



ALCOHOL HARM REDUCTION STRATEGY

LONDON BOROUGH OF HILLINGDON

**AGREED by Safer Hillingdon Partnership
on 13/7/09**

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1. Summary

The *strategic aims* of Hillingdon's Alcohol Harm Reduction Strategy 2008 – 2011 are as follows:

- To establish a strategic framework for developing and delivering the alcohol strategy.
- To improve the measurement and recording of alcohol – related harm.
- To reduce alcohol – related crime and anti – social behaviour.
- To reduce alcohol – related ill – health and improve identification and treatment.
- To increase levels of awareness about responsible drinking.
- To reduce alcohol – related harm to children and young people.

An action plan to be monitored by the Joint Commissioning Group supports each strategic aim.

1.1 The need for a local alcohol strategy

It is a statutory requirement that all Crime and Disorder Reduction Partnerships (in Hillingdon this is the Safer Hillingdon Partnership) have a local Alcohol Strategy in place¹.

The Sustainable Community Strategy, devised by the Local Strategic Partnership "Hillingdon Partners", is informed by a Joint Strategic Needs Assessment and a number of sub-groups, each of which has a delivery plan to implement its part of the Sustainable Community Strategy

¹ Police and Justice Act 2006, schedule 9, amendments to the Crime and Disorder Act 1998:

The responsible authorities for a local government area shall ... formulate and implement

- (a) a strategy for the reduction of crime and disorder in the area (including anti-social and other behaviour adversely affecting the local environment); and
- (b) a strategy for combating the misuse of drugs, alcohol and other substances in the area.



The Hillingdon Sustainable Community Strategy has six priorities:

- Improving health and wellbeing
- Strong and active communities
- Protecting and enhancing the environment
- Making Hillingdon safer
- A thriving economy
- Improving aspiration through education and learning

This strategy relates to

- Priority One of the Hillingdon Sustainable Community Strategy “Improving Health and Wellbeing”, specifically to deliver the best possible health and wellbeing outcomes including promoting equality and tackling inequalities.
- Priority Four “Making Hillingdon Safer”, and its six specific objectives:
 - Continue to substantially reduce crime, so Hillingdon is recognised by all as a safe borough
 - Significantly reduce the fear of crime, especially amongst our most vulnerable residents
 - Boost the trust of residents in their local public service providers, building stronger united communities
 - Involve local people in keeping the community safe, building civic pride and respect
 - Reduce young people’s involvement in offending and disorder, resulting in a reduction in anti-social behaviour
 - Reduce the incidence and cost of fire to the borough

The alcohol specific national indicators in Hillingdon’s Local Area Agreement that a local alcohol harm reduction strategy will deliver against are as follows:

NI 21	Dealing with local concerns about anti-social behaviour and crime by the local council and polic
NI 15	Serious violent crime rate
NI 20	Assault with injury
NI 32	Repeat incidents of domestic violence
NI 41	Perceptions of drunk or rowdy behaviour as a problem
NI 49	Number of primary fires and related fatalities and non-fatal casualties

1.2 National context

Alcohol misuse is associated with health and social problems at the individual, family, community and public level. In the UK the extent of these problems is staggering and well known (more than 10 million people are now drinking above the Government guidelines – 31% of men and 20% of women²). The evidence concerning alcohol related harm locally is set out below. It can be seen from this evidence that there is a strong case for local action on alcohol related harm.

Historically, there have been no priorities or targets for alcohol at national level, and so local responses (where they exist) have developed piecemeal. In most areas these responses are not co-ordinated or planned strategically. The local alcohol strategy should identify areas of the partnership which will benefit from training in the risks and dangers associated with harmful and hazardous drinking, as well as binge drinking.

Alcohol can play an important and positive role in British society. Alcohol is a valued part of our cultural tradition, offering culinary, recreational and emotional pleasure and, if consumed in moderation, has few detrimental side effects. Both public and official attitudes towards alcohol are typified by a high level of ambivalence due to the balances of the pluses and minuses associated with its consumption. But excessive drinking among some sections of the population has become a cause for considerable concern.

While there are economic benefits associated with the alcohol industry, the financial costs to society of alcohol misuse are substantial:

- Reviews of the literature and secondary analysis conducted to support the development of the Alcohol Harm Reduction Strategy for England (2004) indicated that damage to health, crime and disorder, and the loss of work productivity resulting from alcohol misuse cost around £20 billion per year in England and Wales.
- The Alcohol Harm Reduction Strategy for England (2004) estimated that the total annual healthcare costs alone related to alcohol misuse add up to £1.7 billion per year. The bulk of these costs are borne by the NHS.
- In addition to reduced productivity at work, excessive drinking is associated with unemployment. Costs arising from such increased unemployment are estimated to be in the region of £1.9 billion per year.
- However alcohol – related harm should not be viewed in isolation, as alcohol consumption can also have positive effects.
- Drinking at a responsible level can be a source of enjoyment for the vast majority of those who participate.
- Over 1 million people are employed in hotels, pubs, bars, nightclubs and restaurants in the UK.
- Furthermore, the development of the evening economy, driven by the alcohol leisure industry, has supported a revival of city centres across England and Wales.

² National Audit Office publication Reducing Alcohol Harm: health services in England for alcohol misuse October 2008

Safe. Sensible. Social. The next steps in the National Alcohol Strategy (2007).

It is against this backdrop that the Government have sought to provide a national framework that promotes sensible drinking whilst reducing the harms that alcohol misuse can cause.

1. To ensure that the laws and licensing powers the Government have introduced to tackle alcohol – fuelled crime and disorder, protect young people and bear down on irresponsibly managed premises are being used widely and effectively.
2. To sharpen the focus on the minority of drinkers who cause or experience the most harm to themselves, their communities and their families. These are:
 - **Young people under 18 who drink alcohol**, many of whom Government now know are drinking more than their counterparts did a decade ago; and
 - **18 – 24 year old binge drinkers**, a minority of whom are responsible according to Government for the majority of alcohol – related crime and disorder in the night – time economy;
 - **harmful drinkers**, many of whom according to Government don't realise that their drinking patterns damage their physical and mental health and may be causing substantial harm to others.
3. To work together to shape an environment that actively promotes sensible drinking, through investment in better information and communications, and by drawing on the skills and commitment of all those already working together to reduce the harm alcohol can cause.

1.3 Key aims and objectives of the local alcohol strategy

Hillingdon's Alcohol Needs Assessment reports the wide range of harms, both to the individual and also the wider community, that alcohol misuse has. On this basis a local Alcohol Harm Reduction Strategy should be holistic and seek to address the wide spectrum of harm that alcohol misuse can have in the Borough. However the Needs Assessment also notes the positive benefits that alcohol can bring and Hillingdon's Alcohol Harm Reduction Strategy should reflect this also. On this basis the Needs Assessment concludes that the aim of a local Alcohol Harm Reduction Strategy is to minimise the health harms, violence and Anti – Social Behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly.

The specific targets for Hillingdon's Alcohol Harm Reduction Strategy as identified by the needs assessment are:

- 1) To agree a common data set across the partnership for alcohol misuse to improve the understanding of alcohol misuse locally and inform future strategic planning by the Safer Hillingdon Partnership.
 - Information and data sources are known, however data collected is very poor.
Implication – strategy becomes too targeted, as there is no evidence to support local knowledge.
Resolution – improve data collection processes across the partnership to inform future needs assessments and therefore provide evidence to be used to update the local alcohol strategy in the future.
 - The averages for many KPIs for Hillingdon are lower than the regional and national average.

Implication – complacency can set in due to the fact that Hillingdon appears to be performing better in many KPIs than would be expected.

Resolution – much of this is likely to be due to under reporting. The true data will allow a realistic view of what is going on in Hillingdon. There is a need to drive forwards on all of the KPIs as a minimum. Further investigation into all of these areas is advised, with the strategy selecting the key areas which have the widest impact for initial actions. Need to increase partnership working and information sharing protocols.

- 2) To map partnership resources against outcomes and desired outcomes for reducing alcohol related harm.
- 3) To ensure that existing young people's universal, targeted and specialist education and treatment programmes for substance misuse incorporate alcohol and are based on 'what works'.
- 4) To measure public perception of drunk or rowdy behaviour and implement actions to reduce this.
 - A large amount of crime linked to alcohol is violent crime against the person or sexual offences. Many crimes are not recorded as having an influence of alcohol, and therefore it is the crimes with alcohol as a driver which need to be more closely monitored and accurately recorded to allow us to measure this statement more effectively.

Implication – there is a real possibility of the community feeling that crime fuelled by alcohol is a major problem. This can reduce public morale and make members of the community feel very unsafe.

Resolution – Safer Neighbourhood teams already have alcohol as a key priority. Partnership working to remove areas that are renowned for public drinking would be step forward. Evidence suggests that there are areas of the borough which suffer from street drinking and alcohol related anti social behaviour and crime. This sort of partnership working will help to remove some of these areas.
- 5) To agree and implement a communication strategy through the Safer Hillingdon Partnership focusing on alcohol misuse.
- 6) To reduce hazardous and harmful drinking through a programme of early interventions and the provision of accessible, evidence based treatment for those with an alcohol problem and their family members and carers who are affected by someone else's' drinking. This should be in accordance with Models of Care for Alcohol Misuse (June 2006).
 - There is a larger than expected level of hazardous and harmful drinking occurring in the borough. This statement is supported by the research undertaken by the North West Public Health Observatory which extrapolated results from household surveys in an attempt to map the levels of hazardous and harmful drinking across the country. We can also see evidence of this from hospital admissions data, which although can be incomplete, gives a picture of the number of alcohol related admissions.

Implication – a strain is likely to develop on local services. This will include, but not be limited to the emergency services (police, fire, ambulance). This will have effects on other areas of the community, including community safety and financial implications.

Resolution – The local alcohol strategy must set out the requirement for partnership working. Local authority should be in a position to support all of the

impacts of alcohol. PCT should be in a position to support the public health agenda where alcohol is concerned.

- 7) To reduce alcohol related hospital admissions through a partnership approach with Hillingdon Hospital.
- Male admissions to hospital for alcohol specific conditions were twice as high as female admissions.
Implication – the data suggests that males are the largest cohort of the local population with an alcohol problem leading to hospital admission. This is likely to be true however the local community is reported to have a larger proportion of males, hence this pattern follows the expected trend. The concern is that the number of women and young people accessing hospital through alcohol related or alcohol specific conditions is rising.
Resolution – there is a need to reduce the number of people repeatedly presenting to the accident and emergency department or being admitted to other hospital wards.
- 8) To reduce alcohol related assault and associated anti – social behaviour by increasing the use of Conditional Cautioning and Alcohol Treatment Requirements (ATRs) for offenders.

These 8 targets can be condensed into 6 *strategic aims* as follows:

- To establish a strategic framework for developing and delivering the alcohol strategy.
- To improve the measurement and recording of alcohol – related harm.
- To reduce alcohol – related crime and anti – social behaviour.
- To reduce alcohol – related ill – health and improve identification and treatment.
- To increase levels of awareness about responsible drinking.
- To reduce alcohol – related harm to children and young people.

An action plan to be monitored by the Joint Commissioning Group supports each strategic aim.

2. Background

2.1 Alcohol related harm: local profile

Hillingdon has undertaken a detailed needs assessment and further data and supporting information can be found in the Hillingdon Alcohol Needs Assessment 2008.

There are many potential sources of useful data on alcohol – related harm in the local area. Hillingdon has utilised information obtained from the North West Public Health Observatory's (NWPHO) Local Alcohol Profiles (www.nwph.net/alcohol/lape), local data sources where available and feedback from consultation with key stakeholders who can provide information on the local situation. As much of the information produced by the NWPHO deals with public health, this area appears to be the one with the most to gain by future investment. Whilst it is true that further investment in education to reduce the number of harmful and hazardous drinkers will benefit the borough in a number of ways, this will not fix the problem of consumption of excess alcohol by individuals on its own. The strategy should take into account the public health implications, together with the community safety element.

The World Health Organisation has identified four degrees of alcohol misuse, being Hazardous, harmful, moderately dependent and severely dependent

Hazardous Drinkers	This applies to anyone drinking over the recommended limits of the Department of Health Example of treatment intervention: brief harm reduction interventions and advice by GP
Harmful Drinkers	Displaying clear evidence of alcohol related problems extended medical advice in mainstream health/ primary care or other environments
Moderately Dependent	Likely to have increased tolerance of alcohol, suffer withdrawal symptoms have lost some degree of control over their drinking. Example of treatment intervention: specialist treatment e.g. home counselling
Severely Dependent	May suffer from withdrawal fits (e.g. confusion or hallucination); may die escape these effects Example of treatment intervention: intensive specialist treatment hospitalisation and residential rehabilitation)

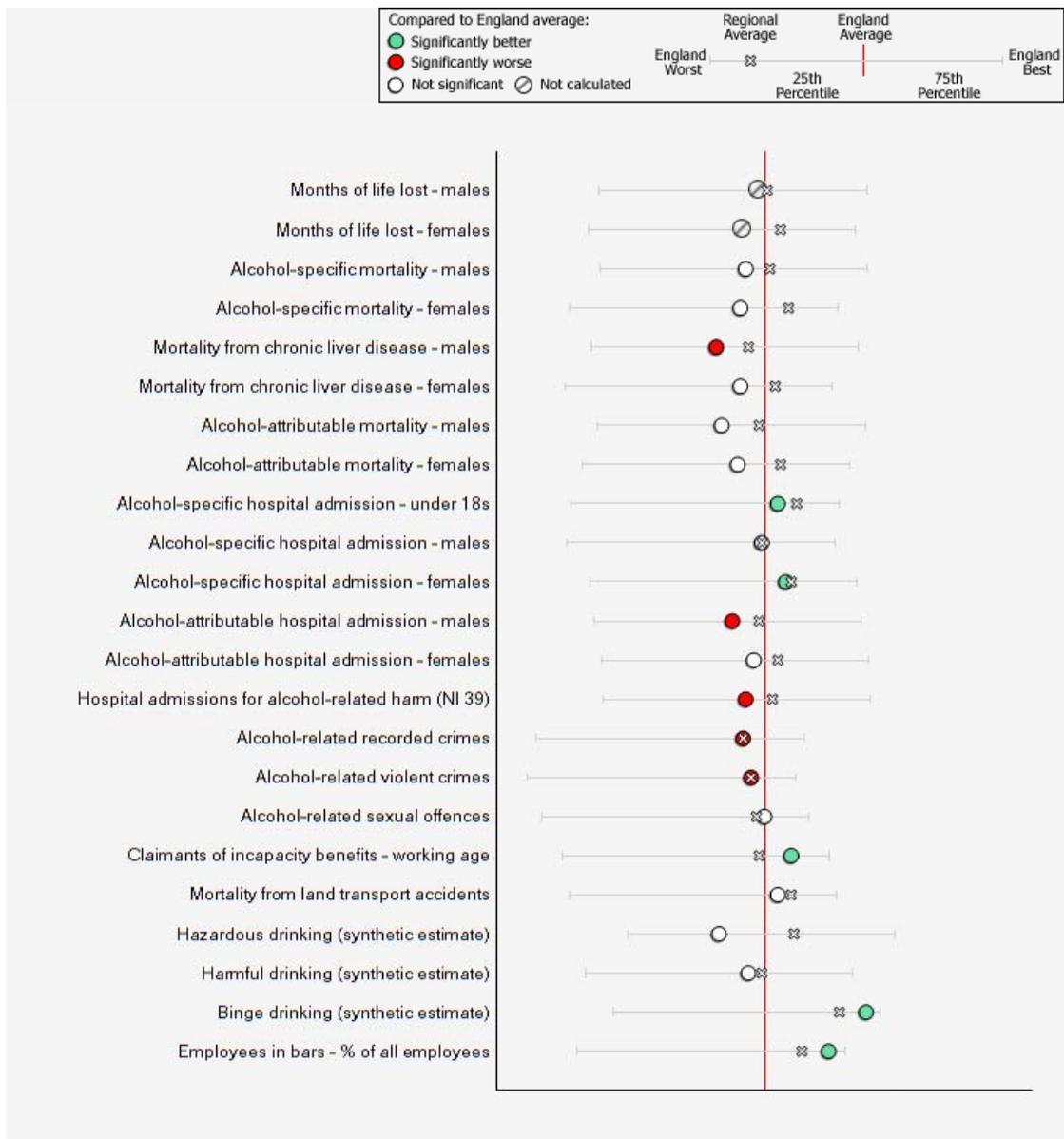
The above reports that most of the adult population of England are either non – drinkers (12%) or low – risk drinkers (67.1%), who drink within the Department of Health's guidelines and suffer no harmful effects. In Hillingdon this would estimate that approximately 129,161 (out of an adult population of 189,110) local residents either do not drink or enjoy alcohol sensibly.

Estimated profile of alcohol consumption in Hillingdon

Non – Drinkers (12.0%)	22,693
Low – Risk (67.1%)	126,892
Hazardous Drinkers (16.3%)	30,824
Harmful (4.1%)	7,753
Moderately Dependent (< 0.4%)	756
Severely Dependent (< 0.1%)	189

The North West Public Health Observatory uses a range of data to rank local authority areas across a range of health related alcohol measures. The rankings released in December 2008 show that out of 21 calculated indicators Hillingdon was close to the average score across England for 11 of the indicators (for example, alcohol attributable mortality rates and female mortality from chronic liver disease).

Hillingdon performs significantly better than the England average for under-18 year olds with alcohol specific hospital admissions, however, on this measure we perform slightly worse than the London average. In relation to the rate of binge drinking in the borough we perform significantly better than both the England and London average. Our ranking for both alcohol related recorded crimes and recorded violent crimes show that Hillingdon is performing at the London average.



According to figures published by the GLA ³, Hillingdon has relatively high levels of Alcohol Specific Hospital Admission for under 18s (ranked 6th worst in London behind Kingston, Bexley, Bromley, Sutton and Islington). Hillingdon has relatively low numbers of alcohol related arrests of 16-21 year olds and average levels of drunkenness among 10-15 year olds.

³ London Assembly Report – Too Much Too Young, Alcohol Misuse Among Young Londoners June 2009 <http://www.london.gov.uk/assembly/reports/health/alcohol-misuse.pdf>

London Borough	Alcohol Specific Hospital Admission Under 18 (2004/05-2006/07)⁴	Alcohol Related Arrests 16-21 year olds⁵ (2007)	Percentage of 10 to 15 year olds who were drunk in the last month (2008)⁶
Barking and Dagenham	43.8	17	10
Barnet	46.7	7	8
Bexley	67.7	40	5
Brent	23.4	55	5
Bromley	63.1	23	15
Camden	54.5	62	4
Croydon	35.6	35	9
Ealing	39.7	26	5
Enfield	39.6	18	9
Greenwich	50.3	7	11
Hackney	31.7	<5	4
Hammersmith & Fulham	49.1	31	n/a
Haringey	50.9	16	2
Harrow	17.2	13	8
Havering	54.2	18	15
Hillingdon	58.6	15	8
Hounslow	41.2	20	9
Islington	58.7	39	5
Kensington and Chelsea	31.3	11	3
Kingston	77	58	11
Lambeth	24.5	21	5
Lewisham	34.4	6	5
Merton	56.4	5	12
Newham	15.6	13	3
Redbridge	31.7	16	8
Richmond	55.4	8	18
Southwark	13.5	22	n/a
Sutton	74.4	82	14
Tower Hamlets	33.3	39	3
Waltham Forest	36.7	<5	7
Wandsworth	41.3	15	n/a
Westminster	36.3	129	3

⁴ Source of Data – Alcohol Specific hospital admission for under 18s, from Local Alcohol Profiles for England, North West Public Health Observatory, available from www.nwph.net/alcohol/lape Data correct as of 07.04.09. These figures do not include A+E attendances. The rate is calculated per 100,000 population based on ONS 2006 mid year population estimates

⁵ Profile of Young Londoners' drinking, 2009, Institute of Alcohol Studies for the London Assembly – data source: Metropolitan Police

⁶ Source: Tellus3 survey of school pupils, 2008 available from www.ofsted.gov.uk

3. Implementation of the strategy

3.1 Strategic framework for implementing the alcohol strategy

The partnership arrangements for ensuring the successful implementation of Hillingdon's Alcohol Harm Reduction Strategy are detailed in the following diagram:

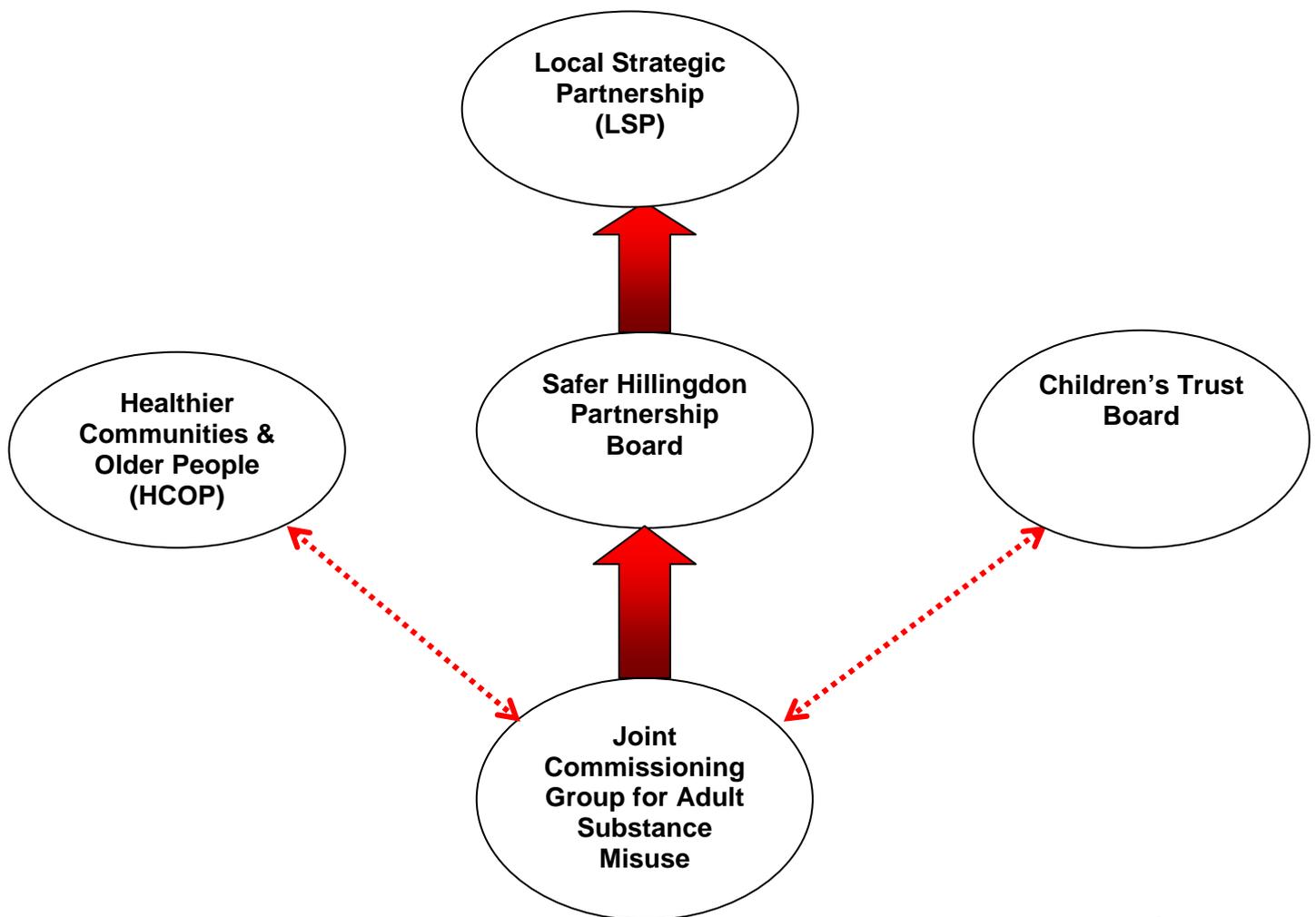


Figure 4: Partnership Structure

The Safer Hillingdon Partnership Board, on behalf of the Local Strategic Partnership is responsible for the borough's Alcohol Strategy, due to the requirement in the Police and Justice Act 2006 for the partnership to have an alcohol strategy. This partnership will provide the strategic vision and leadership for the successful implementation of the strategy.

On behalf of the Safer Hillingdon Partnership Board, the Joint Commissioning Group (JCG) will work to make a reality of the commissioning focus of the borough's Alcohol Harm Reduction Strategy. Specifically the JCG will:

- Develop the borough's Alcohol Harm Reduction Strategy for decision by the Safer Hillingdon Partnership Board.
- Ensure the implementation of the borough's Alcohol Harm Reduction Strategy.
- Review and monitor progress against the objectives and targets in the Alcohol Harm Reduction Strategy and report to the Safer Hillingdon Partnership Board accordingly.
- Make recommendations on resource allocation relating to joint commissioning initiatives to the Safer Hillingdon Partnership Board.

The Drug and Alcohol Action Team (DAAT) will service the Joint Commissioning Group (JCG) and the Safer Hillingdon Partnership Board with regards to the partnerships efforts to reduce alcohol related harm and will be the single point of contact on a day to day basis regarding Hillingdon's Alcohol Harm Reduction Strategy.

5. Monitoring, evaluation and review of the strategy

5.1 Monitoring and evaluation

It will be necessary for the local alcohol strategy to be monitored and reviewed methodically and consistently. Monitoring involves the regular collection of information to establish progress towards actions, targets and objectives. This will enable the Safer Hillingdon Partnership Board to:

- Measure progress towards targets and objectives;
- Assess performance against other areas;
- Understand whether actions and initiatives are achieving the intended results, and if not, why not;
- Establish the overall effectiveness of the strategy; and
- Review and amend the strategy in the light of successes and failures, and changing social, policy and practice environments, to ensure its continued effectiveness.

The Safer Hillingdon Partnership Board, as one of the actions in the local Alcohol Harm Reduction Strategy will establish a framework for the systematic monitoring, evaluation and review of this strategy to help identify:

- How information will be collected;
- How often information will be collected;
- How those affected by the strategy will be able to provide feedback;
- Who is responsible for carrying out monitoring, evaluation and review of the strategy, and who will be involved or consulted;
- When monitoring, evaluation and review should be carried out; and
- How results will be reported to stakeholders.

The Performance Management Framework will measure both what has been done (outputs), and what has changed as a result of this (outcomes) on a *quarterly* basis. In addition each activity will be linked to one or more baseline indicators, so that progress can be measured effectively.

Review of the Strategy

The strategy will be reviewed *annually*. This review will take into account:

- The findings of the monitoring and evaluation, including successes and problems;
- Environmental changes (for example, policy / legislative, economic and social changes) which may demand new or different responses;
- Developments in other localities (or within the local area) – are new schemes emerging as examples of good practice which can be learnt from? and
- Feedback from those affected by the strategy.

Appendix NW Health Observatory definitions

Footnotes	Definition (for full explanation a methods document will be made available soon)
Alcohol-specific	Conditions that are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose). A list of alcohol-attributable conditions with their ICD-10 codes and associated attributable fractions can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf
Alcohol-attributable:	Alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-specific conditions with their ICD-10 codes can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf
a)	The actual indicator value for the local authority as calculated in the definitions below.
b)	The rank of the local indicator value among all 354 local authorities in England. A rank of 1 is the best local authority in England and a rank of 354 is the worst. Two local authorities (City of London and Isles of Scilly) have been omitted from indicators 20, 21 and 22 so in these cases the worst local authority has a rank of 352. For indicator 23, a rank of 1 is the lowest and a rank of 354 is the highest value, as the desirability of the value (what is better or worse) has not been determined.
1,2	An estimate of the increase in life expectancy at birth that would be expected if all alcohol-attributable deaths among males/females aged under 75 years were prevented. (NWPHO from 2004-2006 England and Wales life expectancy tables for males and females [Government Actuary Department], alcohol-attributable deaths from Public Health Mortality File 2004-06 in males/females aged under 75 and Office for National Statistics mid-year population estimates for 2004-06).
3,4	Deaths from alcohol-specific conditions (all ages, male/female), directly standardised rate per 100,000 population (standardised to the European Standard Population). (NWPHO from Office for National Statistics Public Health Mortality File for 2004/06 and mid-year population estimates for 2004/06).
5,6	Deaths from chronic liver disease including cirrhosis (ICD-10: K70, K73-K74) (all ages, male/female), directly standardised rate per 100,000 population (standardised to the European Standard Population). (Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development 2004-2006 pooled).
7,8	Deaths from alcohol-attributable conditions (all ages, male/female), directly standardised rate per 100,000 population (standardised to the European Standard Population). (NWPHO from Office for National Statistics Public Health Mortality File for 2006 and mid-year population estimates for 2006).
9	Persons admitted to hospital due to alcohol specific conditions (under 18s, persons), crude rate per 100,000 population. Numerator counts of between 1 and 5 have been suppressed (indicated as *). (NWPHO from Hospital Episodes Statistics 2004/05-2006/07 and Office for National Statistics mid-year population estimates 2004-2006). Does not include attendance at A&E.
10, 11	Persons admitted to hospital due to alcohol-specific conditions (all ages, male/female), directly standardised rate per 100,000 population. Numerator counts of between 1 and 5 have been suppressed (indicated as *) (NWPHO from Hospital Episodes Statistics 2006/07 and Office for National Statistics mid-year population estimates 2006). Does not include attendance at A&E.

12, 13	Persons admitted to hospital due to alcohol-attributable conditions (all ages, male/female), directly standardised rate per 100,000 population. (NWPHO from Hospital Episodes Statistics 2006/07 and Office for National Statistics mid-year population estimates 2006). Does not include attendance at A&E.
14	NI39: Hospital Admissions for Alcohol Related Harm: directly age and sex standardised rate per 100,000 population, 2006/07. (Department of Health using Hospital Episode Statistics and Office for National Statistics mid-year population estimates).
15, 16, 17	Alcohol-related recorded crimes, crude rate per 1,000 population. (NWPHO from Home Office recorded crime statistics 2007/08). Attributable fractions for alcohol for each crime category were applied, based on survey data on arrestees who tested positive for alcohol by the Strategy Unit.
18	Claimants of Incapacity Benefit or Severe Disablement Allowance whose main medical reason is alcoholism, crude rate per 100,000 (working age, persons) population. (NWPHO from Department for Work and Pensions data Nov 2007 and Office for National Statistics 2006 mid-year population estimates).
19	Estimated number of deaths attributable to alcohol from land transport accidents (ICD-10: V01-V89) (all ages, persons) directly standardised rate per 100,000 population (standardised to the European Standard population). (NWPHO from Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development 2004-06 pooled and Office for National Statistics mid-year population estimates). The Strategy Unit's alcohol-attributable fraction was applied to obtain the estimates.
20	Mid-2005 synthetic estimate of the proportion (%) of the population aged 16 years and over who report engaging in hazardous drinking, defined as consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females. (NWPHO from Health Survey for England, Hospital Episode Statistics, Office for National Statistics mid-year population estimates and mortality data and the Census of Population 2001). Two local authorities (City of London and Isles of Scilly) have been omitted so authorities have been ranked from 1 to 352.
21	Mid-2005 synthetic estimate of the proportion (%) of the population aged 16 years and over who report engaging in harmful drinking, defined as consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females. (NWPHO from Health Survey for England, Hospital Episode Statistics, Office for National Statistics mid-year population estimates and mortality data and the Census of Population 2001). Two local authorities (City of London and Isles of Scilly) have been omitted so authorities have been ranked from 1 to 352.
22	Synthetic estimate of the proportion (%) of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, 8 or more units for men and 6 or more units for women). Estimates originally produced for the Department of Health (2003-2005). Two local authorities (City of London and Isles of Scilly) have been omitted so authorities have been ranked from 1 to 352.
23	The number of employees employed in bars (SIC2003: 5540), as a percentage of all employees. (Annual Business Inquiry 2006, National Statistics, from Nomis website: www.nomisweb.co.uk). A rank of 1 is the lowest local authority value in England and a rank of 354 is the highest. Values that are significantly lower than the England average have been highlighted green and values that are significantly higher have been highlighted red. The desirability of the value (what is better or worse) has not been determined.

