear that professionals and the public should be involved in every stage of developing outcomes frameworks. The Government will publish three separate frameworks for the NHS, public health and social care which are designed to incentivise collaboration and, in some cases, hold organisations to account for providing integrated services. This recognises that the NHS, social care and public health sectors deliver services through unique delivery systems, each with their own structures and governance, and provides for robust accountability mechanisms, which hold organisations to account for the things they are responsible for delivering. For the NHS, the NHS Commissioning Board will be held to account through the NHS Outcomes Framework. An outcomes framework for social care, published for consultation in November 2010, will allow local areas to hold their councils to account for adult social care. In public health, the Public Health Outcomes Framework, which will be published shortly for consultation, will allow the public to hold their councils and the Secretary of State to account for progress.

The Government also recognises that accountability mechanisms can only do so much to foster integration. It will be the day-to-day behaviours at every level of the system which determine how successfully services collaborate with each other and whether this leads to improved outcomes. The new role for local authorities will help to ensure that the right behaviours are being adopted at a local level, as they promote joined-up working and look across outcomes in health and social care.

The Commissioning Outcomes Framework will be used by the NHS Commissioning Board to hold GP consortia to account for their contribution to improving outcomes and to support ongoing improvements in the quality of commissioning. Failure to achieve the minimum level of performance for a significant portion of the Framework (or key aspects of it) could trigger an intervention by the Board. The measures available to the Board range from directing a consortium to fulfil its functions in a different way to, in extreme cases, dissolving the consortium. The Commissioning Outcomes Framework will be developed by the NHS Commissioning Board, with support from NICE. It will have a strong focus on patient reported outcome measures (PROMs) and patient experience, as well as progress in reducing inequalities. CfPS will be working with stakeholders to ensure that outcomes frameworks are transparent, inclusive and accountable.

Patients and public at the heart

The Bill will place the NHS Commissioning Board under a duty, in exercising its functions, to have regard to the need to promote the involvement of patients and their carers in decisions about the provision of health services to them. The NHS Commissioning Board will also be under a duty to issue guidance on commissioning to GP consortia, which could include guidance about how to fulfil their duties in relation to public and patient involvement.

The Bill will place duties on the NHS Commissioning Board and GP consortia to, in the exercise of their respective functions, have regard to the need to enable patients to make choices with respect to aspects of health services provided to them.

The Bill will create a more distinct identity for HealthWatch England, led by a statutory committee within the Care Quality Commission (CQC). The HealthWatch England Committee will carry out the work of CQC related to HealthWatch England and have powers to provide advice to the NHS Commissioning Board, Secretary of State for Health, CQC and Monitor. The Bill will include a power for the Government to set out in regulations how the HealthWatch Committee should be appointed. HealthWatch England will agree standards against which local HealthWatch organisations and local authorities could benchmark performance and spread good practice. The Government will set out proposals for governance and stakeholder engagement at the time of the publication of the Bill. An early priority will be to set out how relationships and accountabilities will work, especially the relationship between local authorities, local HealthWatch and HealthWatch England. CfPS will be contributing to these discussions and helping to make relationships work well.

Local HealthWatch will continue LINks' role in promoting and supporting public involvement in the commissioning, provision and scrutiny of local care services. HealthWatch could decide to take into account patients' views, including whether they feel their rights have been met under the NHS Constitution.

The Bill will therefore provide for local authorities to commission HealthWatch to provide advice and information to enable people to make choices about health and social care. This could include helping people to access and understand information about provider performance and safety, and the NHS Constitution.

The Government has decided to phase local authorities' responsibility for commissioning NHS complaints advocacy services, and allow flexibility to commission from other organisations as well as from local HealthWatch - this could be either local HealthWatch, or other organisations with HealthWatch signposting these services to people.

Funding for LINks will therefore continue through the transition into local HealthWatch, and will be enhanced to reflect HealthWatch's responsibilities. Local authorities will have funding for HealthWatch built into their existing allocations, including additional funding for NHS complaints advocacy and providing advice and information for people making choices.

From 2011, the Government will be working with local authorities as they prepare for their new role in commissioning support for choice and complaints advocacy for patients. The Department of Health will publish a transition plan early in 2011, which will provide for LINks to continue to influence local services while local HealthWatch prepares to start exercising functions. From April 2012, local authorities will fund local HealthWatch to deliver most of their new functions. Responsibility for commissioning NHS complaints advocacy will transfer to local authorities in April 2013.

This phased introduction will give local authorities the opportunity to focus on putting in place robust and effective arrangements for the new local HealthWatch roles. It will better ensure that the quality of NHS complaints advocacy services continues throughout the transition to local authority commissioning.

The Government will invite local authorities to develop pathfinder organisations to help with preparations for local HealthWatch. Pathfinders will be able to explore more fully a number of issues that the consultation has raised and look at how these can best be resolved to make sure that HealthWatch gives patients and the public the strong voice that the consultation responses called for. For example, pathfinders will be able to test which models most effectively deliver locally commissioned services to support patient choice and complaints advocacy. They can highlight any potential conflicts that arise between HealthWatch's different roles and test ways of addressing these. Pathfinders for HealthWatch will also be able to test different structures for governance and accountability of local HealthWatch, including the role of hosts. CfPS will be using its experience of supporting the implementation of LINks to inform this process and to help Healthwatch develop as an inclusive, community facing body.

Patients and the public will be empowered through transparency of information about service quality and outcomes, shared decision-making with clinicians about their treatment and care and choice about who will provide their treatment and care. Local Healthwatch will have a strong voice and will have a strong relationship with councils. Patient and public involvement will be a duty for commissioners. CfPS will be continue to lobby about this aspect of the Bill and will work with stakeholders to ensure that patient and public involvement in the new structures is robust and influential.

New roles for councils

The Bill will require the establishment of a health and wellbeing board in every upper tier local authority. The Bill will allow for health and well being boards to include representatives from lower tier authorities. The Bill prescribes that there must be at least one local elected representative. The Bill provides that the other core members of the health and wellbeing board will be GP consortia, the director of adult social services, the director of children's services, the director of public health, and local HealthWatch. Beyond this core, the local authority can decide who to invite and it will have flexibility to include other members. There will be flexibility for the local authority to delegate functions to the health and wellbeing board where it feels appropriate.

To engage effectively with local people and neighbourhoods, boards may also choose to invite participation from local representatives of the voluntary sector and other relevant public service officials. They will also want to ensure input from professionals and community organisations that can advise on and give voice to the needs of vulnerable and less-heard groups. Boards may also want to invite providers into discussions, taking care to adhere to the principles of treating all providers, existing or prospective, on a level playing field. CfPS will be working with Boards to ensure they develop transparent, inclusive and accountable practices.

At present JSNA obligations extend only to its production, not its application. The Government is therefore introducing in the Bill a new legal obligation on NHS and local authority commissioners to have regard to the JSNA in exercising their relevant commissioning functions. Health and wellbeing boards should have to develop a high-level "joint health and wellbeing strategy" (JHWS) that spans the NHS, social care and public health, and could potentially consider wider health determinants such as housing, or education.

Councils and consortia will be required to have regard to the joint strategic needs assessment, they will also be under a new statutory duty to have regard to the JHWS; health and wellbeing boards will be able to consider whether the commissioning arrangements for social care, public health and the NHS, developed by the local authority and GP consortia respectively, are in line with the JHWS; the health and wellbeing board will be able to write formally to the NHS Commissioning Board and the GP consortia if, in its opinion, the local NHS commissioning plans have not had adequate regard to the JHWS. Equally, it will be able to write to the local authority leadership if the same is true of public health or social care commissioning plans; and when GP consortia send their commissioning plans to the NHS Commissioning Board, they will be under an obligation to state whether the health and wellbeing board agrees that their plans have held due regard to the JHWS and send a copy of their plans to the health and wellbeing board at the same time.

Local authorities may well wish to use health and wellbeing boards to consider wider health determinants such as housing and leisure, or co-ordinating commissioning of children's services. Health and wellbeing boards could become a vehicle for driving wider place-based initiatives, such as the community budget areas announced in the recent Spending Review, focussed on helping turn around the lives of families with multiple problems, improving outcomes and reducing costs to welfare and public services by enabling a more flexible and integrated approach to delivering the help these families need.

The Government aims to accelerate the introduction of health and wellbeing boards through a new programme of early implementers. CfPS will be working with stakeholders to ensure that there is robust scrutiny and accountability of these emerging arrangements.

The Government proposed that the functions exercised by the health overview and scrutiny committee (OSC) would be subsumed within the health and wellbeing board. Respondents were of one voice in saying that the Department had got this wrong. The Department is persuaded that its original proposal was flawed. The Bill will not therefore confer the health scrutiny function on health and wellbeing boards. The Government has acknowledged that there are many examples of very effective health OSCs, undertaking excellent work. CfPS is delighted with this recognition and is grateful to all those who provided comments on this aspect of the White paper proposals.

This doesn't mean that health scrutiny will remain exactly as now. Wider government policy is to give local authorities greater freedom to discharge its functions in different ways. Local authorities will have a new freedom and flexibility to discharge their health scrutiny powers in the way they deem to be most suitable – whether through continuing to have a specific health OSC, or through a suitable alternative arrangement. To enable this flexibility, the Bill will confer the health overview and scrutiny functions directly on the local authority itself. CfPS will be working with stakeholders to support the development of health scrutiny, based on our four principles of good scrutiny.

Given the changes proposed to the delivery of scrutiny functions, CfPS will be working with stakeholders to consider how local HealthWatch organisations relate to the delivery of local authority scrutiny functions, particularly through the pathfinders and early implementers.

In addition to being consulted on the designation of what services are subject to additional regulation (that is, services that need protecting from failure in provision), the local authority will be able to refer decisions about significant changes to any designated services to the Secretary of State. CfPS will be working with stakeholders to provide support for consultations and referrals relating to service changes.

To ensure that the health scrutiny model is consistent with other forms of scrutiny in local authorities, and as democratic as possible, any decision to refer a substantial service change proposal should be triggered by a meeting of the full council. This is a significant change to the autonomy of overview and scrutiny committees that have previously been able to refer changes without reference to Executive Cabinets or full council. This is an aspect that CfPS will continue to lobby on.

The exception to this will be if a number of councils choose to establish a joint scrutiny arrangement, in which case the joint OSC will hold the referral power. When local authorities establish joint OSCs, they will do so on the basis that at an early stage they agree for the decisions of the joint OSCs to be binding on all participating councils. The Department is also considering revisions to the regulations governing referrals, so when deciding to make a referral, local authorities are obliged to publish a timescale for the decision-making process and take account of a wider range of considerations including the duties on NHS commissioners to improve the safety, effectiveness and patient experience of services, and the need for services to be financially sustainable. There will be consultation on these proposed changes to the scrutiny regulations and CfPS will continue to lobby about these aspects.

In future, the local authority's right of referral will apply in relation to any type of provider of NHS-funded services, whatever their governance arrangements and ownership structure. The Bill will include a regulation making power that can enable the Secretary of State to direct NHS commissioners (either directly in the case of the NHS Commissioning Board, directly or via the NHS Commissioning Board in the case of GP consortia) to stop reconfigurations of those services subject to additional regulation, when they are referred to him.

This is one of the few occasions, other than in an emergency, or possibly in complying with EU law, when the Secretary of State will have any ability to interfere with an individual commissioner or provider. In making decisions, the Secretary of State will, as now, be guided by the Independent Reconfiguration Panel, and additionally be required to take account of the safety, effectiveness and patient experience of services and the need for services to be financially sustainable.

The Government intends to take the important step of significantly extending the powers relating to the scrutiny function of local authorities. At present, health is unique amongst all local authority scrutiny arrangements in having powers for the local authority to require autonomous providers to attend scrutiny meetings. This power currently extends to NHS trusts, foundation trusts and primary care trusts. CfPS suggested that the scrutiny powers should be strengthened so that "*any provider of health and social care paid for by public funds should be under an obligation to be transparent, inclusive and accountable for how they plan and deliver services.*" The Bill will enable the Government to extend the powers of local authorities to enable effective scrutiny of any provider of any NHS-funded service, including, for example, primary medical dental or pharmacy services and independent sector treatment centres, as well as any NHS commissioner. The powers will also include scrutiny of local public health services.

They will include the ability to require any NHS funded providers or commissioners to attend scrutiny meetings, or to provide information. In this way local democratic scrutiny will be increased very substantially. The proposed powers for the local authority to scrutinise matters relating to GP consortia's commissioning functions is a very important way of ensuring local public accountability. CfPS is delighted that scrutiny powers are being extended and will be working with stakeholders to ensure the new arrangements work constructively.

Conclusion

Subject to Parliamentary approval, the health and wellbeing board will become a statutory committee of the local authority at the same time that GP consortia take on responsibility for the NHS budget. Although boards will only formally assume their powers and duties in April 2013, they will come into existence in advance of this date. Many areas are already well advanced in their approach to integrated working, and are thinking about and beginning to model how these future arrangements might work. It is important that the system learns from these areas. The Department will shortly write to local authorities inviting interest in becoming an early implementer and to clarify the key transition milestones as they impact upon local government. Subject to the scale of interest, the Department will then work with the early implementers to establish a shared development agenda and explore key issues. CfPS will be working with stakeholders to ensure that the new arrangements build on foundations of transparency, inclusiveness and accountability.

Tim Gilling
Deputy Executive Director, CfPS
December 2010

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 25 January 2011

Subject: Economic and Social Cost of Alcohol in Leeds 2008/09

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose

1.1 The purpose of this report is to introduce and present a report, commissioned by NHS Leeds, which estimates the wider economic and social costs of alcohol-related harm in Leeds. The purpose of this report is to provide an opportunity for the Scrutiny Board (Health) to understand the national and local implications of the Government's proposed public health reforms. It also provides an opportunity for the Board to comment on such proposals.

2.0 Background

2.1 Alcohol plays an important role in society, being consumed by the majority of adults and making an important contribution to the economy. However, the consumption of alcohol has health and social consequences borne both by individuals and their families, and by the wider community - the cost of alcohol in Leeds to the NHS alone has been estimated to be in excess of £20 million per year.

3.0 Health Lives, Health People proposals

3.1 The research report, commissioned by NHS Leeds, and produced by Liverpool John Moores University, is attached at Appendix 1.

3.2 Representatives from NHS Leeds have been invited to outline the report and implications for the City.

4.0 Recommendations

4.1 Members are asked to consider and note the details and issues highlighted by this report and appendices, and identify any issues that warrant further scrutiny.

5.0 Background Documents

- None

The economic and social costs of alcohol-related harm in Leeds 2008-09

liverpool JMU
Centre for Public Health

NorthWest Public Health Observatory

The economic and social costs of alcohol-related harm in Leeds 2008-09

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FOREWORD

Leeds is a vibrant and exciting city that has become a leading centre for the arts, leisure, culture and tourism. Alcohol is a major feature of the life of the city bringing economic benefits in terms of jobs and attracting visitors. I also recognise that alcohol can play an important and positive role in our social and family life, enhancing special occasions and time spent with friends.

However these benefits have a hidden cost. The misuse of alcohol across many of our citizens from young to old is leading to a steady increase in damage to health, crime and disorder, and to loss of work productivity. The services that we all pay for through our taxes, such as health, police, fire and rescue and ambulance are bearing a heavy price for the work they do in managing and reducing the harm caused by alcohol within our communities.

I am pleased to introduce this important report that makes clear the economic impact that alcohol is having on us all.

Organisations working in Leeds, including business and industry, must take the lead in making the reduction of harm caused by alcohol a priority - and we all have a responsibility and a part to play in promoting a sensible drinking culture that reduces violence and disorder, and improves health and wellbeing.

Councillor Mark Dobson

Chair Scrutiny Board – Health and Healthy Leeds Partnership

Executive summary

Alcohol plays an important role in society, being consumed by the majority of adults and making an important contribution to the economy. However, the consumption of alcohol has health and social consequences borne both by individuals and their families, and by the wider community - the cost of alcohol in Leeds to the NHS alone has been estimated to be in excess of £20 million per year. The purpose of this report is to present estimates of the wider economic and social costs of alcohol-related harm in Leeds.

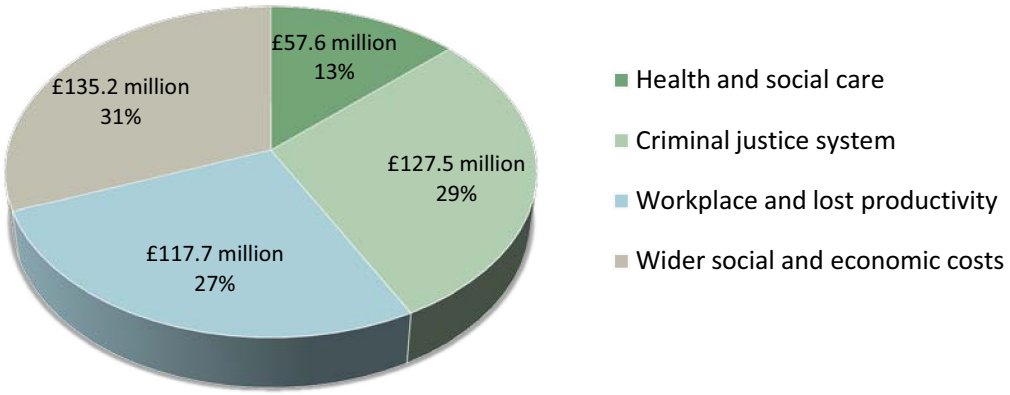
The economic and social costs of alcohol-related harm in Leeds 2008-09

Identifying the costs of alcohol-related harm is essential in informing decision-making across government and multi-agency partners regarding alcohol policy, investment in and commissioning of alcohol interventions at a regional and local level, and at an individual level, influencing lifestyle behaviour. Using cost of illness methodology this report attempts to identify and quantify, in economic terms, the impact of alcohol-related harm in Leeds through expenditure on:

- The costs of **health and social care** for people with alcohol-related ill health, including services provided by NHS Leeds and Leeds City Council;
- **Criminal justice system** costs for alcohol-specific and alcohol-related crimes;
- The costs of **productivity losses in the workplace** due to absenteeism, reduced productivity and premature mortality; and
- An estimate of the intangible or **human costs**, representing the wider impacts of premature death.

Alcohol also makes an important **contribution to the economy**, for example through the key role it plays within the leisure and tourist industry, and the report considers the contribution that the production, distribution and sale of alcohol makes to the Leeds economy.

The methods used to estimate the economic and social costs of alcohol-related harm in Leeds were based on approaches used in other costing studies, in particular those related to alcohol misuse. These methods aim to identify and measure all costs related to alcohol misuse, including the direct costs, indirect costs in the form of production losses, and intangible or 'human' costs. Estimates of the economic and social costs of alcohol-related harm in Leeds in 2008/09 totalled **£438.0 million** across the four categories as follows:



Alcohol consumption and expenditure in Leeds

Presented below is information on alcohol consumption among the general population of Leeds and household expenditure on alcohol.

- In Yorkshire and the Humber, three quarters of men and two thirds of women report drinking in the last week.
- Almost 40% of Yorkshire and the Humber residents drink more than the recommended daily maximums (2-3 units for women and 3-4 for men) on at least one day a week.
- Over 35,000 adults in Leeds may be classified as high risk drinkers; that is, men drinking more than 50 units a week and women drinking more than 35 units a week.
- Households in Yorkshire and the Humber spent more than the England average on alcoholic drinks, despite total household expenditure being less than the UK average.
- The estimated weekly spend on alcoholic drinks in households in Leeds is approximately £4.5 million, indicating a total spend of **£232 million each year** on alcohol in the city

The contribution of alcohol to the Leeds economy

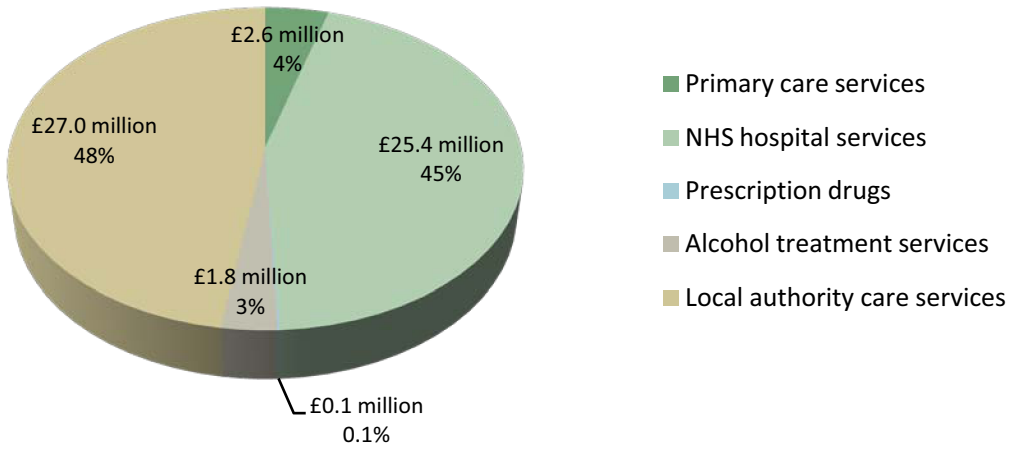
Figures on alcohol-related employment can provide a measure of the contribution that alcohol makes to the Leeds economy and the estimates presented below approximate the size of this benefit.

The majority of alcohol-related employment in Leeds is centred on jobs in pubs, bars and restaurants. Over the last decade, there has been an expansion in the city's entertainment and cultural scene and a corresponding increase in the number of music venues, bars, clubs and restaurants within Leeds city centre.

- In 2008, around 11,000 jobs in Leeds were related to the sale of alcohol, **3% of all jobs in Leeds**.
- The Gross Value Added from jobs related to alcohol retail in 2008 was between £144.4 and £167.1 million, approximately **1% of the total Leeds' GVA** for that year.
- However, the estimates presented are conservative and do not take into account the wider contribution that the night time economy and tourism make to the Leeds economy, sectors that are both closely linked to alcohol retail.

Health and social care

The estimated costs of health and social care for alcohol-related harm in Leeds in 2008/09 are presented below. The majority of the estimated costs arose from NHS hospital services and local authority care services.

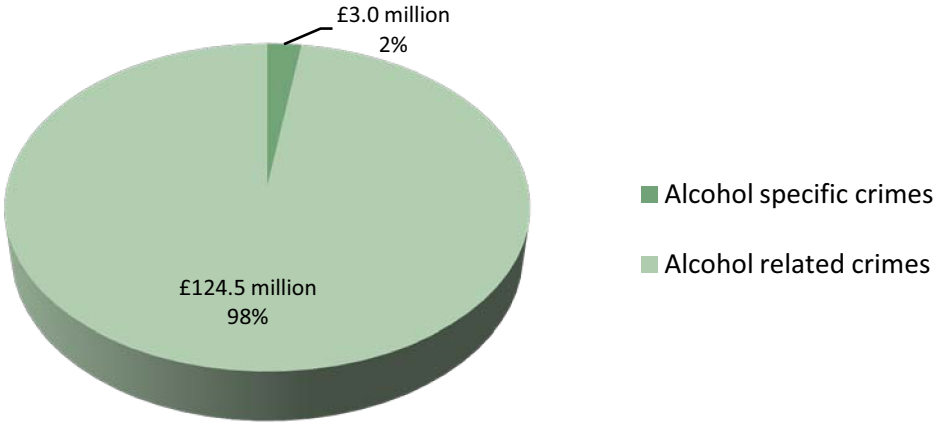


Expenditure on health and social care services was an estimated **£56.8 million** in Leeds in 2008/09. These costs comprised the following service elements:

- **£2.6 million** for the cost of primary care services, including over 96,000 alcohol-related consultations with GPs, practice nurses and other professionals;
- **£25.4 million** for the cost of NHS hospital services, including £13.1 million for inpatient hospital stays, £2.2 million for day hospital cases, £4.9 million for outpatient attendances, £0.7 million for A&E attendances and £4.3 million for ambulance journeys;
- **£0.1 million** on prescription drugs for treating alcohol dependence;
- **£1.8 million** on community and residential alcohol treatment services; and
- **£27.0 million** on local authority care services, including £26.8 million on child care social work and £0.2 million on adult services for alcohol misuse.

Criminal justice service

The estimated costs of alcohol specific and alcohol-related offences in Leeds in 2008/09 are presented below.

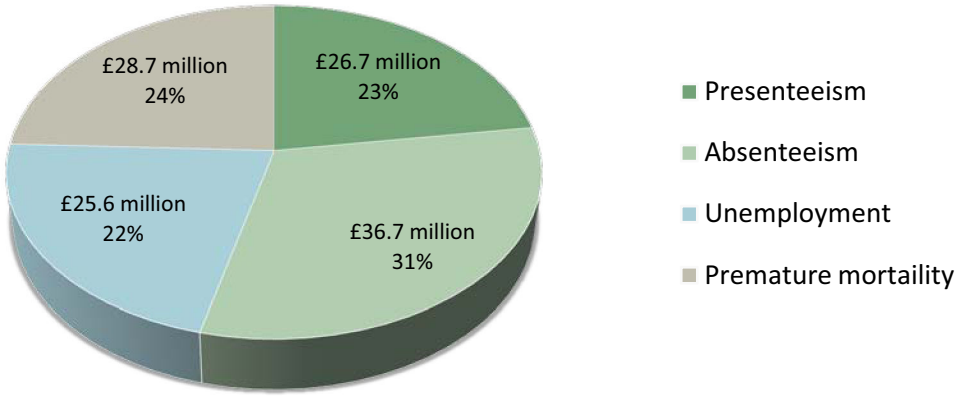


Expenditure on alcohol specific and alcohol-related offences was an estimated **£127.5 million** in Leeds in 2008/09.

- **£3.0 million** for the costs associated with alcohol specific crimes based on national estimates of £208 million.
- **£124.5 million** for the costs associated with alcohol-related crimes, with criminal damage and theft from shops comprising the majority of the offences committed. These costs were broken down across the following three categories:
  - **£8.3 million** spent in the *anticipation of crime*, including defensive expenditure and insurance administration costs;
  - **£96.3 million** arising from the *consequences of crime*, including the physical and emotional impact on victims of crime, the value of the stolen property, property damaged or destroyed and the costs of property recovery, in addition to the costs of victim services and lost output; and
  - **£19.9 million** in *criminal justice system costs*, including police activity, prosecution and court costs, the probation and prison service and other costs such as criminal injuries compensation.

Workplace and lost productivity

Excessive alcohol consumption affects the workplace through impaired performance at work ('presenteeism'), and by increasing the likelihood of employees being absent from work ('absenteeism'). In addition, heavy and dependent drinkers may be more likely to be unemployed. Alcohol also contributes to lost productivity in the workplace through premature deaths related to alcohol use.



Impaired performance at work

Reduced performance in the workplace due to hangovers resulted in costs to the Leeds economy of **£26.7 million** in lost output. Over 210,000 days were lost to hangovers in Leeds in 2008/09.

Sickness absence

Between 6% and 15% of working days lost to sickness may be attributed to alcohol misuse. The annual cost to the Leeds economy arising from sickness absence due to alcohol misuse was estimated to be between £21.4 million and £52.5 million, with a mid-point value of **£36.7 million**.

Unemployment

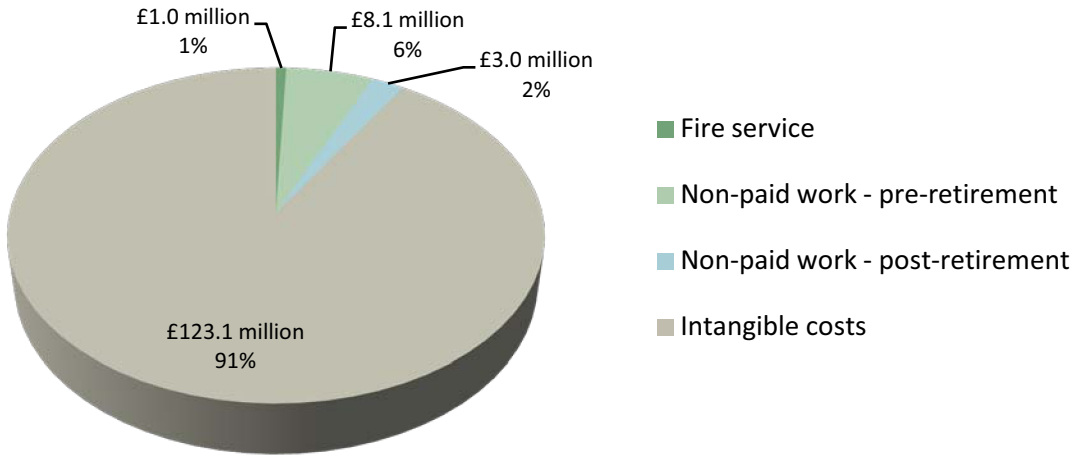
Being a problem drinker may lead to a reduction in the probability of working and over 230,000 days of employment were lost in 2008/09 in Leeds due to alcohol dependence. This represented losses to the Leeds economy of approximately **£25.6 million**.

Premature mortality

There were 140 alcohol-related deaths among the working age population of Leeds in 2007. Based on the reduction in expected years of working life and average earnings for employees in Leeds, the estimated cost of this lost output to the Leeds economy in 2008/09 was **£29.2 million**.

Wider economic and social costs

Premature deaths from alcohol misuse also reduce the contribution that non-participants in the workforce make through unpaid work and activities before and after retirement, and also cause intangible social costs through the pain, grief and suffering that premature death imposes on friends and family members.



Fire and rescue service

An estimated **£1.0 million** was spent on West Yorkshire fire and rescue service attending alcohol-related incidents in the Leeds area, including approximately £0.9 million attending alcohol-related house fires and in the region of £42,000 attending alcohol-related road traffic accidents in Leeds.

Lost value of non-paid work and activities before retirement

Based on estimates of the Leeds working age population not in work, an estimate of **£8.1 million** was calculated for losses of unpaid work and activities attributable to alcohol misuse.

Lost value of non-paid work and activities after retirement

There were 37 alcohol-related deaths between the ages of 65-74 years in Leeds in 2007, yielding an estimate of **£3.0 million** for losses of unpaid work and activities after retirement, such as child care, attributable to alcohol misuse.

Human costs

The potential value of a year of human life was assumed to range between £30,000 and £50,000. The human costs of alcohol misuse arising through premature mortality in Leeds were an estimated **£123.1 million**.

Conclusions

Alcohol misuse imposes a considerable burden on the Leeds economy, costing an estimated **£438.0 million** in 2008/09.

Of the total costs of alcohol-related harm, 13% were due to expenditure on health and social care services, 29% of costs were due to expenditure on crime and within the criminal justice system, 27% were due to lost productivity and 31% were due to the wider social costs of alcohol misuse.

It was not possible to calculate all of the costs associated with alcohol misuse, for example costs associated with cleaning up alcohol-related litter and the costs associated with school failure and reduced educational attainment were not included. It is therefore likely the costs presented underestimate the true burden of alcohol on the Leeds economy.

1 INTRODUCTION

Alcohol plays an important role in society, being consumed by the majority of adults and making an important contribution to the economy, for example through the key role it plays within the leisure and tourist industry.[2] Individuals derive pleasure from consuming alcohol and it can act as a catalyst in social interactions and leisure experiences. In addition, there has been much debate about the beneficial health effects of alcohol.[3] However, the consumption of alcohol also has both health and social consequences and alcohol-related harm presents one of the biggest challenges facing public health and health care systems.

The Leeds Alcohol Strategy for 2007-10[4] estimated that the cost of alcohol in Leeds was £23.13 million per year to the NHS alone. Estimating the proportion of mortality and morbidity attributable to alcohol, crime and offences and productivity losses related to alcohol use enables us to begin to quantify in economic terms the true impact of alcohol-related harm on society (including health and social care, crime, fire and rescue services, and economic productivity). Alcohol-related social costs or 'externalities' are imposed on society when alcohol consumption has negative impacts on unrelated third parties, for example, through violence or threatening and anti-social behaviour. The costs of alcohol use may also include wider, intangible costs such as fear or concerns about alcohol-related violence in the community.

The purpose of this report is to present estimates of the economic and social costs of alcohol-related harm in Leeds. Identifying these costs is essential in informing decision-making across government and multi-agency partners regarding alcohol policy, investment in and commissioning of alcohol interventions at a regional and local level, and at an individual level, influencing lifestyle behaviour. Cost-of-illness (COI) studies, also known as social cost or burden-of-illness studies, investigate both the direct and indirect costs incurred due to an illness or condition from a societal perspective and they are a useful starting point for demonstrating the 'size of the problem' to policy makers.

2 ALCOHOL AND LEEDS

2.1 Alcohol consumption

In Yorkshire and the Humber, 75% of men and 59% of women drank in the last week, with 19% and 13%, respectively reporting to have drunk alcohol on more than 5 days in the last week.[5] The government's daily guideline for drinking are 2-3 units for women and 3-4 for men, and 39% of residents in Yorkshire and the Humber reporting drinking above these daily maximums on at least one day. In addition, 25% reported binge drinking[i] on at least one day (29% of men and 21% of women), a rate higher than the national average of 18%. In 2007/8, the estimated number of adults who engaged in hazardous,[ii] harmful[iii] and binge drinking was significantly higher in the Leeds Local Authority area than the England average, and higher than the regional Yorkshire and Humber average.[6] Approximately 25% of adults in Leeds reported hazardous drinking and 7% reported harmful drinking.

2.1.1 Alcohol-related harm

For male residents in Leeds, alcohol causes an average 10.7 months of life lost and for female residents, an average 4.7 months of life are lost. This compares with 5.1 and 3.5 months lost among male and female residents in West Oxfordshire in the South East of England, respectively. In 2008/09 Leeds had approximately 12,800 alcohol-related hospital admissions (a directly standardised rate of 1,561 per 100,000). This rate is lower than the average rate for England (1,583) but higher than the regional rate for Yorkshire and the Humber (1,525). As shown in Figure 1, the alcohol-related hospital admission rate for Leeds has risen steadily since 2002/03, with 2008/09 showing an increase of 15% from the previous year. Leeds is ranked in the worst quartile nationally for 10 out of the 23 alcohol indicators included in the Local Alcohol Profiles for England.

Box 1: Calculation of the number of high risk drinkers in Leeds

Based on national estimates from the General Lifestyle Survey 2008, 7% and 4% of men and women, respectively, are classified as high-risk drinkers*.

Applying this to the mid-year population estimates of adults in Leeds (n=646,500), an estimated 22,110 men and 13,226 women may be classified as high risk drinkers.

*Drinking more than 50 units per week for men and more than 35 units per week for women

[i] Defined here as drinking 6-8 units of alcohol or more in a single session.
[ii] Drinking that puts people at risk of physical and psychological harm.
[iii] Drinking that is likely to lead to physical or mental harm.

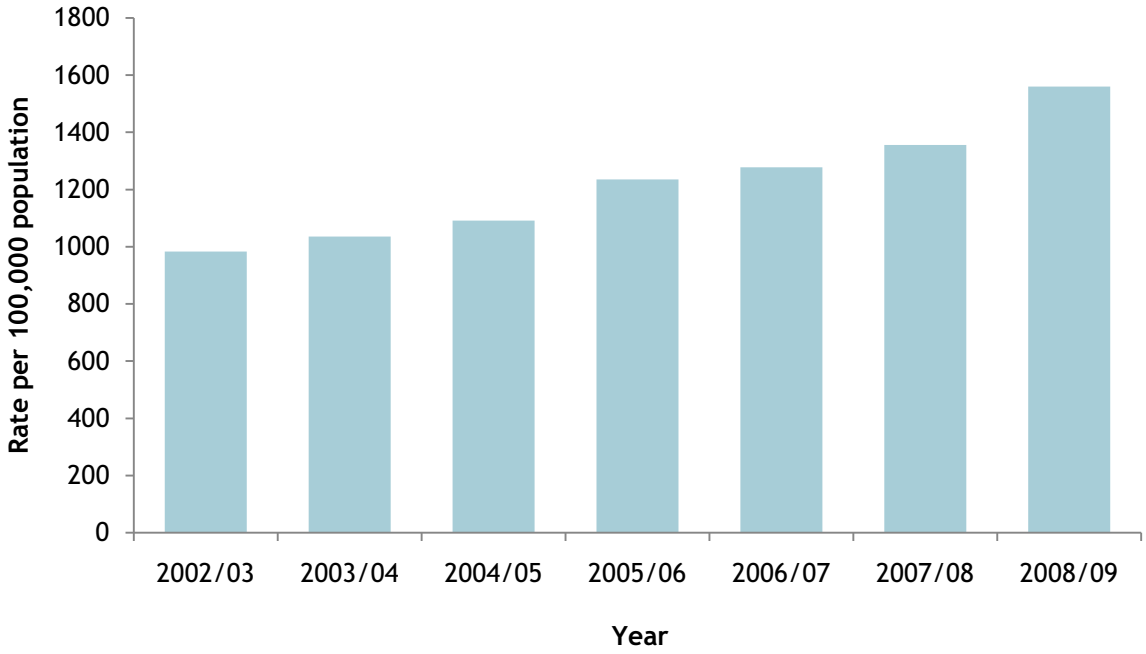


Figure 1. Trends in alcohol-attributable hospital admissions in Leeds (rate per 100,000 population)

2.1.2 Alcohol dependency and treatment

In 2007, the prevalence of alcohol dependence in the past six months among residents of Yorkshire and the Humber was 11.2% among men and 3.1% among women. In 2008/09, 1,889 clients received treatment for alcohol misuse in Tier 3 and Tier 4 agencies in Leeds.

2.2 Household expenditure on alcohol

Over the last two decades, there has been an increasing trend in the affordability of alcohol.[7] For example, in comparison to 1980, alcohol was 70% more affordable in 2009. In addition, purchases of alcohol for consumption in the home have increased overall since 1992, while purchases of alcohol for consumption outside the home have decreased.

In 2006-2008, the average household expenditure on alcoholic drinks in Yorkshire and the Humber was £14.80 per week (60% bought and consumed on licensed premises) amounting to 3.6% of total weekly household expenditure.[8] Although total household expenditure in Yorkshire and the Humber was less than the UK average, as shown in Figure 2, households in the region spent more than the England average (£14.30) on alcoholic drinks. Based on the number of households in Leeds from the 2001 Census (n=301,614), the estimated weekly spend on alcoholic drinks in Leeds is approximately £4.5 million, indicating a total spend of £232 million per annum on alcohol in the city, of which approximately £139 million is spent in on-licensed premises.

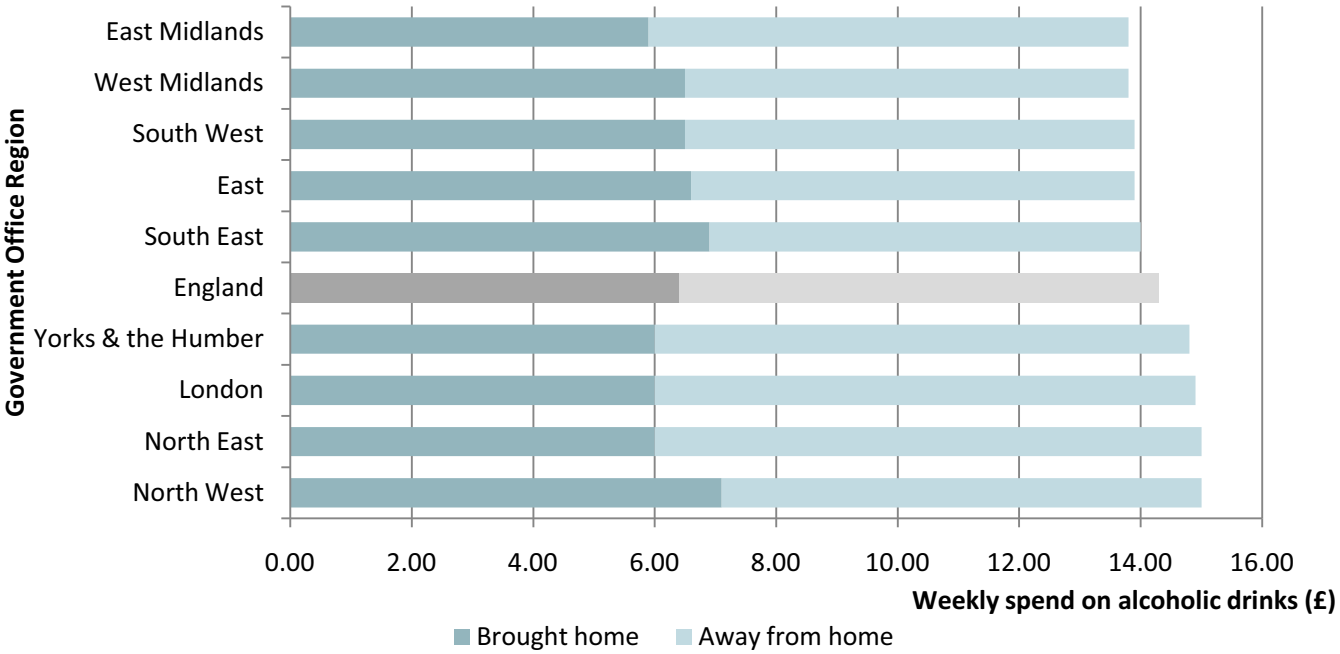


Figure 2. Weekly spend on alcoholic drinking by English Government Region, 2006-2008

2.3 The contribution of alcohol to the Leeds economy

Figures on alcohol-related employment can provide a measure of the contribution that alcohol makes to the Leeds economy, however, they do not provide a measure of the social benefits of alcohol, which lies in its consumption.[9] It should also be noted that the direct relationship between alcohol consumption and employment is unclear, and that the effect of drinking levels on employment levels in industries linked to alcohol may be relatively weak.[10]

In 2008, total employment in the Leeds Local Authority Area (LA) was 417,000 with 133,000 employees based in Leeds City Centre.[11] The majority of alcohol-related employment in Leeds is centred on jobs in pubs, bars and restaurants, and of August 2009, there were 281 licensed premises within Leeds City Centre as shown in Table 1. Employment in other industries linked to alcohol, including the production, distribution and retail of alcoholic drinks, accounted for a smaller share of alcohol-related employment in Leeds.

Table 1. Number of licensed premises in Leeds city centre, August 2009

Type	Number of licensed premises
Bars/ Public Houses	90
Restaurants	97
Takeaway	29
Nightclubs	24
Shops	29
Theatres	4
Social Clubs	4
Casinos/Bingo Halls	4

2.3.1 Alcohol production and distribution

Carlsberg UK Limited is listed as one of the top ten companies Leeds in terms of turnover, but the Carlsberg run brewery sited in Leeds is due to close in 2011 and therefore employment in the production of alcohol accounts for only a very small share of alcohol-related employment in Leeds. Employment related to the distribution of alcoholic drinks may account for a larger share of alcohol-related employment in Leeds, as Leeds is the third largest employment centre for wholesale distribution in England. In addition, ASDA Group Limited, the large supermarket chain, has its headquarters in Leeds and is one of the city's top 10 employers with over 100,000 employees locally. However, it is likely that the proportion of employees' effort related to distribution and retail of alcohol compared to other goods is fairly small.[9]

2.3.2 Alcohol retail

Over the last decade, there has been an expansion in the city's entertainment and cultural scene and a corresponding increase in the number of music venues, bars, clubs and restaurants within Leeds city centre. Since 1994, the number of city centre on-licensed premises and night clubs has more than doubled[4] and Leeds has one of the highest pub and club densities in the UK, having more than 40 pubs and clubs within a single output area (a level of geography that has an average of 400 residents).[12]

According to the Local Alcohol Profiles for England tool, Leeds ranks 97th out of 325 local authorities in England for the number of employees who work in pubs and bars.[6] Approximately 1.7% of Leeds employees work in pubs and bars, equal to an estimated 7,089 employees in pubs and bars across Leeds in 2008, and approximately 2,261 within the city centre. Employees in hotels and restaurants also have a role in the service of alcohol, and in

2008 there were around 25,300 people employed across Leeds in this sector.[11] Therefore, over 32,000 people were involved in the sale of alcohol in Leeds through pubs, clubs, restaurants and hotels as shown in Table 2. However, not all of these jobs are directly related to the consumption of alcohol. Assuming that 90-95% of jobs in bars and clubs, and 15-20% of jobs in restaurants and hotels are related to the consumption of alcohol,[9] then in 2008 between 10,175 and 11,795 jobs in Leeds were related to the sale of alcohol, representing 2-3% of all jobs in Leeds.

Labour productivity estimates[13] indicate an 'approximate Gross Value Added (GVA) per job' in current prices of £14,300 for jobs in bars, pubs and clubs and of £14,000 for jobs in restaurants.[iv] Applying these figures to the number of alcohol-related jobs in Leeds indicates that the GVA from jobs in alcohol retail was between £144.4 and £167.1 million in 2008, approximately 0.8-1% of the total Leeds' GVA in that year.

Table 2. Employment in alcohol retail sales in Leeds, 2008

	Total employees	Proportion related to alcohol	Alcohol-related employment	Approximate GVA per job
Bars and pubs	7,089	90-95%	6,380 – 6,735	£14,300
Hotels and restaurants	25,300	15-20%	3,795 – 5,060	£14,000
Total	**32,389**	**-**	**10,175 – 11,795**	**-**

Sources: NWPHO, Leeds City Council, Annual Business Inquiry

[iv] Jobs related to the service of alcohol in hotel were assumed to have similar labour productivity to jobs related to service of alcohol in restaurants.

3 METHODOLOGY

3.1 Introduction

The overall aim of the study was to identify and measure the economic and social costs of alcohol-related harm in Leeds using cost-of-illness (COI) methodology.[14] The following objectives were addressed in order to meet this aim:

- A review of the existing literature and approaches used in other COI studies, particularly those related to alcohol misuse;
- Identification of new research studies and data that enabled more robust estimates of the economic and social costs of alcohol-related harm to be derived; and
- Calculation of the economic and social costs of alcohol-related harm in Leeds.

3.2 Literature review

Literature searches were undertaken in Medline and the Health Management Information Consortium (HMIC) database to identify studies conducted in the UK and other countries that have examined the economic and social costs of alcohol misuse. The findings of the literature search are summarised in the following section of the report and reported in full in Appendix 1.

3.3 Identification of new research studies

Targeted literature searches were undertaken to identify research studies and data to enable more robust assumptions to be made about the proportion of resources that are alcohol-related. In addition to conducting searches of the academic literature, estimates used in previous COI studies were examined.

3.4 Calculation of the economic and social costs

Estimating the economic and social costs of alcohol-related harm involved: (1) identifying cost-generating components; and (2) attributing a monetary value to them. Costs included in the study were direct costs to health and social care services and the criminal justice system, and indirect costs in the form of production losses. The wider economic and social costs of alcohol-related harm were also considered including intangible or 'human' costs. Intangible costs are more difficult to measure than other types of costs, and consequently this study focused on the costs arising from alcohol-related premature mortality.

4 REVIEW OF THE ECONOMIC AND SOCIAL COSTS OF ALCOHOL-RELATED HARM

4.1 Estimation of the social and economic costs of alcohol use

A recent systematic review identified 22 studies that had examined the social costs of alcohol use.[15] The review found that the methodologies used for cost estimation varied considerably, and that a number of studies incorporated costs (e.g. transfer costs) that should not be included in cost estimation studies according to the *International guidelines*.[1] The full findings of a review of the literature on the economic and social costs of alcohol misuse undertaken for this project are presented in Appendix 1.

4.1.1 Development of international guidelines

Guidelines have been developed as part of an international initiative to develop sound methodologies and approaches for estimating the social and economic costs of substance use, including alcohol, tobacco and illicit drug use. The first set of guidelines was published in 2001,[16] with a second edition published in 2003.[1] In addition to developing a matrix of the major costs to be considered in cost estimation studies, these guidelines have included detailed discussion of the theoretical issues involved in cost estimation studies of substance use. The most recent set of guidelines[17] have been developed as a framework for the estimation of the avoidable costs of substance use. However, methods require further development as currently there are a number of difficulties in estimating avoidable proportions of the total social costs of substance use.

Box 2: Social costs associated with alcohol use

Direct

1. Consequences to health and welfare system
2. Crime, law enforcement and criminal justice
3. Road accidents
4. Fires
5. Environment
6. Research and prevention

Indirect

7. Productivity consequences in the workplace and the home

Intangible

8. Loss of life
9. Pain and suffering

Source: Single *et al.*[1]

4.1.2 Economic and social costs

Definitions of the social costs of alcohol use are shown in Table 3. The *International guidelines*[1,16] have identified the main categories, and suggested cost components, of the direct, indirect and intangible social costs to be included in cost estimates relating to alcohol use as shown in Box 2.

Table 3. Definition of social costs

Cost	Definition
Transfer costs	*Transfer costs* include tax payments, social payments, social allowances and insurance premiums. A recent review found that several transfer costs, including disability pensions, accident compensation, and social security payments were incorporated in some studies of the costs of alcohol use.[15] However, transfer payments are not considered social costs as they do not affect the amount of resources available in society and according to the *International guidelines*[1,16] should not be included in cost estimation studies. In addition, it is double counting to include both productivity losses and the costs of welfare payments in cost estimation studies. However, administrative costs associated with insurance and social welfare payments are counted as social costs. Property theft is also considered a transfer payment as it represents, according to the economic literature, the redistribution of assets from victims to the thieves and their customers. However, studies of the social costs of alcohol use have incorporated the costs of property theft by using the reduction in value of the stolen property in their cost estimations, which is considered a social cost.[15]
Private and external costs	Consumption of alcohol gives rise to both *internal* (*private*) and *external costs*. External costs are associated with the consumption of certain goods and services that fall on third parties (e.g. government funding for alcohol treatment) and private costs are those that affect the consumer (e.g. paying for private medical treatment). Although the total costs of alcohol use include both private and external costs, private costs are often not included in analyses of the social costs of alcohol use because they are considered to be offset by the benefits that a consumer gains from the consumption of alcohol.[1,16] However, costs to individuals and families were included in a recent, rapid review of the societal costs of potentially preventable illnesses, including alcohol misuse.[18] In the case of addictive substances, as Thavorncharoensap *et al.*[15] explain "addictive behaviour seems to violate the assumption of rational consumer behaviour since the addict may derive limited or no utility at all from drinking, yet will continue to do so anyway" (pg 9). The *International guidelines* recommend two approaches: (1) treat addictive substances as conventional goods and services assuming that dependent users are consuming rationally; or (2) estimate the proportion of excessive alcohol consumption and include this in the overall cost calculations.
Gross vs. net social costs	There has been much debate about the beneficial health effects of alcohol; for a full discussion of the evidence see Jones *et al.*[3] Estimation of the net costs of alcohol use takes into account the possible beneficial effects of alcohol consumption, where as estimation of gross costs, includes only costs associated with the negative effects of alcohol consumption. A review of studies of the social costs of alcohol use found that three studies, all from Australia, were based on net cost estimation, 17 studies were based on gross cost estimation, and two studies presented both approaches.[15]

Direct costs

Direct costs are those arising from expenditure as a consequence of alcohol consumption. A wide range of direct costs are associated with the treatment and prevention of alcohol use, including those within healthcare, social services and the criminal justice system.

Indirect costs

Indirect costs relate to the value of lost output due to reduced productivity caused by illness, disability or injury. Many COI studies use the human capital approach (HCA) to estimate indirect costs related to a disease or condition. The HCA is based on an individual's worth to society calculated on the basis of his or her present and future earnings, and it is the traditional method for calculating indirect costs.

Intangible costs

The measurement of productivity losses caused by illness, injury and death represents only a part of the total burden of an illness or disorder.[19] These additional costs may be termed 'human costs' and relate to the impact of illness, injury and death on the individual through pain and suffering, as well as on their friends and family. Although human costs are difficult to measure and express in monetary terms ('intangible'), the willingness to pay (WTP) approach can theoretically be used to determine such costs. However, in practice, the WTP method has been difficult to implement and has been used in very few COI studies.[19] Welfare losses have also been expressed as quality adjusted life years (QALYs), which are commonly used in economic evaluations of healthcare interventions. The QALY incorporates both the quality and quantity of the years of life that a person is expected to have.

4.2 Recent studies of the economic and social costs of alcohol

A total of 27 COI studies were identified that have examined the social and economic costs of alcohol use over the last 10 years. Ten studies examined the social and economic costs of alcohol in the UK, including in the whole of the UK,[20] England,[21-23] Scotland,[24-28] and sub-nationally in London[9] and North Somerset.[29] Eight studies examined the social and economic costs of alcohol use in European countries including Portugal,[30] France,[31,32] the Netherlands,[33] Sweden,[34,35] Germany[36] and Estonia,[37] and one study estimated costs at the European level.[10] Nine studies examined costs in the rest of the world, including the USA,[38-42] Australia[43,44] and Canada.[45] One study examined the economic costs attributable to alcohol at a global level.[46] The majority of studies considered costs from a societal viewpoint, that is, they considered a broad range of external costs related to alcohol misuse including those borne by health and social care services, the criminal justice system and in the workplace as shown in Table 4. Three studies[20,23,31] only considered healthcare expenditure related to alcohol use, but nine studies[9,10,27,28,32,34,35,38,39,43] considered a range of wider costs

related to alcohol use including the benefits of alcohol consumption, human costs (i.e. pain and suffering, quality of life), traffic accidents, research and prevention, and social welfare.

Table 4. Cost categories included

Reference	Cost categories					
	Healthcare	Social care	CJS	Workplace	Intangible	Other
United Kingdom						
UK 2005/06[20]	+	-	-	-	-	-
England 2000/01[21,22]	+	-	+	+	-	-
England 2006/07[23]	+	-	-	-	-	-
Scotland 2001/02[24,25]	+	+	+	+	-	-
Scotland 2002/03[26]	+	+	+	+	-	-
Scotland 2006/07[27]	+	+	+	+	+	-
Scotland 2007[28]	+	+	+	+	+	-
London 2000[9]	+	-	+	+	-	+[a]
North Somerset 2000/01[29]	+	-	+	+	-	-
Europe						
Portugal 1995[30]	+	-	+	+	-	-
France 1996[31]	+	-	-	-	-	-
France 1997[32]	+	-	+	+	-	+[c]
The Netherlands 2000[33]	+	+	+	+	-	-
Sweden 2002[34,35]	+	+	+	+	+	+[c]
Germany 2002[36]	+	-	-	+	-	-
Europe 2003[10]	+	-	+	+	+	+[b,c]
Estonia 2006[37]	+	-	+	+	-	-

Reference	Cost categories					
	Healthcare	Social care	CJS	Workplace	Intangible	Other
Other						
USA 1998[38]	+	-	+	+	-	+[f]
Australia 1998/99[43]	+	-	+	+	+	-
Australia 2004/05[44]	+	-	+	+	+	-
Canada 2002[45]	+	-	+	+	-	-
California 2005[39]	+	-	+	+	+	+[b,c]
Global 2007[46]	+	+	+	+	-	-

CJS – criminal justice system; [a] Benefits of alcohol consumption; [b] Traffic accidents; [c] Research and prevention; [d] Includes only the costs of 'excessive' alcohol consumption

A detailed analysis of the cost components included across the eight studies[9,21,24-29] that examined the social and economic costs of alcohol in Scotland and England is presented in Appendix 1. Table 5 summaries the estimated costs of alcohol-related harm across these studies.

Table 5. Estimated costs of alcohol-related harms in the UK (£ millions)

Component	Reference						
	England 2000/01[21, 22]	London 2000[9]	North Somerset 2000/01[29]	Scotland 2001/02[24,25]	Scotland 2002/03[26]	Scotland 2006/07[27]	Scotland 2007[28]
Healthcare	1,383 – 1,683	52	5	96	110.5	405	267.8
Social care	-	-	-	85.9	96.7	170	230.5
CJS	11,940	1,674[a]	27.3	267.9	276.7[b]	385[b]	727.1
Workplace	5,194 – 6,421	294	15.5	404.5	417.8	820	865.7
Human costs	-[c]	-	-[c]	216.7	223.8	-[c]	1,464.6
Total	**18,571-20,044**	**2,020**	**24**	**1,071**	**1,126**	**2,250**	**3,556**

CJS – criminal justice system; [a] Violent and 'other' crimes including robbery, burglary, theft and criminal damage; [b] Includes fire service expenditure; [c] Discussed but no cost estimates presented

5 THE COSTS OF HEALTHCARE

5.1 Introduction

This section presents estimates of the costs associated with healthcare resource use for conditions attributable to alcohol use.

5.2 GP and practice nurse consultations

The cost of GP and practice nurse consultations was calculated based on the methodology used to update the Cabinet Office estimates for 2008.[23] As there is no direct measure of the number of alcohol-related GP and practice nurse consultation nationally or locally then the following steps were taken.

Based on the findings of the Birmingham Untreated Heavy Drinkers (BUHD) project,[47] it was estimated that between 22% and 35% of GP consultations were alcohol-related among this cohort of heavy drinkers. Following the methods of the Department of Health report,[23] the arithmetic average of these figures, 28.5% was used in the calculation of alcohol-related consultations.

The General Lifestyle Survey (GLS) 2008 found that nationally, the number of GP consultations per year averaged four for males and five for females. The number of alcohol-related GP consultations per year was estimated by multiplying the average number of GP consultations per year by the number of high-risk drinkers in Leeds, and by the proportion of consultations that are alcohol-related (28.5%). For men, an estimated 25,205 GP consultations per year were alcohol-related and the corresponding figure for women was 18,847.

The estimate of alcohol-related consultations was also assumed to apply to practice nurse consultations and the number of alcohol-related practice nurse consultations was therefore calculated in the same way as the GP consultations. The GLS 2003 found that both men and women reported an average of two practice nurse consultations per year. Using similar calculations as previously described, for men an estimated 12,603 practice nurse consultations per year were alcohol-related, the corresponding figure for women was 7,539.

According the Personal Social Services Research Unit (PSSRU), the average 11 minute GP consultation costs £35 including qualification costs, direct care staff costs, salary oncosts and overheads in 2008/09.[48] The cost per consultation with a practice nurse was reported to be £11 including qualifications, salary oncosts and overheads. Applying these costs to the

number of alcohol-related GP and practice nurse consultations yields an annual cost of £1.5 million and £0.2 million, respectively.

- There were an estimated 44,052 alcohol-related GP consultations in Leeds in 2008/09, resulting in an estimated cost of £1.5 million.
- There were an estimated 20,141 alcohol-related practice nurse consultations in Leeds in 2008/09, resulting in an estimated cost of £0.2 million.

5.3 Other primary care usage

The Cabinet Office report[21] and subsequent update in 2008,[23] included costs for alcohol-related use of other primary care services including counselling, community psychiatric nurse visits, health visitors and usage of 'other services'. Data on the usage of these four categories of primary care services over three years were drawn from the BUHD project.[47] Table 6 presents the estimated annual usage of these services by high risk drinkers in Leeds.

Table 6. Estimated annual usage of other primary care services

Service	Estimated number of sessions per high risk drinker per year[a]		Estimated annual usage by high risk drinkers in Leeds	
	Males	Females	Males	Females
Counselling	0.20	0.93	4,422	12,300
Community Psychiatric Nurse	0.07	0.17	1,548	2,248
Health visitor	0.00	0.07	0	926
Other professionals	0.17	0.50	3,759	6,613

[a] Taken from Birmingham Untreated Heavy Drinkers project

The unit costs for each service element were taken from PSSRU 2009.[48] Community psychiatric nurse and health visitor visits were based on the costs of a 20 minute session, £18 and £32, respectively including qualification, staff oncosts and overheads. The unit cost of counselling, £42, were based on the costs of an hour of client contact and the cost of visits to 'other professionals', £1.58, were based on the costs presented in the 2008 report, uplifted to 2008/09 prices using the Hospital and Community Health Services (HCHS) pay and prices index. Applying these costs to the usage figures yielded a total annual cost of £0.8 million, as shown in Table 7.

Table 7. Estimated costs of annual usage of other primary care services

Service	Cost for usage of other primary care services		
	Males	Females	Total
Counselling	£185,722	£516,601	£702,323
Community Psychiatric Nurse	£27,342	£39,722	£67,064
Health visitor	£0	£29,626	£702,323
Other professionals	£5,932	£10,436	£16,368
Total	**£218,996**	**£596,385**	**£815,381**

5.4 Hospital inpatient visits and day hospital attendances

In order to estimate the number of hospital inpatient visits and day hospital attendances directly and indirectly attributable to alcohol, data were extracted for Leeds local authority from the Department of Health's NI39 data. This national indicator provides local measures of the rate of hospital admissions for alcohol-related harm derived from Hospital Episode Statistics (HES) data. The number of alcohol-related inpatient episodes and day patient episodes were extracted for 2008/09 for a range of alcohol-related conditions[v] as shown in Table 25 in Appendix 2.

There were a total of 4,997 alcohol-related inpatient episodes of care and 3,519 alcohol-related day patient episodes of care. According to the PSSRU 2009,[48] the national average cost per episode for an inpatient stay is £2,626 and the average cost per day case is £638. Applying these costs to the number of alcohol-related hospital inpatient visits and day hospital attendances yielded costs of £13.1 million and £2.2 million respectively.

- There were an estimated 4,997 alcohol-related hospital inpatient visits in Leeds in 2008/09, resulting in an estimated cost of £13.1 million.
- There were an estimated 3,519 alcohol-related day hospital attendances in Leeds in 2008/09, resulting in an estimated cost of £2.2 million.

5.5 Outpatient visits

The cost of outpatient visits was calculated based on the methodology used to update the Cabinet Office estimates for 2008.[23] As there is no direct measure of the number of alcohol-related outpatient visits nationally or locally then the following steps were taken.

[v] For further details on the risks of alcohol consumption and diseases and injury see Jones *et al*[3]

Findings from the BUHD project,[49] indicated that, compared to the general population, high risk drinkers were twice as likely to have used outpatient services in the past three months. Average outpatient attendances per year were reported to be an average of 1.08 for men and 1.16 for women in the GLS 2008. Based on the assumption that higher-risk drinkers use outpatient services twice as much as the general population, i.e. 2.16 and 2.32 attendances per year respectively, then the excess usage of 1.08 and 1.16 attendances per annum can be assumed to be alcohol-related attendances. Multiplying the excess usage figures by the number of high risk drinkers in Leeds yields an estimated 39,221 alcohol-related outpatient attendances per year (23,879 for men and 15,342 for women).

According to PSSRU 2009,[48] the average costs for attending adult outpatient services were £126 for 2008/09. Applying this figure to the number of alcohol-related outpatient attendances per year yields an annual cost of £4.9 million.

- There were an estimated 39,221 alcohol-related outpatient attendances in Leeds in 2008/09, resulting in an estimated cost of £4.9 million.

5.6 Accident and emergency attendances

An overall estimate of the number of alcohol-related attendances at accident and emergency (A&E) departments in Leeds is not available. However, data collected by the Safer Leeds Partnership shows that in 2009 over half of all patients who attended Leeds A&E departments complaining of assault had either consumed alcohol or believed that their assailant was drunk. In 2008/09, assaults accounted for approximately 12% of all A&E attendances in Leeds, indicating that alcohol was a factor related to attendance in approximately 7% of all A&E attendances.

Literature-based estimates of the number of A&E attendances which are alcohol-related vary, but the estimate based on the Leeds data appears to lie at the lower end of these. Studies conducted in Liverpool[50] and Birmingham[51] have estimated that between 12% and 3% of all A&E attendances, respectively, are alcohol-related. However a study conducted in Inverness,[52] which measured alcohol concentrations in saliva among attendees found that 22-25% of attendances were alcohol-related. The Cabinet Office report and recent update[21,23] used an estimate of 35% based on a MORI survey of A&E staff, and the recent Scotland report[28] used a range of estimates between 2% and 40%.

Estimates of the number of alcohol-related attendances in A&E are therefore presented as low, mid and high estimates based on 2.9%, 7% and 35% of A&E attendances being alcohol-related. These proportions are applied to the number of A&E attendance within Leeds

Primary Care Trust (PCT) in 2008/09 (n=35,030). According to the PSSRU 2009,[48] costs for A&E services for 2008/09 ranged from £126 to £93, depending on whether treatment led to admittance. Taking the average of these costs gave an estimated cost of £110 per A&E attendance. Applying this cost to the estimated number of alcohol-related attendances resulted in costs between £0.1 million and £1.3 million, as shown in Table 8.

Table 8. Estimated costs of alcohol-related A&E attendance

Proportion of A&E attendances that are alcohol-related	Number of alcohol-related attendances	Cost of A&E attendances
2.9%	1,016	£111,238
7%	2,452	£268,505
35%	12,261	£1,342,525

- There were an estimated 1,016 to 12,261 alcohol-related A&E attendances in Leeds in 2008/09, resulting in estimated costs between £0.1 and £1.3 million.

5.7 Ambulance service

Ambulance services in Leeds are provided by the Yorkshire Ambulance Service (YAS). In 2008/09 there were 451,060 emergency and urgent patient journeys across the entire region serviced by the YAS. Assuming that 16% of the estimated population of Yorkshire and the Humber reside in Leeds (based on mid-year population estimates for 2008) then an estimated 71,740 patient journeys occurred within the Leeds area.

As with the calculations presented for A&E attendances, estimates of the number of alcohol-related ambulance journeys are presented as low, mid and high estimates based on 2.9%, 7% and 35% of journeys attendances being alcohol-related. No national average cost for emergency ambulance journeys was reported by the PSSRU for 2008/09. Therefore the average cost was calculated from the average of the 2007 prices for the average cost per patient journey of paramedic unit or emergency ambulance journey (£344 and £263, respectively), uplifted to 2008/09 prices to give an average cost of £318. Applying this cost yielded estimates between £0.7 million and £8.0 million, as shown in Table 9.

Table 9. Estimated costs of alcohol-related emergency ambulance journeys

Proportion of A&E attendances that are alcohol-related	Number of alcohol-related attendances	Cost of A&E attendances
2.9%	2,080	£661,006
7%	5,022	£1,595,531
35%	25,109	£7,977,653

- There were an estimated 2,080 to 5,022 alcohol-related emergency and urgent ambulance journeys in Leeds in 2008/09, resulting in estimated costs between £0.7 and £8 million.

5.8 Alcohol dependency prescribed drugs

Drugs used in the treatment of alcohol dependence include disulfiram, long acting bendiazepines, clomethiazole and acamprosate.[vi] Following the methodology presented in the Cabinet Office report[21] and subsequent update,[23] the cost of prescriptions for these drugs were identified from the Prescription Cost Analysis for 2008/09.

In 2008/09, the net ingredient cost (NIC) to Leeds PCT for prescribing drugs used in substance dependence was £2.3 million. This cost was not broken down according to the individual substances prescribed but based on national data the assumption was made that acamprosate and disulfiram accounted for 1.5% and 0.9% of the items dispensed within this category, resulting in a total annual cost of £56,234 in 2008/09 prices.

Although long-acting benzodiazepines, such as chlordiazepoxide, and clomethiazole are also used for alcohol withdrawal as they are indicated for use in the treatment of other conditions it was not possible to determine the costs attributable to alcohol dependence. The NIC to Leeds PCT in 2008/09 for prescribing hypnotics and anxiolytics was £855,786.

- The costs of prescribing drugs for alcohol dependency in Leeds in 2008/09 were estimated at £56,234.

[vi] British National Formulary. 56 ed. London: British Medical Association and Royal Pharmaceutical Society of Great Britain; 2008

5.9 Alcohol treatment services

A wide range of treatment services are provided for alcohol users in Leeds by public sector, private sector and voluntary organisations. Services range from brief interventions (within tier 1 and 2 treatment settings) to specialist structured care and inpatient detoxification (tier 3 and 4, as defined in Models of Care[53]). Funding is also directed through a range of agencies as detailed below and in Table 10.

Community alcohol services in Leeds are delivered through a number of different treatment providers receiving funding through NHS Leeds, the local authority Adult Social Care department, Leeds Supporting People and the Safer Leeds Partnership. In addition, the Leeds Addiction Unit is funded by NHS Leeds to deliver structured intervention and detoxification for patients with complex needs.

There are three main charities in Leeds who receive funding through various streams to deliver a variety of interventions. Addiction Dependency Solutions is funded through Local the local authority Adult Social Care department and NHS Leeds to deliver community alcohol interventions and through NHS Leeds to provide brief interventions in a primary care setting. The service is also funded through the Safer Leeds Partnership to deliver treatment intervention to individuals accessing the Alcohol Treatment Requirement scheme. A scheme that provides probation supervision and alcohol treatment to offenders who have committed an alcohol related offence. St Anne's Community Services provides specialist support for alcohol users, through the provision detoxification and rehabilitation beds, and a floating support service for alcohol detoxification, rehabilitation and aftercare. The service receives funding from NHS Leeds to deliver the inpatient detoxification, the local authority Adult Social Care department to provide a rehabilitation service and from Leeds Supporting People to deliver aftercare through the floating support service. St Georges Crypt, a Christian Charity, provides care and support for homeless, vulnerable and disadvantaged people and offers two treatment services in Leeds which are both funded by Leeds Supporting People. Regent House, a Wet House is a hostel for men and permits residents to drink within the confines of the hostel and is the only project of its kind in Leeds. A second wet hostel in the city, Carr Beck, provides accommodation and support services for female dependent drinkers through Leeds Housing Concern. The Faith Lodge service, a dry hostel, provides a structured programme of skills training and confidence building. The hostel provides 14 beds for residents who have made a conscious decision to stay off alcohol and/or drugs permanently.

Expenditure on alcohol treatment services in Leeds also includes spending on out of area detoxification and rehabilitation services through NHS Leeds and the Adult Social Care budget, and alcohol arrest referral. The Alcohol Arrest Referral Service in Leeds is provided

by Crime Reduction Initiatives with funding support from the Safer Leeds Partnership. The service works in custody and the community supporting clients to access a range of services including; prescribing, housing, education training and employment and primary health care.

Table 10. Expenditure on alcohol treatment services in Leeds, 2008/09

Service	Agency or agencies providing service	Commissioned by	Annual cost
Community alcohol services	Addiction Dependency Solutions	NHS Leeds	£96,200
Community alcohol services	Addiction Dependency Solutions	Adult Social Care	£71,728
Community detoxification	Leeds Addiction Unit	NHS Leeds	£994,046
Primary Care Brief Intervention	Addiction Dependency Solutions	NHS Leeds	£140,000
Residential detoxification	St Anne's Community Services	NHS Leeds	£237,211
Residential rehabilitation	St Anne's Community Services	Adult Social Care	£357,619
Floating Housing Support	St Anne's Community Services	Leeds Supporting People	£31,180
Wet House (men)	St George's Crypt	Leeds Supporting People	£85,347
Wet House (women)	Carr Beck/Leeds Housing Concern	Leeds Supporting People	£109,003
Dry house	Faith Lodge	Leeds Supporting People	£76,875
Out of area detoxification	Various	NHS Leeds	£150,000*
Out of area rehabilitation	Various	Adult Social Care	Unknown
Alcohol treatment requirement	Addiction Dependency Solutions	European Union/Safer Leeds Partnership	Unknown
Alcohol arrest referral	Crime Reduction Initiatives	European Union/Safer Leeds Partnership	Unknown

*majority of expenditure on drug treatment services

Source: NHS Leeds

As shown in Table 10, expenditure on alcohol treatment services in Leeds in 2008/09 was £1.8 million not including expenditure through the Adult Social Care service budget, which is considered in Section 6.2. Including these Adult Social Care expenditure, and assuming that spending on out of area detoxification was half the amount reported, expenditure on alcohol treatment services in Leeds in 2008/09 was £2.2 million.

- The costs of providing alcohol treatment services in Leeds in 2008/09 were estimated at £1.8 million.

6 THE COSTS OF SOCIAL CARE

6.1 Children's and families services

Forrester and Donald[54,55] found that substance misuse was a common issue within child care social work. Based on a study of case files across four London boroughs over a 1-year period,[54] they found that parental substance misuse emerged as a major factor in 34% of cases; 14% of families were affected solely by alcohol misuse and 9% of families were affected by both drug and alcohol problems. Currently, no national study has been undertaken on the extent and nature of parental substance misuse in social work cases.

According to the Personal Social Services Expenditure and Units Costs published for England, gross total expenditure by Leeds City Council on Children's and Families services was £109,056,000 in 2007/08. Estimates for gross total expenditure on child care social work associated with parental alcohol misuse are presented in Table 11, according to different assumptions about the proportion of child care social work cases that are alcohol-related. Based on these assumptions, alcohol-related expenditure on children's and families services in Leeds in 2007/08 was between £15.3 million and £37.1 million. Using the GDP deflator series, the costs were uplifted to 2008/09, yielding estimated costs between £15.7 million and £38.0 million, with a mid-point estimate of £26.8 million.

Table 11. Estimated alcohol-related expenditure on children's and families services in Leeds

Proportion of child social care that is alcohol-related	Costs	
	2007/08	uplifted to 2008/09
Any substance misuse = 34%	£37,079,040	£38,011,461
Alcohol misuse or drug and alcohol misuse = 23%	£25,082,880	£25,713,635
Alcohol misuse only =14%	£15,267,840	£15,651,778

- The costs of child social work associated with parental alcohol misuse in Leeds in 2008/09 were estimated to be between £15.7 million and £38.0 million, with a mid-point estimate of £26.8 million.

6.2 Adult social care

According to the Personal Social Services Expenditure and Units Costs for England, gross total expenditure by Leeds City Council on adult services for substance abuse was £488,000 in 2007/08. It is not clear what proportion of this expenditure was spent in relation to alcohol misuse. Assuming that between 25% and 50% of expenditure was related to alcohol misuse, alcohol-related expenditure on adult social care services in Leeds in 2007/08 was between £122,000 and £244,000, respectively. Using the GDP deflator series, the costs were uplifted to 2008/09, yielding estimates between £125,068 and £250,136, with a mid-point estimate of £187,602.

- The costs of adult social care services related to alcohol misuse in Leeds in 2008/09 were estimated to be between £125,068 and £250,136, with a mid-point estimate of £187,602.

7 CRIMINAL JUSTICE SYSTEM COSTS

7.1 Alcohol-specific crimes

There are several low-level offences that are alcohol-specific. A recent update of the costs of alcohol-related crime found that the total cost attributable to alcohol-specific offences in England, including driving offences that do not result in death, was £208 million.[56]

The cost of an arrest was estimated at £165.15, based on an estimate of 5 hours for a drunk and disorderly arrest and for police time of £33.03 per hour. Court costs associated with alcohol-related crime were estimated based on the Office of Criminal Justice Reform's marginal unit costs and the costs (to the police, the Crown Prosecution Service, Legal Aid and Her Majesty's Courts Service) of a summary non-motoring offence in which the defendant pleaded guilty was assumed to be £407. The authors report that it was not possible to put a cost on the issuing of a caution, over and above the cost of first arresting the offender.

Proceedings, cautions and sentence disposal data were not available at a sufficient level for estimates of the volumes of alcohol-specific crime within Leeds to be calculated. The national figure was therefore adjusted to the Leeds population, assuming that 1.5% of the population of England reside within the Leeds area. Based on these calculations, the estimated cost attributable to alcohol-specific offences in the Leeds area is in the region of £3.0 million.

For a range of offences, including alcohol-related sale, purchase and consumption offences, the police may issue penalty notices for disorder (PNDs). The recent update of the costs alcohol-related crime estimated that based on 1.5 hours of police time at a cost of £33.03 per hour and a payment rate of 52%, the net cost of issuing PNDs for alcohol-specific offences was approximately £800,000.[56] Applying these estimates to the 1,787 PNDs issued by West Yorkshire Police in 2008, resulted in costs attributable to alcohol-specific PNDs of £42,498.

- The cost attributable to alcohol-specific offences in Leeds in 2008/09 was in the region of £3.0 million.

7.2 Alcohol-related crimes

It is difficult to accurately measure the proportion of crimes and offences that are alcohol-related, but studies have shown an association between alcohol misuse and disorderly and offending behaviour. Among young people, a Home Office study [57] demonstrated that there was an association between binge drinking and involvement in disorderly and criminal behaviour and based on analysis of the 2003 Offending, Crime and Justice Survey (OCJS), Matthews and Richardson[58] found that those who frequently drink to excess were more likely to report offending in the previous year than those who reported drinking less frequently.

Levels of recorded crime aggregated by offence group in Leeds LA in 2008/09 were extracted from Home Office statistics. In order to estimate the number of offences within these categories, national recorded crime statistics were used to apportion the aggregated number of offences. For example, there were 1,407 recorded robberies in Leeds LA in 2008/09 of which, according to national data, 88% were robbery from an individual and 12% were robbery from a business, resulting in 1,243 and 164 offences, respectively. These calculations were repeated for 20 alcohol-related offences. To take into account underreporting of crimes, a multiplier was applied to each recorded offence to better estimate actual volumes of crime. The multipliers were taken from two studies by Dubourg *et al*,[59] and Brand and Price,[60] respectively. The proportion of crimes and offences that were alcohol-related were taken from the 2005 OCJS.[61] These figures were based on the proportion of incidents committed by offenders aged 10-25 years old according to whether they had taken alcohol, or drugs and alcohol at the time of the incident. The proportion of alcohol-related crimes and offences were applied to the estimated number of offences in Leeds LA in 2008/09 across 20 offences, yielding the estimates shown in Table 12. Overall, there were an estimated 85,973 alcohol-related crimes and offences in Leeds LA in 2008/09, with criminal damage and theft from shops comprising the majority of the offences committed.

Table 12. Estimated number of alcohol-related crimes and offences

Type of offence	Recorded crime 2008/09	Multiplier	Estimated total offences	Proportion of alcohol-related crimes	Estimated alcohol-related offences
Burglary in business	6,368	3.7	23,562	7%	1,649
Burglary in a dwelling	9,248	2.2	20,346	7%	1,424
Criminal damage	16,586	4.3	71,320	37%	26,388
Theft of a vehicle	2,732	1.2	3,278	34%	1,115
Theft from a vehicle	7,775	2.8	21,770	34%	7,402
Aggravated vehicle taking	188	1.2	226	34%	77
Theft from a person	1,490	4.6	6,856	7%	480
Theft of a pedal cycle	1,732	3.6	6,234	7%	436
Theft from shops	5,331	100.0	533,147	7%	37,320
Other theft	7,851	2.7	21,199	7%	1,484
Robbery from individual	1,243	3.7	4,599	7%	322
Robbery from business	164	3.7	607	7%	43
Sexual offences	715	5.2	3,718	21%	781
Homicide	9	1.0	9	21%	2
Causing death by dangerous driving	0	1.0	0	100%	0
Assault on a constable	240	7.7	1,849	19%	351
Assault without injury	2,722	7.7	20,956	19%	3,982
More serious wounding	323	1.8	582	26%	151
Less serious wounding	5,468	1.8	9,842	26%	2,559
Violent disorder	20	1.8	36	21%	8

Leeds LA, 2008/09

Two Home Office studies estimated the economic and social costs of crime in 2000 and 2005, respectively.[59,60] Updated estimates of the unit costs of crime for each of the 20 offences were taken from Dubourg *et al,*[59] with the exception of crimes in the commercial and public sector which were taken from Brand and Price[60] as these figures were not updated in the more recent study. Costs were divided into three categories, estimating: (1) costs in anticipation of crime; (2) costs as a consequence of crime; and (3) criminal justice system costs. Unit costs were uplifted to 2008/09 using GDP deflators published by the HM Treasury. Applying these cost estimates to the estimated number of alcohol-related crimes and offences yielded total costs of £124.5 million, as shown in Table 13.

- There were an estimated 85,973 alcohol-related crimes and offences in Leeds LA in 2008/09, yielding total costs of £124.5 million.

Table 13. Estimated cost of alcohol-related crimes and offences in Leeds LA, 2008/09

Type of offence	Estimated total costs of alcohol-related crime			
	In anticipation	As a consequence	Criminal Justice System	Total
Burglary in business	£1,958,338	£2,556,146	£1,010,090	£5,524,574
Burglary in a dwelling	£644,453	£2,804,503	£1,841,062	£5,290,018
Criminal damage	£1,470,102	£20,761,437	£3,780,262	£26,011,800
Theft of a vehicle	£1,160,849	£3,829,788	£252,193	£5,242,831
Theft from a vehicle	£1,396,963	£5,402,712	£420,772	£7,220,447
Aggravated vehicle taking	£80,055	£264,112	£17,392	£361,559
Theft from a person	£60,563	£282,082	£118,398	£461,043
Theft of a pedal cycle	£16,372	£149,330	£149,330	£315,033
Theft from shops	£1,399,353	£2,332,255	£932,902	£4,664,511
Other theft	£55,675	£504,372	£507,827	£1,067,875
Robbery from individual	£7,686	£1,705,009	£951,954	£2,664,649
Robbery from business	£69,058	£120,054	£74,370	£263,482
Sexual offences	£7,102	£24,972,887	£2,927,648	£27,907,636

Type of offence	Estimated total costs of alcohol-related crime			
	In anticipation	As a consequence	Criminal Justice System	Total
Homicide	£816	£2,869,303	£314,879	£3,184,999
Causing death by dangerous driving	£0	£0	£0	£0
Assault on a constable	£0	£473,738	£101,858	£575,595
Assault without injury	£0	£5,369,008	£1,154,382	£6,523,390
More serious wounding	£344	£1,216,305	£2,466,133	£3,682,782
Less serious wounding	£5,818	£20,582,862	£2,845,235	£23,433,916
Violent disorder	£17	£73,227	£16,657	£89,901
Total	**£8,333,564**	**£96,269,131**	**£19,883,343**	**£124,486,039**

8 THE COSTS OF LOST PRODUCTIVITY

8.1 Presenteeism

Costs for alcohol-related reduced productivity in the workplace (or presenteeism) were not calculated in the Cabinet Office report,[21] but were included in the most recent estimate of the economic and social costs of alcohol in Scotland.[28] Calculation of these costs was based on a survey of employees undertaken by reed.co.uk, which found that an average of 0.68 days[vii] annually were lost due to alcohol-related reduced productivity in the workplace.

Assuming that full-time workers lose 0.68 days per year and part-time workers lose 0.34 days, a total of 218,857 days were lost in Leeds in 2008/09 due to alcohol-related reduced productivity in the workplace. Following the methodology presented in the study of the economic and social costs of alcohol in Scotland in 2007,[28] the median gross weekly earnings of full-time employees in Leeds in 2009 were uplifted by 10% and 20% to reflect the estimated additional costs incurred by employers, such as National Insurance and other oncosts. The median gross costs per day for employers in Leeds were £116.85 (with 10% uplift) and £127.48 (with 20% uplift). As shown in Table 14, the cost of the lost output due to alcohol-related presenteeism was between £25.6 million and £27.9 million, with a mid-point value of £26.7 million.

Table 14. Costs of alcohol-related presenteeism in 2008/09

	Days lost due to presenteeism	With 10% uplift	With 20% uplift
Assuming all employees lose 0.68 days per year	257,176	£30,051,684	£32,783,656
Assuming full-time workers lose 0.68 days per year and part-time workers lose 0.34 days per year	218,857	£25,573,983	£27,898,891

- An estimated 218,857 days were lost due to alcohol-related reduced productivity in Leeds in 2008/09, with associated costs between £25.6 and £27.9 million, with a mid-point value of £26.7 million.

[vii] Respondents reported turning up to work with a hangover on average two and a half days a year and reported themselves to be 27% less efficient on these days.

8.2 Absenteeism

The costs of alcohol-related absenteeism were also calculated based on the methodology presented in the study of the economic and social costs of alcohol in Scotland in 2007.[28] Using estimates from the Cabinet Office report,[21] between 6% and 15% of working days lost to sickness were attributed to alcohol-related sickness.

In 2008, the CBI/AXA Absence Survey found that the average days of sick leave in Yorkshire and the Humber was approximately 8.9 days. Based on the total number of person in employment in Leeds (n=378,200), and assuming that part-time workers have an average of 4.45 days of sick leave, there were nearly 3 million (2,864,449) days of sick leave in Leeds in 2008/09. Table 15 summarises the costs associated with days of sick leave according to whether 6% or 15% of the proportion of days of sick leave are assumed to be alcohol-related. The annual cost to Leeds economy in 2008/09 was estimated to be between £21.4 million and £52.5 million, with a mid-point value of £36.7 million.

Table 15. Costs of alcohol-related absenteeism in Leeds, 2008/09

	Total days of absence	Number of days of alcohol-related sick leave		Costs due to alcohol-related sick leave*	
		6%	15%	6%	15%
Full-time employees	2,362,918	141,775	354,438	£17,319,822	£43,299,556
Part-time employees	501,531	30,092	75,230	£3,676,145	£9,190,362
All employees	**2,864,449**	**171,867**	**429,667**	**£20,995,967**	**£52,489,917**

*Costs presented are the mid-point values based on the median gross cost per day uplifted by 10% or 20%

- Between 171,867 and 429,667 days were lost due to alcohol-related absenteeism in Leeds in 2008/09 with associated costs between £21.0 million and £52.5 million, with a mid-point value of £36.7 million.

8.3 Unemployment

Estimation of the costs due to alcohol-related employment followed the methods presented in the Cabinet Office report.[21] The methodology presented in this report was based on a study conducted by MacDonald and Shields,[62] who found that being a problem drinker led to a reduction in the probability of working by between 7% and 31%. Using these findings the Cabinet Office report[21] estimated that male heavy drinkers spent an average 11.4 days

per year unemployed with a corresponding figure of 8.1 days per year unemployed for female heavy drinkers. The number of economically active, alcohol dependent males and females in Leeds was calculated by applying national estimates of the proportion of heavy drinkers in the population (see Box 1) to the number of working age adults in Leeds in 2008 (aged 16-64M/59F; n=516,600) and multiplying by the economic activity rate. Based on these calculations there were an estimated 15,031 economically active, alcohol dependent males and 7,462 economically active, alcohol dependent females in Leeds in 2008.

Applying the estimates of 11.4 days per year unemployed for males and 8.1 days per year unemployed for females resulted in a total of 231,796 days per year of unemployment due to alcohol dependence in Leeds in 2008/09 (171,350 days of unemployment for male heavy drinkers and 60,445 days of unemployment for female heavy drinkers). The estimated cost to the Leeds economy in 2008/09 of unemployment due to alcohol dependence was £25.6 million.

- A total of 231,796 days were lost due to alcohol-related unemployment in Leeds in 2008/09 with associated costs of £25.6 million.

8.4 Premature mortality

The number of potential years of working life lost directly and indirectly due to alcohol misuse were calculated. The number of alcohol-related deaths in 2007 (latest data available) were calculated and are presented in 5-year age bands in Table 16.

Table 16. Number of alcohol-related deaths in Leeds, 2007

	Age (years)										
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Total
Males	1	8	2	8	11	15	11	12	22	16	106
Females	0	1	1	0	0	5	7	6	7	7	34
Total	1	9	3	8	11	20	18	18	29	23	140

Source: NWPHO

The years of potential working life lost were calculated by assuming that all of the deaths occurred at the mid-point within each age band and that men and women both retire at the age of 65 years. Overall, there were a total of 2,440 years of potential working years of life lost in Leeds in 2007; 1,963 among males and 477 among females. These figures were

adjusted to reflect the employment rate in 2008 of 73.1% among males and 69.5% among females. The value of this loss of potential working life was estimated by multiplying the years of employed life lost by the average earnings for male and female employees in Leeds in 2009, adjusted for the proportion of the workforce in full-time and part-time employment. Future earnings were discounted at 3.5% and a productivity growth rate of 2% per annum was assumed.[22] The estimated cost to the Leeds economy in 2008/09 was £29.2 million, comprising costs of £24.2 million and £5.1 million arising from alcohol-related deaths among males and females, respectively.

- A total of 2,440 years of potential working years of life were lost in Leeds in 2007 with associated costs of £29.2 million.

9 WIDER SOCIAL & ECONOMIC COSTS

9.1 Fire service attendance at alcohol-related house fires and RTAs

Expenditure on fire fighting and rescue operations in West Yorkshire was £69.1 million in 2008/09.[63] Assuming that 34% of the population of West Yorkshire reside in Leeds, then an estimated £23.5 million was spent on delivering fire fighting and rescue operations in the Leeds area. The following calculations considered the costs that the fire services incur due to alcohol-related house fires and road traffic accidents.

A report by the Department for Communities and Local Government found that substance use, including legal and illegal substance use, was common at the time of fires. In around 33% of the fire cases investigated, the victim was impaired by alcohol. Alcohol was reported to have been a direct cause of fire in 25% of fires and as a factor affecting the response to the fire in 26% of fires. In 2008/09 there were 84 primary (building) fires in West Yorkshire in which the occupier was impaired or possibly impaired by alcohol or drugs; 34 of these were in Leeds District.[viii] Assuming that the average cost of fire service attendance at a domestic fire was £27,544 per house fire resulted in estimated costs of £936,496.

There were 983 road traffic accidents (RTAs) attended by West Yorkshire Fire and Rescue Services in 2009/10; 3% of incidents attended by the service within that year.[64] In Great Britain in 2008, an estimated 6% of all road casualties occurred when someone was driving whilst over the legal alcohol limit.[65] Assuming that 6% of all RTAs attended were alcohol-related and that 3% of fire service expenditure on fire fighting and rescue operations was spent on attending RTAs, then the estimated cost in 2008/09 was £124,454. Assuming that 34% of the population of West Yorkshire resides in Leeds then the approximate costs for attending alcohol-related RTAs in Leeds in 2008/09 was in the region of £42,000.

- Costs associated with fire service attendance at alcohol-related house fires and RTAs were estimated at £1.0 million.

9.2 Lost value of non-paid work and activities before retirement

The value of the lost output among non-participants in the workforce was calculated based on the methods presented in the study of the economic and social costs of alcohol in Scotland in 2007.[28] These calculations assumed that non-participants in the workforce would have undertaken a variety of unpaid work and activities and the methods were

[viii] Personal communication from West Yorkshire Fire and Rescue Service.

similar to those used to calculate the value of lost productivity in the workforce in Section 8.4. These data indicated that 27% of men and 31% of women in the Leeds area were not in employment. To place a value on the time spent on non-work activities, the Scottish report[28] used the wage of the occupational group with the lowest median weekly earnings. As this data was not available for Leeds, the weekly earnings of the bottom 10% of earners in 2009, of £279.40 for males and £267.40 for females, was used in the calculations presented here. Converting these to annual earnings resulted in proxy annualised earnings of £14,569 for males and £13,943 for females.

Applying these annual values to the premature years of life lost among the non-participants in the workforce, discounting future earnings at 3.5% and assuming a productivity growth rate of 2% per annum,[22] resulted in costs to the Leeds economy of £8.1 million. These costs comprised £6.4 million and £1.7 million arising from alcohol-related deaths among males and females, respectively.

- Costs associated with the lost output of non-participants in the workforce were estimated at £8.1 million.

9.3 Lost value of non-paid work and activities after retirement

The value of non-paid work undertaken between retirement and the age of 75 was also calculated. Between the ages of 65 to 74 years there were 37 alcohol-related deaths in Leeds in 2007. Based on the expected life span, a total of 559 years of life were lost prematurely after retirement. Using the same methodology as the study of the economic and social costs of alcohol in Scotland in 2007,[28] the value of the non-paid activities undertaken was calculated as the annualised half of the weekly earnings of the bottom 10% of earners in Leeds in 2009 of £270.30, giving a value of £7,047 per year for males and females. Applying this value to the premature years of life lost and discounting by 3.5%, yielded total costs associated with non-paid work and activities after retirement up to the age of 75 years of £3.0 million (£1.8 million for males and £1.2 million for females).

9.4 Intangible costs

The intangible or human costs associated with alcohol-related morbidity and mortality were calculated based on the methods presented in the study of the economic and social costs of alcohol in Scotland in 2007.[28] These study identified two values of a year of life: (1) £30,000 based on the upper threshold QALY used by the National Institute for Health and Clinical Excellence; and (2) £50,000 based on the views of the Department of Health. As in the

Scotland study, these values were used to estimate the human costs associated with premature mortality directly and indirectly due to alcohol misuse.

Years of life lost up to the age of 75 years were calculated based on the number of alcohol-related deaths in Leeds in 2007, within 5-year age bands. A total of 5,235 years of life were lost due to premature mortality in Leeds in 2007. As shown in Table 17, applying a value of £30,000 to every year of life lost due to alcohol-related premature mortality in Leeds in 2007 yielded total costs of £92.3 million (discounted at 3.5%). For a value of £50,000 per life year the associated costs were £153.9 million (discounted at 3.5%). The midpoint of these values was £123.1 million.

Table 17. Intangible costs of premature mortality

	Years of life lost	Costs of premature mortality	
		£30,000 per life year	£50,000 per life year
Males	3,894	£67,898,626	£113,164,377
Females	1,341	£24,434,469	£40,724,114
Total	5,235	£92,333,095	£153,888,492

- A total of 5,235 years of life were lost due to premature mortality in Leeds yielding intangible or human costs between £92.3 million and £153.9 million, with a midpoint of £123.1 million.

9.5 School failure and reduced educational attainment

Alcohol use among young people is associated with school failure and reduced educational attainment. In the 2007 ESPAD report, 13% of young people aged 15-16 years old reported performing poorly at school or work because of their alcohol use. A recent study based on data from the UK National Child Development Study[66] found that male heavy drinking in adolescence had a negative effect on the receipt of postsecondary qualifications by age 42. Males from working-class families were most affected by heavy alcohol use in these analyses, but heavy alcohol use had little effect on female educational attainment. Analyses of data from the US National Longitudinal Survey of Youth 1979, has shown that late graduation as a consequence of binge drinking during the senior year of high school is associated with lower labour earnings.[67,68]

Although there is evidence for an association between alcohol use among young people and educational attainment, and the subsequent effects of this on earning potential, there are

currently no methods on the basis of which it would be possible to estimate the related costs to society.

9.6 Alcohol-related litter

Alcohol-related litter represents a serious environmental health and community safety issue in many communities.[69] For example, a study of drug and alcohol-related litter in a social housing community in Scotland found little evidence of drug related litter, but identified more than 1,400 items of alcohol-related litter, much of which was glass (including intact and broken glass).[70] Of the quarter of respondents to the 2008/09 British Crime Survey[71] who thought that people being drunk or rowdy in public places was a very or fairly big problem in their area, two-thirds reported experiencing cans and bottles left on the streets or thrown into gardens, and as part of a local campaign to tackle litter in Stockport, alcohol-related litter was identified on 62% of paths.[72]

Although there is evidence to suggest that alcohol-related litter can be a significant issue in many communities, there is currently insufficient data on the basis of which it would be possible to estimate the costs associated with alcohol-related litter clean-up.

10 DISCUSSION

Alcohol misuse imposes a considerable burden on the Leeds economy, costing an estimated £438.0 million in 2008/09. Of the total costs, 13% were due to expenditure on health and social care services, 29% of costs were due to expenditure on crime and within the criminal justice system, 27% were due to lost productivity and 31% were due to the wider social costs of alcohol misuse.

Alcohol plays an important role in society and makes a contribution to the Leeds economy, both directly and indirectly, through employment in industries related to alcohol. The contribution that alcohol makes to the Leeds economy is mainly through employment in pubs, bars and restaurants, and the expansion in the city's nightlife scene has been central to the development of the city centre over the last decade. The Leeds economy also derives a small benefit from employment in industries related to the production, distribution and retail of alcoholic drinks. The social benefits of alcohol lie in its consumption and in the Yorkshire and Humber region, three quarters of men and almost three fifths of women report drinking on a weekly basis. Households in the region also spend more per week than the national average on alcoholic drinks, with households in Leeds alone spending an estimated £4.5 million on alcoholic drinks per year. However, as well as bringing benefits, alcohol is associated with a range of harms. For example, the impact of alcohol on health shortens the life expectancy of male and female residents in Leeds by an average of 11 and 5 months, respectively, and resulted in approximately 12,800 alcohol-related hospital admissions in 2008/09. There is also an association between alcohol use and offending, and excessive alcohol consumption also affects productivity in the workplace, for example, by increasing the likelihood of employees being absent from work.

Cost-of-illness methods were used to estimate the economic and social costs of alcohol-related harm in Leeds, an approach which was been widely used in other costing studies to estimate the burden of alcohol misuse to society. These methods are not a form of economic evaluation but they do provide a clear means of presenting and understanding the economic costs attributable to alcohol use. The impact of alcohol-related harm in Leeds was examined by estimating: alcohol-related expenditure on health and social care and within the criminal justice system; the wider costs including productivity losses in the workplace; and the human costs representing the impact of illness, injury and death on the individual through pain and suffering, as well as on their friends and family.

The total annual burden of alcohol to the Leeds economy was estimated to be £438.0 million in 2008/09. As shown in the Table 18 below, the wider social costs of alcohol misuse

(including human costs) and lost productivity together comprised nearly three fifths of the total costs to the Leeds economy. Health and social care costs comprised the smallest amount of the costs attributable to alcohol use.

Table 18. Annual costs of alcohol misuse to the Leeds economy, 2008/09

Resource	Annual cost (£ million)
Health and social care	57.6
Criminal justice system	127.5
Workplace and productivity	117.7
Wider social costs	135.2
Total	**438.0**

It should be noted that there are limitations to the estimates derived. Some costs associated with alcohol misuse have not been calculated; including the costs associated with cleaning up alcohol-related litter and the costs associated with school failure and reduced educational attainment. The costs calculated were often based on assumptions drawn from the national and international literature and in these cases it is not known whether the estimates derived were over or under the true costs. However, where possible we have presented conservative estimates for these costs.

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APPENDICES

Appendix 1: Studies of the economic and social costs of alcohol misuse

METHODS

A review of the existing literature was undertaken to locate studies conducted in the UK and other countries that have examined the economic and social costs of alcohol misuse. Literature searches were conducted in Medline and the Health Management Information Consortium (HMIC) database to identify relevant English language studies published since 1999 (see Box 2).

Box 2. Search strategies

Medline (n=101)

1 ((burden or cost) adj (disease or illness or ill health)).ti,ab.
2 ((social or societal) adj cost*).ti,ab.
3 (economic adj (cost* or impact*)).ti,ab.
4 1 or 2 or 3
5 alcohol.ti,ab.
6 4 and 5

HMIC (n=43)

1 alcohol.ti,ab
2 cost*.ti,ab
3 (social OR societal OR economic).ti,ab
4 1 AND 2 AND 3

After removal of duplicates, a total of 140 references were identified. Thirteen references were deemed to be relevant based on abstract and title screening and full copies of these publications were sought, 11 of which were identified as cost-of-illness studies. In addition, the references of retrieved articles and other sources[ix] were scanned for additional references. An additional 16 references were identified in this manner, and therefore a total of 27 cost-of-illness studies were identified that examined the social and economic costs of alcohol use. This section focuses on a detailed analysis of the cost components included across the eight studies[9,21,24-29] that have examined the social and economic costs of alcohol in Scotland and England. The two studies[20,23] that only considered the costs of alcohol use to the NHS were not examined further.

[ix] Other references known to the authors, for example Thavorncharoensap et al.[15]

HEALTHCARE COSTS

A summary of the cost components related to alcohol-related healthcare resource use which have been included in UK studies of the social and economic costs of alcohol misuse is shown in Table 19.

Table 19. Healthcare cost components

Component	Reference						
	England 2000/01[21,22]	London 2000[9]	North Somerset 2000/01[29]	Scotland 2001/02[24,25]	Scotland 2002/03[26]	Scotland 2006/07[27]	Scotland 2007[28]
GP and practice nurse consultations	+	+	+	+	+	+	+
Community psychiatric team	-	-	-	+	+	+	+
Hospital inpatient visits	+	+	+	+	+	+	+[b]
Hospital outpatient visits	+	+	+	+	+	+	+
Day hospital attendances	+	-	-	+	+	+	+
A&E attendances	+	+	+	+	+	+	+
Ambulance services	+	+	+	+	+	+	+
Drug prescriptions	+[c]	-	+[c]	+	+	+[d]	+[e]
Laboratory tests	+	+	-	+	+	+	+
Alcohol treatment services	+	-	+	-[f]	-	-[f]	+
Other	+[g]	-	+[g]	+[h, i]	+[h]	-	-
Total costs (£ million)	**1,383 – 1,683**	**51.7**	**4.7**	**95.6**	**110.5**	**405**	**267.8**

[a] Community psychiatric nurses; [b] Psychiatric, non-psychiatric and maternity; [c] Dependency-prescribed; [d] GP-prescribed; [e] Community-prescribed; [f] Included within social care costs; [g] Counselling, community psychiatric nurse, health visitor and 'other services'; [h] Health board payments; [i] Health visitors.

Health care cost components have included both primary and secondary care costs, and the costs of specialist alcohol treatment services. All studies calculated resource use relating to conditions wholly (e.g. alcoholic liver cirrhosis) and partly (e.g. breast cancer) attributable to alcohol consumption based on alcohol-attributable fractions.

GP and practice nurse consultations

For the studies of alcohol costs in England (including the whole of England,[21] London[9] and North Somerset,[29] respectively) estimates of GP and nurse practice consultations due to alcohol misuse were based on data from the 2000/01 General Household Survey (GHS)[73] combined with, for two studies,[21,29] data from the Birmingham Untreated Heavy Drinkers Study (BUHDS).[47] The 2000 London study[9] used estimates from the 2001/02 Scotland study.[24,25] For the four studies of social and economic costs of alcohol misuse in Scotland,[24-27] estimates for consultations wholly and partly attributable to alcohol were based on data from Scottish general practices (either Continuous Morbidity Recording or the Practice Team Information database in later studies). The proportion of consultations

wholly and partly due to alcohol use were calculated based on alcohol-attributable fractions.[21,24,74]

Community psychiatric team

Only costs relating to community psychiatric nurses were included in the 2000/01 England study, based on service use from the BUHDS.[47] For all four Scottish studies,[24-27] the amount of community psychiatric team contact attributable to alcohol use in Scotland was assumed to be the mid-point between the proportion of GP and inpatient visits attributable to alcohol.

Hospital inpatient visits

Hospital inpatient visits directly and indirectly attributable to alcohol were based on data from hospital admissions databases (Hospital Episode Statistics for England and Scottish Morbidity Record for Scotland). Wholly and partly alcohol-attributable visits were calculated based on alcohol-attributable fractions.[21,24,74]

Hospital outpatient visits

For England and North Somerset, outpatient attendances due to alcohol misuse were based on data from the 2000/01 GHS[73] and BUHDS.[47] For the four studies of alcohol misuse in Scotland,[24-27] outpatient attendances due to alcohol misuse were assumed to be the mid-point between the proportion of GP and the inpatient visits attributable to alcohol. For the 2000 London study,[9] estimates for the proportion of outpatient visits related to alcohol use were based on assumptions from the 2001/02 Scotland study.[24,25]

Day hospital attendances

For the 2000/01 England study,[21] day hospital attendances attributable to alcohol were estimated in the same way as inpatient visits. For the four Scottish studies,[24-27] day hospital attendances due to alcohol were assumed to be the mid-point between the proportion of GP and the inpatient visits attributable to alcohol.

Accident and emergency attendance

In the 2000/01 England study[21] and North Somerset study,[29] accident and emergency (A&E) attendance attributable to alcohol misuse was estimated based on Hospital Activity Statistics and research by MORI.[21] For the 2001/02 and 2002/03 Scotland studies,[24-26] the number of A&E attendances attributable to alcohol misuse were estimated based on data from ISD Scotland and the assumption that 12% of A&E attendances are alcohol-related.[50] For two more recent studies of alcohol-related costs in Scotland,[27,28] the proportion of A&E attendances estimated to be alcohol-related were based on assumptions drawn from the 2000/01 England study[21] and a range of sources,[23,27,51,75,76] respectively.

Ambulance services

Estimates of alcohol-related ambulance service resource use were calculated using an approach similar to the one used to estimate A&E attendance, although the 2007 Scotland study was based on assumptions drawn from different sources.[23,27,77-79]

Drug prescriptions

Data on the number of drug prescriptions attributable to alcohol misuse were drawn from the Prescription Cost Analysis. For the majority of studies,[21,24-27] only the costs of drugs specifically prescribed for alcohol dependency, acamprosate and disulfiram, were included. The 2007 Scotland study[28] also included the proportion of costs attributable to use of naltrexone hydrochloride and benzodiazepines in the treatment of alcohol dependency and alcohol withdrawal syndrome, respectively.

Laboratory tests

The number of laboratory tests attributable to alcohol use was estimated from the number of GP consultations directly attributable to alcohol consumption for all studies except the 2007 Scotland study,[28] which was based on an arbitrary assumption that 25% of patients consulting with a GP or practice nurse because of alcohol misuse would undergo blood and biochemistry tests.

Alcohol treatment services

For studies of the costs of alcohol in England[21] and in North Somerset,[29] spending on specialist alcohol treatment services was based on a mapping of alcohol services by Alcohol Concern.[80] Data from an Audit Scotland report were used to inform the costs estimates presented in the 2007 Scotland study.[81]

Other

In the studies of alcohol-related costs in England and North Somerset, additional costs relating to primary care use, including counselling, health visitors, community psychiatric nurses and other undefined services, were based on data from the 2000/01 GHS[73] and BUHDS.[47] The 2001/02 and 2002/03 Scotland studies,[24-26] included health board payments to alcohol-related voluntary organisations.[82]

SOCIAL CARE COSTS

As shown in Table 20, only the four studies that examined the social and economic costs of alcohol use in Scotland incorporated social care expenditure in the overall costs of alcohol misuse.

Table 20. Social care cost components

Component	Reference						
	England 2000/01[21,22]	London 2000[9]	North Somerset 2000/01[29]	Scotland 2001/02[24,25]	Scotland 2002/03[26]	Scotland 2006/07[27]	Scotland 2007[28]
Children and families services	-	-	-	+	+	+	+
Community care	-	-	-	+	+	+	-
Children's hearing services	-	-	-	+	+	+	+
Criminal justice social work	-	-	-	+	+	+	+
Care homes	-	-	-	-	-	-	+
Total costs (£ million)	**-**	**-**	**-**	**85.9**	**96.7**	**170**	**230.5**

Children and families services

Alcohol-related expenditure on children's social work in Scotland was drawn from Local Government Finance Statistics, and based on the assumption that 24% of cases were related to alcohol misuse.[83] The 2007 Scotland study[28] also presented calculations based on assumptions that between 15% and 45% of social cases were alcohol-related.

Community care

Expenditure on community care for alcohol-related problems, including day centres, residential and nursing homes and other services were only included in the 2001/02 and 2006/07 Scotland studies.[24,25,27] Estimates were based on the assumption that 20%[24,25] and 25%[27] of expenditure on community care services, respectively, was attributable to alcohol misuse. The 2007 Scotland study included expenditure on care homes for adults, assuming that between 25% and 50% of costs were related to alcohol misuse.

Children's hearing services

The numbers of referrals to the Children's Hearing System were drawn from the Scottish Children's Reporter Administration. Assumptions used to calculate the costs of children and families services were applied to estimate the proportion of costs related to alcohol misuse.

Criminal justice social work

The assumption that 27% of alcohol-related community service and probation orders were alcohol-related was used as a proxy for the proportion of criminal justice social work expenditure associated with alcohol misuse in all four Scottish studies.[24-28]

CRIMINAL JUSTICE SYSTEM COSTS

As shown in Table 21, resource use within the criminal justice system was included as a cost component for the majority of studies of the economic and social costs of alcohol use in the UK. Costs incurred in anticipation of, in response to and as a consequence of alcohol-related crime were included in the studies of alcohol-related costs for England,[21] North Somerset[29] and Scotland (2007).[28] Only costs in response to alcohol-related crime were included in the earlier studies of alcohol-related costs in Scotland.[24-27]

Table 21. Criminal justice cost components

Component	Reference						
	England 2000/01[21,22]	London 2000[9]	North Somerset 2000/01[29]	Scotland 2001/02[24,25]	Scotland 2002/03[26]	Scotland 2006/07[27]	Scotland 2007[28]
Anticipation of crime [a]	+	+	+	-	-	-	+
Response to crime[b]	+	+	+	+	+	+	+
Consequences of crime[c]	+	+	+	-	-	-	+
Drink driving	+	+	+	+	+	+	+
Emergency services	-	-	-	-	+	+	-
Total costs (£ million)	**11,940**	**1,674[d]**	**27.3**	**267.9**	**276.7[e]**	**385[e]**	**727.1**

[a] Defensive expenditure (e.g. security measures) and administrative costs for insurance; [b] criminal justice costs including police, court and prison expenditure; [c] Emotional impact on victim, victim services and lost output; [d] violent and 'other' crimes including robbery, burglary, theft and criminal damage; [e] includes fire service expenditure

It is difficult to accurately measure the proportion of crimes and offences that are alcohol-related, and the studies of alcohol-related costs in England and Scotland consequently drew on a range of estimates. For example, the 2000/01 England study[21] and North Somerset study[29] were based on estimates of alcohol-related crime from the NEW-ADAM arrestee survey,[22] and on the assumption that 47% of violent offences[84] and 36% of homicides[85] are alcohol-related. The 2001/02 Scotland study, and the subsequent updates for 2002/03 and 2006/07, were based on the assumption that 25% of crimes and offences are alcohol-related,[86] and the most recent assessment of alcohol-related costs in Scotland[28] used alcohol attributable fractions derived by the University of Sheffield.[87] The source for estimates of the proportion of crimes and offences attributable to alcohol are summarised in Table 22.

Table 22. Source of estimates for the proportion of alcohol-related crimes and offences

Reference	Crimes and offences included	% alcohol-related	*Source*
England 2000/01[21,22] North Somerset 2000/01[29]	Homicide	36%	*Brookman & Maguire*[85]
	Common assault	47%	*British Crime Survey*[84]
	Wounding	47%	*British Crime Survey*[84]
	Sexual offences	13%	*NEW-ADAM*[22]
	Burglary (in business or in a dwelling)	17%	*NEW-ADAM*[22]
	Criminal damage	47%	*NEW-ADAM*[22]
	Robbery (from individual or business)	12%	*NEW-ADAM*[22]
	Theft (from a person; of a pedal cycle; of a vehicle; from a vehicle; attempted vehicle theft; other theft and handling)	13%	*NEW-ADAM*[22]
London 2000[9]	Violent crime	40%	*British Crime Survey*[88]
	Robbery	75%	*Bennett 2000*[89]
	Burglary in a dwelling	8%	*Bennett 2000*[89]
	Burglary in business	17%	*Bennett 2000*[89]
	Theft from a vehicle	0%	*Bennett 2000*[89]
	Theft of a vehicle	30%	*Bennett 2000*[89]
	Shoplifting	7%	*Bennett 2000*[89]
	Other theft	13%	*Bennett 2000*[89]
	Criminal damage	29%	*Bennett 2000*[89]
Scotland 2001/02[24,25] Scotland 2002/03[26]	Serious assault (including homicide); handling offensive weapons; robbery; other non-sexual violent crimes; sexual assault; lewd and indecent behaviour; other crimes of indecency; housebreaking; theft by opening lockfast places; theft of a motor vehicle; shoplifting; other theft; fraud; other crimes of dishonesty; criminal damage; crimes against public justice; drugs; other crimes; simple assault; breach of the peace; other misc offences; motor vehicle offences	25%	*Bennett 1998*[86]
Scotland 2006/07[27]	Serious assault	40%	*Unclear*
	Rape and attempted rape	40%	*Unclear*
	Minor assault	40%	*Unclear*
	All other recorded crime	25%	*Bennett*[86]
Scotland 2007[28]	Serious assault, other non-sexual crimes of violence	3-48%	*University of Sheffield*[87]
	Robbery	1-11%	*University of Sheffield*[87]
	Total sexual offences	2-43%	*University of Sheffield*[87]
	Housebreaking (domestic dwelling/non-dwelling and other)	1-11%	*University of Sheffield*[87]
	Theft from or of a motor vehicle	0-46%	*University of Sheffield*[87]
	Shoplifting	1-11%	*University of Sheffield*[87]
	Other theft	1-11%	*University of Sheffield*[87]
	Criminal damage	4-58%	*University of Sheffield*[87]
	Minor assault	1-36%	*University of Sheffield*[87]

Costs associated with alcohol-specific crimes in the 2000/01 England study[21] included drunkenness in custody suites, costs incurred in Magistrate Courts when processing drunkenness, disorder and other related offences, and drink driving. For custody costs, estimates of the costs for alcohol-specific and alcohol-related arrests[90] were combined with estimates of the proportion of alcohol-related crimes and offences[22] and numbers of arrests.[91] Estimates for costs incurred in Magistrate Courts were taken from the Criminal Justice Statistics for England and Wales.[92] Drink driving costs included those related to arrest,[90] proceedings at Magistrate and Crown courts,[93] lost output, the health service and

human costs.[94-96] For the four Scottish studies,[24-28] drunkenness and drunk driving were included as alcohol-specific costs and included those related to custody, court proceedings and prosecution, and imposing penalties.

Anticipation of crime

Costs in anticipation of crime, including security expenditure and insurance administration, were included in the studies of alcohol-related costs for England,[21] London,[9] North Somerset[29] and Scotland (2007).[28] Cost estimates were based on unit costs drawn from Home Office studies of the economic and social costs of crime.[59,60]

Consequences of crime

Costs as a consequence of crime, covering the cost of damaged or stolen property, victim support, the physical and emotional impact of crime and lost output, were included in the studies of alcohol-related costs for England,[21] London,[9] North Somerset[29] and Scotland (2007).[28] Cost estimates were based on unit costs drawn from Home Office studies of the economic and social costs of crime.[59,60]

Response to crime

Costs incurred as a result of crime through the criminal justice system were included in all studies, and included costs related to the police, courts and prison and probation services. For studies of alcohol-related costs in England,[21] London,[9] North Somerset[29] and Scotland (2007),[28] the average costs of alcohol-related crime and offences were based on Home Office estimates of the economic and social costs of crime.[59,60] For the earlier studies of alcohol-related crime in Scotland,[24-27] costs were drawn from expenditure on the police, courts and prisons in Scotland.

WORKPLACE AND PRODUCTIVITY COSTS

The majority of studies that have examined the social and economic costs of alcohol use in the UK have considered the impact of alcohol on the workplace and wider economy. Excessive alcohol consumption affects the workplace through impaired performance at work ('reduced productivity'), and by increasing the likelihood of employees being absent from work ('absenteeism'). In addition, heavy and dependent drinkers may be more likely to be unemployed. Alcohol also contributes to lost productivity in the workplace through premature deaths related to alcohol use. As shown in Table 23, all eight studies examined alcohol-related costs associated with the workplace and wider economy.

Table 23. Workplace and productivity costs

Component	Reference						
	England 2000/01[21,22]	London 2000[9]	North Somerset 2000/01[29]	Scotland 2001/02[24,25]	Scotland 2002/03[26]	Scotland 2006/07[27]	Scotland 2007[28]
Premature mortality	+	-	+	+[a]	+	+	+
Absenteeism	+	+	+	+	+	+	+
Reduced productivity	-[b]	-	-	-	-	+	+
Unemployment	+	-	+	+	+	+	+
Total costs (£ million)	**5,194 – 6,421**	**294**	**15.5**	**404.5**	**417.8**	**820**	**865.7**

[a] Working and non-working population; [b] Not able to calculate

Premature mortality in the working population

Deaths directly and indirectly related to alcohol misuse were estimated based on data from Mortality Statistics for England and Wales[97] for the studies of costs in England, and from the General Register Office for studies of costs in Scotland. The numbers of alcohol-related deaths were used to estimate the number of years of working life lost, based on the assumption that men and women retire at the age of 65. Data on economic activity in the UK were drawn from the Labour Force Survey. For the 2000/01 England, 2006/07 Scotland and 2007 Scotland studies,[21,27,28] costs were estimated based on the HCA, that is, lost output due to premature mortality was estimated as the product of the number of alcohol-related deaths and the present value of future earnings based on average wages (for example, from the New Earnings Survey[98] or more recently the Annual Survey of Hours and Earnings[99]). The 2001/02 Scotland study[24,25] used the WTP approach, which involves assessing the monetary value which people put on reducing the risks associated with mortality. The costs associated with premature mortality among the working population were based on the value for a year of life derived by the then Department of the Environment, Transport and the Regions (DETR) of £27,022 (2001/02 prices).

Absenteeism

For the 2000/01 England study, employee absences due to alcohol dependence were estimated to be 1.27 times more likely than among those without alcohol dependence and absences due to alcohol-related injury were assumed to contribute to two additional days of absence over and above the population average.[100] After accounting for part-time and full-time employment rates in 2001, and based on estimates of alcohol dependency among employees,[101] almost 11 million days were estimated to have been lost among alcohol dependent employees. Incorporating absences due to alcohol-related injuries, based on national prevalence rates for alcohol consumption,[73] an upper estimate of around 17 million days lost due to alcohol misuse was calculated. The 2001/02 Scotland report only included days lost due to alcohol dependency. Assuming that alcohol dependent employees in Scotland,[102] were three times more likely to be absent than non-dependent employees resulted in an additional 1,164,344 working days lost due to alcohol dependency. The 2006/07 and 2007 Scotland studies,[27,28] were based on estimates from the 2000/01 England study that between 6 and 15% of working days were lost to alcohol misuse.[x] These estimates were applied to national level data on absenteeism (2006 and 2008 CBI survey) adjusted to Scotland.

Reduced productivity

No alcohol-related costs for reduced productivity in the workplace were calculated for the 2000/01 England study,[21,22] or the earlier estimates of the economic and social costs of alcohol in Scotland.[24-26] Based on a survey of employees by reed.co.uk, calculations of reduced productivity in the workplace in the 2006/07 and 2007 Scotland studies[27,28] were based on the assumption that an average of 0.68 days[xi] annually were lost due to alcohol-related reduced productivity in the workplace.

Unemployment

The 2000/01 England study was based on data showing that heavy male drinkers (>50 units a week) spend an average of 11.4 days per annum out of employment.[62] A high estimate of the number of days out of employment for heavy drinkers also included female drinkers. The 2001/02 Scotland study[24,25] used data on the prevalence rate for alcohol dependency stratified by employment status[102] to calculate the unemployment rate among those with alcohol dependency. This in turn was used to calculate the excess employment rates among males and female dependent drinkers. The 2006/07 Scotland study[27] replicated the methodology presented in this earlier Scottish study, and the 2007 Scotland study[28] presented estimates based on both approaches.

[x] Estimates presented in the 2000/01 England study actually corresponds to 6-10% of days lost.

[xi] Respondents reported turning up to work with a hangover on average two and a half days a year and reported themselves to be 27% less efficient on these days.

INTANGIBLE COSTS

As shown in Table 24, attempts were made to calculate the human costs (e.g. pain and suffering) associated with alcohol-related morbidity and mortality in the studies of alcohol-related costs in England[21] and Scotland.[24-28] These costs are known as 'intangible' costs, because of the difficulties in quantifying and measuring them.

Table 24. Human costs associated with alcohol misuse

Component	Reference						
	England 2000/01[21,22]	London 2000[9]	North Somerset 2000/01[29]	Scotland 2001/02[24,25]	Scotland 2002/03[26]	Scotland 2006/07[27]	Scotland 2007[28]
Human costs associated with premature death	-	-	-	-	-	-	+
Premature mortality, non-working population	-	-	-	+	-	+	+
Premature mortality, post-retirement population	-	-	-	-	-	-	+
Total costs (£ million)	**-[c]**	**-**	**-[c]**	**216.7**	**223.8**	**-[c]**	**1,464.6**

[a] Included in workplace and productivity costs; [b] Not included in total cost estimates; [c] No cost estimate presented.

The 2000/01 England study[21,22] discussed the human costs associated with alcohol-related morbidity and mortality but these costs were not quantified as no current UK studies were identified that examined the value of human costs associated with alcohol misuse. The 2001/02 study of alcohol-related costs in Scotland[24,25] and subsequent updates in 2002/03 and 2006/07[26,27] estimated the costs of premature mortality among the non-working population using a value for a year of life derived by DETR of £27,022 (2001/02 prices). This estimate was produced using a WTP approach, as described in Section 0. The most recent analysis of alcohol-related costs in Scotland (2007)[28] used two potential values for a year of life: (1) £30,000 based on the upper threshold QALY used by the National Institute for Health and Clinical Excellence; and (2) £50,000 based on the views of the Department of Health.

OTHER SOCIAL AND ECONOMIC COSTS

Other costs associated with alcohol use were considered across the included studies. These included costs related to the fire service,[27,28] research and prevention,[21,24,25] and the benefits of alcohol consumption.[9]

Fire service

The two most recent studies of the social and economic costs of alcohol misuse in Scotland[27,28] considered the costs to fire service. For the 2006/07 Scotland study,[27] costs relating to the attendance of fire fighting and rescue services at fires started deliberately were included, of which 25% were assumed to alcohol-related. The 2007 Scotland study[28] included the cost of fire service attendance at alcohol-related road traffic accidents and at house fires, in which alcohol was a direct or indirect factor. These two cost estimates were not able to be quantified in the 2001/02 Scotland study.[24]

Research and prevention

Costs relating to expenditure for alcohol-related research and prevention efforts were incorporated in the 2000/01 England and 2001/02 Scotland studies.[21,24] It was not clear how much expenditure on research costs was included in the 2000/01 England study. Costs relating to health promotion and prevention by the Health Education Board for Scotland (HEBS), Scottish Executive and Health Boards were included in the 2001/02 Scotland study at a total annual cost of £1.2 million.[24,25]

Benefits of alcohol consumption

Only one study, of the economic costs of alcohol in London,[9] attempted to calculate the benefits of alcohol consumption. The following 'benefits' of alcohol consumption were considered: distribution of alcohol expenditure between employees, businesses and government; individual pleasure gained from drinking; and the wider effects of alcohol consumption such as increases in employment in the alcohol service and tourism industries. The output, income and employment generated by the alcohol industry were not considered as measures of social benefits in the study of the costs of alcohol misuse in England,[21] as the authors argued that it was unlikely that "in the absence of alcohol consumption in the economy the money spent on alcohol would not have been used elsewhere" (pg 13). In addition, external benefits were not included as no research has been conducted that has assigned monetary values to alcohol's contribution to the development of social networks and social capital. The 2000 London study[9] included an estimate of the consumer surplus[xii] related to alcohol consumption. The authors calculated that the real

[xii] A measure of the difference between what a person is willing to pay for a commodity and the amount he or she is actually required to pay.[21]

pleasure of drinking alcohol to consumers in London was around 50% more than what they actually spent on purchasing it.

Costs not considered

Litter costs associated with alcohol use include discarded bottles, cans and broken glass.[43] However, none of the studies of the social and economic costs of alcohol misuse in the UK, or internationally, examined costs associated with the impact of alcohol on the environment. This appears to be because adequate data on the basis of which it would be possible to estimate alcohol-related litter costs are currently unavailable.

ESTIMATING THE SUBNATIONAL COSTS OF ALCOHOL MISUSE

Bolam and Coast[29] compared the results of simple population-based calculations with more complex methods for estimating the economic cost of alcohol misuse in North Somerset. Both methods were based on those of the 2000/01 England study.[21,22] Using the simple method, the authors calculated the population-attributable fraction for both the lower and upper estimates of national costs for all costing areas of the 2000/01 England study.[21,22] The more complex method involved replicating the 2000/01 England study[21,22] by applying local data to each of the individual costing areas. The authors found that the simple method provided only a crude estimate of the economic burden in North Somerset and concluded that more accurate assessment of sub-national costs warranted detailed study of each cost area.

Appendix 2: Additional tables

Table 25. Alcohol-related inpatient episodes: NI39

Diagnosis	Number of alcohol-related inpatient episodes	Number of alcohol-related day patient episodes	Number of bed days
Mental and behavioural disorders due to use of alcohol	1,616	1,153	5,835
Degeneration of nervous system due to alcohol	4	2	22
Alcoholic polyneuropathy	2	2	10
Alcoholic myopathy	1		3
Alcoholic cardiomyopathy	4	2	25
Alcoholic gastritis	13	3	22
Alcoholic liver disease	418	156	2,353
Chronic pancreatitis (alcohol induced)	130	54	624
Ethanol poisoning	304	359	495
Toxic effect of alcohol, unspecified	36	32	54
Accidental poisoning by and exposure to alcohol	6	3	15
Malignant neoplasm of lip, oral cavity and pharynx	74	33	1,313
Malignant neoplasm of oesophagus	54	25	1,441
Malignant neoplasm of colon	9	10	2,677
Malignant neoplasm of rectum	11	11	1,695
Malignant neoplasm of liver and intrahepatic bile ducts	8	2	398
Malignant neoplasm of larynx	13	9	490
Malignant neoplasm of breast	45	22	2,453
Epilepsy and Status epilepticus	679	335	4,962
Hypertensive diseases	1,856	1,498	41,702
Cardiac arrhythmias	1,279	542	24,711
Haemorrhagic stroke	22	5	928
Ischaemic stroke	11	3	658
Oesophageal varices	15	45	276
Gastro-oesophageal laceration-haemorrhage syndrome	8	7	30

Diagnosis	Number of alcohol-related inpatient episodes	Number of alcohol-related day patient episodes	Number of bed days
Unspecified liver disease	64	42	564
Acute and chronic pancreatitis	56	12	1,544
Psoriasis	41	54	1,082
Spontaneous abortion	33	161	267
Pedestrian traffic accidents	18	8	381
Road traffic accidents – non-pedestrian	45	30	1,206
Water transport accidents	0	0	1
Air/space transport accidents	0		16
Fall injuries	241	184	14,042
Work/machine injuries	13	23	384
Firearm injuries	3	2	44
Drowning	2		35
Inhalation of gastric contents/Inhalation and ingestion of food causing obstruction of the respiratory tract	5	2	32
Fire injuries	6	3	57
Accidental excessive cold	3		73
Intentional self-harm/Event of undetermined intent	287	295	1,535
Assault	97	158	863
Total	**4,997**	**3,519**	**105,860**

Source: NWPHO

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Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 25 January 2011

Subject: Updated Work Programme 2010/11

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose

1.1 The purpose of this report is to present and update members on the current activity across a number of work areas and present an outline work programme. The Board is asked to consider, amend and agree its work programme, as appropriate.

2.0 Background

2.1 At its meetings on 25 June 2010 and 27 July 2010, the Board received a number of inputs to help members consider the Board's priorities during the current municipal year. This included specific inputs from:

- Executive Board Member for Adult Health and Social Care
- Deputy Director (Adult Social Services)
- NHS Leeds – Chair and Chief Executive
- Leeds Teaching Hospitals NHS Trust (LTHT) – Chair and Chief Executive
- Leeds Partnerships Foundation Trust (LPFT) – Chair and Chief Executive
- Leeds Director of Pubic Health

2.2 At those meetings a number of potential work areas were identified by members of the Board and were subsequently confirmed in an outline work programme. However, members will be aware that the work programme should be regarded as a 'live' document, which may evolve and change over time to reflect any in-year change in priorities and/or emerging issues.

2.3 As such, and as in previous years, the work programme, including any emerging issues, will continue to be routinely presented to the Scrutiny Board for consideration, amendment and/or agreement: The work programme was most recently presented and agreed at the Scrutiny Board meeting held on 21 December 2010, and an updated version is now presented at Appendix 1 for consideration.

3.0 Update on specific work areas and associated activity

3.1 This section of the report seeks to provide a more detailed update on specific activities and elements of the Board's work programme.

NHS White Paper – *Equity and Excellence: Liberating the NHS*

3.2 A separate item summarising current progress against the proposals has been included elsewhere on the agenda.

NHS White Paper – *Healthy Lives, Healthy People*

3.3 A separate item summarising the proposals and the consultation questions posed has been included elsewhere on the agenda.

Children's Cardiac Surgery Services – national review

3.4 A meeting of the regional Health Scrutiny Member Network took place on 12 January 2011. At that meeting, Members were presented an update on progress of the review and informed that the review outcomes/ recommendations are expected to be published in February 2011 and subject to consultation until June 2011.

3.5 It is currently proposed that the recommendations will be considered by a Joint Health Scrutiny Committee, made up of representatives from the regions Health Overview and Scrutiny Committee. Precise details of the membership of the joint committee are still to be finalised.

Quality Accounts (2010/11)

3.6 Quality Accounts are annual reports to the public from providers of NHS healthcare about the quality of services they deliver. The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer. It allows leaders, clinicians, governors and staff to demonstrate their commitment to continuous, evidence-based quality improvement, and to explain their progress to the public.

3.7 As part of the process for producing Quality Accounts, appropriate Overview and scrutiny Committees must be provided with an opportunity to comment on their contents. Consideration of Quality Accounts (2010/11) is identified on the work progamme for consideration in April 2011. However, it is proposed to present a report to the Board at its next meeting (February 2011) to consider options available to ensure the timely input into finalising the Quality Accounts for various organisations across the City.

Health service Developments Working Group

3.8 The most recent meeting of the working group took place on 14 December 2010. A summary of the outcome of discussions will be presented to the Board at the meeting for information.

4.0 Work programme (2009/10)

4.1 Members will be aware that the Scrutiny Board's work programme should be regarded as a 'live' document, which may evolve and change to reflect any in-year change in priorities and/or emerging issues. As such, in the context of the information presented in this report and discussed at the meeting, the Scrutiny Board is asked to consider the current work programme (Appendix 1) and agree / amend as appropriate.

5.0 Recommendations

5.1 Members are asked to note the details presented in this report and to agree / amend the current work programme, as appropriate.

6.0 Background Documents

- Scrutiny Board (Health) – Work programme (June 2010)
- Scrutiny Board (Health) – Work programme (December 2010)

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APPENDIX 1

Scrutiny Board (Health)
Work Programme 2010 /11

Item	Description	Notes	Type of item
Meeting date – January 2011			
Equity and Excellence: Liberating the NHS	To consider an overall update on the proposed NHS reforms, alongside the government's response to the issues raised as part of the consultation process.	Subject to publication of the government's response.	B
Public Heath consultation / proposals	To consider government proposals regarding the delivery of Public Health Services.	White Paper published	B
Economic & Social Cost of Alcohol in Leeds	To consider the research report aimed at estimating the economic and social costs of alcohol-related harm in Leeds.	Research undertaken / report produced by Liverpool John Moores University	B
Meeting date – February 2011			
Equity and Excellence: Liberating the NHS	To consider an overall update on the proposed NHS reforms.	Part of the Board's ongoing consideration of the proposed NHS reforms.	B
Sexual Health Strategy	To consider the Sexual Health Strategy for Leeds.		B

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2010 /11

Meeting date – March 2011			
Health Priorities	To consider draft health priorities for Leeds		DP
Quarterly Accountability Reports	To receive quarter 3 performance reports		PM
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR
Meeting date – April 2011			
Quality Accounts	To consider draft quality account submissions for 2010/11		PM
Annual Report	To agree the Board's contribution to the annual scrutiny report		

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2010 /11

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
Health Service Developments Working Group	All Board members (subject to availability)	• Working Group established in July 2010 • Working group meeting held on 14 September 2010 • Next meeting scheduled for 14 December 2010	14 Sept. 2010 Feb. 2011 April 2011
Liberating the NHS Working Group	Open to all members of the Board, but with core membership of: • Cllr. Dobson • Cllr. Harrand • A. Giles	• Established in July 2010 to consider the proposals contained in the White Paper 'Equality and excellence: Liberating the NHS', alongside the subsequent and supporting consultation documents. • Meeting with Leeds Local Medical Committee held on 8 October 2010.	*TBC*

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Healthier Communities	To consider the outcome of the recent peer review and the associated actions/ improvement plan.	Process for publication to be confirmed. Member of the peer review team to be invited to present the report (TBC).
Narrowing the Gap	To consider the impact of the 'Narrowing the Gap' initiative, in terms of improving healthy outcomes.	Added to the work programme: December 2009, but no formal consideration of issue in 2009/10. Highlighted as an area to consider in July 2010.
Children's Cardiac Surgery Services	To contribute to the national review and consider any local implications.	First newsletter published (August 2009) National stakeholder event held 22 October 2009. Local (regional) involvement event to be held on 17 June 2010. Briefing note produced by National Specialised Commissioning Team (NSCT) published in August 2010. Discussions around forming a series of joint health scrutiny committee to consider the proposals are on-going.

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

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Unscheduled / Potential Items		
Item	**Description**	**Notes**
Children's Neurosurgery Services	To contribute to the national review and consider any local implications.	**Carried over from 2009/10.** First bulletin published (September 2009) National stakeholder event held 30 November 2009. Newsletter issued in April 2010. Local involvement likely to be towards the end of 2010.
Foundation Trust Status	To consider LTHT's progress against its aspiration of attaining Foundation Trust status.	**Carried over from 2009/10.** Initial and subsequently revised proposals considered in 2009/10. Details regarding anticipated changes in costs to support proposed new governance arrangements requested in May 2010
Primary Care Service Development and use of the Capital Estate	To consider the NHS Leeds' longer-term strategy for developing/ delivering services through its capital estate.	**Added to the work programme in December 2009**, but no formal consideration of issue in 2009/10. It may be more appropriate to consider this matter across the whole local health economy.

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Unscheduled / Potential Items		
Item	**Description**	**Notes**
Health Scrutiny – Department of Health Guidance	To receive and consider revised guidance associated with health scrutiny and any implications for local practice.	**Carried over from 2009/10.** Revised guidance was due to be published in November 2009, but was subsequently delayed until after the general election. No firm publication date is yet available and may be superseded by the details and any subsequent legislation and regulations arising from the White Paper – Equity and Excellence: Liberating the NHS
Specialised commissioning arrangements	To consider the current arrangements for specialised commissioning within the region and the role of scrutiny.	**Carried over from 2009/10.** No formal consideration of issue in 2009/10. Regional work with other local authorities is on-going. The next regional member network meeting is to be confirmed.
Openness in the NHS	To consider how the Department of Health guidance is interpreted and implemented locally.	**Carried over from 2009/10.** No formal consideration of the issue in 2009/10 and may be better linked with any detailed consideration of the White Paper – Equity and Excellence: Liberating the NHS

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Unscheduled / Potential Items		
Item	**Description**	**Notes**
Dermatology Services	To consider proposals for the delivery of dermatology services.	Follow up to the issues considered in 2009/10. **Added to work programme in July 2010.**
Hospital Discharges	To consider a follow up report on progress against the recommendations (i.e. 15, 16 and 17) detailed in the Independence, Wellbeing and Choice inspection report	Identified as potential issue for 2009/10 but insufficient capacity to consider the issue. **Highlighted as a potential area for scrutiny by the Executive Board member in June 2010.**
Out of Area Treatments (Mental Health)	To consider the report prepared by Leeds Hospital Alert and the response from LPFT.	Leeds Hospital Alert report received 1 July 2009. Responses received from LPFT in July 2009. No formal consideration of issue in 2009/10. **Carried over from 2009/10.**

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Unscheduled / Potential Items		
Item	**Description**	**Notes**
Use of 0844 Numbers at GP Surgeries	To consider the impact of the recent Government guidance on local GP practices and any implications for patients.	**Carried over from 2009/10.** Various correspondence exchanged and clarification sought. The Board to maintain a watching brief and kept up-to-date with any developments. No formal consideration of issue in 2009/10.

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