The Sandwell multi-agency management group for high impact problem drinkers

Interim evaluation

September 2017

AUTHOR DETAILS

The lead authors of this report are Mike Ward (Alcohol Concern), who co-designed *Blue Light* and helped establish the Sandwell project, and Mary Bailey, the Alcohol Project Manager at Sandwell Council. Mary Bailey led the quantitative evaluation, including an estimation of the costs of the target individuals in the year prior to entering the group and during the group management process. The qualitative review, led by Mike Ward, was based on an online survey and interviews with members of the strategic and operational groups.

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www.alcoholresearchuk.org

Opinions and recommendations expressed in this report are those of the authors.

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EXECUTIVE SUMMARY

In 2015, the Metropolitan Borough Council of Sandwell, working with Alcohol Concern, adopted the *Blue Light* approach to develop a local response to high impact, change-resistant problem drinkers.

The two key elements of *Blue Light* are:

- Training specialist and non-alcohol specialist staff in working with change-resistant drinkers.

- Setting up a multi-agency group to manage the impact of, and encourage change with, this client group through joint working and planning.

This report is an interim evaluation, funded by Alcohol Research UK, of the experience and impact of Sandwell *Blue Light* on both clients and professional practice.

Establishment of the project

The Sandwell *Blue Light* process began in July 2015. A multi-agency steering group met three times to agree the terms of reference, operational protocols and information governance framework, including consultation with the council's legal department on information sharing. A strategic group was then formed to oversee the process and an operational group was established to manage clients.

The operational group was launched in November 2015. 16 individuals were identified as meeting the eligibility criteria. We estimate that this group of clients had cost police, ambulance, hospital and Accident & Emergency services £244,154 in the year prior to the establishment of the *Blue Light* process.

Post-intervention data was sought on the change in the cost impact from these clients. Not all of the 16 clients had been on the case list for a full 12 months; therefore, data was only gathered on the nine clients who had been subject to the approach for one year. Data for the remaining clients will be added to this report when it is available.

Data for the nine clients who have so far been involved for a full year of *Blue Light* shows a reduction on costs from £244,154 at baseline to £92,730 at the end of Year 1. After adjusting this figure to account for the death of one client and imprisonment of one other, this represents an estimated cost saving of £142,838.

The project costs were £25,000 – this includes £5,000 to Alcohol Concern for support in setting up the group and allocated staff costs in the local authority and local services (see below for details).

On this basis, the estimated return on investment is 471% (i.e. a £25,000 investment for a £142,838 cost reduction).

Of the 16 individuals identified at the start of the process:

- Four (25%) have successfully completed a course of treatment with community alcohol services.

- Three (15%) are currently accessing community alcohol support services with some degree of sustained engagement.

- One died.

- One was imprisoned.

- All other individuals are subject to a range of ongoing harm reduction and engagement approaches.

The project in Sandwell has not, however, been without its problems. The key challenge has been to engage hospital and mental health service staff, who did not commit resources to this process. This may reflect specific conditions and relationships in Sandwell. A similar problem has been to secure consistency of membership: the turnover in some services has been considerable. For example, the representation from one emergency service changed twice in the first year.

The success of the group, despite these challenges, has highlighted the importance of:

- Strategic leadership – Sandwell benefitted from embedding the process in the public health team and having a strategic group of more senior managers to provide further oversight.

- Operational leadership – the group had consistent, active leadership and management from the Council's public health department, with the Alcohol Project Manager operating as a champion for the group and ensuring a consistent approach.

- The local alcohol services – local services need to be central to the *Blue Light* process and should be encouraged to work assertively with the high impact drinkers coming through the group.

Overall, this evaluation suggests that:

- The multi-agency *Blue Light* process offers the potential for a significant return on investment, with modest up-front investment.

- The effectiveness and cost-effectiveness of the approach is measurable.

- Client benefit is significant and demonstrable through evidence of engagement with substance misuse services.

The interviews and survey also showed that adopting *Blue Light* led to:

- Improved joint working between agencies.

- Opportunities to challenge poor practice.

- Support to commissioners to identify unmet need, and gaps and blockages in care pathways.

In Sandwell, the *Blue Light* process was quick to establish and led to enthusiastic engagement from most partner agencies. It was sustainable over the evaluation period, with results that could be captured both qualitatively and quantitatively. As a low-cost intervention, it had potential for significant cost-savings and the capacity to make a tangible difference to the lives of people who both suffer high levels of alcohol-related harm and represent a significant cost to local communities.

INTRODUCTION – THE BLUE LIGHT PROJECT

The *Blue Light* project is Alcohol Concern's initiative to develop alternative approaches and care pathways for change-resistant drinkers who place a significant burden on public services. The approach seeks to challenge the pessimistic belief that nothing can be done for people who appear not to want to change. *Blue Light* asserts that there are positive strategies that can be used with this client group.

The *Blue Light* manual contains tools for understanding why clients may not engage, assessing risk, managing harm and encouraging change. It is available at: www.alcoholconcern.org.uk/blue-light-project

Blue Light offers the positive message that intervention is possible. Services may not always be able to 'treat' someone and make them change completely, but working together they can help drinkers reduce the harm and manage the risk they pose to themselves and others.

The dissemination of *Blue Light* involved a series of local pilots, in areas as diverse as Lincolnshire, Medway and Merton. However, the key pilot to date has been in the West Midlands borough of Sandwell.

NB: Quotes in italics are either from interviews or the online survey. Interview quotes are anonymised and attributed using a number provided in brackets following the quote. Survey quotes are not attributed.

The Sandwell pilot and evaluation

The Metropolitan Borough of Sandwell is North of Birmingham. It has a population of 308,000 of whom 70% are White British, White Irish, European or other white. The Local Alcohol Profiles for England show that Sandwell has significantly higher levels of alcohol-related hospital admissions and mortality than the national average.

Sandwell were early adopters of the *Blue Light* project and asked Alcohol Concern to work locally to implement the approach. As a first step 28 frontline workers from health, criminal justice and housing services in the borough were asked: *What priority should be given to tackling high impact change resistant drinkers?* The answers were very clear: 96% felt that they were a high or medium priority, of whom 73% felt this group were a high priority.

All existing *Blue Light* pilots have consisted of four elements:

- Embedding the *Blue Light* approach in strategic/commissioning thinking.
- Training of specialist and non-alcohol specialist staff.
- Building a business case for other interventions such as assertive outreach.
- Setting up a multi-agency group to manage the impact of, and to encourage change within, this client group through joint working and planning.

This report presents a quantitative and qualitative process evaluation of the Sandwell multi-agency group, as well as estimated cost-savings based on local data captured pre- and post-intervention.

Sandwell client example:

"One of my clients is the wife of one of the Blue Light clients and the group has been positive for her because it has increased the support to her partner and reduced the burden on her." (4)

This evaluation was funded by Alcohol Research UK Small Grant. The funding was approved by Alcohol Research UK's independent Grants Advisory Panel, and the decision preceded the merger of Alcohol Research UK and Alcohol Concern by over a year. The work was undertaken by Mary Bailey, Alcohol Project Manager at Sandwell Borough Council and Mike Ward, the originator of the *Blue Light* project, with the support of Annie Steel and Sue Garret from Swanswell. Mike Ward undertook the interviews with stakeholders.

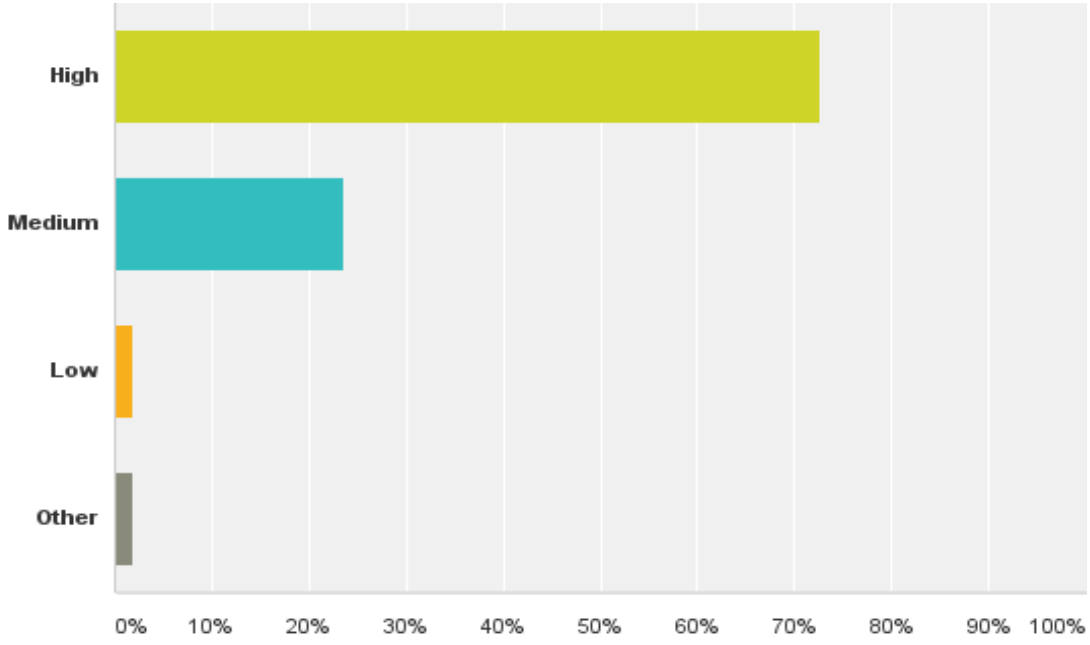
The service costs used to calculate the return on investment are outlined in Appendix 2.

Initiating the group process in Sandwell

In March 2015, Sandwell Public Health and its partners took a strategic decision to set up a multi-agency group to tackle problem drinkers who place a significant burden on public services – particularly the emergency services. A core focus of the approach was the reduction of repeat demand on emergency and acute services.

The initial project survey showed that local services saw interventions with this client group as a high priority.

What priority should be given to tackling this group of clients?



Comments about this client group included:

- *We need to improve multi agency communication.*
- *We need to integrate services.*
- *It is sometimes very frustrating for the clients because they feel some services have no time for them and don't want to listen.*
- *People who have dual diagnosis (mental health and substance misuse issues) can be discriminated against by Mental Health services as it is convenient to blame alcohol or drugs rather than poor mental health for their problems.*
- *Access to services can be denied.*
- *These clients are sometimes difficult to support due to lone working risk.*
- *More should be put into place to give support.*
- *More activities are required to keep them occupied.*

A strategic group was set up to drive the development forward. It consisted of:

- West Midlands Police;
- Swanswell Community Alcohol Service;
- Adult Social Care, Sandwell Metropolitan Borough Council;
- West Midlands Ambulance Service;
- Black Country Partnership Foundation Trust;
- Sandwell West Birmingham Hospital Trust;
- West Midlands Fire Service;
- National Probation Service;
- Community Rehabilitation Company;
- Iris Drug Treatment Services;
- Sandwell Women's Aid;
- Anti-Social Behaviour Team, Sandwell Metropolitan Borough Council; and,
- CentrePoint, Christian Church Registered Charity.

11 of the partner agencies signed up to a data-sharing agreement and committed to an operational multi-disciplinary approach. The group then set out model terms of reference and operational protocols. This process required three meetings over three months. The outputs included:

- eligibility criteria;
- referral process;
- information-sharing protocols;
- the preferred management framework;
- links to other multi-agency groups e.g. MAPPA;
- the ideal membership;
- information governance arrangements;
- administration arrangements; and,
- establishment of an evaluation methodology.

The main outputs from these discussions are in Appendix 1.

The partner agencies then split into two separate groups:

- an ongoing strategic group, which met occasionally to review the process; and,
- an operational group, which met monthly to jointly manage clients.

Sandwell client example:

"In one case where housing was proving to be a problem, we accessed someone from floating support and it began to open up housing options." (3)

The operational group

The Sandwell multi-agency group began in November 2015 and met thereafter every month. For the first six months, an independent chair, Mark Holmes (Alcohol Concern), led the group to provide expertise in the management of the target client group. This role then passed to the Alcohol Project Manager based in the local authority Public Health Department. Swanswell, the local provider of alcohol services, are currently moving towards co-chairing and taking on leadership functions within the group alongside Public Health.

> *"Mark Holmes was really useful in giving examples of how to work with these clients." (8)*

The operational group meetings follow a consistent structure:

- All participants to sign a confidentiality statement (see Appendix 1).
- Chair asks for nominations (i.e. specific clients) to be discussed at the meeting – initially, these are referred to by initial only. New potential clients are presented anonymously while it is decided whether there are grounds for information sharing and whether the client is having sufficient impact to warrant management through the group.
- Reviews of action plans and action to date for existing clients. These may lead to revised action plans or case closure.
- For new nominations, a more detailed description is given and other agencies may choose to share what they know. Discussion focuses on what the aims and outcomes are, and how these might be achieved.

- The default position is that Swanswell will be asked to develop an action plan for the next meeting which will target how outcomes will be achieved. This task may be delegated to another agency if appropriate.

- This process is repeated for each client.

The average caseload for the meeting is 10-12 clients. Each is discussed for up to 15 minutes and time allocation is biased to the top of the list. Actions are circulated no more than a week after the meeting.

Three key risks were identified with this process:

- A two-hour meeting can lead to fatigue, so later discussions can be more problematic.

- Agencies may fail to 'own' their respective actions within the planning process.

- The public health lead often has to take on multiple roles including note-taking and chairing.

The discussion around each client is very specific to that person. However, the Chair makes use of a checklist (set out below) developed by Alcohol Concern specifically to guide the Chairs of multi-agency groups.

A process checklist

1	Have people been spoken to about agency concerns, the impact of their presenting problems and been given relevant brief advice about changing their situation and seeking help?
2	Have people been referred to relevant specialist services?
3	Has someone assessed the client to identify barriers to change and engagement. Are there reasons why this person will find it difficult to change? These could include low self-esteem, physical health problems, or peers who sabotage change.
4	Has someone undertaken a specific assessment of risks e.g. fire risks, trip hazards in the home, noise nuisance?
5	Has the client had a physical health check with their GP and/or a dental or other physical check?
6	Have motivational interventions or a motivational interviewing approach been used with the person?
7	Has the client been offered ongoing enhanced personalised education, i.e. highlighting the very specific risks?
8	Have efforts been made to promote self-efficacy, i.e. encouraging the client to believe that change is possible?
9	Have efforts been made to involve family members, significant others or relevant carers, where appropriate, in care planning?
10	Has contingency management been used, i.e. incentivising engagement with treatment through the offer of food vouchers, or other small incentives?
11	Have efforts been made to reduce any potential harms to the client or other people e.g. ensuring a smoke alarm is fitted, thinking about trip hazards in the home?
12	Has a single care coordinator been identified to manage and coordinate the care?

13	If the client shows motivation to change have arrangements been put in place to enable a fast track into care?
14	Have community care resources been considered for purchasing outreach, befriending or other support?
15	Have assertive outreach or peer support approaches been used? Could a PCSO make contact with this person?
16	Has consideration been given to whether anything is supporting the negative behaviour, e.g. is a family member buying alcohol?
17	Are there legal powers which can be used to contain the behaviour?

Quantitative impact

The main focus of the quantitative analysis has been the cost savings achieved. However, the analysis also provided important information on the clients and their pathway into the group.

Who are the clients?

The review process began nine months after the group had begun (in November 2015). At that point, a total of 16 individuals had been identified as meeting the eligibility criteria.

Client	Referring organisation	Gender	Age
A	ASB Team	Male	50
B	Police	Male	59
C	Sandwell Women's Aid	Female	50
D	Probation	Male	48
E	Probation	Male	62
F	ASB team	Female	47
G	Police	Male	48
H	Street Triage/ambulance	Male	34
I	Police	Female	57
J	ASB team	Male	60
K	ASB team	Female	52
L	MARAC referral	Male	43
M	Sandwell Women's Aid	Female	49
N	Adult Social Care	Male	56
O	ASB team	Female	49
P	Sandwell Women's Aid	Male	43

The most noticeable aspect of the client referral data is the lack of referrals from the health sector. In particular, the lack of any referrals from the local hospital. Furthermore, health services were poor attendees at the group. In equivalent groups elsewhere (see section 11 below) hospital services were active participants and a source of referrals. In Sandwell, the predominant referral source has been the criminal justice system. This is recognised as a gap locally and efforts are being made to address it through local discussions between public health and the health trusts.

Costings

Baseline estimates of the costs associated with each individual's use of emergency services during the 12 months prior to the introduction of *Blue Light* were developed for comparison with post-intervention costs 12 months after adoption. The data is set out in the table below.

BLUE LIGHT CLIENT DEMAND COSTS: Prior to & after launch of *Blue Light*										
CLIENT	**AMBULANCE** 12 months prior	**AMBULANCE** 12 months after	**A&E/ HOSPITAL** 12 months prior	**A&E/ HOSPITAL** 12 months after	**POLICE** 12 months prior	**POLICE** 12 months after	**TOTAL PRE**	**TOTAL POST**	**TOTAL SAVING**	**NOTES**
A	£3,060	£1,363	£12,989	£132	£2,005	£841	£18,054	£2,336	£15,718	Engagement with dual diagnosis service - abstinent as at Jan 2016 & positively closed to Blue Light group
B	n/a**	n/a**	£3,294	£0	£10,833	£2,889	£14,127	£2,889	£2,810*	Went into prison Jan 2016 – unclear re: support for drinking whilst in prison. Yet to be released
C	£3,600	£856	£3,562	£132	£8,010	£1,562	£15,172	£2,550	£12,622	Engaged with alcohol services and positively closed to Blue Light Oct 2016
D	n/a**	n/a**	£19,005	£9,085	£28,937	£13,134	£47,942	£22,219	£25,723	Some progress - still open to Blue Light
E	£33,222	£22,287	£5,625	£1,405	£12,924	£4,159	£51,771	£27,851	£23,920	CBO in place to address nuisance WMAS calls – denies help for drinking
F	£10,560	£2,076	£6,682	£2,297	£31,200	£1,891	£48,442	£6,264	£42,178	Engaged with alcohol services – abstinent as at May 2016 & positively closed to Blue Light.
G	n/a**	n/a**	£2,101	£3,690	£37,680	£21,387	£39,781	£25,077	£14,704	On-off engagement with alcohol services
H	£1,848	£0	£852	£1,624	£3,300	£0	£6,000	£1,624	£4,376	Successfully engaged into recovery support services
I	£1,002	£84	£528	£1,836	£1,335	£0	£2,865	£1,920	£787**	Client died 10/9/16: fall & bleed on brain. Progress re: CV, housing & AA sponsor.
TOTAL	**£53,292**	**£26,666**	**£54,638**	**£20,201**	**£136,224**	**£45,863**	**£244,154**	**£92,730**	**£142,838**	

* Nominal saving of £11,238 reduced pro-rate to 3 months = £2,810
**Nominal saving of £945 reduced pro-rata to 10 months = £787

Clients for whom full 12 months follow-up data is not available									
CLIENT	**AMBULANCE** 12 months prior	**AMBULANCE** 12 months after	**A&E/HOSPITAL** 12 months prior	**A&E/HOSPITAL** 12 months after	**POLICE** 12 months prior	**POLICE** 12 months after	**TOTAL PRIOR**	**TOTAL AFTER**	
J	£1,920		£3,116		£1,240		£6,276		Engaging with alcohol services – no recent ASB/ offending
K	£2,696		£960		£2,842		£6,498		Positive closure
L	£4,500		£0		£651		£5,151		Managed via ODOC
M	£480		£801		£801		£2,082		Engaging with alcohol services. Little emergency service demand
N	TBC		£5,066		£1,642		£6,708		Closed to alcohol services – positive occasional use.
O	TBC		£0		TBC		£0		Positive closure from alcohol services. Little emergency service demand
P	TBC		£2,347		TBC		£2,347		Engaging with alcohol services
TOTAL	**£81,991**	**n/a**	**£66,928**	**n/a**	**£143,400**	**n/a**	**£292,319**	**n/a**	

*n/a – West Midlands Ambulance Service call out information is not possible for individuals of no fixed abode – it has therefore been excluded from the costing exercise as it may give a false sense of cost / demand without a specified call out postal address

Three caveats have to be entered:

- It cannot be proven that the process itself generated change in individuals.

- A part of the reduction is due to death of client I, ten months into the process. Therefore, the total annual saving of £945 has been reduced pro rata to a 10-month saving of £787.

- A part of the reduction is due to the imprisonment of client B three months into the process. Again, the cost saving of £11,238 has been reduced pro rata to a three-month saving of £2,810.

The service costings used to calculate the savings are set out in Appendices 2 and 3

The total saving across nine clients was £142,838.

The investment was £5,000 paid to Alcohol Concern to set up the group and re-allocation of existing staff time. Costed at £50 per hour, staff attendance at meetings over 12 months cost around £12,000. The support costs from the Alcohol Project Manager based in public health were calculated at £8,000 e.g. organising meetings, taking and sending out the minutes and agendas each month.

On this basis, the return on investment is: 471% (£25,000 investment for a £142,838 cost reduction).

Of these 16 individuals involved in the intervention:

- Four (25%) had successfully completed a course of treatment with community alcohol services.
- Three (15%) were currently accessing community alcohol support services with some degree of sustained engagement.
- One died.
- One was imprisoned.
- All other individuals were subject to a range of on-going harm reduction and engagement approaches.

Qualitative impact

Qualitative views of the process were gathered through an online survey sent to all members of the strategic or operational group, interviews with members of both groups, and attendance at a group meeting.

An online survey was sent to all 31 past and present members of the operational and strategic groups. 13 people responded (a 42% response rate) all of whom were current members of one or other group. Some members who were approached had moved on and others specifically delegated the task to the current representative. These were divided as follows:

Answer Choices	Responses	
I am a member of the operational group	53.85%	7
I am a member of the strategic group	15.38%	2
I am a member of both the operational and strategic group	23.08%	3
I work with clients who have been through the group but am not a member	0.00%	0
Other	7.69%	1
Total		13

NB the "other" is the manager of staff involved in the process.

11 professionals involved in the group were interviewed. These included staff from public health, alcohol services, mental health services, National Probation Service, the Community Rehabilitation Company, Ambulance Service and domestic violence services. The following sections set out their views on a range of issues related to the impact of the group.[1]

10.1 How would you describe the effectiveness of the Blue Light operational group?

70% of survey respondents felt that the group was either effective or very effective, with only one describing it as ineffective.

Answer Choices	Responses	
Very effective	30.77%	4
Effective	38.46%	5
Average	23.08%	3
Ineffective	7.69%	1
Very ineffective	0.00%	0
Other	0.00%	0
Total		13

Interviewees were also very positive about the *Blue Light* group.

[1] For the purposes of anonymisation, each interview respondent has been allocated a number. The number given in the brackets following interview quotes refers to the number allocated to the respondent. Further identifying information would compromise the anonymity of respondents.

- *It is something we need in Sandwell because we have a population with years of drinking…The group gives us time to focus on harm reduction…The group is a good example of partnership working and it shows we have a workforce who care. (9)*
- *(It) is a forum to take clients for whom there has not been a joined-up approach. It closes the gap for vulnerable and costly clients. (5)*
- *It is valuable but it needs to be regional rather than just Sandwell. We need groups in the Black country and Birmingham. (11)*
- *I am surprised how the partners have come to the table. It has been a well-attended group. Bodies such as the Fire Service which could have been peripheral have become involved. (7)*
- *I think it is a good opportunity to get together to talk about clients we don't usually get the chance to discuss. (4)*
- *In some cases, it gave us another perspective on their drinking – either seeing it more or less of a problem. You can see from other angles than your own agency's. (8)*
- *…it is useful and beneficial in getting partner agencies together and getting to know some of the agencies. (1)*
- *From a service perspective, there are benefits. It is good to have other people's understanding of what people are doing. We are beginning to see the impact on other services especially 999 services. (6)*
- *It is quite beneficial because of the number of calls and the costs they impose on agencies. It is useful to take people to the group. (3)*

Sandwell client example

In one case the group helped to understand the reasons that someone was not attending Swanswell and how he needed help with supporting him with those. (8)

How would you describe the impact of the Blue Light operational group on the clients it manages?

10 respondents felt that the group had had a significant or positive impact on clients. Three felt it had had little impact. This may reflect that not everyone who nominates someone to the group will see a positive change for their client.

Answer Choices	Responses	
A significant impact	23.08%	3
A positive impact	53.85%	7
Little impact	23.08%	3
No impact	0.00%	0
Other	0.00%	0
Total		13

The interviewees were positive about the group's impact on clients.

- *Many are rollercoaster clients. Some start to eat and take care of themselves. Then they go back to their old friends. We have got people into treatment who have not gone in before. Therefore, they are no longer treatment resistant. They know what treatment is about and will be more willing to go back. (9)*
- *The figures show that it is making a difference. You need to measure impact differently with this client group. With this client group, even 1 out of 10 is success. (5)*
- *…drinking is just one factor in their lives. It has also helped people to focus on these other needs. (8)*
- *It is good when they start getting help. We know that they will fall off the wagon but it helps the most chaotic be picked up and try again. (11)*

Sandwell client example

One client posed a risk to ambulance services and others and was unwashed and unkempt. He was viewed in a very negative way which gave people a reason for not working with him, but bringing the client to the Blue Light group began to engage people in working with them. (8)

Do you believe that the clients have accessed services they would not have secured otherwise?

10 respondents felt that the group had helped clients access services that they would not otherwise have accessed. Only one respondent felt that this was not the case and two were unsure.

Answer Choices	Responses	
Definitely	30.77%	4
Probably	46.15%	6
No	7.69%	1
Unsure	15.38%	2
Other	0.00%	0
Total		13

Interviewee comments were again positive:

- *Yes, it helps to explore in a multi-agency approach. Often it is housing but it does look at wider themes such as housing, health etc. (2)*
- *We have got people to engage in services. (9)*
- *Absolutely. It is the paradigm shift to "we want to support you". It is easy to manage a caseload by DNAs. (7)*
- *More services are aware and yes, the clients are getting help. Sometimes Swanswell won't know about the clients. We can now identify them to the alcohol services. (4)*
- *In some cases, yes – the Blue Light group has helped them to access services and encouraged people to try harder with clients and it has highlighted some agency support that is there that we did not know existed. Some it has highlighted people we need to make an effort with – particularly getting Swanswell to be more assertive. (1)*
- *People are taking a bit more interest. The services are there but they are now coming to the forefront of people's visions but perhaps not as much as they should be getting. Having the other agencies does help to make referrals so having someone to pass them on to really helps. (11)*

Is the group working with the right clients?

The interviewees were asked whether the group is working with the right clients. Two interviewees said they did not have the information to answer that question. However, most believed the group was working with the right clients and recognised that the group has turned clients away if necessary and that the discussions around this can be very positive.

What is the impact of the *Blue Light* operational group on joint working?

The other benefit of the multi-agency group approach is the potential for improvements to joint working. 12 respondents felt it had improved joint working. No-one felt it had worsened joint working.

Answer Choices	Responses	
It has improved joint working significantly	**30.77%**	4
It has improved joint working to some extent	**61.54%**	8
It has not improved joint working	**7.69%**	1
It has worsened joint working	**0.00%**	0
Other	**0.00%**	0
Total		**13**

Two survey respondents provided comments on this question:

- *I think in some cases it has helped significantly if involvement engages people we have not really engaged with before. For other cases, joint working was already very strong.*

The interviewees also identified the benefit of improved joint working.

- *Yes, it has improved verbal communication – it is not just sending discharge letters. It is not enough to send a letter and assume it has been read. (7)*
- *Yes, most definitely. Partnership is the key. If we don't work together people slip through the cracks. (4)*

However, one interviewee qualified this by saying that:

- *it has improved joint understanding not necessarily joint working. (6)*

How could membership of the Blue Light operational group be improved?

The most debated *process* aspect of the group was whether the group had the right membership.

Answer Choices	Responses	
The membership is what it should be	**38.46%**	5
Changes to the membership are required (please describe below)	**30.77%**	4
Other	**30.77%**	4
Total		**13**

Although the responses were not unanimous, the comments do suggest a specific concern about a lack of health and mental health input.

- *More representatives from mental health and the health sector.*

- *More voluntary organisations - to widen agencies that we may be unfamiliar with but who may be fundamental to gaining a way in.*
- *Commitment from hospitals to present data about regular attenders.*
- *I think it appears to be comprehensive.*
- *Housing need to be part of the group and GP service.*
- *Hospital/A&E presence and input required. More active involvement from Mental Health services needed – all the caseload has mental health issues and this link could/should be a lot stronger.*
- *It is noticeable that the agencies in attendance have changed since the Blue Light Operational group first came into being. Ambulance Service and GP colleagues, in particular, are struggling to attend. When changes have occurred within my own organisation, this has left me having to sacrifice my own attendance at Blue Light Operational Group meetings. The Group is still viewed as secondary and an add on rather than integral to the objectives of individual agencies. Without mandatory buy-in, the effectiveness of this group is determined by the turn out around the table.*

Three interviewees felt the membership was appropriate, however, most highlighted the poor engagement from health and mental health services.

- *Mental health services and the mental health crisis team are absent or only present occasionally. Their approach feels very defensive. A crisis team should be a more active player in this process. (9)*

A couple of interviewees also commented on the turnover of ambulance and fire service staff which presents a problem of continuity.

10.7 In your view could the setting up of the operational group have been improved?

Although some people felt the setting up of the group could have been improved, the comments suggest that this is mainly a repetition of the concerns about the membership.

Answer Choices	Responses	
The setting up of the group could have been improved (please describe)	**38.46%**	5
The setting up of the group could not have been improved	**46.15%**	6
Other	**15.38%**	2
Total		**13**

A single comment summarised the views:

- *…when the group was set up we secured senior level commitment from both emergency services and a vast range of support services (including*

acute A&E/hospital). Unfortunately, staff turnover/changes and the link / commitment from acute health sector was lost. I therefore wonder whether the approach may be better hosted/managed by the acute sector to gain some commitment/ownership from them?

Most interviewees had similar views:

- *I think it was set up well and quickly. (5)*
- *We did give time to take the group with us through the process. (9)*

Are you happy with the information sharing protocols?

Interviewees were uniformly positive with the information sharing arrangements. One commented: *We had quite lengthy discussions about information governance. Everybody wanted a silver bullet solution - a single legal power that solved the problem. However, most people can be managed via client consent and section 115 of the Crime and Disorder Act. (9)*

How effective is the client-focused action planning within the meetings?

The survey asked about the effectiveness of the client-focused action planning process within the meetings. The answers to this reflected the answers about impact of the process on the clients generally in the earlier questions. The vast majority felt it was effective or very effective with only one respondent feeling it was ineffective.

Answer Choices	Responses	
Very effective	**23.08%**	3
Effective	**61.54%**	8
Ineffective	**7.69%**	1
Other	**7.69%**	1
Total		**13**

Survey comments included:

- *There need to be more pro-active actions to provide outcomes.*
- *It would be useful to have an identified end goal for each case so have a focus on where we are heading for each case.*
- *Tangible actions are often arrived at during meeting discussions but ownership and planning of that could be improved by use of care planning template to strengthen ownership of actions.*
- *It can be very effective when the agency knows a great deal about the client and what she / he wants to achieve from the Blue Light Group.*

The interviewees had similar views:

- *Generally, each person is given a task and that is effective. (2)*
- *Yes, most definitely, but it needs something reported in-between meetings to check out the progress. (4)*

One commented: *There is a possible need for renewed training. We need to re-focus on what can be done: options, risks and harm reduction. Do we have enough knowledge of the other services that could help people – small voluntary organisations etc. (9)*

The specialist alcohol service role

The local alcohol service provider, Swanswell, have been integral to the group process and were centrally involved in setting up the group. It was, therefore, important to ask about perceptions of their role. These questions were only asked in the interviews.

- *They have begun to take on the chairing of the group. The original lead has left but the new people will take this on. Swanswell have been very good at pushing the IBA plus training. We are very lucky to have a provider like them. They have been very flexible e.g. waiving the "three missed appointments and you are out" rule. (9)*
- *Swanswell is good – they are starting to chair it now. They have been helpful. (2)*
- *We have lost the original lead and the subsequent replacement – we do need consistency. (4)*
- *I think it is adequate. (8)*
- *Yes, Swanswell's lead was really good - very timely and shared information well and had the information to hand. The lead is now changing. (1)*
- *Again, we need a more assertive response. (6)*
- *Yes – Swanswell are very amenable. (11)*
- *Could the response from Swanswell be improved? It could but not sure how. (3)*

General comments on the Blue Light Operational Group

Both respondents to the survey and the interviewees were asked a general question about the group to gather any other thoughts. Some of these repeated earlier comments e.g. about membership gaps or consistent attendance.

- *It provides a safe space to talk about clients. The workers are tearing their hair out. We know there is no solution but it helps to talk about it. (9)*

- *The fact that you are getting people around the table to talk about these clients is an advantage. This helps understand how each other's services work. I now understand the problems with the ambulance service has identifying problems with alcohol. (5)*
- *It has made people think about the impact on the public purse. Workers need to see that context and encourage them to work with and reduce burdens. (7)*
- *More regular statistics would be good. Having ambulance service data for example has been very useful. It does help focus on the right clients. Having that data every 2-3 months rather than yearly would be good. (1)*
- *Possibly the group should arrange a current assessment. (2)*
- *Need to ensure parked clients are returned to after prison etc. (1)*
- *Sitting on the group it is difficult to gel the strategic and operational sides of it. It is very action orientated. We need some more strategic action. Need to get the bigger picture. (6)*
- *The chair is really good. (3)*
- *Perhaps more linkage to the GPs. (2)*
- *It is a lengthy process to share information. We need to be bringing laptops into meetings to speed the process up. This would be a more time effective process. (5)*
- *We need stronger links with a volunteer perspective. (8)*

What gaps exist in the services for high impact change resistant drinkers?

The survey and the interviews asked about what, other than the group, would improve the response to change resistant drinkers. The two most common responses were:

- assertive outreach services
- more specialist housing support

Outreach was the most commonly mentioned. Although one respondent said: *I would like more outreach if there was new funding but not at the cost of other services. (7)*

Other suggestions included:

- *Alcohol care team / provision within hospital – currently there is no dedicated support provision for those with entrenched alcohol misuse.*
- *More use of punishments with civil and police powers.*
- *Care support / services whilst in prison - this remit/provision is still very unclear and some of our caseload are in and out of prison with no real evidence of professional curiosity from prison staff about alcohol needs - this is an opportune time of sobriety to do some work with such clients and a missed opportunity.*

- *Access to controlled safe drinking environments i.e. wet houses; dedicated long term conditions management capacity for this group and end of life care provision.*
- *In Public Health, there is a real paradigm shift away from addressing chronic needs to more prevention / early intervention. We cannot afford to work to such a simple/naive paradigm when we have an established drinking culture with a population showing the physical and mental ramifications of years of alcohol abuse. We must ensure we work to both agendas without losing the focus on what can sometimes be a politically unpopular and morally judged group of individuals - placing the issue at the point of the substance not on a failure of the individual.*
- *It is important to look at mental capacity and how this impacts on our client group.*
- *Make use of peer mentors and volunteers to fill the gaps made by overstretched statutory health and criminal justice services to befriend those change resistant drinkers.*
- *A focus on the Sikh community – there is a group of drinkers out there but they are not coming through to the group.*
- *We do need to prevent escalation to this group. How can we target the tier below?*
- *Dual diagnosis is a key issue.*

Sandwell client example

In one case the chair wrote a letter to adult social care to try and improve the response to a very vulnerable man who was sleeping rough. The Blue Light group turned work with him into action - it did lead to progress - it wasn't instant it took some months but it was really beneficial. Everyone had this person in their sights. It generated people reflecting on what help could be provided. (8)

Comparisons with *Blue Light* groups in other areas

Over the last two years Alcohol Concern has set up multi-agency groups in five other parts of the country. The analysis of the operation and impact of these groups is a larger task than can be undertaken in this context. However, as part of the research the process was reviewed in three other areas to provide some context and comparison.

For purposes of anonymity, these areas are not named in this report and are identified as:

Area A – a non-metropolitan unitary authority
Area B – a unitary metropolitan borough
Area C – a large county with groups in each borough and district

This report is not intended to be an analysis of each of these groups. Instead we have highlighted a couple of features that differentiate each group from the Sandwell group.

Area A – a non-metropolitan unitary authority

This group was set up at the same time as the Sandwell group and has a similar workload and approach to client management. From the outset, it was decided that this group would focus on drugs and alcohol. It is not possible to judge whether this approach has any advantages or disadvantages.

In comparison with Area A, Sandwell has benefited in having a service provider that has been much more active in the setting up of the group and providing leadership in targeting the clients identified.

However, the group in Area A has been very supported by having:

- Access to a very flexible and supportive housing provider.
- Active adult safeguarding involvement from the local authority.
- Membership from mental health services and the hospital frequent flyers team.

Area B – a unitary metropolitan borough

This group developed as an alcohol focused group and was set up six months after the Sandwell group. Again, it has benefited from mental health and hospital involvement. Alcohol related brain injury clients were a more common feature of the work of this group than either Area A or Sandwell. No explanation can be put forward for this and it may simply be random chance.

The more specific difference with Sandwell or Area A was that Area B had dedicated outreach capacity within the local alcohol service. This was a huge asset for the group and enabled much more active targeting of hard to engage clients.

However, the key difference with Sandwell is that a decision was taken to merge the work of the *Blue Light* group in to the local multi-agency vulnerable person's hub. It is too early to make judgements about the effectiveness of this approach.

Area C – a large county with groups in each borough and district

Area C set up a Blue Light multi-agency group in each of its boroughs and districts. The success of the groups has varied from area to area. The most robust process has been in the largest urban area. However, the key feature of this process has been the specific presence of an outreach service which is having real success in reducing crime reports of high volume offenders.

Alcohol offenders identified and referred by the police are targeted by the outreach service.

Sandwell client example
We are working with a white British man in his late 40s who is a client on the Blue Light group. He was a drug user many years ago, but has now moved on to problematic drinking. The key issues are his repeated 999 calls and A&E attendance. He has physical health problems and some signs of brain damage although not at the levels of Korsakoff's. He had been open to the alcohol service seven times previously.

He has been the victim of domestic violence from his partner over several years. She would put cigarettes out on him, hit him around head or have him beaten up by others. He attended A&E with head injuries due to this violence.

In the past, he has been on an Alcohol Treatment Requirement (ATR) which didn't work. His poor memory wouldn't support the structured approach that the ATR required – he would forget appointments and be breached.

He has been on the Blue Light group for about a year and, as a result, engaged with Swanswell. Because the previous problems with the ATR structure were understood, the new approach was built around home visits especially after he withdrew from the relationship and moved house.

Attendance at A&E and 999 calls have both declined. The domestic violence victimisation has also gone down. (10)

Lessons for wider consideration

The evaluation of the Sandwell Blue Light group shows that:

- The multi-agency group process offers the potential for a significant return on investment.
- The upfront costs of this process can be kept low.
- The set-up time is relatively brief.
- The effectiveness and cost-effectiveness of the group process is measurable.
- Non-alcohol specialist services appear very willing to be involved in these processes and recognise the need for such an approach.

Alongside the costed benefits from reduced client impact, the process can also:

- Improve joint working.
- Improve client care and care planning.
- Identify unmet need and blockages in the system.

These clients can be a politically unpopular group. Their needs are also different from the population targeted by preventive interventions more usually associated with public health. Nonetheless, the Sandwell project suggests that setting up a multi-agency group to manage high impact drinkers can be a positive and cost effective step for any area where there are concerns about this group of problem drinkers.

The review also allowed the identification of a checklist of issues that other areas will need to think about when developing this type of approach:

- Strategic leadership – Sandwell benefited from embedding the process in the public health team and having a strategic group of more senior managers to provide some oversight for the process.
- Information sharing – this was resolved in Sandwell leading to the methodology set out in the terms of reference, but it is important that each area comes to its own resolution with review from legal services.
- Membership – it is important to secure membership across the health, social care, housing and community safety spectrum. Engaging the health sector has been the challenge in Sandwell.
- Consistency of membership – the turnover of staff in some services, especially emergency services, has been a challenge.
- The need for operational leadership – the group has benefited from having had consistent, active leadership from the Alcohol Project Manager, based in the Council's Public Health department
- The local alcohol services – alcohol services need to be central to this process and be encouraged to work assertively with the high impact drinkers coming through the group.
- Assertive outreach – in Sandwell the process has identified the need for assertive outreach. This is almost inevitable, but the Blue Light group remains a useful route to proving the need for such services and targeting them effectively.

APPENDIX 1

Terms of Reference and Operating Procedures for the Blue Light multi-agency group in Sandwell

1. Introduction

The perception exists that if a problem drinker does not want to change, nothing can be done to help until the person discovers some motivation. Alcohol Concern's *Blue Light* project has challenged this approach. It has shown that harm reduction, risk management and motivation enhancement strategies exist and can be used with change resistant drinkers. More importantly tackling this group will target some of the most risky, vulnerable and costly individuals in society.

- Sandwell MBC and its partners aim to work together to target the burden on our community from change resistant problem drinkers.

2. A multi-agency group targeting the highest risk drinkers

An intensive response cannot be offered to the vast number of drinkers who are not engaging with services. Alcohol Identification and Brief Advice and the offer of services are a reasonable approach to a large swathe of these drinkers. However, a small group require a more targeted approach.

The borough has set up a multi-agency framework for managing high risk change resistant drinkers. At the heart of this process is a multi-agency group which meets at least monthly.

3. Aim

The aim of this group will be to:

- Improve the management of change resistant drinkers and thereby reduce the impact that they are having on the community generally and public services specifically.

4. Membership

This will have core membership of:

- Police
- Hospital
- CCG
- Probation
- Local authority social care
- Local authority community safety/ASB teams
- Swanswell
- Mental health services
- Ambulance / Fire Service

- Housing
- Primary care
- Women's Aid
- Drug Services

A quorum of five members will be required for the meeting to proceed.

5. Level of attendance

It is vital that the person representing each agency is of the appropriate level to engage with this process, i.e. operational but with some seniority to ensure that actions are taken.

6. Identifying the clients

The group members will individually be responsible for identifying the change resistant drinkers that they want to see being discussed at the meeting. A single definition of this client group is not possible but the people to be managed by the group are likely to meet the following definition:

i.	**An alcohol problem**
	• Have an enduring pattern of problem drinking, dating back at least ten years **&** • Score 20+ on AUDIT **or** • Be classified as dependent on SADQ (16-30 = moderate dependence/30 is severe dependence range is 0-60) **or** • Have other markers of dependence on alcohol (Ethanol levels or biomarkers such as LFT scores may also be used)
ii.	**A pattern of not engaging with or benefiting from alcohol treatment**
	Clients will: • Have been subject to alcohol Identification and Brief Advice (IBA) **&** • Have been referred to services, usually on more than two occasions, and have not attended, attended and then disengaged or remained engaged but not changed.
iii.	**A burden on public services**
	Clients will either directly, or via their effect on others e.g. their family, be placing a burden on the following services: • Health • Social care including adults involved with children's services • Criminal Justice / ASB / Domestic violence Services • Emergency services (999) • Housing and homelessness agencies The burden will be mainly due to: • multiple use of individual services

	but in a few cases may be due to placing an exceptional burden on these services because of a single risk (e.g. a sex offender released from prison with a pattern of problematic drinking.) Appendix 1 sets out indicators of high burden clients which may indicate the type of client to be tackled through this process.
	Exception 1 – level of risk
	An exception category will be required. For example, a person may meet the first two criteria (dependence and non-engagement) but the burden on public services is due to a single exceptional risk.
	Exception 2 – engaged with other multi-agency groups
	If a person is already engaged with another multi-agency group e.g. MARAC or MAPPA they will not be taken on by the Blue Group without a clear decision from the other group. The assumption will usually be that management will remain with the existing group.

It is recognised that this group can only manage a small number of high burden clients at any one time. Therefore, as a check and control on the process:

- When a new client is presented to the meeting it will be down to the partner agencies to agree that this is an appropriate and manageable referral at that point in time.

7. Chair and note taking

The chair of the meeting (and a deputy) will be agreed by the members of the group. For the sake of consistency the chair should remain the same from meeting to meeting.

Notes of the meeting will be in the form of a spreadsheet which will be updated each meeting.

Each partner agency who is involved with the client will be expected to update their notes on the client after each meeting.

8. Information sharing

This guidance is based on HM Government's *Seven golden rules for information sharing*. The phrases in bold below are quotes from the *rules* (See appendix 1).

The multi-agency group operates within the borough's information sharing protocol which is available on the council website. All participating agencies must be signatories to this protocol.

Information cannot be shared about these clients unless the basis on which the sharing occurs is clear and agreed by the members. This will be either because:

- Client consent has been secured; or
- The Data Protection Act recognises that public interest allows the sharing of information, as do other laws such as the Human Rights Act. The public interest generally lies in the prevention of abuse or harm, or the protection of others, including the protection of public safety.[2]

Consent forms

Many partners will have their own client consent forms. These will be acceptable to the group as long as it is clear that appropriate information sharing is permitted with the group.

Alternatively, the consent form attached at appendix 6 can be used.

Confidential person-identifiable information that is disclosed in the public interest will be proportionate and relevant and not excessive to the case concerned.

As a result, the following process is followed:

- **Information will be ideally shared with consent:** The referring agency will secure consent to share information with the members of the multi-agency group.

If this is not possible:

- Outline but anonymous details of the client will be presented to the group in order to consider **safety and well-being** concerns which might allow information sharing. Discussion and agreement will take place as to whether: considerations of the safety and well-being of the person and others who may be affected by their actions create a public interest case can be made for sharing the information.

If this is agreed:

- **Keep a record:** The agreement will be recorded in the minutes with the reason for the decision and the relevant legal framework. The three key legal frameworks are listed in appendix 3.
- Inform the service user who is the subject of that information of the decision to disclose. This will happen even where their consent is not required, unless it

[2] The Public Interest test applies when consent cannot be obtained or has been sought and refused. Circumstances that meet the public interest test are as follows:

- Promoting the welfare of children
- Protecting children or adults from significant harm
- The prevention, detection or prosecution of serious crime.

NB The Public Safety test applies when consent should not be sought The public safety test is met when to seek consent, or delay the information sharing while consent is sought would heighten the risk of significant harm to a child or adult at risk.

would not be safe to do so or would otherwise undermine the purpose of the disclosure e.g. allow a perpetrator to avoid detection.

If there are any doubts about the legality of sharing a particular set of information further advice should be sought from the relevant organisation's Information Governance Lead or Caldicott Guardian.

9. Security and data management

Confidentiality of data must be maintained when case details need to be circulated for panel meetings.

At all stages of the exchange the principle that the information should be available only to those who have a specific and legitimate need to see it must be maintained by all parties.

Data must only be sent if the means of transmission is secure and it can be established that the appropriate recipient's access to the transmission is equally secure. Only the original paper copies of papers are retained by the coordinator. All other copies are returned and destroyed.

Data must be stored securely, regularly reviewed and disposed of in accordance with the receiving organisation's Retention and Disposal policy and procedures when no longer required for the purpose it was originally obtained.

10. Facilitating data collection and performance management

The performance of the group will be measured by looking at whether the process has reduced the burden on public services. Therefore:

- at entry into the process, the referring agency will provide details on service usage over the last 6-12 months e.g. number of arrests, ASB complaints, 999 calls, hospital admissions. This will allow monitoring over time. It will also allow a judgement about the appropriateness of the client for the group.

11. Process

This section sets out a process for managing the multi-agency meeting.

- The chair of the meeting reminds all concerned of the protocols within the agreed sharing of information document.
- The chair ensures the identity and agency of all people in the meeting is clear to ensure that all are covered by the information-sharing protocol.

- New clients for the process will be presented.
- The chair will ensure the information-sharing permissions are in place for this person.
- The referring agency will present a short case history of the person. Other agencies will share any available information on that person.

- The partner agencies will develop and agree a joint action/care plan for each individual. Although this care plan will be jointly owned, lead responsibility will lie with the agency who brought the client to the group. They will draft and store the

care plan. A copy will be held by the chair of the group and by other agencies who may be involved with this person. They will retain the lead on this until the case is closed or it is passed to another agency in the group.

- The care plan will use the *Blue Light* multi-agency group checklist in appendix 4 to provide a framework for the plan and to ensure that the key opportunities are being addressed.

Two particular issues must be addressed:

- The partner agencies will ensure that, where relevant, their staff are aware that when this service user is identified a specific response is required e.g.:
    - Positive encouragement will be given to promote client self-belief.
    - Harm reduction and risk management advice will be given.

This should draw on the approaches set out in the *Blue Light* manual.

- It should be clarified whether:
    - Signed permission for Swanswell to make contact has been secured. If not all agencies who come into contact with this person should be seeking this consent.

- If consent is secured, Swanswell should be contacted within two working hours.

- If consent is not secured, the multi-agency meeting will ensure that agency staff continue to seek opportunities to engage and the group will consider alternative approaches e.g.:
    - Barriers which may be preventing engagement in services.
    - Alternative approaches to engaging the person.
    - Other local resources, such as faith groups, which could be utilised to work with the individual.
    - Involving family members.
    - Identifying incentives to engage the person in treatment.
    - The possible use of compulsory powers.

- In some cases it will be decided that a small sub-group (or conference-call) will be set up for an individual involving a group of workers more specific to that person. This will operate under the same confidentiality / information-sharing protocol and will report back to the main group.

- In some cases this group will be responsible for identifying, recording and reporting unmet need to commissioners. In the light of this data the SDAP will review whether specific service development is required e.g. an expansion of outreach capacity.

- If appropriate, the group will:
    - ask the borough to consider an expedited process to assess the person for community care resources.
    - consider the use of legal powers such as civil injunctions.

12. Swanswell role

Once Swanswell have consent to make contact:

- They will offer an assertive response including a swift appointment, a home visit or a meeting at a convenient location.
- Wherever possible the referring agency should undertake an initial joint visit.
- Swanswell will require the provision of relevant risk information.
- Swanswell will make assertive efforts to reduce risk and harm and engage the person into service.
- Partner agencies will work in concert by reinforcing messages to the person about harm reduction and encouraging change.
- All agencies involved with the person will report back to the monthly meeting on progress and next steps.

- If consent is secured and Swanswell manage to engage the person, they will work within their existing resources to:

  - maintain engagement
  - assess risk
  - reduce harm and manage risk
  - encourage engagement with general services such as primary care
  - encourage engagement with specialist services.

- Where appropriate Swanswell will engage other agencies to support their work. This involvement should be agreed wherever possible, e.g. the ambulance service jointly visiting a client.

13. Terminating the process

The group's oversight will be terminated:

- If the person is successfully engaged with specialist services and it is agreed by the group that client's behaviour is more stable.
- If the person is sentenced to prison or enters hospital as a long stay patient.
- If the person moves away from the area. However, in these circumstances, the group will ensure that information has been shared, if appropriate, with local agencies in the new area.
- In some cases a decision will be taken to remove the person from the group's consideration if it is felt that no further benefit will be gained from the process. In this case the group needs to be sure that at least one agency has ongoing oversight.

If the person dies during the process, consideration will be given to whether an alcohol related death review process should be recommended.

14. Measuring the impact

The impact targets for this work are very straightforward and will encompass output and outcome targets.

Output: The number of clients identified by the multi-agency group who are engaged and the period of engagement.

Outcome: The reduction in the behaviours which had brought the client to the attention of the multi-agency group e.g. hospital attendances, arrests, 999 calls etc.

The key outcome target will be to reduce the cost burdens presented by the clients meeting the definition and brought to the multi-agency group by 20% per annum.

15. Equality and diversity

The organisations participating in this process are committed to ensuring that it treats service users fairly, equitably and reasonably and that it does not discriminate against individuals or groups on the basis of their ethnic origin, physical or mental abilities, gender, age, religious beliefs or sexual orientation.

16. Reviewing these arrangements

These arrangements will be reviewed after 6 months and annually thereafter. This review will ensure the process is relevant and fit for purpose.

Agreement to Terms of Reference

I confirm that our agency will be a partner to the Blue Light Multi-Agency process and will adhere to the Terms of Reference above and the associated information sharing protocol indicated.

For and on behalf of the Client

Signature

Name

On behalf of (Agency)

Date

Position

Address

Email

Telephone number

Annex 1

HM Government - Seven golden rules for information sharing

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.

4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.

5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.[3]

[3] HM Government – Information Sharing – Pocket Guide - 2008

Annex 2

Frameworks within which information sharing may happen

Where there is concern that a child may be suffering, or is at risk of suffering harm, the child's safety and welfare must be the first consideration. In these circumstances the Safeguarding Children Boards Child Protection Procedures, must be followed.

Where there is concern that a vulnerable adult may be suffering, or is at risk of suffering harm, the individual's safety and welfare must be the first consideration. In these circumstances the local Multi Agency Safeguarding Policy and Procedure, must be followed.

If the purpose is:

- primary or secondary health care use and
- the care and treatment of the patient is central to the purpose and
- the patient identifiable data is shared only between those responsible for the delivery of that care and treatment
  then consent can be reasonably implied.

Three pieces of legislation allow information sharing in different settings:

- The European Convention on Human Rights, incorporated into English law from October 2000, by the Human Rights Act 1998: Article 8: Right to respect for private and family life states that:
  1. Everyone has the right to respect for his private and family life, his home and his correspondence.
  2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

- The Crime and Disorder Act 1998 - Section 115 as amended by the Police Reform Act 2002 gives power to any person to disclose information to police authorities and chief constables, local authorities, probation committees, various health authorities, various fire and emergency authorities, and (since 2005) registered social landlords, or persons acting on their behalf so long as such disclosure is necessary for the purposes of any provision of the CDA. These purposes include a range of measures, such as: local crime audits, anti-social behaviour orders, sex offender orders and local child curfew schemes. In addition, the CDA requires local authorities to exercise their own functions with due regard to the need to do all that it reasonably can to prevent crime and disorder in its area.

- The Criminal Justice Act 2003 extended the scope of MAPPA by imposing a duty on public bodies outside the criminal justice system, including NHS Trusts, to co-operate with the responsible authority for MAPPA.

In practical terms this duty imposes the following obligations:

- A general duty to cooperate in the supply of information to other agencies in relation to risk assessment and risk management.
- A duty on professionals to consider, as part of the care planning process, whether there is a need to share information about individuals who come within the MAPPA criteria.
- The need to develop protocols between agencies for exchanging information and other forms of cooperation.

Annex 3

Confidentiality Statement for meetings

Name of meeting:
Date/time:
Venue:

Confidentiality Statement: I agree that information shared at this meeting is only to be used in relation to working with adults as outlined within the Sandwell Blue Light meeting terms of reference. Information shared at this meeting will not be used outside of this group for any other purpose than that agreed within this meeting. All personal information shared should be treated as highly confidential and all data should be transported and stored in accordance with each agency's information security policy and procedures.

Name	Organisation	Contact details	Signature

Signature of the chair as witness to the above signatures

_____ **Date**_____

Annex 4

Blue Light Multi-Agency Information Sharing Protocol - Consent Form
The professional stated below, believes that you may be at risk of harming yourself or other people and is seeking your consent to make a referral to the Sandwell Blue Light multi-agency management group.

If you agree to give your consent, some or all of the following information may be shared - your personal details, information about your carers, your current environment and details of the risk. This may be shared with a multi-agency group, which could include representatives from health, police, emergency services, the local authority, housing providers and substance misuse services.

These people are qualified and will consider the information put forward and make recommendations on how the care you receive might be extended to support you further with any difficulties you may be experiencing. The professionals involved are trained to protect your rights to privacy and confidentiality and this will be respected at all times.

(If we believe you are at significant risk, or if other people are at risk, professionals can still disclose information under common law "Duty of Confidence" without your consent, or if we have a legal obligation to do so, such as under the Crime and Disorder act 1998)

Please provide the relevant information below:

Is this information about you? ☐ Yes ☐ No

If 'No', who is the information about?

Name of data subject:

Address:

DOB (ddmmyyyy):

Are you are acting as: Parent/Guardian/Carer

Other (please describe)

Have the reasons for requesting consent been explained to you?
☐ Yes ☐ No

I give (name of agency/person)…….. consent to process information in relation to a safeguarding concern in relation to myself and I am the above named person.

Client signature……
Date……

To be filled out by the relevant professional the information is being obtained by.

Organisation:

Name of professional:

Professional's role:

Contact details:

If consent was not obtained please state why below: (e.g. not given, not practicable due to risk, mental capacity)

APPENDIX 2

Blue Light Project: Evaluation Methodology

Paper by Mary Bailey, Alcohol Project Lead in Sandwell

The Blue Light project sets out to provide a framework which can identify, engage and build a long term rapport with treatment resistant drinkers. Since the introduction of this project, various multidisciplinary team members have worked to build motivation and to reduce the risk of any potential harm either to the clients themselves and the wider public population.

In the Sandwell borough, the multidisciplinary team incorporates public health, ambulance, police, probation, fire, local GP services, mental health professionals, alcohol treatment provider and various other NHS personnel. These liaise together for monthly reviews to assess the progress of these clients through their interactions with them. The clients of this service are inevitably people with complex physical health issues, social factors and mental health needs. Although there are existing alcohol services in place within the Sandwell borough, there are a proportion of individuals who find it difficult to engage with services and could thus be left ignored or fall through the system until crisis moment occurs. Hence, the coordination and integration between various public services is of paramount importance in order to ensure that these clients are monitored and an effective management plan tailored to the needs of the individual client can be conducted.

The feedback from all these multidisciplinary team meetings has shown that significant progress has been made with respect since the integration of services and the production of data sharing agreement. The clients have been more engaged with services and thus have been less likely to present to emergency services as a result of a crisis. In order to formally quantify the impact of this group, a cost-effective analysis has been proposed. Furthermore, to further strengthen the authenticity of the analysis, a qualitative analysis through the use of questionnaires has also been recommended.

Background

It is estimated that the annual cost of alcohol to society is around 21 billion pounds per year. This can be broken down into NHS costs which are predicted at around 3.5 billion, alcohol related crime which includes police, probation and prison costs at around 11 billion and lost productivity due to alcohol which is projected at around 6.5 billion per year [(1)]. Only around 6% of people who suffer from alcohol receive treatment [(2)]. The vast majority of this treatment is only applied during emergency admissions and crisis moments for the individual. In the case of treatment resistant drinkers they are found to receive even less treatment and yet they are the cohorts that use disproportionate levels of NHS services, police and criminal justice services [(2)]. The Birmingham Untreated Heavy Drinkers Project (BUHD) explored the effects and outcomes of untreated heavy drinking over a ten year period [(3)]. Five hundred participants between the ages of 25 and 54 were recruited. The study results showed that heavy treatment resistant drinkers use hospital services at a constantly higher rate

than the general population. In terms of A&E attendance, this is estimated at around double the frequency for heavy drinkers compared to the public cohort. Only around 10% of the investigated cohort seeked help in terms of treatment, referral to specialist alcohol inpatient and community services. This study concluded that there was a need to increase awareness in the community and between different professional members so that these individuals at greatest risk can be identified and targeted community approaches can be put in place before the client seeks services during an emergency or crisis episode [3].

The 2004 Alcohol Harm Reduction Strategy for England highlighted the need for specialist targeted approaches for people with complex alcohol treatment resistant drinkers. With current focussed intervention plans there is a large emphasis and need for engagement between the individual and other services. This arrangement is often difficult to achieve and the most problematic drinkers avoid services [4, 5]. For this cohort it is of paramount importance that a focussed specialist delivered intervention involving different multidisciplinary team members is planned [6]. Public Health England have suggested that around 95% of dependent drinkers are not engaged with alcohol services. This cohort of the public includes individuals with very complex health, social and psychological needs. They include those with criminal justice histories, personality disorders and mental illness [7]. Thus for the purposes of a cost effective evaluation of Sandwell's *Blue Light* group it is imperative to consider all public service groups including NHS, ambulance, police, probation & prisons, fire and mental health services to establish the true nature of the problem and to quantify the difference made by the initiation of the multidisciplinary team within the Sandwell borough.

In terms of therapy, evidence shows that flexible counselling and motivational enhancement through rapport and use of community teams is more cost effective than older rigid systems of treatment for alcohol problems [8]. There is an increased emphasis on psychosocial treatments especially within the most vulnerable treatment resistant drinking cohort. Due to their poor engagement with services, it is vital that a focussed MDT approach utilising various psychosocial treatments is catered for in order to improve the long term outlook for both the client and society [9]. The UK Alcohol Treatment Trial (UKATT) was one of the first trials which assessed the importance of psychological and community therapies in order to improve motivation and rapport with severely alcohol dependent individuals [10]. The study concluded that both motivational enhancement therapy and social behaviour networking therapy incurred a fivefold saving in terms of expenditure on health, social, criminal and mental health services. Due to such evidence, there is an even greater emphasis on the co-ordination of groups such as the blue light project in order to identify and build a long term rapport with vulnerable treatment resistant drinkers.

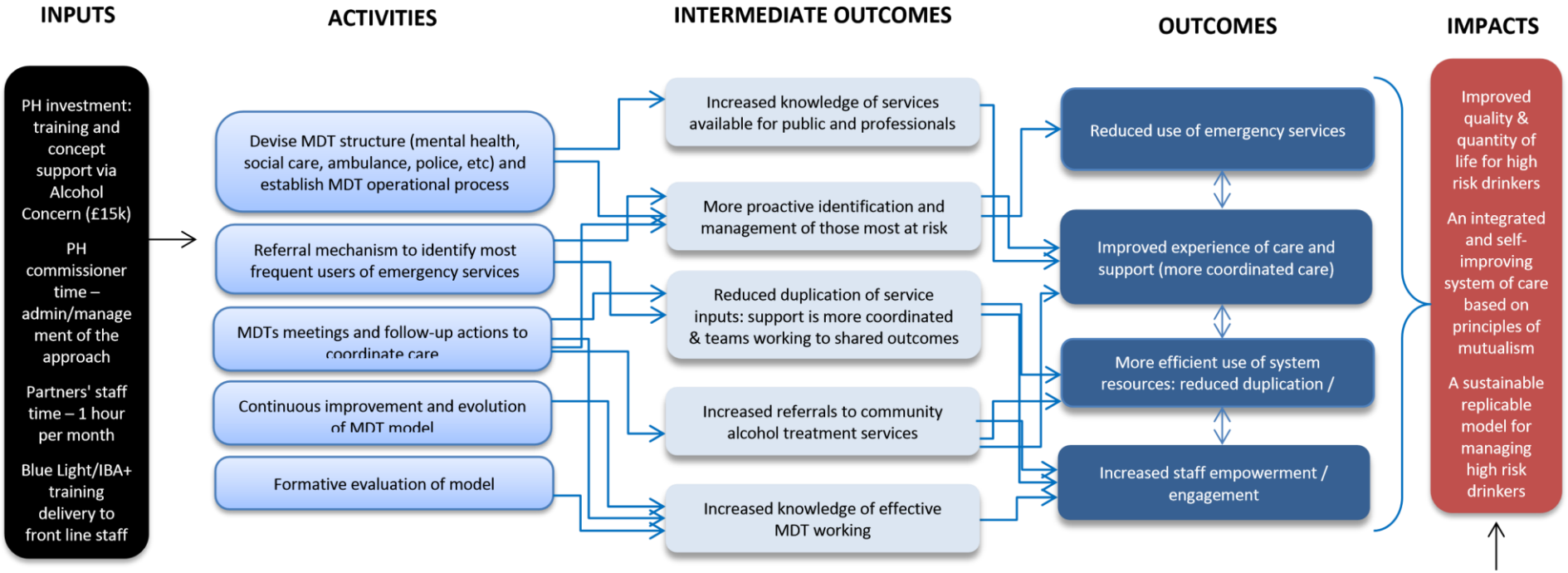
Nottingham Blue Light Group Findings

One of the most effective blue light groups created thus far is based in Nottingham. They conducted a similar quantitative and qualitative analysis to the one suggested in this report (11). They collated data using interviews with the staff of the team and managers, interviews with people who worked alongside the team in the local Blue Light meeting including East Midlands Ambulance Service, Nottinghamshire Fire Service, the police, hepatology and primary care as well as its commissioners. However, with their analysis they only assessed financial impact upon emergency presentations, hospital costs and emergency telephone call service costs. This would only portray one aspect of cost saving and did not include the other major organizations involved in patient care. For Sandwell, we are proposing a multivariate analysis with detailed cost effective evaluations for all the major emergency services involved to provide a more accurate and reliable quantification of the savings produced by the commencement and integration of the service.

Logic Model for Sandwell's Blue Light approach:

RATIONALE

There is clear scope for improving the care of the highest risk drinkers in Sandwell. Too often, support is only accessible to those willing to engage and attend services. This does not provide for some of the most vulnerable in our population - nor does it represent a good use of resources. We have therefore devised the Blue Light Multi-Disciplinary Team (MDT); they will operate as 'teams without walls', coordinating and drawing on inputs from different services to focus on the needs of those most at risk.



CORE ASSUMPTIONS

That partners function well as a team: the whole is greater than the sum of its parts
That the right individuals have been identified
That effective, harm reduction interventions can be made once individuals have been identified

CONTEXTUAL FACTORS

National policy / regulation; funding; patient / public expectation; support from local partners; supply of appropriate workforce

Quantitative Analysis

This involves a cost-effective analysis model which proposes to quantify the impact of the interventions of the group from a financial viewpoint. Data from the following local emergency services will be used:

- Hospital/ A&E,
- Ambulance,
- Police,
- Fire

For all clients being managed under the *Blue Light* approach, data will be collected from each of the above listed emergency partners for a period of 12 months prior to commencement of the Blue Light approach. The dataset collected will include the following details of the client from each involved partner within the proposed time frame:

- Number of encounters with the service
- Type of encounter/ presentation to the service
- Cost of encounters/ presentation to emergency services

For each of these domains, the different sectors of the multidisciplinary team will provide data with relation to the client list. Once this data is assimilated units costings will be applied to each domain for every client, thus producing a cost of each individual to public services before the introduction and intervention of this group within the Sandwell borough.

This same methodology will be applied for the prospective comparison study which will show the involvement of services over a twelve month period after the commencement of the multidisciplinary team. This dataset will include exactly the same data as the retrospective analysis. This will then allow a valid and reliable comparison to be analysed within the two studies. This will then quantify the cost savings, providing accurate, reliable data on the impact of the blue light service within the Sandwell borough.

Costings

The various unit costs for each of the different services have been researched, as shown below:

Police Costings

The dataset for police costings, shown in the following tables, were identified from the recent Home Office report *The Economic and Social Costs of Crime* .[12]

Table 2: Summary of average and total cost estimates, by crime type and cost category

Offence category	In anticipation of crime (£) Security expenditure	Insurance administration	As a consequence of crime (£) Property stolen and damaged	Emotional and physical impact on victims	Lost output	Victim services	Health services	In response to crime (£) Criminal Justice System (incl. Police)	Average cost (£)	Number of incidents (000s)	TOTAL COST (£ billion)
Crime against individuals and households											
Violence against the person	2	-	-	13,000	2,500	10	1,200	2700	19,000	880	16.8
Homicide	-	-	-	700,000	370,000	4,700	630	22,000	1,100,000	1.1	1.2
Wounding (serious and slight)	2	-	-	12,000	2,000	6	1,200	2,700	18,000	880	15.6
Serious wounding	10	-	-	97,000	14,000	6	8,500	13,000	130,000	110	14.1
Other wounding	0	-	-	120	400	6	200	1,300	2,000	780	1.5
Common assault	0	-	-	240	20	6	-	270	540	3,200	1.7
Sexual offences	2	-	-	12,000	2,000	20	1,200	3,900	19,000	130	2.5
Robbery/Mugging	0	40	310	2,400	420	6	190	1,400	4,700	420	2.0
Burglary in a dwelling	330	100	830	550	40	4	-	490	2,300	1,400	2.7
Theft	40	30	310	160	10	0	-	60	600	7300	4.4
Theft (not vehicle)	-	20	130	100	4	0	-	90	340	3,800	1.3
Vehicle theft	70	50	500	220	20	0	-	30	890	3,500	3.1
Criminal Damage	10	20	190	200	30	0	-	60	510	3,000	1.5
All crime against individuals and households (£ billion)	0.7	0.5	4.1	17.0	2.9	0.0	1.3	5.7	2,000	16,400	32.2
Commercial and public sector victimisation											
Burglary not in a dwelling	900	50	1,200	-	40	-	-	490	2,700	960	2.6
Theft from a shop	30	-	50	-	-	-	-	20	100	31,000	3.1
Theft of commercial vehicle	3,400	1,500	4,600	-	60	-	-	70	9,700	40	0.3

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Table A1.6: Average cost estimates for all violence against the person

Category of cost	Data Source	£ per incident Serious wounding Estimate: Low	Best	High	Other wounding Low	Best	High	All wounding Low	Best	High
In anticipation of crime		-	**10**	**350**	-	**0**	**0**	-	**2**	**40**
Defensive expenditure	Mintel "U.K S.M 1999"	-	10	350	-	0	2	-	2	40
As a consequence of crime		**90,000**	**120,000**	**150,000**	**550**	**730**	**910**	**11,000**	**15,000**	**19,000**
Physical and emotional impact	Highways Economics Note 1 (1998)	73,000	97,000	120,000	90	120	150	8,800	12,000	15,000
Victim services	NAVSS Annual Report 1998	-	6	-	-	6	-	-	6	-
Lost output	H'ways Econs. N.1 (1998)	11,000	14,000	18,000	300	400	500	1,500	2,000	2,500
Health services	Highways Economics Note 1 (1998)	6,400	8,500	11,000	150	200	250	900	1,200	1,500
In response to crime		**12,000**	**13,000**	**14,000**	**1,100**	**1,300**	**1,300**	**2,400**	**2,700**	**2,800**
Police activity	Various	5,300	6,700	7,000	490	620	650	1,100	1,400	1,400
Prosecution	Flows and Costs	-	250	-	-	20	-	-	50	-
Magistrates courts	Flows and Costs	-	60	-	-	6	-	-	10	-
Crown court	Flows and Costs	-	440	-	-	40	-	-	90	-
Jury service	Various	30	60	110	3	5	10	6	10	20
Legal aid	Flows and Costs	-	650	-	-	60	-	-	130	-
Non legal-aid defence	Flows and Costs adapted	80	150	310	7	10	30	20	30	60
Probation Service	Flows and Costs	-	260	-	-	20	-	-	50	-
Prison Service	Flows and Costs	-	2,600	-	-	240	-	-	520	-
Other CJS costs	Flows and Costs	-	1,100	-	-	100	-	-	220	-
Criminal injuries compensation admin	CICB	-	1,200	-	-	110	-	-	250	-
TOTAL cost per incident		**100,000**	**130,000**	**160,000**	**1,700**	**2,000**	**2,200**	**14,000**	**18,000**	**22,000**

Appendix 1: Best, low and high average cost estimates for selected offence types

Table A1.1: Average cost estimates for burglary in a dwelling

Category of cost	Data Source	£ per incident Estimate: Low	Best	High
In anticipation of crime		**330**	**430**	**520**
Defensive expenditure	Various	240	330	420
Insurance administration	ABI Insurance Statistics Yearbook	-	100	-
As a consequence of crime		**-**	**1,400**	**-**
Value of property stolen	BCS 1998	-	580	-
Property damaged/destroyed	BCS 1998	-	270	-
Property recovered	BCS 1998	-	-20	-
Lost output	BCS 1998	-	40	-
Emotional impact	BCS 1998	-	550	-
Victim services	NAVSS Annual Report 1998	-	4	-
In response to crime		**440**	**490**	**510**
Police activity	Various	190	240	250
Prosecution	Flows and Costs	-	8	-
Magistrates courts	Flows and Costs	-	5	-
Crown court	Flows and Costs	-	10	-
Jury service	Various	1	2	5
Legal aid	Flows and Costs	-	20	-
Non legal-aid defence	Flows and Costs adapted	3	7	10
Probation Service	Flows and Costs	-	20	-
Prison Service	Flows and Costs	-	160	-
Other CJS costs	Flows and Costs	-	10	-
TOTAL cost per burglary		**2,200**	**2,300**	**2,500**

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Table A1.2: Average cost estimates for theft of and from vehicles and attempts

Category of cost	Data Source	(£ per incident) All vehicle crime Estimate: low	best	high	Theft of vehicle low	best	high	Theft from vehicle low	best	high	Attempted theft low	best	high
In anticipation of crime		**120**	**120**	**200**	**-**	**690**	**1,100**	**-**	**70**	**110**	**-**	**30**	**50**
Defensive (security) expenditure	Mintel "UK Security Market '99"	-	70	140	-	370	730	-	40	90	-	20	40
Insurance admin.	ABI Ins. Stats Y'book	-	50	-	-	320	-	-	20	-	-	9	-
As a consequence of crime		**-**	**730**	**-**	**3,000**	**4,000**	**4,400**	**-**	**480**	**-**	**-**	**240**	**-**
Value of property stolen	BCS 1998	-	460	-	-	3,800	-	-	200	-	-	0	-
Property dam./dest'd.	BCS 1998	-	150	-	0	460	-	-	110	-	-	120	-
Property recovered	BCS 1998	-	-110	-	-1,800	-1,200	-780	-	-10	-	-	0	-
Lost output	BCS 1998	-	20	-	-	60	-	-	10	-	-	7	-
Emotional impact	BCS 1998	-	220	-	-	890	-	-	180	-	-	120	-
Victim services	NAVSS Ann'l Rep't '98	-	0	-	-	0	-	-	0	-	-	0	-
In response to crime		**20**	**30**	**40**	**60**	**70**	**80**	**20**	**30**	**30**	**10**	**10**	**-**
Police activity	Various	10	20	-	30	40	40	10	10	20	5	7	-
Prosecution	Flows and Costs	-	1	-	-	2	-	-	1	-	-	0	-
Magistrates courts	Flows and Costs	-	1	-	-	1	-	-	1	-	-	0	-
Crown court	Flows and Costs	-	1	-	-	2	-	-	1	-	-	0	-
Jury service	Various	3	6	10	-	0	1	-	0	-	-	0	-
Legal aid	Flows and Costs	-	2	-	-	4	-	-	2	-	-	1	-
Non legal-aid defence	Flows and Costs adapted	-	0	1	0	1	2	-	0	1	-	0	-
Probation Service	Flows and Costs	-	2	-	-	6	-	-	2	-	-	1	-
Prison Service	Flows and Costs	-	6	-	-	20	-	-	6	-	-	3	-
Other CJS costs	Flows and Costs	-	1	-	-	1	-	-	0	-	-	0	-
TOTAL cost per vehicle crime		**890**	**890**	**970**	**3,700**	**4,800**	**5,500**	**570**	**580**	**620**	**280**	**280**	**300**

Table A1.5: Average cost estimates for homicide

Category of cost	Data Source	£ per incident		
		Low estimate	Best estimate	High estimate
In anticipation of crime		**0**	**0**	**0**
Defensive expenditure	Unknown	-	-	-
As a consequence of crime		800,000	1,100,000	1,300,000
Physical and emotional impact	Highways Economics Note 1 (1998)	520,000	700,000	870,000
Victim services	NAVSS Annual Report 1998	-	4,700	-
Lost output	Highways Economics Note 1 (1998)	270,000	370,000	460,000
Health services	Highways Economics Note 1 (1998)	470	630	790
In response to crime		**19,400**	**22,000**	**23,000**
Police activity	Various	8,600	11,000	11000
Prosecution	Flows and Costs	-	410	-
Magistrates courts	Flows and Costs	-	100	-
Crown court	Flows and Costs	-	720	-
Jury service	Various	50	90	180
Legal aid	Flows and Costs	-	1,100	-
Non legal-aid defence	Flows and Costs adapted	130	250	510
Probation Service	Flows and Costs	-	430	-
Prison Service	Flows and Costs	-	4,200	-
Other CJS costs	Flows and Costs	-	1,700	-
Criminal injuries compensation admin	CICB	-	2,000	-
TOTAL cost per homicide		**820,000**	**1,100,000**	**1,400,000**

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Table A1.7: Average cost estimates for sexual offences

Category of cost	Data Source	£ per incident		
		Estimate: Low	Best	High
In anticipation of crime		**-**	**2**	**40**
Defensive expenditure	Mintel "UK Security Market 1999"	-	2	40
As a consequence of crime		**600**	**15,000**	**150,000**
Physical and emotional impact	Highways Economics Note 1 (1998)	90	12,000	120,000
Victim services	NAVSS Annual Report 1998	-	20	-
Lost output	Highways Economics Note 1 (1998)	300	2,000	18,000
Health services	Highways Economics Note 1 (1998)	150	1,200	11,000
In response to crime		**3,400**	**3,900**	**4,000**
Police activity	Various	1,500	1,900	2,000
Prosecution	Flows and Costs	-	60	-
Magistrates courts	Flows and Costs	-	7	-
Crown court	Flows and Costs	-	180	-
Jury service	Various	10	20	40
Legal aid	Flows and Costs	-	200	-
Non legal-aid defence	Flows and Costs adapted	30	50	110
Probation Service	Flows and Costs	-	60	-
Prison Service	Flows and Costs	-	1,200	-
Other CJS costs	Flows and Costs	-	160	-
TOTAL cost per sexual offence		**4,300**	**19,000**	**150,000**

Table A1.8: Average cost estimates for robbery of individuals

Category of cost	Data Source	£ per incident		
		Estimate: Low	Best	High
In anticipation of crime		**-**	**40**	**50**
Defensive expenditure	Mintel "UK Security Market 1999"	-	0	10
Insurance administration	ABI Insurance Statistics Yearbook	-	40	-
As a consequence of crime		**1,200**	**3,300**	**35,000**
Physical and emotional impact	BCS 1998/ Highways Ec. Note 1 (1998)	540	2,400	30,000
Value of property stolen	BCS 1998	-	330	-
Property damaged/destroyed	BCS 1998	-	30	-
Property recovered	BCS 1998	-	50	-
Lost output	BCS 1998/ Highways Ec. Note 1 (1998)	100	420	4,300
Health services	BCS 1998/ Highways Ec. Note 1 (1998)	-	190	420
Victim services	NAVSS Annual Report 1998	-	6	-
In response to crime		**1,200**	**1,400**	**1,400**
Police activity	Various	530	680	710
Prosecution	Flows and Costs	-	20	-
Magistrates courts	Flows and Costs	-	4	-
Crown court	Flows and Costs	-	40	-
Jury service	Various	3	7	10
Legal aid	Flows and Costs	-	60	-
Non legal-aid defence	Flows and Costs adapted	9	20	40
Probation Service	Flows and Costs	-	20	-
Prison Service	Flows and Costs	-	450	-
Other CJS costs	Flows and Costs	-	70	-
TOTAL cost per robbery		**2,400**	**4,700**	**36,000**

Table A1.9: Average cost estimates for common assault

Category of cost	Data Source	£ per incident		
		Estimate: Low	Best	High
In anticipation of crime		**-**	**0**	**1**
Defensive expenditure	Mintel "UK Security Market 1999"	-	0	1
As a consequence of crime		**-**	**270**	**-**
Physical and emotional impact	BCS 1998	-	240	-
Victim services	NAVSS Annual Report 1998	-	6	-
Lost output	BCS 1998	-	20	-
In response to crime		**240**	**270**	**280**
Police activity	Various	100	130	140
Prosecution	Flows and Costs	-	5	-
Magistrates courts	Flows and Costs	-	1	-
Crown court	Flows and Costs	-	9	-
Jury service	Various	-	1	3
Legal aid	Flows and Costs	-	10	-
Non legal-aid defence	Flows and Costs adapted	2	4	8
Probation Service	Flows and Costs	-	5	-
Prison Service	Flows and Costs	-	50	-
Other CJS costs	Flows and Costs	-	20	-
Criminal injuries compensation adminCICB		-	20	-
TOTAL cost per common assault		**510**	**540**	**550**

Table A1.14: Average cost estimates for robbery of commercial or public sector premises

Category of cost	Data Source	£ per incident		
		Estimate: Low	Best	High
In anticipation of crime		**-**	**1,300**	**-**
Defensive (security) expenditure	BSIA estimate adapted	-	1,200	-
Insurance administration	ABI Insurance Statistics Yearbook	-	100	-
Precautionary behaviour	Unknown			
Reduced quality of life	Unknown			
As a consequence of crime		**1,800**	**2,300**	**9,200**
Value of property stolen	CVS 1994 adapted	-	1,500	-
Value of property damaged/destroyed	CVS 1994 adapted	-		-
Lost output	BCS 1998 adapted	-	120	-
Health services	BCS 1998/ Highways Ec. Note 1 (1998)	-	50	-
Emotional/other impact	BCS 1998 adapted	140	590	7,400
In response to crime		**1,200**	**1,400**	**1,400**
Police activity	Various	530	680	710
CPS	Flows and Costs	-	20	-
Magistrates courts	Flows and Costs	-	4	-
Crown court	Flows and Costs	-	40	-
Jury service	Various	3	7	10
Legal aid	Flows and Costs	-	60	-
Non legal-aid defence	Flows and Costs adapted	9	20	40
Probation Service	Flows and Costs	-	20	-
Prison Service	Flows and Costs	-	450	-
Other CJS costs	Flows and Costs	-	70	-
TOTAL cost per robbery		**4,300**	**5,000**	**12,000**

Table showing indicative resource costs of disposals		
Disposal	**Youth**	**Adult**
Prosecution (amount depends on who took charging decision and the outcome)	£400 to £1400	£400 to £1400
Street disposal (such as PND or for youths the YRD)	£5 to £40	£5 to £40
PND following arrest[34]	£250 to £350	£250 to £350
Simple caution or reprimand/warning following CPS advice	£350 - £450	£300 to £450
Conditional caution	Not yet available	£300 to £450
No further action following CPS advice	£350 to £450	£300 to £450
Simple caution or reprimand/warning without CPS advice	£250 to £400	£250 to £350
Street-issued cannabis warning	N/A	£10 to £20
Cannabis warning following arrest	N/A	£250 to £350

Probation & Prison costs

The following data was collected from the Ministry of Justice report *Probation Trusts Unit Costs*.(13)

Probation Trusts Unit Costs, 2011-12 (revised)

Unit Cost and percentage of total fully apportioned cost to NOMS

Remaining percentage of total fully apportioned cost to NOMS

Probation Trust	Cost per Pre-Sentence Report	% of Total FA Cost to NOMS	Cost per Offender Supervised on Licence Post-Custody	% of Total FA Cost to NOMS	Cost per Community Order/ Suspended Sentence Order	% of Total FA Cost to NOMS	% of Total Spend Covered by Indicators	Court Work (other than Assessments and Reports) including Bail Services	Victim Liaison	Manage the Sentence Pre Release From Custody	Approved Premises
Avon & Somerset	£175	5%	£2,545 r	13%	£3,325	50%	68%	7%	2%	11%	12%
Bedfordshire	£190	4%	£2,435 r	12%	£4,640	42%	58%	6%	3%	12%	22%
Cambridgeshire	£130	4%	£1,845 r	8%	£4,195	61%	73%	6%	2%	10%	10%
Cheshire	£200	6%	£2,755 r	12%	£4,640	50%	68%	9%	2%	11%	11%
Cumbria	£295	7%	£3,060 r	11%	£4,765	52%	70%	7%	1%	11%	11%
Derbyshire	£175	5%	£1,990 r	9%	£3,850	58%	72%	7%	1%	12%	7%
Devon & Cornwall	£175	4%	£2,955 r	10%	£5,365	53%	68%	9%	2%	12%	9%
Dorset	£345	7%	£1,920 r	8%	£5,720	51%	66%	8%	1%	8%	17%
Durham Tees Valley	£220	7%	£2,180 r	11%	£2,860	53%	70%	9%	1%	12%	8%
Essex	£165	5%	£1,940 r	9%	£2,895	62%	76%	8%	1%	11%	5%
Gloucestershire	£235	5%	£2,255 r	10%	£4,755	56%	70%	4%	1%	14%	11%
Greater Manchester	£90	3%	£1,835 r	11%	£3,980	59%	73%	7%	1%	8%	11%
Hampshire	£155	5%	£2,825 r	12%	£4,215	55%	72%	5%	1%	12%	11%
Hertfordshire	£185	6%	£2,585 r	11%	£2,770	64%	81%	7%	2%	10%	0%
Humberside	£230	6%	£2,415 r	10%	£3,950	49%	65%	8%	2%	13%	12%
Kent	£270	6%	£2,580 r	14%	£3,995	52%	72%	7%	1%	15%	4%
Lancashire	£260	7%	£2,120 r	11%	£3,005	51%	69%	8%	1%	14%	8%
Leicestershire	£275	6%	£2,545 r	11%	£4,455	52%	70%	5%	1%	13%	11%
Lincolnshire	£295	5%	£3,240 r	14%	£4,325	50%	69%	6%	2%	13%	10%
London	£260	6%	£2,380 r	13%	£5,240	51%	70%	8%	1%	15%	6%
Merseyside	£210	5%	£2,620 r	16%	£4,565	51%	72%	9%	1%	8%	9%
Norfolk & Suffolk	£190	4%	£2,890 r	12%	£4,705	53%	68%	7%	2%	11%	13%
North Yorkshire	£155	4%	£3,060 r	10%	£4,910	57%	71%	7%	1%	10%	10%
Northamptonshire	£140	3%	£1,925 r	11%	£3,450	52%	67%	9%	1%	14%	9%
Northumbria	£255	7%	£2,685 r	8%	£3,915	57%	72%	8%	1%	13%	6%
Nottinghamshire	£185	6%	£2,220 r	11%	£4,055	51%	69%	6%	2%	12%	11%
South Yorkshire	£215	5%	£2,380 r	11%	£4,690	54%	70%	6%	1%	10%	13%
Staffordshire & West Midlands	£250	7%	£2,200 r	12%	£3,430	47%	65%	8%	1%	13%	12%
Surrey & Sussex	£180	4%	£2,740 r	13%	£4,400	52%	69%	9%	2%	12%	8%
Thames Valley	£255	7%	£2,640 r	12%	£4,345	47%	67%	6%	1%	11%	15%
Wales	£225	6%	£2,440 r	10%	£4,435	62%	78%	5%	1%	10%	5%
Warwickshire	£305	6%	£3,510 r	13%	£4,045	49%	69%	1%	-	9%	20%
West Mercia	£210	5%	£2,105 r	9%	£4,765	64%	78%	6%	1%	10%	5%
West Yorkshire	£170	5%	£2,215 r	12%	£3,920	52%	69%	9%	2%	12%	8%
Wiltshire	£310	6%	£2,965 r	10%	£5,745	63%	78%	7%	2%	13%	0%
National[1]	£215	5%	£2,380 r	12%	£4,135	53%	70%	7%	1%	12%	9%

Source: National Offender Management Service

Total national fully apportioned cost to NOMS[2]	£820,393,958

Notes to Table:

1. National unit costs are calculated from the total fully apportioned cost to NOMS allocated across all Probation Trusts providing an average overall unit cost. The national percentage of total fully apportioned spend is the percentage of the total national fully apportioned cost to NOMS by category.
2. Total national fully apportioned cost to NOMS across each of the unit costs and other categories for all 35 Probation Trusts.

The unit costs represent the actual cost in each Probation Trust. There may be mitigating factors to why Probation Trust Unit Costs differ and so the Indicators should not be viewed as a directly comparable measure in isolation.

Unit costs have been rounded to the nearest £5. National totals are formed from unrounded figures and were rounded subsequently to the nearest £5. For this reason, totals may not equal the sum of the constituent parts.

Percentages are formed from unrounded values, and are presented to the nearest whole percentage. Percentage of total spend was formed from unrounded percentages and rounded subsequently to the nearest whole percentage. For this reason, totals may not equal the sum of the constituent parts.

- represents negligible, less than 0.5% but greater than 0%

r represents revised figure. Revisions have been made to the methodology used to derive the unit cost of Cost of Offender Supervised on Licence Post-Release From Custody. This change only affects the unit costs for this category, and does not affect the total fully apportioned cost to NOMS, nor the percentage of the fully apportioned cost to NOMS which this category represents. The previously published National unit cost per offender supervised on licence post release from custody for 2011/12 was £1,190. The revised figure is £2,380

Table 1: Summary by Prison Function 2013-14

Function	Certified Normal Accommodation	Average Population	Direct Resource Expenditure	Cost per Place	Cost per Prisoner	Overall Resource Expenditure	Cost per Place	Cost per Prisoner
Male category B	6,251	6,215	£165,357,952	£26,455	£26,606	£207,315,241	£33,167	£33,356
Male category C	28,745	29,115	£629,223,487	£21,890	£21,612	£879,160,313	£30,585	£30,196
Male dispersal	3,316	3,199	£144,821,624	£43,674	£45,273	£190,277,929	£57,382	£59,484
Female closed	952	698	£22,944,065	£24,101	£32,875	£31,041,365	£32,606	£44,477
Female local	2,930	2,668	£99,169,491	£33,846	£37,173	£124,636,433	£42,538	£46,720
Female open	248	191	£5,921,471	£23,877	£31,084	£7,961,207	£32,102	£41,791
Male closed YOI (ages 15-21)	5,322	5,264	£149,306,562	£28,055	£28,366	£208,748,985	£39,224	£39,659
Male YOI young people (ages 15-17)	1,275	664	£48,359,812	£37,939	£72,858	£62,909,968	£49,354	£94,780
Male local	24,611	31,446	£747,088,910	£30,357	£23,758	£1,005,915,621	£40,873	£31,989
Male open	4,478	4,339	£77,258,822	£17,251	£17,806	£113,110,033	£25,257	£26,069
Totals	**78,127**	**83,798**	**£2,089,452,194**	**£26,744**	**£24,935**	**£2,831,077,096**	**£36,237**	**£33,785**

Source: National Offender Management Service

Table 24: General price assumptions *(continued)*

Description	Value in the base period (2008)	Unit
Average cost of a magistrates court	£1,672	£
Average cost of a Crown Court	£112,496	£
Annual average cost per prisoner	40,547.92	£/annum
Monthly average cost per prisoner	£3,664	£/per prisoner
Insurance administration per incident 2004 – domestic	£236,036,812.11	
Insurance administration per incident 2004 – commercial	£198,416,935.68	
Insurance administration per incident 2004 – public	£133,743,468.95	
Gross Value Added in England	£989,641,393,235.74	
Crime prevention officer	£1,571.84	£/starter

Ambulance Costings

Back to Index

National Schedule of Reference Costs - Year 2014-15 - NHS trusts and NHS foundation trusts - Ambulance

Currency Code	Currency Description	Activity	National Average Unit Cos	Lower Quartile Unit Cos	Upper Quartile Unit Cos	No. Data Submissions
ASC1	Calls	9,491,159	£7	£6	£8	11
ASH1	Hear and treat or refer	575,168	£35	£26	£43	11
ASS01	See and treat or refer	2,270,229	£180	£148	£198	11
ASS02	See and treat and convey	5,107,902	£233	£203	£256	11

These are the rough estimated ambulance costs and these have been collected from the NHS Government reference costs 2014-2015 [14].

Hospital Costings

The NHS unit costs have been derived from the NHS Government reference costs 2014-2015. [14]

Reference costs 2014-15

Table 1: FCE based average costs 2012-13, 2013-14 and 2014-15

Point of delivery	2012-13 £	2013-14 £	2014-15 £
Day case	693	698	721
Elective inpatient (excluding excess bed days)	3,366	3,375	3,573
Non-elective inpatient (excluding excess bed days)	1,489	1,542	1,565
Excess bed day	273	281[4]	303
Outpatient attendance	108	111	114
A&E attendance	114	124	132

Table 3: spell based average costs (£), 2012-13 – 2014-15

Point of delivery	2012-13 £	2013-14 £	2014-15 £
Day case	696	698	723
Elective inpatient (including excess bed days)	3,706	3,688	3,910
Non-elective inpatient (including excess bed days)	2,118	2,160	2,233

22. A spell is the period from admission to discharge within a single provider and may comprise of more than one FCE. HRG4+ supports spell based grouping. It is possible to group individual FCEs to a HRG, but the overall spell groups to a HRG based on the coding in all the FCEs within the spell (Figure 3).

Table 2: Calculating the average cost of a normal delivery

	A	B	C	D= A*C
Setting	Activity	FCEs	National Average Unit Cost (£)	Activity x unit cost (£)
Day case	75	75	380	28,511
Elective Inpatient	1,499	1,499	2,031	3,043,738
Elective Inpatient Excess Bed Days	132	-	402	53,103
Non-Elective Inpatient- Long Stay	152,136	152,136	2,597	395,033,567
Non-Elective Inpatient-Long Stay Excess Bed Days	47,702	-	430	20,512,375
Non-Elective Inpatient- Short Stay	223,594	223,594	1,293	289,184,966
Total	**-**	**377,304**	**1,876**	**707,856,260**

Reference Cost Collection: National Schedule of Reference Costs - Year 2014 - 15 NHS trusts and NHS foundation trusts

Index	Description	Total Activity	Unit Cost	Total Cost
Total Quantum				61,208,013,570
Total HRG's	Total HRG's			38,145,081,873
Total Outpatient Attendances	Total Outpatient Attendances			8,360,800,156
Total Other Currencies	Total Other Currencies			14,702,131,542
EL	Elective Inpatients	1,472,590	£ 3,573.02	5,261,594,722
EL_XS	Elective Inpatients Excess Bed Days	431,147	£ 359.13	154,838,090
NEL	Non-Elective Inpatients	3,903,867	£ 2,930.12	11,438,790,263
NEL_XS	Non-Elective Inpatients excess bed days	3,380,432	£ 295.80	999,936,997
NES	Non-Elective Short Stay	5,450,599	£ 586.93	3,199,139,260
DC	Day Case	5,578,774	£ 720.78	4,021,050,206
RP	Regular Day or Night Admissions	223,302	£ 354.67	79,199,469
CL	Consultant Led	52,116,966	£ 132.00	6,879,289,251
NCL	Non Consultant Led	20,903,147	£ 70.88	1,481,510,904
OPROC	Outpatient Procedures	10,836,116	£ 134.22	1,454,441,505
CMDT	Cancer Multi-Disciplinary Team Meetings	1,434,580	£ 110.73	158,847,907
EM	Emergency Medicine	19,107,021	£ 131.92	2,520,585,169
CHEM	Chemotherapy	2,729,954	£ 449.12	1,226,079,523
CC	Critical Care	2,746,664	£ 1,043.53	2,866,219,898
IMAG	Diagnostic Imaging	9,440,280	£ 87.62	827,154,952
HCD	High Cost Drugs	1,982,162	£ 877.42	1,739,194,001
NM	Nuclear Medicine	426,672	£ 274.53	117,133,561
RAD	Radiotherapy	2,855,371	£ 135.10	385,774,694
REHAB	Rehabilitation	3,008,889	£ 317.20	954,413,054
SPC	Specialist Palliative Care	775,488	£ 156.78	121,583,944
RENAL	Renal Dialysis	4,070,447	£ 131.17	533,927,599
DADS	Directly Accessed - Diagnostic Services	7,128,172	£ 31.61	225,326,591
DAPS	Directly Accessed - Pathology Services	356,528,477	£ 2.16	768,697,043
MHCC	Mental Health Care Clusters	250,491,883	£ 16.19	4,056,041,912
MHCCIA	Mental Health Care Clusters Initial Assessments	755,151	£ 292.74	221,061,862
MH	Mental Health	11,638,256	£ 210.39	2,448,589,569
CHS	Community Health Services	89,450,160	£ 59.04	5,281,127,509
AMB	Ambulance	17,444,458	£ 96.35	1,680,838,445
CF_NET	Cystic Fibrosis-Network Care provider	3,507	£ 4,733.09	16,598,940
CF_SPEC	Cystic Fibrosis	7,260	£ 12,262.64	89,026,730

Fire Costings

Fire costings have been extracted from the national archives on fire safety and unit costs over the last decade. [15]

Table 3.7: Average costs by location, 2000-2004 (£ current prices)

		All incidents*	Domestic	Commercial	Public sector	Non-building	Vehicle**
2000	Response	1,670	2,360	6,180	2,570	1,510	1,260
	Consequential	3,340	19,310	36,400	32,430	1,170	3,330
2001	Response	1,630	2,320	5,970	2,620	1,450	1,000
	Consequential	3,380	20,370	43,150	41,180	920	2,850
2002	Response	1,820	2,780	10,330	3,800	1,630	1,690
	Consequential	3,490	20,300	52,280	46,530	1,020	2,840
2003	Response	1,860	2,820	7,310	2,970	1,670	1,090
	Consequential	3,290	22,160	45,880	43,470	880	3,070
2004	Response	2,290	3,050	9,390	7,490	2,000	1,350
	Consequential	3,200	21,850	34,410	32,710	980	3,050

* Including false alarms but excluding special service incidents
** Excluding derelict vehicles

Table 3.4: Average consequential and response costs per fire, 2000-2004

Average consequential and reponse costs per fire excl. false alarms (current prices) £		2000	2001	2002	2003	2004
Consequential costs	Property damage per fire	1,805	1,977	1,999	1,879	1,669
	Cost of fatalities per fire*	749	671	671	717	715
	Cost of injuries per fire*	721	691	711	655	759
	CJS costs per fire**	101	97	90	95	125
	AVERAGE COST PER FIRE	**3,377**	**3,436**	**3,471**	**3,346**	**3,268**
Response costs	Response costs per fire	1,669	1,633	1,816	1,861	2,289

* These averages include fires where there were no fatalities or injuries
** This average is calculated across all fires, not just deliberate fires

Estimates for consequence and response costs

Table 22: Average consequential and response costs per fire

Region	Property damage per fire	Lost business per fire	Cost of fatalities per fire[1]	Cost of injuries per fire[1]	CJS[2] costs per fire[3]	Costs to police per fire[3]	Costs to the prison service per fire[3]	Cost of non-detected arson per fire[3]	Average consequence cost per fire	Response cost per fire
North East	£2,096	£58	£514	£705	£307	£25	£151	£408	£4,263	£3,093
North West	£2,934	£80	£1,043	£2,004	£309	£25	£152	£410	£6,956	£2,954
Yorkshire & The Humber	£2,199	£70	£1,124	£1,099	£285	£23	£140	£377	£5,316	£2,699
East Midlands	£2,899	£89	£1,082	£1,691	£220	£18	£108	£292	£6,400	£2,988
West Midlands	£2,704	£87	£1,157	£1,045	£237	£19	£116	£315	£5,681	£3,204
East of England	£2,784	£88	£828	£1,579	£159	£13	£78	£211	£5,740	£3,471
South East	£2,724	£77	£979	£1,287	£147	£12	£72	£195	£5,494	£3,397
South West	£3,220	£100	£1,577	£1,557	£164	£13	£81	£218	£6,930	£3,771
London	£2,286	£69	£598	£1,929	£94	£8	£46	£125	£5,155	£3,293
ENGLAND	**£2,634**	**£79**	**£972**	**£1,499**	**£210**	**£17**	**£103**	**£278**	**£5,792**	**£3,186**

[1] These averages included fires where there were no fatalities or injuries

[2] Criminal Justice System

[3] This average was calculated across all fires, not just deliberate fires

Table 23: Average consequential and response costs per fire

England		2008
Consequential costs	Property damage per fire	£2,634
	Lost business per fire	£79
	Cost of fatalities per fire[1]	£972
	Cost of injuries per fire[1]	£1,499
	CJS[2] costs per fire[3]	£210
	Costs to police per fire[3]	£17
	Costs to the prison service per fire[3]	£103
	Cost of non-detected arson per fire[3]	£278
	Average consequence cost per fire	£5,792
Response costs	Response cost per fire	£3,186

[1] These averages include fires where there were no fatalities or injuries

[2] Criminal Justice System

[3] This average is calculated across all fires, not just deliberate fires

Table 24: General price assumptions

Description	Value in the base period (2008)	Unit
Average fire safety labour cost per hour	£16.05	£/h
London weighted firefighters pay	£5,248.02	£/annum
Average London fire safety labour cost per hour	£20.01	£/h
Value of fatality	£1,648,539	£
Value of serious injury	£185,241	£
Value of slight injury	£14,279	£
Cost of mobilisation (per vehicle)	£0.82	£
Victim cost per criminal damage incident	£817	£
Annual cost to Police (Crown Prosecution Service) due to arson	£99,874,263	£/annum
Annual cost to forensic unit due to arson	£1,125,344	£/annum
Cost to Crown Prosecution Service and forensic unit per deliberate fire	£2,137	£
Penalty notice for disorder	86.74	£

Mental Health Costings

The following data on mental health unit costs were obtained from Royal College of Psychiatry, DSI Unit costs. [16]

Table DS1 Unit costs

Item	Unit	Unit cost (£ 2011/12 prices)	Source	Assumptions
Section 136 suite	per occurrence	1,388	1	Cost as an acute psychiatric ward for one bed day plus a mental health act assessment.
Mental health act assessment	per occurrence	1,059	2	Based on the assumption of three hours for two section 12 doctors plus an approved mental health practitioner.
Health Care Practitioner (HCP) triage	per occurrence	92	2	Assumed one hour; cost at the midpoint of an advanced Nurse and FME as it could be either.
Forensic Medical Examiner (FME)	per occurrence	132	2	Assumed medical consultant for one hour.
Admission	per admission	13,719	1	Based on the unit cost of £329 per acute psychiatric care bed day multiplied by the average number of days per admission in this sample: 41.7
Street triage	per contact	53	2	Costed as assertive outreach; per hour of patient contact; assuming one hour of contact.
Link worker	per contact	68	2	Assume mental health nurse; Per hour of face to face contact; Assume 1 hour contact; Excluding qualifications.
Custody costs				
Time in custody for those who were on a Section 136 and taken to custody	per custody occurrence	497	3	Cost based on the mean number of hours in custody for those who were under an Section 136 and taken to custody: 12.42 hours multiplied by the unit cost per hour in custody of £40
Time in custody for those who were arrested	per custody occurrence	384	3	Cost based on the mean number of hours in custody for those who were arrested: 9.60 hours multiplied by the unit cost per hour in custody of £40
Police attendance costs				
Cost of police attendance for those who were on a Section 136	per occurrence	495	3	Cost based on the mean number of minutes of total police attendance per incident for those who were put under a Section 136: 510.63 minutes multiplied by the unit cost per minute for a police officer of £0.97
Cost of police attendance for those who were arrested	per occurrence	457	3	Cost based on the mean number of minutes of total police attendance per incident for those who were arrested: 471.55 minutes multiplied by the unit cost per minute for a police officer of £0.97
Cost of police attendance for those who were not arrested or put under a Section 136	per occurrence	267	3	Cost based on the mean number of minutes of total police attendance per incident for those who were not arrested or put under a Section 136 but did have police attend the incident: 275.54 minutes multiplied by the unit cost per minute for a police officer of £0.97

Sources:
1. Department of Health. *NHS reference costs 2010/11.* URL: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131140 (accessed 04/09/13) Inflated to 2011-12 prices using The Hospital & Community Health Services (HCHS) index pay and price index from PSSRU 2012 (source 2 below).
2. Curtis, L. *Unit Costs of Health and Social Care 2012.* Personal Social Services Research Unit, University of Kent, 2012.
3. Direct communication with Devon and Cornwall police - July 2013.

Summary of costings used in the main report data analysis

A&E/Hospital

A&E attendance cost	£132 per attendance
A&E Investigation and treatment	A&E treatment comprising ECG £25, bloods £20 (& possible radiology £100 if physical injury)
Cost of admission	Regular ward admission £354
Cost of stay for each admission	Cost per day for bed £303

West Midlands Ambulance Service

Category of call out	Cost per ambulance call - £7 Hear & treat & refer - £35 See & treat & refer - £180 See & treat & convey - £234

Police

Police attendance for those not arrested	*£267*
Police attendance for those arrested	*£457*
Stay in custody	*Average stay 9.6 hrs £384*
Forensic med examiner in custody	*£132 per occurrence*

References for Appendix 2

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(10) Jim Orford et al, Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT) BMJ 2005; 331 doi: http://dx.doi.org/10.1136/bmj.331.7516.541 (Published 08 September 2005)

(11) Mike Ward, Lauren Booker, An Evaluation of the Nottinghamshire Alcohol Related Long Term Condition Team

(12) The Economic and Social costs of Crime, Home Office Research Study 217.
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(13) Probation Trust Unit Costs, Ministry of Justice, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/218335/probation -trust-unit-costs-tables-11-12.pdf

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