



House of Commons
Public Accounts Committee

Reducing Alcohol Harm: health services in England for alcohol misuse

**Forty-seventh Report of Session
2008–09**

*Report, together with formal minutes, oral and
written evidence*

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Summary

Alcohol misuse is a significant and growing problem in England, with more than 10 million people now regularly drinking above the guidelines set by Government. Alcohol misuse places a considerable burden on the National Health Service (NHS), costing an estimated £2.7 billion per year. In 2006–07, there were some 811,000 alcohol-related hospital admissions, representing a 71% increase in four years. Between midnight and 5am on weekend nights nearly three-quarters of all attendances at accident and emergency (A&E) departments are alcohol-related.

In 2004, alcohol harm became subject to a national government strategy, which was updated by the Department of Health (the Department) and the Home Office in 2007. Since April 2008, the Department has also been responsible for delivering against a Public Service Agreement (PSA) indicator on the rate of increase of alcohol-related hospital admissions.

Primary Care Trusts (PCTs) are responsible for determining local health priorities and have control over the majority of NHS spending. PCTs are free to decide for themselves how much to spend on services to address alcohol harm. Many PCTs, however, do not know what they spend on such services and across England there is little correlation between need and expenditure. Where services are commissioned there is frequently a lack of performance monitoring and examination of whether what is provided represents value for money.

In 2008, the Department introduced a number of new measures designed to help address alcohol harm: providing extra funding for GPs to screen new patients; increasing alcohol-specific training for doctors, and creating 20 pilot sites designed to improve specialist treatment services. The Department has, however, yet to demonstrate its ability to effectively influence local commissioners, the drinks industry, and people's drinking behaviour. The Department also needs to work more closely with the other government departments which are responsible for policies affecting alcohol consumption, such as taxation and licensing. Achieving this will be necessary if the Department is to reduce levels of alcohol harm and succeed against the PSA indicator.

On the basis of a report by the Comptroller and Auditor General,¹ we took evidence from the Department on the performance of the National Health Service in addressing alcohol harm; the Department's influence on local commissioners, and the Department's work to encourage sensible drinking.

¹ C&AG's Report, *Department of Health, Reducing Alcohol Harm: health services in England for alcohol misuse*, HC (2007–08) 1049, 29 October 2008

Conclusions and recommendations

- 1. Alcohol misuse places a large and growing burden on local health services, in particular, accident and emergency departments.** Primary Care Trusts (PCTs) have no obligation to make tackling alcohol misuse a priority, and few have got to grips with the problem. In 2009, following the first year of the new PSA, Strategic Health Authorities should challenge each PCT to demonstrate what progress they have made towards reducing the level of alcohol-related hospital admissions, irrespective of whether they have made alcohol harm a priority or not.
- 2. Some preventive services, such as 'brief advice' for those who are drinking too much, can be delivered effectively by social workers, police and other officials outside the health service, but this requires effective partnership working at the local level. There is little evidence that this is happening.** Regional Directors of Public Health, working through the new Regional Alcohol Offices, should identify examples of local preventive and partnership projects which are delivering results, and support their replication in areas which have the most acute alcohol problems.
- 3. General Practitioners (GPs) have an important role to play in identifying alcohol misuse and advising people to cut down, but are not doing so consistently. A new scheme to encourage such work is likely to have only limited effects.** Since April 2008, the Department has funded a new £8 million a year Directed Enhanced Service to pay GP practices to undertake alcohol screening, but this only applies to newly-registered patients. The Department should review the results of the new service after the first year and assess whether, in the light of its limited coverage, the numbers of people screened make this a meaningful and cost-effective intervention.
- 4. Only around 1 in 18 people who are dependent on alcohol receive treatment and the availability of specialist services differs widely across England.** The Department has announced a scheme to provide pilot sites with additional funding and support for specialist services. At the end of the pilots, the Department should publish the results, showing what has been achieved and assessing whether a national expansion of the model would provide a cost-effective means to tackle the demonstrable variations and gaps in service provision that currently exist across English regions and between PCTs.
- 5. While there is increasing evidence about the effectiveness of different types of treatment, there is frequently a lack of monitoring of whether what is provided by the public, private and voluntary sectors represents value for money.** The Department, working with the National Treatment Agency for Substance Misuse, should put in place systems to regularly appraise the performance of current services, and publish a compendium of good practice which has been shown to be cost-effective.

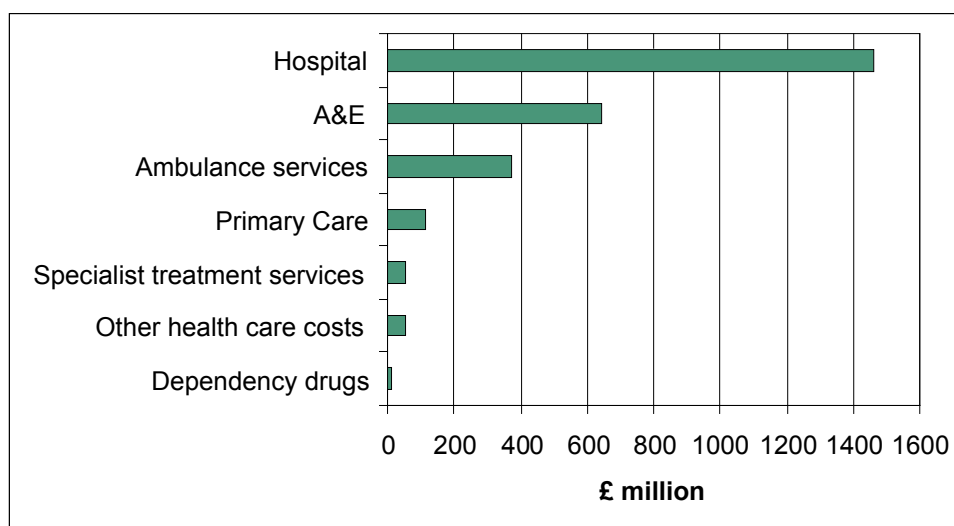
6. **People who are dependent on alcohol often need immediate medical care, combined with wider long-term counselling and practical support, but services are often not joined up, increasing the risk that people will simply relapse into their former drinking habits.** The Department should develop detailed proposals for 'stepped care' for alcohol misuse, including practical ways in which PCTs should work with other service providers, including those responsible for social care, housing, employment.
7. **The Department's sensible drinking guidelines were changed from weekly to daily limits in 1995, but 11 years later almost two-fifths of people did not know the current recommended guidance.** Further research conducted in 2008 found that 77% of people did not know how many units were contained in a typical large glass of wine. In view of this widespread and longstanding lack of clarity in the minds of the public, the Department should assess whether the current guidelines are fit for purpose or should be replaced with something more readily understood.
8. **By July 2008, only 3% of alcoholic products had fully complied with the drinks industry voluntary labelling scheme.** If a significant improvement is not evident from the planned 2009 review of compliance, the Department should consider a mandatory labelling scheme.
9. **There is little evidence that Whitehall-wide action on other policies and regulations which affect alcohol consumption—such as licensing, taxation and glass sizes—is effectively coordinated.** The Department should identify all other government initiatives and policy areas which affect alcohol misuse and ill-health, assess how these support or conflict with the Department's objectives and communicate any issues of concern to senior officials in other government departments.
10. **Alcohol has become steadily cheaper in relation to income; meanwhile, consumption and health damage have increased.** The Department has published an independent review which found that alcohol has become 69% more affordable between 1980 and 2007. The review suggested that changes to the pricing and promotion of alcohol could deliver reductions in health harms. As part of its work to promote responsible drinking, the Department should work with other government departments to develop policies which will help to prevent excessive consumption.

1 NHS actions to address alcohol misuse and to treat its effects

1. More than 10 million people, 31% of men and 20% of women, are now regularly drinking above the guidelines set by Government, and many of these are likely to suffer ill-health or injury as a result.² The Department accepts that alcohol harm is getting worse.³

2. Alcohol misuse places a considerable burden on the NHS. The Department estimates that alcohol misuse costs the health service in the order of £2.7 billion per year (**Figure 1**). In 2006–07, there were more than 811,000 alcohol-related NHS hospital admissions in England, an increase of 71% on 2002–03 when the figure was around 473,000. Alcohol-related admissions account for some 6% of all admissions.⁴ Nearly three-quarters of all attendances at hospital accident and emergency (A&E) departments between midnight and 5am on weekend nights are alcohol-related.⁵

Figure 1: Annual estimated costs of alcohol harm to the NHS, 2006–07



Note: 'Hospital' includes inpatient visits (both directly and partly attributable to alcohol misuse) and outpatient attendances. 'Other health care costs' include alcohol-related counselling, community psychiatric nurse visits and health visits.

Source: National Audit Office, based on Department of Health data

3. Primary Care Trusts (PCTs) are responsible for commissioning local health services to address alcohol harm and since April 2008 they have been able to choose to include the rate of alcohol-related hospital admissions in their operating plans. However, many PCTs have neither drawn up strategies to address alcohol harm in their areas nor secured a clear picture of their spending on services to address it. Nearly a third (29%) of PCTs were unable to provide the National Audit Office with an overall estimate of their spend on

2 Q 80; C&AG's Report, para 1

3 Qq 37–40

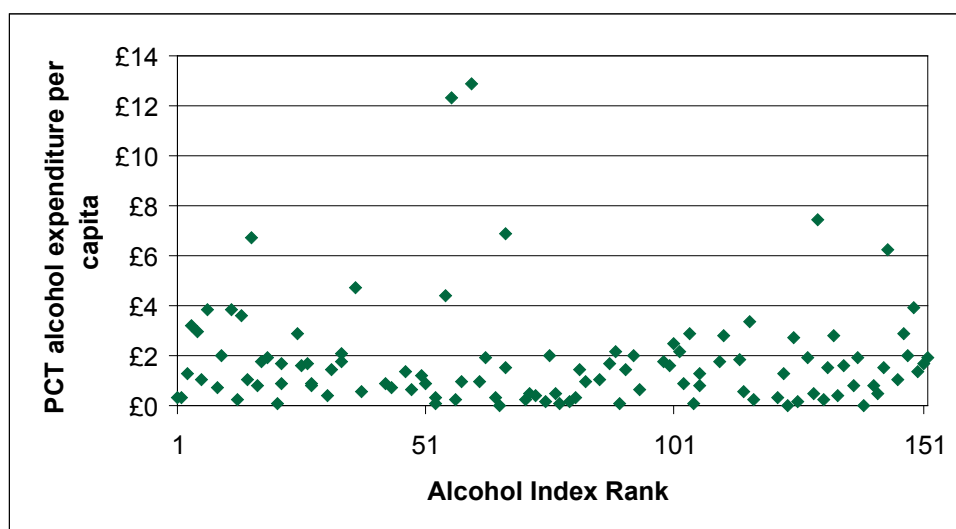
4 C&AG's Report, para 4.11, text box p11

5 Q 31; C&AG's Report, text box p11

alcohol services. Those who could provide an estimate spent an average of £600,000 in 2006–07. Some 22% had not carried out a local needs assessment for alcohol services since January 2004, and only 58% of PCTs were involved in developing a local alcohol strategy.

4. The spending by PCTs is not related to the need for services, and there is little correlation between the amount of alcohol harm in an area and the amount spent (**Figure 2**).⁶ The Department believes that the increased priority now attached to tackling alcohol harm by PCTs, together with the requirement for them to undertake Joint Strategic Needs Assessments with Local Authorities, and better commissioning under the World Class Commissioning programme, will bring about improvement.⁷ From September 2008, the Department has been establishing a network of Regional Alcohol Offices to provide dedicated resources at the regional level.⁸

Figure 2: PCT expenditure patterns for services to reduce alcohol harm



Note: The PCT expenditure figure includes dedicated alcohol-specific funding from PCTs to Drug and Alcohol Action Teams. The Alcohol Index Rank combines a number of indicators of alcohol harm. A score of 1 indicates the lowest level of alcohol harm and 152 the highest.

Source: National Audit Office

5. PCTs have often looked to their local Drug and Alcohol Action Teams to take the lead in commissioning services to tackle alcohol harm, but these bodies focus primarily on specialist services for the treatment of illegal drug use. For each of the 1.1 million dependent drinkers, on average approximately £197 is spent on specialist alcohol treatment services, compared with £1,744 per head for drug treatment.⁹ The Department recognises that while drug and alcohol treatments are not directly comparable, a more sustained effort and more systematic approach to alcohol misuse is needed.¹⁰

6 C&AG's Report, para 2.6

7 Qq 2, 4–5; C&AG's Report, paras 2.3, 2.10–2.11

8 C&AG's Report, para 2.24

9 C&AG's Report, paras 13, 2.4, recommendation g

10 Qq 9, 75; C&AG's Report, para 2.4

6. Early identification and advice for people who are drinking more than sensible levels, but have not become dependent on alcohol, can be effective in reducing health harm and the burden on A&E departments. Only in recent years, however, has there been greater certainty about the best way to provide brief interventions. There are as yet only a few examples of good practice, and GPs do not consistently offer such services.¹¹

7. Research conducted in 2004 showed that only 1 in 18 (5.6%) of alcohol dependent people in England were getting treatment (1% for the worst performing region) and only one person made use of specialist services for every 2.7 referrals.¹² Provision of such services is patchy, with considerable variation across England whether hospital-based, residential, or in the community. Early analysis of data from a new monitoring system suggests some improvement but the Department acknowledges the need for more specialist services in some areas, and has recently announced a scheme to provide additional support and funding to 20 pilot sites designed to improve such services.¹³

11 Qq 16–17, 28–31, 36

12 Qq 86–88

13 Qq 78–79, 87, 93–94; C&AG's Report, paras 4.14, 4.16

2 The Department's role in supporting the NHS

8. Since April 2008, the Department has been responsible for performance against a new PSA indicator on the rate of alcohol-related hospital admissions. PCTs have the option of including this indicator in their operating plans, and 46 of the 50 areas with the biggest alcohol problems had done so in 2008–2009.¹⁴ In autumn 2009 the Department expects to publish the 2008–2009 performance of all PCTs against the new indicator.¹⁵

9. In line with the Department's policy to give greater powers of decision-making and control to local commissioners, there are no national standards for services to address alcohol harm and there is wide variation in the provision of services across England.¹⁶ The Department was unable to provide a picture of overall levels of provision, such as the proportion of specialist services provided by non-NHS agencies, or the social costs of alcohol dependency compared to drug dependency.¹⁷

10. Despite the burden of alcohol misuse on the NHS, until 2008 there was no incentive for the primary care system to provide advice and treatment for alcohol misuse as the £7.7 billion GP contract did not include any provision for this.¹⁸ The Department has now introduced a new service for GP practices to screen for alcohol harm, which will cost £8 million per year.¹⁹ However, the initiative only covers newly registered patients, which the Department acknowledges is a relatively small percentage of the population.²⁰

11. There is a lack of alcohol-specific training for doctors; only half (56%) of GPs surveyed by the National Audit Office reported having received such training during their basic medical education.²¹ Recognising this gap, the Department has provided £650,000 in 2008–09 for medical schools to develop training intended to equip 60,000 new doctors over 10 years with the skills to help people who are drinking too much.²²

12. There is a growing evidence base on what can work in tackling alcohol harm. This will be strengthened further by studies, such as the current *Screening and Intervention Programme for Sensible drinking (SIPS)*, designed to provide additional evidence on the cost-effectiveness of 'brief advice'. Where services are commissioned, however, there is frequently a lack of performance monitoring and a lack of evaluation to assess whether what is provided by the public, private and voluntary sectors represents value for money.²³

14 Q 6

15 Qq 3, 6, 90–91

16 Qq 89–91

17 Qq 67–69, 76–77

18 Qq 16–17; Public Accounts Committee, Forty-first Report of Session 2007–08, *NHS Pay Modernisation: New contracts for General Practice services in England*, HC 463, p9.

19 Q 16

20 Qq 28–30

21 C&AG's Report, para 3.14

22 Qq 20–27

23 Qq 68–70; C&AG's Report, para 4.19, Appendix 6

The voluntary sector accounts for some 53% of specialist rehabilitation services, with the private sector providing around 8%.²⁴ The Department recognises that the emerging evidence about what works needs to be better translated into what is delivered at a local level, and that good practice such as that seen in alcohol projects in Liverpool and in Paddington should be followed through more systematically.²⁵

13. Service integration, to provide complete ‘care pathways’ for patients, is limited in many areas at present. For example, some patients may go through rehabilitation services but do not have appropriate support when they are discharged.²⁶ The Department believes that the evidence would support a ‘stepped care’ approach, providing measured interventions at each step, such as different types of therapy or detoxification. It is committed to publishing the evidence for this approach for practitioners.²⁷

24 Ev 20

25 Qq 36, 72

26 C&AG’s Report, para 4.21

27 Qq 70, 73–74

3 The Department's influence on alcohol consumption and its social effects

14. Rates of alcohol abuse are getting worse, particularly in comparison to smoking, where the Department is making more progress.²⁸ The Department believes that as well as better NHS services to prevent and treat alcohol misuse, improvements in rates of alcohol abuse will depend on providing better information and education and establishing the right environment for people to control their alcohol consumption.²⁹

15. The Department provides guidance to the public in the form of recommended 'sensible limits' for lower risk alcohol consumption, expressed in terms of 'units'. In 1995 the limits were revised from weekly limits to daily guidelines, but more than a decade later there is still confusion in the minds of the public and the media, with references still being made to weekly limits. A survey in 2006 found that almost two-fifths of people could not say what the sensible drinking guidelines were. Further research, conducted in 2008, found that 77% of people did not know how many units were contained in a typical large glass of wine.³⁰

16. In 2008, in response to the lack of awareness, the Department started a new education campaign to increase public understanding generally about alcohol units and the health risks of exceeding the guideline amounts.³¹ The campaign is part of a wider programme—'Know Your Limits'—which was introduced in 2006. This programme was initially targeted at binge drinking by young adults, a significant problem in the UK when compared with other countries.³² The Department planned to spend more than £6 million on the 'Know your Limits' campaign in 2008–09.³³ There is some evidence emerging that the recent advertising campaigns are improving the public's understanding of units, but the Department accepts that the evidence base for education and awareness campaigns more generally needs to be strengthened and is working to achieve this.³⁴

17. While the Department is responsible for performance against the new alcohol-related indicator in the Public Service Agreement, other parts of government also influence rates of alcohol harm, in particular through policies on pricing and taxation.³⁵ The Department has published research which suggests that changes in the pricing and promotion of alcohol could deliver reductions in health harms, crime and absenteeism from work.³⁶ The review found that alcohol became 69% more affordable in relation to average incomes,

28 Q 38

29 Qq 41, 80, 85

30 Q 11; C&AG's Report, paras 3.2–3.4

31 Q 11; C&AG's Report, paras 3.2–3.4, 3.6

32 Q 83; C&AG's Report, para 1.11

33 C&AG's Report, para 3.6

34 Q 84; C&AG's Report, para 3.6, Appendix 2; Ev 13

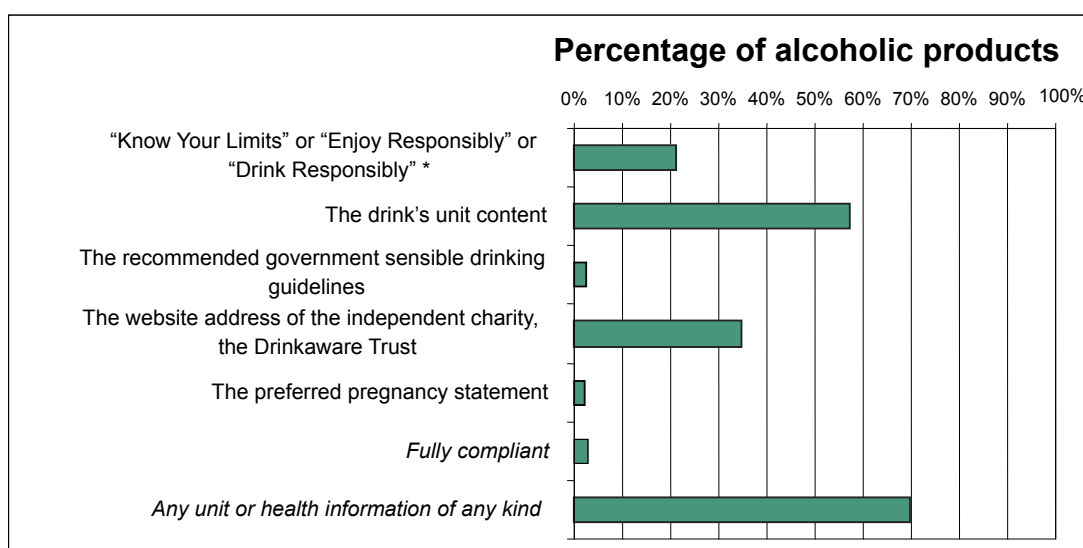
35 Qq 15, 43, 80–81; C&AG's Report, para 1.13

36 Qq 95–96; Ev 27; report referenced in Ev 27, *The Effects of Alcohol Pricing and Promotion*, University of Sheffield, September 2008

between 1980 and 2007. Alcohol prices are influenced by a range of factors, including industry costs and taxation levels.

18. The Department has worked with the drinks industry to develop a voluntary agreement on drinks labels. However, a first-stage report undertaken in March 2008 showed that uptake of the agreement has been unsatisfactory (**Figure 3**) and only 3% of products complied with the labelling scheme in its entirety.³⁷ The representative body for supermarkets, the British Retail Consortium, reports that its six largest members, covering 75% of the grocery market, expect to complete labelling changes by the end of 2009.³⁸ The Department is committed to assessing the success of the labelling agreement again, with results expected in summer 2009. The Department will then consider whether to introduce a mandatory code.³⁹ The leading drinks producer Diageo has indicated that it would support a mandatory labelling scheme.⁴⁰

Figure 3: Uptake of five aspects of the voluntary labelling scheme



Note: * Includes drinks with responsible drinking slogan incorporated anywhere on the label rather than just as a heading. All figures are adjusted to market share values.

Source: Campden & Chorleywood Food Research Association Group. *Monitoring Implementation of Alcohol Labelling Regime (including advice to women on alcohol in pregnancy)*, June 2008

19. The Department's initiatives are not always joined up with those of other government departments. For instance, campaigns on drink driving limits are not connected to the Department's guidance on units, yet one large glass of red wine at 13% per cent strength would place a driver at or over the limit. The strength of alcoholic drinks has increased and glass sizes have grown.⁴¹ The Department is currently considering the results of a recent consultation on glass sizes, although weights and measures is the responsibility of the

37 Qq 48, 50–52, 57–60; C&AG's Report, para 3.10

38 Ev 30

39 Q 56

40 Ev 33

41 Qq 12–14, 66; Ev 18

National Weights and Measures Laboratory.⁴² The Department's current consultation on the principle of a mandatory alcohol retail code includes glass sizes as a possible element of the code; premises could be required to offer customers the choice of the smallest size of glass permitted under legislation.⁴³

20. The Department has also worked with the drinks industry to develop a social responsibility code and with the Drinkaware Trust, an independent charity. However, a review of the code, which covers drinks promotions and the way licensed premises are managed, showed that some aspects are not being adhered to by drinks manufacturers, retailers and managers of licensed premises. For example, people aged under 18 are frequently admitted to age-restricted venues where they cannot legally purchase alcohol.⁴⁴ The Department accepts that more could be done in this area and is considering whether the code should be made mandatory.⁴⁵ The British Retail Consortium is currently consulting its members on whether there should be a mandatory code, but does not believe that more regulation is the way to address the alcohol problem in the UK.⁴⁶

21. The Drinkaware Trust, established in early 2007, is expected to raise £12 million to fund education campaigns. This is, however, a very small figure compared with the £30 billion UK market for alcoholic drinks.⁴⁷

42 Qq 33–35

43 Q 66; Ev 18

44 KPMG, *Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks*, April 2008

45 Qq 49, 53–55

46 Ev 30

47 Qq 44–47; C&AG's Report, para 1.11

Formal Minutes

Wednesday 15 July 2009

Members present:

Mr Edward Leigh, in the Chair

Keith Hill

Mr Don Touhig

Mr Austin Mitchell

Draft Report (*Reducing Alcohol Harm: health services in England for alcohol misuse*), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 21 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Forty-seventh Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

[Adjourned till Wednesday 14 October at 3.30 pm

Witnesses

Wednesday 12 November 2008

Page

Mr Hugh Taylor CB, Permanent Secretary, **Dr Will Cavendish**, Director Health and Well-Being, and **Mr Mark Prunty**, Senior Medical Officer, Alcohol, Drugs and Tobacco Programme, Department of Health, and **Dr Barbara Hakin**, Chief Executive, East Midlands Strategic Health Authority

Ev 1

List of written evidence

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Oral evidence

Taken before the Committee of Public Accounts on Wednesday 12 November 2008

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Mr David Curry
Mr Ian Davidson

Mr Austin Mitchell
Dr John Pugh
Phil Wilson

Mr Tim Burr, Comptroller and Auditor General, **Mr Michael Whitehouse**, Assistant Auditor General and **Mr Mark Davies**, Director, National Audit Office, were in attendance.

Mr Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, was in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL REDUCING ALCOHOL HARM: HEALTH SERVICES IN ENGLAND FOR ALCOHOL MISUSE (HC1049)

Witnesses: **Mr Hugh Taylor CB**, Permanent Secretary, **Dr Will Cavendish**, Director Health and Well-Being and **Dr Mark Prunty**, Senior Medical Officer, Alcohol, Drugs and Tobacco Programme, Department of Health and **Dr Barbara Hakin**, Chief Executive, East Midlands Strategic Health Authority, gave evidence.

Q1 Chairman: Good afternoon; welcome to the Committee of Public Accounts. Today we are considering the Comptroller and Auditor General's Report on Reducing Alcohol Harm: health services in England for alcohol misuse; welcome back to Hugh Taylor who is Permanent Secretary to the Department of Health. Would you like to introduce your colleagues, please?

Mr Taylor: Yes, could I introduce Dr Barbara Hakin, who is the Strategic Health Authority Chief Executive for the East Midlands Area., Dr Will Cavendish who leads the work on this and a number of other policy areas in the Department of Health, and Dr Mark Prunty, a Senior Medical Officer within the Department with particular responsibilities for substance abuse.

Q2 Chairman: Thank you, Mr Taylor. Could you please look at paragraph 2.3 which tells us on page 17 that "PCTs found it difficult to provide us with details of their spending on services . . ." How can we be confident that we know what is going on, that you know what is going on, that this is a priority when apparently PCTs have difficulty knowing how much they themselves are spending?

Mr Taylor: It is clear that to address alcohol harm we expect PCTs to commission effectively based on an assessment of needs in their local populations in partnership with other local agencies, and resource planning and investment decisions should follow that. The situation is improving—there are some signs of progress, even since the NAO carried out its survey, but it is clear that the PCTs should have a stronger grip on resource planning than the survey results show,

Q3 Chairman: You are going to now make sure they do that are you?

Mr Taylor: Our priorities here are to make sure first of all that PCTs are doing what they should do, which is to assess the needs of their local populations and, second, we want to encourage them—

Q4 Chairman: Because 40% do not have a strategy, one-fifth do not know the level of harm in their areas—this is important stuff, you need to get a grip on them, do you not, and we need to know how much they are spending overall, what they are spending on individual services, what is the level of harm in their areas and they ought to have a strategy. That is something that your department can do, is it not?

Mr Taylor: We certainly want them to carry out a proper needs assessment of their areas, they certainly should have and have now got access to better data to support them to do that than they have had in the past. Since last October *Local Alcohol Profiles for England* have been published.

Q5 Chairman: The answer to my question is yes.

Mr Taylor: PCTs should be addressing this as an issue in the way that I have said.

Q6 Chairman: Thank you very much. If we look at paragraph 22 in the summary on page 9 we see "The new PSA indicator on alcohol is a way of encouraging local NHS organisations to focus on alcohol harm." Great. However, we also read, "The adoption of the indicator locally is optional." Why is it optional and how can we be confident it is going to reduce the number of hospital admissions if this new target is optional?

Mr Taylor: First of all we will measure the progress on the indicator against the performance of all PCTs and we will publish information on the progress of all PCTs. What we did with the introduction of the

 Department of Health

vital signs framework was to broaden our approach effectively away from top-down management to a stronger emphasis on PCTs looking out to their populations, and they were given a range of indicators rather similar to the system applying to local authorities which they could prioritise. As the Report confirms, 99 PCTs prioritised alcohol, 46 of the 50 areas with the biggest alcohol problems did so and we are encouraged by that as an indication of the seriousness with which the NHS is addressing the issue. We think it is important that PCTs should be allowed to set their own priorities in this area although all the evidence is that more and more of them are seeing this as a priority within their area.

Q7 Chairman: Fair enough, but let us look at figure 7 which we find on page 19, which tells us—and we can see it for ourselves, it is very graphically there in that map, is it not—there is little correlation between the number of alcohol misusers and the amount spent on specialist alcohol services across PCTs. This is rather worrying, is it not? You would expect that where the index of alcohol harm was most you would expect to get a lot more spending, but that does not necessarily follow. We also read in paragraph 2.4, just to push things along a bit—and we all know that alcohol abuse causes huge amounts of problems; our sister committee estimates it at £7.3 billion a year, this is the report out this week from the Home Affairs Committee—that £197 is spent per dependent drinker compared with £1,744 per drug user. Despite what you said in your last answer, which as always is very reassuring, they are doing the right thing, they are spending much less per dependent alcohol user than they are on drugs and services across the country are very patchy indeed and do not necessarily relate to where the most harm is.

Mr Taylor: We certainly think there is scope for improvement in this area as a result of greater prioritisation at PCT level, there is no question about that. We think there is some evidence of progress in that respect as PCTs strengthen their commissioning capability, take joint needs assessment increasingly seriously and look out to their populations to look for where they can make the most effective interventions. We need to be a bit careful about drawing a tight correlation between level of spend and effectiveness of spend—I think the NAO Report itself provides some helpful caveats in that respect. What we should be looking for is progress on, for example, the key indicator which we have set in relation to hospitals and hospital admissions.

Q8 Chairman: Yes, everything you are telling me is beautifully put, very reassuring, but you are not actually answering a single question I am putting to you.

Mr Taylor: I think I am.

Q9 Chairman: You are not actually, with respect. For instance, I gave you a fact, £197 is spent per dependent drinker compared with £1,744 per drug user; you refuse to acknowledge that.

Mr Taylor: First of all it is apples and pears in the sense that treatment of people with drug problems is inherently more expensive than treatment of dependent people with alcohol abuse; it is partly to do with the nature of the treatment, it is partly to do with the rate at which people with acute drug problems present and so on, so it is apples and pears. That is not to say that we do not need a more sustained effort than we have got at the moment and a more systematic approach to dealing with alcohol abuse.

Q10 Chairman: Why has there been a sudden burst of activity in 2008? A lot of these new initiatives started in 2003 but not much happened in the first few years, then suddenly—it is not because of the interest of this Committee and the NAO, is it, that we have had these new initiatives suddenly this year—for example, regional alcohol offices, supplementary guidance for PCTs, on-line training, information for drinkers, consultation on retailing code, a new Directed Enhanced Service, all in 2008? It is not because of the NAO is it?

Mr Taylor: To be fair the first annex to the Report indicates that following the 2004 strategy there has been a pretty constant stream and a cumulative stream of initiatives from the department which have been aimed first of all at improving education and information in relation to alcohol generally, in relation to helping the environment in which people make choices about alcohol and in relation to supporting the NHS, for example, with advice on commissioning. That has undoubtedly gathered steam; I am sure the NAO survey was another stimulus but certainly the department has been pushing away at this agenda for some time. Can I also add that one of the things that has made a difference has been the new emphasis in the vital signs framework away from just setting single top down targets, but giving PCTs in effect more licence to set their own priorities.

Q11 Chairman: I bet you if I asked people in this room to put up their hands and say what do you think is a sensible level of drinking they would probably say for a man 21 units a week—that is engraved on my consciousness, but that is wrong, is it not, because 13 years ago you changed your guidelines. If you look at page 23, figure 8, the guideline is no longer 21 units of alcohol per week, men should not regularly drink more than three or four units per day and women two or three units per day. Even the *Daily Telegraph* got it wrong, they said “The government recommends a limit of 14 units of alcohol a week for women and 21 for men” but that is not actually right, they have a daily limit now, do they not? Why have you had so much difficulty in getting your message across 13 years after you changed your guidelines?¹

Mr Taylor: There has been some progress in getting this message across and some survey data does show that people think they know what the levels are. I am sure in some people’s consciousness that still does

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relate to the weekly rate rather than the revised approach which we think is probably more balanced in terms of daily guidelines. That is why, frankly, we launched this big programme, the *Know Your Limits—Units* campaign earlier this year—early indications are that that is having some effect. Other things which have changed of course are that overall the alcohol content of drinks has increased and glass size and so on has also increased in pubs so there has been some confusion in the public mind about units.

Q12 Chairman: Can I stop you? This is very important because if you go into our pub now and loads of our children—my children are going to pubs—are being offered a large pub glass, 13%, a glass of red wine, that apparently is 2.3 units. If you have one large glass in a pub you immediately—

Mr Taylor: At 13% alcohol I think.

Q13 Chairman: Yes, a glass of red wine, 13%, quite normal, you are immediately up to the limit for driving.

Mr Taylor: Yes.

Q14 Chairman: I am not sure again how many people in this room could immediately answer that question, and I think this is something perhaps where you should be more open with the public, that if you drink one large glass of red wine in the pub you are straight up to the limit.

Mr Taylor: That has been very much the purpose of the campaign which we have been running, both through national campaigns and through local information. We are doing an evaluation at the moment of the immediate effects of that and provided we get the results through in time I could let the Committee have a note on how that is coming out. I expect that to show some overall improvement in public understanding of what the units are, but I am sure we have a long way to go on that.

Q15 Chairman: What worries me—and this is for you now because we do not often get you, we often get Mr Nicholson who heads the health service, you are the Permanent Secretary and you are going to help us on lifestyle choices, public health choices—you are losing this battle are you not? The number of hospital admissions for alcohol has doubled over the last 30 years; are you losing this battle? Maybe it is a battle you cannot win, maybe it is something to do with society and it is just beyond your scope.

Mr Taylor: I do not think we would take that view, we think that it is possible with social marketing to increase public awareness of units and of what is safe and responsible drinking. We need to do that in co-operation with other key players, including those in industry and those retailing alcohol, so it has got to be part of a much wider approach so that information about this is more easily accessible to people who are drinking and they are drinking in an environment which is more supportive of them in that respect, and all those things come together. It is about in one sense education, enabling people to make healthy choices, but also putting them in an

environment so that, for example, labelling on bottles of wine, on beer and in pubs is clearer and up to date.

Q16 Chairman: It is a pity that having spent £7.3 billion on the new GP contract—we know a lot about that in this Committee and you know about it, you appeared—there is nothing we see in 3.17 on the Quality and Outcomes Framework for GPs on alcohol. That is my last question.

Mr Taylor: As you know the department has just launched a Directed Enhanced Service which effectively has the same effect as the QOF in terms of incentivisation of GPs to support GP practices in better intervention and offering brief advice, and an £8 million commitment is part of that plan.

Chairman: So you are fixing that; thank you very much. Richard Bacon.

Q17 Mr Bacon: I am interested in your last answer because it says in the Report that three-quarters of attendances at accident and emergency in peak hours are alcohol-related. We know that a significant proportion of domestic violence is alcohol-related and if dealing with this were really a high priority you would not have thought at the last minute, after the GP contract had been negotiated, finalised and signed, oh, we had better get a bit of directed enhanced service which, as the Report says, you did in September 2008 because you were coming before the Committee of Public Accounts. It would have been integral in your thoughts and in your strategy from the word go when you were spending this £7 million or £8 million on the new GP contract, would it not?

Mr Taylor: There have been lots of competing demands on the QOF structure with other clinical priorities being taken into account. I know when decisions on that have been made the potential of using QOF and DES for alcohol services has been considered and the honest answer must be that other things have been prioritised. However, it is important to say too that what we have seen over the last two to three years is a growing recognition of the potential harm that alcohol is doing and a growing consensus about effective ways of intervening to prevent it. I am not sure that we have been in as confident a position as all that until pretty recently.

Q18 Mr Bacon: Alcohol has just got steadily cheaper, has it not? That is part of the problem.

Mr Taylor: Certainly over time I am sure one of the factors—certainly international evidence suggests that the price of alcohol is one of the issues.

Q19 Mr Bacon: This is a case for joined-up governance with your colleagues in the Treasury is it?

Mr Taylor: As you know decisions on tax, if that is where you are leading me, are very much a matter for the Chancellor and I am not going to tread into that territory.

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Q20 Mr Bacon: I would not dream of leading you there Mr Taylor. Could I ask you about the training of doctors? It says in 3.14 that fewer than half of the NAO sample of GPs felt that they had adequate training and you have provided £650,000 in 2008-09 for medical schools to develop training that is intended within ten years to produce 60,000 new doctors specifically trained to identify and advise or treat people who are drinking too much. Why does it take ten years to produce doctors who can help with alcohol? If three-quarters of attendances at A&E are alcohol-related the fact that you are prepared to sit back and have it take ten years and only put £650,000 into it does not, to be honest, sound like you are taking it seriously.

Mr Taylor: If that were all we were doing it would be a fair criticism.

Q21 Mr Bacon: Why does it take ten years? Why do you not say that by a certain date, 2010 or whatever it is, we will have done it?

Mr Taylor: That is related to the introduction of a stronger emphasis on educating doctors in training in this area from the word go, and if course it takes a long time to train a doctor, so that is the core training with which doctors are being provided.

Q22 Mr Bacon: It does not actually take ten years to train a GP does it?

Mr Taylor: Not at all.

Q23 Mr Bacon: How long does it take to train a GP from the moment they go to medical school until they qualify—

Dr Prunty: It is 60,000 over a ten year period that will be trained.

Q24 Mr Bacon: Sorry, my question is how long does it take to train a GP from the moment they enter medical school as a fresh undergraduate until they can put up their hand and say I am a GP; what is that time interval, seven years?

Dr Prunty: It takes in the order of eight or nine years depending on their training path.

Q25 Mr Bacon: Yes, but it is not ten years, is it?

Dr Prunty: The figures refers to the number of doctors who are in undergraduate training over the next ten years who will be trained in this area, so it does not mean that the training will not take place in year one, two, three and four, but after the end of ten years all doctors in training will have received alcohol training.

Q26 Mr Bacon: What is the total number of doctors who get trained in a ten year period?

Dr Prunty: 60,000.

Q27 Mr Bacon: It is 60,000, so it is all of them over that period.

Dr Prunty: Yes.

Mr Taylor: Can I just add to that? In addition to that core training one of the things we have been doing recently is to build effectively more learning capacity, education capacity, within our existing system. For

example, we are about to launch, what is called in the jargon an “e learning” facility over the web which will enable all primary care practitioners—GPs, practice nurses and others—to get themselves trained up on best practice in relation to the use of brief intervention, one of the things that is mentioned in the NAO report, because one of the concerns that has been expressed in the field is that people do feel under-developed in that area.

Q28 Mr Bacon: That kind of brings me to my next point because the Directed Enhanced Service which is screening newly registered GP patients²—this was the thing introduced in September 2008 to take account of the fact that there is nothing in the GP contract—only refers to newly registered patients; why not everyone? I mean, what is the turnover of the average GP surgery? If the average GP list is 1250 how long will that take in numbers of years completely to replace itself? Do any of the doctors know?

Dr Hakin: It is hugely varied but it is a relatively small percentage.

Q29 Mr Bacon: I would have thought so, yes.

Dr Hakin: It is important to remember that as well as the Directed Enhanced Service—which took a very considerable time to negotiate so it was not a last minute thing in September, that was when it was finalised and those services are an absolutely integral part of the contract, they are not an add-on, as Hugh said they are just an alternative to QOF—as well as that a significant number of PCTs are actually using another kind of enhanced service so we are already, because of the devolution of people’s ability to do things, seeing PCTs across the country delivering local services and actually screening far more than the newly registered patients. In terms of what goes into the GP contract, as Hugh rightly pointed out, it is a question of prioritisation, there are competing priorities, heart disease, lung disease. Alcohol is of significant importance and we are working on how we might improve it.

Q30 Mr Bacon: If you look at the bottom of page 27, note 23 “The average number of adults per GP list is 1250, so if all hazardous and harmful drinkers were the target, we could anticipate that each GP has about 325 patients drinking above the guidelines. Around 63% of adults visit their GP in a year so GPs could have the opportunity to identify over 200 patients per year” but they are only doing 66. This new scheme, which is at the point of contact with the patient, is only targeting newly registered patients. I know from electoral rolls that urban and rural turnover is very different, but if in an urban area you can get 15% or more turnover of an electoral roll I am sure it is the same with GPs. That would leave, even in the most concentrated areas, 85% of the available possible cohort not being touched by this enhanced provision.

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Dr Hakin: That is right and again we are working to look at the contribution in the future to increase it, but as I say other priorities such as smoking and vascular disease all have to be taken into account. There is huge range of priorities.

Q31 Mr Bacon: I know that there is a huge range of priorities, but I go back to the point I made at the beginning. [Up to] Three-quarters of all attendances at accident and emergency are alcohol-related. I forget what figure it is for domestic violence, but it is very high just as an absurdly high proportion of crime—it is 71% of violent crime—relates to funding a drug habit. It is very, very concentrated around alcohol, the attendances, and we know the pressure on A&E, it is absolutely enormous. Surely this would be a relatively small investment to get this right. You sound like you are admitting that you are ignoring 85% and just doing what you can after the event.

Dr Hakin: We are completely committed, in the whole of the GP contract, to ensuring that everything we put into it is cost-effective, and it is only recently that we have had more certainty about the brief interventions, so for this particular occasion we had other priorities but I am sure there will be discussions in the future about extending that. As I say, if you just look at Lincolnshire alone, Lincolnshire PCT, has a Local Enhanced Service that pays additional sums to both doctors and pharmacists to actually deliver these brief interventions to patients.

Q32 Mr Bacon: The evidence at 3.16 suggests that some of the brief interventions are both ineffective and expensive. Can you distinguish what are the factors that make for an effective and economical brief intervention rather than one that is expensive and not that effective?

Mr Taylor: One of the things that we are doing there is a research programme that is referred to in the NAO Report called SIPS which is looking at the way brief interventions are done across 53 sites and we are doing some analysis of what turn out to be the best and most cost-effective ways of doing that. While the overall methodology of brief interventions is well evidenced and well documented, both in this country and abroad, there are still lessons to be learned about the best ways to do it.

Q33 Mr Bacon: I am running out of time but I have two quick questions, one about glasses, the size in which alcohol is sold; that is a statutory matter is it not, whether it is sold by a pint or a half pint and the size measure in which spirits are sold? There was talk of moving to the Australian system where you have something larger than a half but less than a full pint, and presumably it is the same for wine glasses and the size in which they are sold in licensed premises is controlled by law is it not?

Dr Cavendish: That is largely a matter for DIUS.

Q34 Mr Bacon: For DIUS?

Dr Cavendish: They lead on weights and measures and it is a weights and measures issue as I understand it.

Q35 Mr Bacon: Presumably you could be liaising with your colleagues in whoever it is—it might be HMRC, I do not know—to influence what is the statutory size at which alcohol is sold. The Chairman referred to this large glass of wine; you could be influencing that through your public health role.

Dr Cavendish: What we are consulting on at the moment is whether we need to take action to expand the range of choice available to people. In the alcohol consultation that closed last month we posed the question of whether we should make sure that there was a range of choices available on glass size, exactly so that people could get a smaller size if they wanted to, because there was some evidence that people could not. They wanted to go in, have a small glass of wine and they were refused service; that is something we think we should probably take action on, but the consultation closed last month and Ministers are considering it at the moment.

Q36 Mr Bacon: Finally, the best place to look surely is where things are going well and on page 28 it gives an example at Liverpool and at St Mary's Hospital, Paddington, of where things are going well. Why do you think it is that there are so few examples of good practice?

Mr Taylor: We could provide more examples of good practice. There are some that are emerging across the country, including in your own area, so I do not think we are short potentially of examples of good practice. The argument in the Report, which we have to accept, is that that good practice is not being followed through systematically.

Chairman: Thank you very much; Mr Ian Davidson.

Q37 Mr Davidson: Can I ask whether or not we are essentially losing the battle against alcohol abuse? Are things getting better or worse?

Mr Taylor: Measured by the indicator which we have set ourselves as the key indicator to measure future progress, at the moment things are getting worse. In other words, the number of hospital admissions—

Q38 Mr Davidson: I just want you to be clear, things are getting worse. Can I just clarify then, compared to as it were the battle against smoking, are things getting better in relation to smoking abuse?

Mr Taylor: Yes.

Q39 Mr Davidson: So there is a contrast. To what do you ascribe the fact that you are doing better against smoking and worse against alcohol?

Mr Taylor: First of all the public health messages on smoking are more straightforward and more simple because in essence they are do not do it and any smoking harms you.

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Q40 Mr Davidson: I understand that.

Mr Taylor: Alcohol is a fundamentally more complex message because at certain levels it does not harm you. The other thing is unquestionably that smoking has been shown conclusively, if we can get you to stop smoking, to have the biggest single impact of any public health measure. We have been at it for longer, we have learned more about how to do it in overall public health terms.

Q41 Mr Davidson: Is it mainly then a question of information? It is an information battle rather than anything else.

Mr Taylor: It is three things: it is information and education, it is getting the right environment where people are making those choices properly and, thirdly, it is about better service provision, and one of the things we have succeeded in doing with smoking to some extent is getting effective—although I think it is a simpler task—local interventions on, for example, smoking cessation services. It is not just one thing.

Q42 Mr Davidson: I understand that. We have had a letter in from the BMA—usually when they send us stuff it is all self-serving but this time it is relating more to the general issues that we are dealing with. Do you agree with their analysis about how to tackle alcohol abuse? They are mentioning higher tax and I think there is a clear correlation between price and consumption, is there not? They mention irresponsible promotions and the display of standard labelling—is there a consensus between yourselves and the BMA on that?

Mr Taylor: Certainly in the latter area which is around the area of labelling, of promotion, of the retail environment, there is a very strong consensus. As you know we have been consulting—

Q43 Mr Davidson: What about the question of price? I understand that it is not for you to decide what the tax level should be, but do you agree with their analysis that higher price would discourage consumption?

Mr Taylor: The international evidence suggests there is a correlation between price and consumption.

Q44 Mr Davidson: In terms of your relationship with the drinks industry I wonder about the extent to which you are handicapped by the fact that the drinks industry is simply too powerful both economically and politically to allow you to do the sorts of things that you might want as compared to smoking where the industry was less powerful. Could you comment on that?

Mr Taylor: It is important that we work together with industry on this and there have definitely been some encouraging signs. They themselves have put up some money to work on better education and programmes on sensible drinking and so on.

Q45 Mr Davidson: Sorry, how much have they put up?

Mr Taylor: It is £12 million over three years.

Q46 Mr Davidson: How much is their turnover per year?

Mr Taylor: They make a lot of money.

Q47 Mr Davidson: So as a percentage it is infinitesimal.

Mr Taylor: We, as you know, have worked closely with them on a voluntary code in relation to retailing practice and we published a report in July having had a survey done by KPMG which, frankly, was disappointing in relation to how that voluntary code is working, which is why we are now consulting.

Q48 Mr Davidson: Disappointing—sorry, can I just clarify, disappointing means that they were not doing it. As I understand it the figure was that only 3% used the labelling scheme in its entirety, that was the voluntary agreement, and I would say that only 3% is disappointing and I would have thought another way of saying it is that they were not abiding by it.

Mr Taylor: There was some indication, for example, that well over 50% were including information on units.

Q49 Mr Davidson: Yes, they were doing something but they were not actually doing what they had agreed, is that correct? What they agreed was the full monty so only 3% of the labels had on them what they had voluntarily agreed to put on them.

Mr Taylor: Just in relation to the labelling exercise, strictly speaking the time period over which we asked them to comply with our suggestions on labelling has not yet finished, that exercise has still some time to run and that is clearly a problem. In relation to other examples of retailing which is to do with promotion and the way licensed premises are managed, staff trained and so on, which are all features of a voluntary code, again the KPMG report found instances where that clearly was not being followed which is why we are now consulting on the mandatory code.

Q50 Mr Davidson: We have disappointment there at 3% but what sort of percentage have we got there that are not following it?

Mr Taylor: I am sorry, can you remember?

Dr Cavendish: I did not quite catch the question.

Q51 Mr Davidson: This is in reference to the point about them not following the voluntary code.

Dr Cavendish: There are two different reports. There is one report that was following the question of whether the alcohol industry was—

Q52 Mr Davidson: That is the 3% one.

Dr Cavendish: That is 3% in full compliance. Around two-thirds are putting unit labelling on their bottles and cans but only 3% are doing it in the entirety. There was a separate report on the social responsibility code that the alcohol industry pulled

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together in 2005; that was not a representative sample, KPMG looked at some clubs and pubs and some retailers.

Q53 Mr Davidson: What were the results?

Dr Cavendish: As the Permanent Secretary said they were frustrating. Some were doing great practice, often the larger ones—

Q54 Mr Davidson: That is generally not a good thing, is it? I just want to be clear.

Dr Cavendish: I cannot give you a number.

Q55 Mr Davidson: But you must say it is unsatisfactory.

Dr Cavendish: Yes.

Q56 Mr Davidson: Can I just clarify one point that you are making there about the labelling. You are arguing in the industry's defence that they were putting something on it to do with units but only 3% were doing the whole thing. If they were actually putting something on about units surely at the same time as they did that they could have put everything that they had already agreed to on it, so why would they strike a voluntary code and then not actually abide by it. I could understand if there was an issue about it takes a while to get the labels printed and everything else, but if they have changed to put something on it why did they not change it to put everything that they actually agreed on it unless they are bad people?

Dr Cavendish: We are looking for a majority of the alcohol industry to be in compliance with the agreement on labelling by the end of this year. We will then do some research on whether that is the case or not and we will take a decision—indeed, we put this in the consultation in July—in March next year of whether we will move to a mandatory position or not.

Q57 Mr Davidson: That is not actually answering what I am asking. What I am trying to identify is the extent to which the industry are genuinely committed to this voluntary approach, and it seems to me that if they have made some change to include information about units, but they have not actually done the complete change to what was voluntarily agreed, that is an indication of bad faith is it not?³

Dr Cavendish: Sections of the industry have complied more strongly, others have not.

Q58 Mr Davidson: Can you tell us who has not complied?

Dr Cavendish: Some of the major companies.

Q59 Mr Davidson: Can you tell us the names?

Dr Cavendish: We can provide the list; it was published at the time.

Nick Lawrence, Deputy Director
Head of Alcohol, Drugs and Tobacco
Health Improvement and Protection Directorate
Department of Health

Q60 Mr Davidson: Can you just give us one of the bad names then—can you remember any of them?

Dr Cavendish: We have an issue with Diageo—and we could again find some more background on their position and our position on why they seem unwilling to comply with the voluntary position. Indeed, some companies have asked for mandatory labelling because they believe a level playing field would be the appropriate position for government to take.

Q61 Mr Davidson: It would be very helpful if you told us who were the laggards who are behaving badly and who were adopting a more constructive position and we actually had it in writing. Could we have it reasonably quickly because sometimes it takes us a long, long time to get information out of departments and even if you cannot produce everything that we want from this Committee, maybe you will let us have that early in order that we can do with it as we see fit. Coming on to the question of joined-up government some would say how appropriate is it and what sort of message does it send out when alcohol abusers can get enhanced benefits through the benefit system? Is that not something that sends out entirely the wrong signal?⁴

Mr Taylor: I am not quite sure where that argument would take you. Do you mean people who have been convicted?

Q62 Mr Davidson: No, people in my constituency have indicated their unhappiness about the fact that alcohol abusers get additional money through the benefits system and they think that that actually rewards bad behaviour. Is that something that you agree with?

Mr Taylor: I just am not sure that I am aware of the situation in which people would be getting extra benefits.

Q63 Mr Davidson: You are not aware of it—surely you must speak to the other departments.

Mr Taylor: Yes.

Q64 Mr Davidson: Surely if another department dealing with benefits was undertaking a course of action which was undermining the message you were seeking to project you would want to comment to them on that.

Mr Taylor: If that were the case.

Q65 Mr Davidson: Have you commented on this at all if you are not even aware of it?

Mr Taylor: I have to say that the issue and the way that you have expressed it, that there may be perverse incentives which are supporting people who

³ Ev 16

⁴ Ev 17

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are alcohol misusers, then that would be something that I would want to follow through, but that has not been raised as an issue.

Q66 Mr Davidson: It has been raised now. The final point that I wanted to ask about relates to the point that was made by one of my colleagues about glasses. I understand of course the point about glasses in pubs but one of my members of staff actually raised with me the fact that Habitat and Debenhams and the like are now moving towards much larger glasses, more fashionable, larger glasses so that by the time you have filled one of those you have almost taken half a bottle of wine. Have you been speaking to people in the glassware industry as well as those who are actually in pubs because pubs have tended to sharpen up their act a bit and are much more responsible than they were and drinking at home is now much more of a problem. People are much more likely to drink more if the glasses they are using, particularly for wine and spirits, are themselves larger. Is there anything that you are doing in that regard?⁵

Mr Taylor: Our discussions have focused primarily around the way in which alcohol is dispensed rather than glasses sold, but I will follow that up. I am not aware of us being involved in any such discussions.

Mr Davidson: Thank you.

Chairman: Thank you, Mr Davidson. Listening it strikes me that perhaps a supplementary hearing where the chief executive of Diageo might be summoned to this Committee might concentrate his mind, so we might think about that. Mr Pugh.

Q67 Dr Pugh: The figure given in the NAO Report says that £217 million is spent on alcohol services by PCTs. Am I right in assuming that the bulk if not all of that £217 million is spent on dealing with people who have acute alcohol dependency issues rather than on health promotion and stuff like that?

Mr Taylor: That would be accurate.

Q68 Dr Pugh: Are we aware how much of that money—and my principal line of questioning is concerned really with the severely dependent—is spent in the private sector commissioning rehab and the like?⁶

Mr Taylor: I do not have that specific figure in my head for the private sector. I know that a lot of the service provision in that area is provided by the third sector, by the voluntary sector.

Q69 Dr Pugh: The voluntary and private sector, but you have no idea how much we are actually spending with organisations outside the NHS.

Mr Taylor: I have a figure in my mind of about 50% but it may be more than that. A significant proportion of specialist services in that area are provided by the third sector.

Q70 Dr Pugh: The fact that these services exist does not necessarily mean that they work; have you commissioned any research into which of the variety

of the voluntary sector or private sector or public sector providers actually do the job of rehab best? We are all probably aware of acquaintances and the like, people who go off to rehab, come back and find themselves not much better but the person who provides the rehab financially benefits, if I can put it like that, and there is a lack of integration sometimes, a lack of follow-through. In terms of looking at what we call the patient pathway here can we differentiate between simply going through the motions and actually effective practice?

Mr Taylor: There is evidence on best practice in this area as in other areas and effectively that surrounds stepped progress so that you need measured interventions at each step. It is a chronic relapsing condition, problems with severe alcohol, so it is not inherently surprising that some people who go through it—

Q71 Dr Pugh: There is not a high success rate, we understand that.

Mr Taylor: Overall it is demonstrated that a combination of therapy, cognitive behaviour type treatment services, supplemented in some cases by detox-like facilities—

Q72 Dr Pugh: What I am aware of is piecemeal across the country there are different regimes in place; this Report makes it clear that there are different regimes in different places but I have not seen any sort of consistent spreading of best practice or even any real rating of how efficacious any of these regimes are; have you any sort of data that would help here?

Mr Taylor: We have some data which was produced for the study which we published in 2005 (Alcohol Needs Assessment Research Project (ANARP)) which looked at the evidence base for interventions, and some of that of course relates to how well the interventions are delivered on the ground, so it is one thing to describe them, the other is to see how they are delivered. When I talk to the specialists about this they will say the evidence of what works is there, the question is getting people to go out and do it—commission it effectively and then deliver it.

Q73 Dr Pugh: It is effective commissioning really that it is all about, is it not? My concern is that as you go to the GP with a problem, the GP does something in referring you to rehab so he thinks he has done something, the rehab people then do something, the person is then returned to the community and the problem then replicates itself. That must be happening pretty frequently.

Mr Taylor: Certainly the evidence as I understand it suggests that at each step in that process what you want is a properly worked-through stepping up process, so moving somebody from referral, right through, for example, to detox would not be the right step, unless they are presenting with very, very acute problems. You would want to go through several steps before doing that which would include properly constructed questionnaires, interviews, some counselling and so on before getting to the end.

⁵ Ev 18

⁶ Ev 20

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Q74 Dr Pugh: Would it be fair to say that at the moment the data is not there on what is the most effective patient pathway.

Mr Taylor: I am certainly influenced by the fact that I sat with some of the most eminent people who told me that the evidence is there for what works: it is a stepped process of interventions and I think the issue for us is communicating that more effectively out to the field. One of the things we have committed to is to publish what evidence we have on best practice in the field through what we are describing as the *Alcohol Learning Centre* so that practitioners out there can look at what works.

Q75 Dr Pugh: The Chairman put before you the fact that you spend £197 on the alcohol dependent but on drug dependency you spend £1,744 per capita. When asked to explain this you said actually drugs problems and drug addictions are quite tricky, but what seems to be the case in your answers so far is that an alcohol dependency is just as difficult and just as intractable. Severe alcohol effects that means.

Mr Taylor: Severe alcohol dependency is intractable. My recollection is that the difference is—and I am going to do this off the top of my head so you will forgive me—that around 50% of people with severe drug problems effectively recognised their need for, and get, services, which means that there is a higher overall percentage who have that problem who need to get through to specialist treatment services. The equivalent proportion of alcohol dependent people needing this kind of specialist treatment is much lower—the international evidence in my mind suggests about one in ten; we might be benchmarking ourselves against one in ten and we are at 5.6%. Secondly, most drug treatment itself involves methadone substitution. We do not use substitute drug therapy very much in alcohol and it is inherently more expensive. That is all I meant when I was talking about the cost.

Dr Pugh: A friend of mine who is an alcoholic—not a Parliamentary friend—

Mr Bacon: So a Liberal Democrat.

Q76 Dr Pugh: Not a Liberal Democrat either, stated that one reason why he felt he could not get the clear support that he wanted within his own areas and neither could other alcoholics was because when alcoholics present themselves and deal with their problems, what they do is they go to the off licence and purchase alcohol and by and large drink it at home, and there is no real social dimension to it, whereas the drug user if they cannot get their drugs, first of all have not obtained them legally and, secondly, may well commit crime in order to obtain them, so although the problems are much the same the social cost to society of a person persisting with a drug habit as opposed to a severe alcohol habit may differ. I am not necessarily convinced of that but have you done any sort of calculation that would enable you to know what the social cost is, all the

costs of maintaining a population of alcoholics as opposed to maintaining a population of drug addicts.⁷

Mr Taylor: There are some estimates of the total cost of alcohol abuse, both to society—

Q77 Dr Pugh: But that does not disaggregate things like binge drinking and misbehaviour and so on.

Mr Taylor: No, it does not. Just from the highly dependent group I do not think we have such information. We do have estimates of some of the social costs for the wider category of all alcohol-related harms. (These cover all misusers, including hazardous and harmful drinkers). We can provide such information for the committee.

Q78 Dr Pugh: Because they go to A&E pretty frequently and they do not work and may even get extra benefits for all I know. You do not know that information but you are not surprised that most GPs talk about a shortage of rehab, 73% according to the NAO Report, and 63% say that there are too few alcohol counselling sessions.

Mr Taylor: We recognise that there is a need for more provision both of rehab and, for example, detox. I am not surprised to hear GPs say that they feel that is a need.

Q79 Dr Pugh: That seems to reinforce the point that you are simply not spending enough money on this problem, or do you think in fact that even if you do spend money you do not solve the problem?

Mr Taylor: It is to do with working out what services are needed. As PCTs prioritise this area, which they are showing evidence of doing, what will follow from that is more investment so I would expect there to be an increase in provision in services as people prioritise.

Chairman: We have a division now and I am warned that there may be multiple divisions which will make our life very difficult. We are going to drive the divisions, go down and come back as quickly as possible to get through the last few questions. It is going to be a problem but we will try our best.

The Committee suspended from 4.19 pm to 4.23 pm for a division in the House.

Chairman: We are now quorate. Phil Wilson?

Q80 Phil Wilson: The first thing I want to ask you is: do you feel overwhelmed at the problem when you have got 10 million problem drinkers who drink regularly, 31% of men and 20% of women? Do you feel the whole service is being overwhelmed?

Mr Taylor: No, I do not think we do feel overwhelmed, certainly in comparison to what I think is an even more challenging problem which is that of obesity. Provided we focus this properly by effective public campaigns and by the sorts of steps which have been under discussion in this Committee about improving the way drink is promoted and sold, and by then ensuring that we get better services at local level to deal with hazardous and harmful drinkers as well as dependent drinkers, then I think

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we should begin to see progress in this. I think it would be fair to say that already there is a sense—and Barbara and I were talking about this before—partly as a result of the public awareness campaigns that we have been driving and partly because of the drip-drip-drip on PCTs in relation to this as an issue, of growing awareness both publicly and in the NHS of the need to address this issue. Nevertheless, as the Report confirms, we have got a way to go.

Q81 Phil Wilson: However perfect the system is and if every PCT has worked out what its priorities are as far as alcohol is concerned, it is ultimately a cultural problem, is it not?

Mr Taylor: Not just, but the fact of the matter is levels of alcohol consumption in this country grew dramatically in the period between 1960 to 2000 and that has to be as a result of a combination of factors including cultural factors. There have been some indications of stabilisation since then but, partly as a result of this increasing alcohol consumption, what we are seeing is increased evidence of the impact on people's health. So I do not think we should see it as an overwhelming problem but one which demands increasing focus both from the Department (because this is an area, as the Chairman has pointed out, where I think we can add value through working across other government departments) and through national campaigning and through effective local prioritisation in the NHS.

Q82 Phil Wilson: I am trying to find the international comparisons at the minute.

Mr Taylor: There is an interesting annex on that at the back.

Q83 Phil Wilson: I am going to come to that. There were some figures where basically as far as the rest of Western Europe is concerned there are a lot of countries whose populations drink similar amounts to us but the problem we have is binge drinking. Do you tend to focus your attention on tackling binge drinking?

Mr Taylor: I think the international picture is mixed in the sense that other countries in Europe do have higher levels of alcohol consumption than we do although our trend rate is up whereas some others' are down. Some studies have suggested that we have higher rates of what is called binge drinking in this country and that has been a focus of attention, partly because of its links to social disorder and other problems, and partly because it is damaging to people's health and puts them in harm's way, not just because of the impact on their health but for other reasons to do with crime and so on. One of the things that we have done deliberately from that point of view is in the last two TV and other campaigns we have done, we have very deliberately targeted at people in the binge drinking group, younger people who are drinking, like the recent campaign which shows people's evenings reversed. I do not know if you have seen it on the TV where the line "you wouldn't start an evening like this so why finish it like this?" is very, very deliberately targeted at that group of the population. What we want to do is to

use that campaign to begin to measure what effect it has had on the target audience and, rather as we have done with smoking in the past, is to use that as benchmark data to see if we can then target that group of people and others more effectively in the future.

Q84 Phil Wilson: You mentioned the international context, Appendix Two on page 39, it is the second paragraph at the bottom there: "In the countries studied for this report, a number of education and awareness campaigns aimed at preventing alcohol misuse and harms have been developed." It goes on to say: "However, for none of these campaigns has their effectiveness in altering drinking behaviour been demonstrated." Ultimately, we can talk about what kind of services PCTs should be developing, and obviously it should be something that is consistent around the country and targeting the appropriate populations, but in the international context the evidence seems to be that the only way that we are going to resolve this is if we increase the price of alcohol—and I am not saying I agree with that, I am just saying this is what the Report is saying—and also the age limits. In the US, for example, those states where the minimum drinking age is 21 years old find that they do not have as many problems with that, so it is big, major cultural changes and also the tax regime as far as drink concerned that need to be the fundamental foundations to make sure that we have a cultural change in drinking. This is what I was getting at about do you feel overwhelmed, not that you cannot deal with it, not that you feel you are being defeated, just that you are overwhelmed that you are taking two steps forward and one step back?

Mr Taylor: I think the first thing I would say is that where the Report says that there is not always a good evidence base around educational campaigns, internationally or nationally, that is a fair cop, and one of the things we have tried to do is to build an evidence base around that. With smoking, for example, we have worked very hard to construct campaigns which are based on evidence, so for example one of our targets at the moment is to reduce smoking in the routine manual work group, which has stubbornly refused to come down as fast as it has in other groups. We have a campaign plan there which is targeted very specifically. We feel confident enough there because we have some measures to say we are actually going to set an outcome measure for that overall campaign of reducing the number of smokers in that group by a target limit. In a sense that is a public education campaign. We feel that we have enough confidence in the various measures that we have built up over the years to do something like that. I do not think we are quite as confident yet as that on alcohol but that is the sort of evidence base we want to build up.

Q85 Phil Wilson: The other question I was going to ask around this is how can you solve the problem with drink when someone can go into a supermarket and buy 20 cans of lager for £10? At least in licensed premises, premises like pubs and clubs for example,

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I know they have happy hours et cetera, at least it can be regulated and somebody if they are being responsible can monitor what is happening but somebody can just go into a supermarket and buy that much alcohol. What can you do to ensure that these people do drink responsibly, especially when they are taking it home? It is not the same as sending the police round to the pub, is it?

Mr Taylor: Clearly in one sense there are limits to what you can do because this is a matter in the end of individual choice. Part of our campaign is to try and get people to make better choices and, as I have said in somewhat Mandarin-ese language I recognise, to create an environment in which it is easier for them to make those choices and certainly not one where they are being encouraged, frankly, to drink more than they need to. For example, one of the things we try to do is to discourage—and the industry have accepted this—promoting alcohol in a way that suggests it is going to improve people’s sex lives or attractiveness. But still images of that kind persist, so I think there are things that we can do to make things better in that respect. Obviously in the end if a young person, or indeed anybody else, is determined to get hold of lots of drink and drink it, that is not something that we are in a position to control.

Q86 Phil Wilson: In the North East of England, which is obviously an area of the country very close to mine—this is paragraph 4.5 on page 31—a study estimated that only 1% of alcohol-dependent people were accessing treatment in the lowest rated region, which is the North East. Has that improved?

Mr Taylor: I think one of the real reasons for taking a more positive view of that is the extent to which in the regional strategies which were published in July, which coincided with Lord Darzi’s Next Stage Review (which was based on the regional strategies and Barbara will have produced her own), the one for the North East had recognised the particular problems of alcohol dependency and harm and there are clearly dedicated action plans to get moving on that. There is certainly a recognition of the need to make a step change in both commissioning and delivery in the North East and I know the PCTs there are working with the strategic health authority to prioritise that much more effectively.

Chairman: Okay, thank you very much, we will come back as quick as possible and try and get our last questioner Mr Mitchell in.

The Committee suspended from 4.35 pm to 4.42 pm for a division in the House.

Chairman: Mr Mitchell?

Q87 Mr Mitchell: Cheers! Why is it that access to specialist treatment is so low? Only 5.6% of alcohol dependent people in this country get treatment; it is 10% in the United States and for drug users it is 55%? Why is it so bad?

Mr Taylor: I think internationally 10% is regarded as a sort of benchmark and there are some places in this country where we are getting to a 10% figure—in parts of London and Manchester for example. We are really for the first time beginning to get

consistent, reliable data on service provision through a new monitoring system we have introduced from April this year (The National Alcohol Treatment Monitoring System (NATMS)). Although it is much too early to be confident about this, when we measured the level of provision four years ago for a study for our strategy (ANARP), at that stage around 63,000 people a year were getting treatment from those services. Between April and August this year, according to this monitoring information (NATMS), 66,000 people were in treatment, which does seem to show that the numbers are going up. Clearly, however, to get to what we would regard as normal benchmark figures, we should do better.

Q88 Mr Mitchell: You have to do a lot more. Do you not have to be tougher with them in the sense that for every 2.7 referrals, only one person actually made use of specialist services? They drift away, in a happy haze perhaps, but they do not get through. You have got to push these people, you have to hound them and you have to discipline them and yet it says in this letter from Alcohol Concern that they can face waiting times of up to 12 months to access specialist services. That is pathetic.

Mr Taylor: The latest data we have (NATMS) is that 89% of people who are receiving alcohol treatment services were getting them within six weeks, so I am not quite sure what Alcohol Concern’s figures are based on, although I would say there may well be some cases where people have to wait longer. I think the key thing about this though is that for the sorts of interventions we are talking about to be effective you do have to have a compliance from the individual, they have to want to benefit from the services, and where that is not the case it is going to be very difficult for the services to be effective.

Q89 Mr Mitchell: Yes, but it would be much better if you had a national strategy of forcing the PCTs to do it and then gave them the responsibility to lead. Again, it is a letter from Alcohol Concern, which you have probably seen, that says primary care trusts have to lead on the reduction of alcohol-related harm. It goes on that PCTs must show “clearer leadership and be directly accountable for reducing alcohol-related harm and hospital admissions, even if delivery of services is devolved to local agencies”. That is true, is it not, unless you get the PCTs pushing it, it is not going to happen?

Mr Taylor: We agree that the central responsibility for taking this forward has got to be the PCTs. All we are saying is that we want them to do the commissioning of services effectively. We have got a number of things which we think will help them to do that better than they have in the past. There is the *Joint Strategic Needs Assessment* with local authorities and other partners and the World Class Commissioning process, which is both strengthening their core commissioning capability and is getting them to focus on alcohol as one of their priorities as part of their five-year strategic plans, so we think there are some positive signs there.

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Q90 Mr Mitchell: Is it not possible for me to say that you are pussy-footing around, you are not being as tough as you should be, you are not setting national standards in the way you should be, and the reason you are doing that is because you know that drink is the curse of the journalistic classes and there will be an outcry saying “It’s the nanny state”?

Mr Taylor: No, the reason that we have taken the approach we have done in relation to this for performance management purposes is that we want PCTs to look out to their populations rather than spending their time looking up to please us, and they should be making their own prioritisation decisions on alcohol—

Q91 Mr Mitchell: You should be pushing them.

Mr Taylor: I do not think we are pussy-footing.

Q92 Mr Mitchell: Let me turn to Dr Cavendish, It seems to me just as an observer (I was going to say as an alcoholic and a fat person!) you are being much tougher on obesity and much firmer about what people should do than you are on alcohol.

Dr Cavendish I think we are taking the same approach. Our approach is to educate and inform people to make healthy choices, to deal with a changed society so that it is easy for them to do so, and make sure we provide appropriate services that identify, advise and treat. Whether it comes to moving on food labelling, whether it comes to restricting alcohol advertising or food advertising, whether it comes to social marketing campaigns to give people the information and advice they need to make better decisions, it is a common approach because, you are right, we face common problems in both. They are both rising but they both cut to the heart of what individuals and families choose to do, so our approach has to be one about informing, advising and educating but creating a society in which people are better able to lead healthy lives. Those are our approaches in both obesity and alcohol.

Q93 Mr Mitchell: I think we have got a good drug treatment programme in North West Lincolnshire and it seems to be working okay, but alcohol abuse is the poor relation of drug treatment.

Mr Taylor: I think that is one of the reasons why your Primary Care Trust is one of those which is in the group of 20 which we have just announced—

Q94 Mr Mitchell: Could you give me some figures on that; I would like to have something to be proud of.⁸

Mr Taylor: Okay, what I am saying is we have given you some extra money and provided you with extra support from the centre, giving you the push that you need in order to increase access to specialist treatment for example.

Q95 Mr Mitchell: You have done research presumably. You did not want to commit yourself on the Treasury’s view on the taxation of alcohol, but the research must show that price is a big deterrent to boozing. I know we are the Labour Party and the Scots are very powerful and they are always wanting to protect the Scottish whisky industry, but we should really approach this by putting up taxation on alcohol because the costs have come down relative to the standard of living and wages, et cetera. The only real solution that is going to deter people is more expensive booze.

Mr Taylor: Well, leaving the question of taxation aside, which I get into at my peril—

Q96 Mr Mitchell: What does the research show?

Mr Taylor: The research shows there is a link between price and consumption and one of the things we are doing at the moment is we have asked group of specialists in the University of Sheffield to look at that as an issue and ministers are looking at their report as we speak.

Mr Mitchell: Thank you.

Chairman: I think we can now end our inquiry because of the multiple divisions. Thank you very much for your evidence. I do assure you that this picture by Jan Havicksz on the cover of the NAO Report of a drinking orgy is not a picture of the Committee of Public Accounts! Thank you very much.

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Supplementary memorandum from the Department of Health

Question 11 (**Chairman**): *Why have you had so much difficulty in getting your message across 13 years after you changed your guidelines?*

GETTING THE MESSAGE ON UNITS ACROSS, IMPROVEMENTS IN THE PUBLIC KNOWLEDGE AND UNDERSTANDING OF UNITS

Summary of advertising impact

- In line with all campaigns run by the Department, DH carried out pre and post campaign tracking.
- The campaign is performing well, as measured by good campaign awareness levels and increases in knowledge of units.
- There were 522 respondents to this tracking research, which was undertaken at mid wave (ie after the initial burst of advertising).
- The tracking research was carried out by TNS from 16 June—7 July 2008. (NB. This evaluation took place before the second wave of the campaign, which addressed the health consequences of drinking).

Level of recall

TV advertising was key in driving unit awareness—69% of respondents claimed it as their source of information. 61% said that, having seen the TV adverts, they had a better idea of the number of units in alcoholic drinks.

- Recognition of DH advertising was 66% (COI average for similar spend campaigns is 64%).—Rising to 73% when prompted.
- Recognition is higher amongst the 25–34 age group, at 85%, C1, C2s and harmful drinkers.
- Radio adverts had low recognition overall at 21% (COI average 34%) although they worked well for the harmful drinkers audience. They are not included in the next phase (November 2008—January 2009).
- Printed adverts worked well, with 38% recognition, against a COI average of 22%—with wine and lager doing especially well.

Knowledge of units

- More people are claiming knowledge of units already, but, when tested, this was still lower than claimed. However, there is a definite correlation between improved knowledge and the advertising campaign, for example, there were increases in units knowledge for wine:
 - At the pre-wave (ie before the campaign) only 7% of drinkers correctly said that there were 10 units in a bottle of wine (13.5% ABV) but this rose significantly to 13% at the mid-wave (after the initial burst of advertising);
 - At the pre-wave, only 6% correctly said there were three units in a large glass of wine (250ml at 12.5% ABV) but this rose significantly to 21% at the mid-wave.
- There has also been an improvement in the proportion of people giving the correct daily units guideline figures, from 29% to 34% saying that the recommended maximum number of units per day for men is three to four, and 37% (up from 34%) giving the correct answer of two to three for women.

Campaign reach

- The campaign is reaching a good proportion of the population:

85%	25–34;
78%	35–54;
72%	55–64; and
55%	65+.
- The campaign is doing particularly well with harmful drinkers; with 81% reach (73% sensible drinkers and 70% hazardous drinkers).
- Respondents' emotional engagement was sceptical, but in line with the results received on the binge drinking campaign, and good, considering the units message is one that people do not want to take on board. This “brick wall of refutability” was highlighted as a key challenge in the strategy.
- Impressions of the advertising are generally positive, with 3/4 of people saying it offers good advice.

- Relevance hovers at around 50% of people believing the adverts are for “people like me” but varies for different groups. It is higher for 25–34s (67%) and harmful drinkers (57%) and lower for 65 + s (22%).

At this stage of the campaign, shifts in attitudes are not really to be expected. Nonetheless, there has been an acceptance of the situation in the UK, with an increased agreement that we tend to drink more than is good for us; from 77–82%. (This has clearly been influenced by the campaign; for those aware of the campaign it rises to 85%, and for those not aware the figure is 72%).

However, again as expected at this stage, there is work to be done to maximise the campaign’s relevance across different groups in society and to motivate people to address the amount that they drink. (When asked if they should cut down on the amount that they drink, 66% of harmful drinkers and 54% of hazardous drinkers agreed).

WEBSITE TRACKING SURVEY

Use and usefulness of Units Website

Topline results on website use (19 May 2008—22 October 2008):

Visits 345,400
(Could include repeat visitors)

Unique visitors 312,990
(Those who visited the site once only)

Page views 1,122,895
New site visits 90.57%

Fieldwork

Fieldwork was conducted from 16 July to 8 August 2008, with 613 responses in total. The results are extremely promising with:

- 74% rating the website as excellent or very good, and most (81%) claiming they would recommend the site;
- 95% found the information easy to understand;
- 38% claimed they will try to keep track of what they drink;
- 33% will discuss units of alcohol with friends, family or colleagues; and
- 31% will try to stay within the recommended daily limits.

TNS Presentation to DH, HO and COI

The TNS full presentation of the interim findings from the TNS evaluation of the *Know Your Limits—Units Campaign* is attached.¹ The presentation was given to DH, the Home Office and the Central Office for Information on 2 September 2008.

KNOW YOUR LIMITS—UNITS CAMPAIGN—BACKGROUND INFORMATION

Reasons for the campaign:

- There are people of all ages who do not know their units or the guideline daily amounts for sensible drinking.
- Over the years, glass sizes and measures have increased, and so has the alcoholic content of many drinks. This makes judging units harder.
- Some people are still not aware of the links between alcohol consumption and harm to health.

Context of the campaign:

- In October 2006, DH launched the first ever Know Your Limits campaign aimed at 18–24 year old binge drinkers. This ran again in October 2007 and January 2008.
- In May 2008, DH broadened the focus of the Know Your Limits campaign, to include unit awareness. This Units campaign targets all drinkers over the age of 25.
- The Units campaign launched in May 2008 and a further burst runs from 17 November 2008, through to the end of January 2009.

Content of the campaign:

The campaign has two phases. Phase one focuses on helping people (25 +) to understand how many units there are in the alcohol they drink. Phase two promotes an understanding of the link between drinking alcohol and ill health.

¹ Not printed here.

The first burst of the campaign in May 2008 featured TV, outdoor, radio, press and online activity (including a new website nhs.uk/units). The campaign also included the provision of information and educational materials aimed at GPs and NHS staff.

Overall objectives of the campaign:

- to increase awareness of the units of alcohol in the most common drinks amongst the adult population aged 25+;
- to increase awareness of the recommended guideline daily amounts for sensible drinking (two to three for women/three to four for men);
- to increase understanding amongst the adult population of the health consequences of regularly exceeding the guideline daily amounts; and
- to highlight sources of support to change drinking habits.

Question 28 (Mr Bacon): *How many GP patients receive alcohol interventions following the introduction of the new DES?*

EXTENT TO WHICH GPs' PATIENTS RECEIVE ALCOHOL INTERVENTIONS FOLLOWING THE INTRODUCTION OF THE NEW DES

Directed Enhanced Services (DES) are incentives above and beyond the basic services in the GP contract. The alcohol DES is part of enhanced services under the GP contract, and is in addition to the services already provided by GPs.

From autumn 2008, the alcohol DES will target patients who are new registrations with GPs. GPs will screen these patients, identify misuse and provide brief advice or refer patients where appropriate. This is in addition to identification and advice already provided as a part of normal practice. (The NAO report found 45% of GPs regularly asked their patients about their alcohol use).

The new DES provides an incentive for GPs to identify more misusers and to provide interventions.

Target group

The average number of adult patients on a GP list is around 1,300. About 8% of adults change their GP or register with a GP for the first time every year. This amounts to approximately 3,300,000 new registrations annually.

These 3,300,000 newly-registered patients represent the target group for the DES.

DES details

The guidance provided to PCTs on the DES states:

Practices will be required to screen newly registered patients aged 16 and over using either one of two shortened versions of the World Health Organisation (WHO) Alcohol Use Disorders Identification Test (AUDIT) questionnaire: FAST or AUDIT-C. FAST has four questions and AUDIT-C has three questions, with each taking approximately one minute to complete.

If a patient is identified as positive, the remaining questions of the ten question AUDIT questionnaire are used to determine hazardous, harmful or likely dependant drinking.

Following identification, the practice should deliver a brief intervention to those identified as drinking at hazardous or harmful levels. Dependent drinkers should be referred to specialist services.

Local Enhanced Service (LES)

PCTs wishing to give alcohol a higher priority in primary care can choose to introduce a LES to target a wider patient group than those directed by the DES. Dr Hakin cited Lincolnshire as an example of a PCT introducing such a LES.

The Primary Care Service Framework, published by DH in May 2008, provides PCTs with the foundation for a LES. The Framework provides guidance for PCTs and Practice-based commissioners on the alcohol services best delivered in primary care. The Framework includes a sample care pathway, suitable for local modification, screening tools, intervention guidance and the relevant Read codes to record GP activity in this area.

ADDITIONAL RESOURCES TO SUPPORT GPs

Medical training on alcohol

Specific undergraduate medical training on alcohol, in place this year, will ensure that all of the 6,000 undergraduates who leave medical school each year have adequate training to recognise and address alcohol misuse in their patients.

DH has also worked with the Royal College of General Practitioners to provide training for GPs in identifying and supporting patients with alcohol problems.

E learning module

The e-learning for health facility on Identification and Brief Advice in Primary Care Settings is set for launch before the end of 2008. It will comprise an interactive, on-line training module to provide primary care professionals with the skills and knowledge to deliver information and brief advice to patients. This will be available on the newly-established Alcohol Learning Centre website at www.alcohollearningcentre.org.uk.

RESEARCH ON EXTENT OF GPs' ENGAGEMENT

ANARP

The Alcohol Needs Assessment Research Project (ANARP) research in 2005 found that GPs have always asked patients about how much alcohol they drink when they had concerns about them. It also found that GPs are the main source of referral to alcohol treatment services (after self-referral) and that they support many more patients within their practices.

NAO

The NAO survey of GPs found that 45% of GPs reported carrying out regular checks on their patients' alcohol use and 48% used a questionnaire to determine alcohol use for their new patients. Some 56% reported having undertaken alcohol misuse training during their basic medical training.

Question 57 (**Mr Davidson**): *To what extent is the industry genuinely committed to the voluntary labelling scheme on alcohol products?*

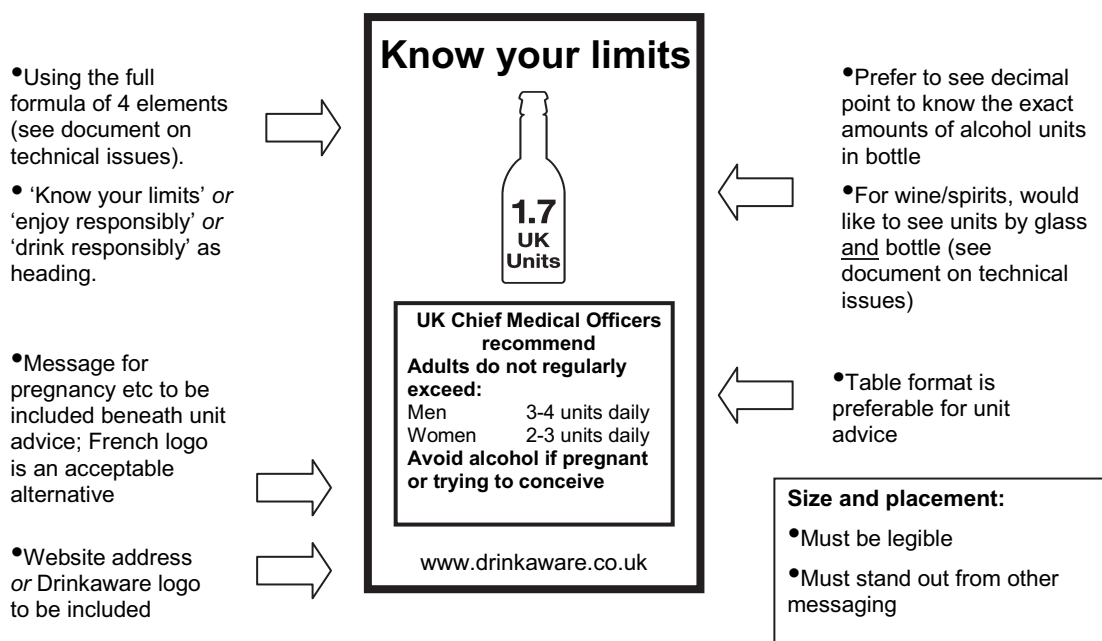
EVALUATION OF THE VOLUNTARY LABELLING SCHEME ON ALCOHOLIC PRODUCTS

The voluntary labelling agreement

In May 2007, the Government secured a voluntary agreement with the alcohol industry to introduce labels showing unit and other health information on alcohol drink containers, by the end of 2008.

The voluntary labelling agreement expects labels on each product to include units and health information as set out in the diagram below.

Proposed label format



The Government has asked the alcohol industry to include advice for pregnant women on labels “Avoid alcohol if pregnant or trying to conceive”. As an alternative, a logo is permitted, but the wording is preferred. The industry as a whole has not made a commitment to include this advice.

Monitoring the implementation of the voluntary agreement

In June 2007, the Government’s renewed alcohol strategy *Safe, Sensible, Social—the next steps in the National Alcohol Strategy* included a commitment to monitor the implementation of this voluntary agreement.

The Department of Health commissioned CCFRA (Campden and Chorleywood Food Research Association) to undertake a survey to monitor the extent to which the voluntary agreement has been followed.

The survey results on the extent to which the alcohol labelling agreement with industry has been implemented will inform the Government’s approach to the future control of unit and health information for alcoholic drinks.

Monitoring research: Method and objectives

In March 2008, CCFRA sampled nearly 500 product types, packaging formats and branded/own label products from over 60 major supermarkets, leading convenience stores and off licences to see whether they included unit and health information. Food Standards Agency guidance on Clear Food Labelling was used to select the criteria to assess whether or not such information, when present, was easy to find, read and understand.

The objective of the monitoring survey was to conduct a market survey of the labels of alcoholic drinks available on the UK market as a whole, in order to assess the extent to which the voluntary labelling agreement was being implemented at that time.

The CCFRA survey findings include information on brands and compliance with the agreement amongst those sampled. This information is provided with the report.

Note that the objective was not to actually compare compliance between different producers or brands, and the sample results cannot be used in a statistically valid way for this purpose.

The full research findings of the CCFRA survey were published July 2008, as *Monitoring Implementation of Alcohol Labelling regime (including advice to women on alcohol and pregnancy)*. The report is available on the DH website at: http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_086412

Monitoring research: Conclusions

CCFRA concluded that sensible drinking information on labels of alcoholic drinks is only being used to a limited extent and that there was a wide variety in the elements included on the labels and how they were portrayed.

CCFRA recorded the following variations (among others):

- 57% of the assessed samples contained some information regarding UK units; and
- the CMOs’ sensible drinking guideline information was only found in the agreed format on 2.4% of the samples.

On pictorial representation of a pregnant women:

- 2% (nine out of 458) of samples used the pregnancy statement; and
- 14.4% (66 out of 458) of samples contained the pregnancy logo.

We are in discussion with the alcohol industry about the way in which market share will be reported in the findings, and this may mean small revisions of these percentages (likely to be slightly upwards) when the final data on compliance with the agreement are published next Spring.

Note on Diageo

Diageo accounts for between a fifth to a quarter of the UK drinks market and its response to the Government’s consultation on alcohol *Safe, Sensible, Social—Consultation on further action* (July–October 2008) included the following:

“[. . .] we are opposed to measures such as pricing restrictions, a statutory retailing code, health warning labels and end frames on advertising that are unproven, without an evidence base and have very considerable unintended consequences.”

Question 61 (Mr Davidson): *How is it alcohol abusers can get enhanced benefits through the benefit system?*

ALCOHOL DEPENDENCY AND BENEFIT ENTITLEMENT

- Alcohol dependency does not bring benefit entitlement.
- Entitlement to incapacity benefits depends on the effect that a person's condition, or conditions, have on their capability for work rather than the condition itself.

Medical test of incapacity

The medical test of incapacity for work is the Personal Capability Assessment (or Work Capability Assessment for Employment and Support Allowance customers). This assesses the effects of a person's condition on their ability to carry out a number of everyday activities relevant to work.

A majority of people with a recorded diagnosis of alcohol dependency also have other diagnoses, for example mental illness, which result in their incapacity for work.

Employment and Support Allowance

Employment and Support Allowance (ESA) is a new way of helping people with an illness or disability to move into work, rather than stay on benefits.

Employments and Support Allowance was introduced in October 2008 and replaced Incapacity Benefit and Income Support paid on incapacity grounds for new customers.

Existing customers in receipt of Incapacity Benefit or Income Support prior to the introduction of Employment and Support Allowance continue to receive their existing benefits, so long as they continue to satisfy the entitlement conditions.

Benefits Reform

The recent DWP Green paper *No One Written off: Reforming Welfare to Reward Responsibility*, published on 21 July 2008, offered a consultation framework on how best Jobcentre Plus might draw more people currently in receipt of benefit into employment.

The consultation closed on 13 October 2008 and officials are considering the responses. The Green Paper can be found on the DWP website at: <http://www.dwp.gov.uk/welfarereform/noonewrittenoff/>

Question 66 (Mr Davidson): *Have you been speaking with the glassware industry about the size of glasses as well as those in pubs and clubs? (this also picks up the Chairman's line of questions in 12–13 and Mr Bacon's 33–35)*

THE GLASSWARE INDUSTRY

No national data is collected on size of glasses sold for domestic use. The ONS estimates that the typical size of wine glass drunk is 170ml (this includes drinking in the home).

Government has not had discussions with the glassware industry on this issue, but would expect that a range of glass sizes should be on offer to the public and to industry. We have received no representations suggesting that this is not the case.

REGULATION OF GLASS SIZES (QQ 12–13)

Unit Content of typical servings

A 12% ABV wine would contain the following number of units:

125ml glass = 1.5 units

175ml glass = 2.1 units

250ml glass = 3 units

A 40% serving of spirits could contain the following number of units:

25ml "single" = 1 unit. "Double" = 2 units

35 ml "large single" = 1.4 units "Large double" = 2.8 units.

This means consuming a 250ml glass of wine, or a large double spirits, could represent an individual's recommended regular daily limit (two to three units for women, three to four units for men).

How unit intake corresponds to drink driving limits

The blood alcohol limit for drivers is 80 milligrammes of alcohol in 100 millilitres of blood (80mg/100ml). One unit of alcohol is usually reckoned to equate to 15mg.

As a rough guide to alcohol absorption, for an 11-stone man drinking two units of alcohol quickly on an empty stomach, the alcohol content his blood will rise to a peak of 30mg/100ml after about an hour. His blood alcohol level would rise still higher if he were to drink at a rate of more than one unit an hour.

Susceptibility to alcohol varies from one person to another, depending on a range of physical factors, including weight, gender, age and general metabolism. There is no certain way of judging how much an individual can drink and stay under the legal alcohol limit or drive safely.

Any amount of alcohol will affect judgement to some degree, including whether to have another drink or not.

The Government continues to stress the only safe option:

- avoid even the smallest amount of alcohol when driving.

LEGISLATION CONTROLLING GLASS SIZES IN LICENSED PREMISES (QQ33 – Q35)

DIUS (through the National Weights and Measures Laboratory (NWML)) has responsibility for weights and measures policy and legislation which sets out the specified quantities in which alcohol may be sold by the glass. The aim in regulating the sizes of glass is to ensure that consumers have access to information on the quantities of alcohol being offered and that they can easily tell the difference between the sizes, allowing them to monitor their intake and to make cost and value comparisons more easily.

Under existing weights and measures legislation (the Weights and Measures (Intoxicating Liquor) Order 1988):

- wine may only be sold by the glass in 125 ml, 175 ml or a multiple of those sizes (eg 250 ml).
- spirits may only be sold in servings of 25ml or 35ml; or a multiple of those sizes (eg a 50ml double).
- beer may be sold in $\frac{1}{3}$ pint, $\frac{1}{2}$ pint or 1 pint. (NWML are consulting on whether to permit sale of $\frac{2}{3}$ pint).

However, licensees remain free to choose which of these sizes they offer to their customers.

Sizes available to consumers

National data is not collected on glass sizes. However, a growth in the number of pubs that only offer alcohol for sale in larger servings has been widely reported by the media.

Media coverage earlier this year highlighted a perceived growth in the use of 250 ml wine serving and the decline in the use of 125 ml. The Royal College of Physicians (and others) have claimed that a growth in the use of larger sized servings of wine by the glass has had a detrimental effect on health.

The KPMG review of alcohol industry social responsibility principles, published in July 2008, found evidence of pubs/bars promoting bigger wine glass sizes, plus use of doubles as a default spirits measure, as well as an association with drunkenness.

In 2007, the Office for National Statistics (ONS) estimated the average wine glass size drunk is 170ml (this includes drinking in the home). This has risen from 125ml in the 1970s.

A recent survey by The Publican trade magazine found that 16% of pubs claimed that 125 ml was their “normal” size for the sale of wine by the glass, 70% claimed that 175 ml was their normal size while 14% of pubs claimed that 250 ml was their normal size.

Action in this area by DH and DIUS

In October 2008, the National Weights and Measures Laboratory (NWML) issued a consultation on the future of specified quantities. The consultation focuses on the deregulation of specified quantities for all pre-packaged goods (apart from wines and spirits) by implementing a recent EU Directive (2007/45/EC). It also sought views on whether the existing specified quantities for non-bottled alcoholic drinks (which are outside the scope of the Directive) remain appropriate.

DIUS has not proposed major changes. Its consultation closes in January 2009.

The Department of Health recently consulted on the principle of a mandatory alcohol retail code. The consultation identified glass sizes as a possible ingredient of the code. For example, premises could be required to offer customers the choice of the smallest standard size of glass permitted under legislation.

Ministers are still considering the responses to the consultation and will make an announcement in December. Should government announce a mandatory code, it would develop the detailed content of this in 2009.

Private Members Bill on Sale of Wine

Greg Mulholland MP, the Shadow Lib Dem Health spokesperson, tabled a Private Members Bill which would require all licensed premises to sell wine in a 125 ml size (in addition to any other size they may offer) in order to ensure consumers have the choice of this smaller size. Due to lack of time in the 2007–08 parliamentary session, the Bill did not receive a second reading.

The Government did not support the Bill, on the basis that DIUS would soon be consulting on the issue of wine glass sizes generally, and because existing statutory powers mean primary legislation is not necessary in this area.

Question 68 (**Dr Pugh**): *How much of the provision of specialist rehabilitation services is by the independent sector?*

EXTENT OF PROVISION OF SPECIALIST REHABILITATION SERVICES BY THE INDEPENDENT SECTOR

Estimate of extent of provision by the independent sector

The Alcohol Needs Assessment Research Project (ANARP), published in autumn 2005, presented information at a national and regional level on the range of alcohol use disorders in the population and the range and extent of services available to offer treatment for alcohol problems. This included the classification of agencies providing services by sector and service type.

The ANARP findings suggested that the NHS accounted for around a third of providers (33%) and that the independent sector accounted for just over 60% of providers (Voluntary sector 53.4% and private sector 7.7%). These findings were based on the sample of providers responding to the ANARP survey.

Most services in the independent sector are supported by funding provided by the local PCT, or by the local authority, or both.

PCTs' spend on alcohol services

DH does not collect detailed information on PCTs' spend in this area. DH made a very clear decision to lift the burden of data collection on PCTs. This data would tell us very little about service access, quality or effectiveness. These are the factors which really matter to NHS patients. DH would expect this information to be held locally in some form to enable cost-effective commissioning of services in line with need.

DH has focused on securing data on need and service delivery outcomes. For example:

Local Alcohol Profiles for England (LAPE)

Since October 2007, LAPE have provided an arrangement of local health and social indicators relating to alcohol harm to underpin PCTs' local needs assessment, planning and commissioning. Details at: <http://www.nwph.net/alcohol/>

National Alcohol Treatment Monitoring System (NATMS)

Established in April 2008, the NATMS provides detailed performance data on the provision of specialist alcohol treatment services, including the numbers of people in treatment for dependency.

Details at: <http://www.ndtms.net/alcohol.aspx?level=datagcy>.

Question 76 (**Dr Pugh**): *What is the cost to society of alcohol harms?*

COSTS TO SOCIETY OF ALCOHOL HARMS

- *Safe, Sensible, Social—Consultation on further action*, published on 22 July 2008, shows that we now estimate the total cost of alcohol harm to society to be between £17.7 billion and £25.1 billion a year.
- Of this total, the costs to the NHS in England are estimated at £2.7 billion per year.
- The consultation document also provides a broad overview of the social impact of alcohol misuse in its introduction and opening sections.

Safe, Sensible, Social—Consultation on further action Impact Assessments, published to accompany the consultation, includes details of the costs of alcohol related crime. (See Appendix 2 of the document). An outline of the key findings is below.

The cost of alcohol harm to the NHS in England—An update to the Cabinet Office (2003) study, also published to accompany consultation, sets out details of the costs of alcohol related harm to the health services. An outline of the top line estimates from this is below.

The *Safe, Sensible, Social* consultation, and the suite of accompanying documents published with it, can all be found on the DH website at: http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_086412

Earlier studies of the costs of alcohol harm

An earlier study of the costs of alcohol was published in 2003, by the Cabinet Office *Alcohol Misuse: how much does it cost?* A report by the Cabinet Office Strategy Unit, *Alcohol harm reduction strategy* followed in 2004.

These documents considered the financial and social costs to family and social networks, and costs to the workplace, in addition to the costs of crime/public disorder and those in the health services.

The relevant documents can be found on the Cabinet Office website at: http://www.cabinetoffice.gov.uk/strategy/work_areas/alcohol_misuse.aspx

Outline costs of alcohol-related crime

- Updated estimates on the costs of alcohol-related crime were provided the Home Office and included in the Impact assessments published with the consultation.
- The total costs of alcohol-related crime are estimated to be £9–15 billion

The costs of alcohol-related crime were calculated in three parts:

- (i) the costs associated with general offences that are estimated to be attributable to alcohol;
- (ii) alcohol-specific offences and their estimated cost to the criminal justice system; and
- (iii) costs associated with the issuing of PNDs for alcohol misuse and alcohol-related crime and disorder.

The greatest part of the total cost of alcohol-related crime stems from the cost of general offences related to alcohol misuse.

The costs associated with general offences that are attributable to alcohol are estimated at £8.75–£14.78 billion.

Alcohol-specific offences and their estimated cost to the criminal justice system are estimated at £208 million.

Costs associated with the issuing of Penalty Notices for Disorder (PNDs) for alcohol misuse and alcohol-related crime and disorder are estimated at £3.3 million.

Costs of alcohol-related harm to the NHS in England

- The total cost of alcohol harm to the NHS is estimated as £2.7 billion per annum in 2006–07 prices.

This new estimate of the costs is significantly higher than the previous Cabinet Office (2003) estimates.

Three core factors that will drive increases in these costs are:

- NHS unit costs will have increased over time, partly due to inflation.
- More accurate data is now available, including improved estimates of the number of drinkers at “increasing risk” and “higher risk”.
- Increasing numbers of alcohol-related admissions also suggest that the cost has risen.

ESTIMATED BREAKDOWN OF THE TOTAL COSTS TO THE NHS

<i>Cost Estimate (2007/07 prices)</i>	<i>(£m)</i>
Hospital inpatient & day visits	
— Directly attributable to alcohol misuse	167.6
— Partly attributable to alcohol misuse	1,022.7
Hospital outpatient visits	272.4
Accident and emergency visits	645.7
Ambulance services	372.4
NHS GP consultations	102.1
Practice nurse consultations	9.5
Laboratory tests	N/A
Dependency prescribed drugs	2.1
Specialist treatment services	55.3
Other health care costs	54.4
Total	2,704.1

BACKGROUND TO THE ESTIMATES

The discussion and calculations that underpin these figures are set out in *The cost of alcohol harm to the NHS in England—An update to the Cabinet Office (2003) study*. This document sets out the methods and assumptions on which these figures are estimated.

A significant caveat relates to the number of hospital admissions on which these figures are partly based. Although we can accurately measure the number of alcohol specific admissions to hospital (based on alcohol specific illnesses, such as acute alcohol poisoning and alcoholic liver disease) we can only estimate the number of alcohol attributable admissions (such as those for stroke, cancer and coronary heart disease, caused by other factors as well as alcohol).

The use of alcohol attributable admissions data provides a much more comprehensive picture, but it introduces a new data source where further refinements will be made in future to make these data more robust.

ALCOHOL RELATED HEALTH HARMS TO SOCIETY

Key facts and Statistics

- Over a quarter of the population (10 million adults) regularly drink above DH guidelines accounting for 3/4 of consumption in UK.
- 2.6 million adults regularly drink at higher-risk level—8% of men and 6% of women. This 7% of the population drink a third of all the alcohol consumed.
- The affordability of alcohol doubled between 1970 and 2001.

Morbidity

People who regularly drink above lower-risk levels are:

- 4.5 times more likely to get cancer of the mouth, neck and throat;
- 3.5 times more likely to get liver cancer;
- at 2–4 times the risk of high blood pressure;
- more than twice as likely to suffer from an irregular heartbeat; and
- 13 times more at risk of liver cirrhosis.

Other risks are fatigue, depression, weight gain, memory loss, poor sleep and sexual difficulties.

In addition:

- Women are nearly 2.5 times more likely to get breast cancer.
- Men aged 34–64 constitute the largest single group of those admitted to hospital as a result of their drinking.

Mortality

- From 1993 to 2006, the number of deaths from chronic liver disease in England more than doubled, from 2,774 to 5,852.
- Average age at death from chronic liver disease is 59 and falling.

ALCOHOL RELATED INEQUALITIES

Compared to more affluent areas, as a result of excess alcohol use areas of highest deprivation have:

- Two to three times higher loss of life.
- Two to five times more admissions to hospitals.

IMPACT ON THE NHS

- Alcohol misuse is calculated to cost the health service £2.7 billion per annum.
- In 2006–07, there were 811,443 alcohol-related hospital admissions.
- That is, 6% of all hospital admissions are alcohol related.
- They are rising by around 80,000 admissions a year.
- Men aged 35–74, drinking at increasing-risk and higher-risk levels are responsible for 44% of all alcohol-related hospital admissions.
- Up to 35% of all A&E attendance and ambulance costs may be alcohol-related.

IMPACT ON WIDER SOCIETY

Disorder

- A fifth of all violent incidents in 2005/06 were committed in or around pubs.
- 63% of 18–24 year old drinkers admit to committing criminal or disorderly behaviour while drinking.
- Around half of all violent incidents take place on a Friday or Saturday, between the hours of midnight and 6am.
- The British Crime Survey shows that 46 per cent of victims of violent incidents believed the offender to be under the influence of alcohol.
- 76,000 facial injuries in the UK each year are linked to drunken violence.
- Alcohol is a major factor in 33% of burglaries and 50% of street crime.

Accidents

- Alcohol features in around 20–30% of accidents. Drunken drivers are another clear hazard, including for passengers and for pedestrians.

Supplementary memorandum submitted by the NAO

Questions 93–94 (Mr Austin Mitchell): *Investment in Alcohol Services in Lincolnshire*

- As part of the Alcohol Improvement Programme launched by the Minister for Public Health in November 2008, 20 “Early Implementation” (EI) PCTs have been selected to “go further a little bit faster” in implementing improvements to reduce alcohol related admissions.
- 35 PCTs with high levels of alcohol-related hospital admissions were invited to bid to be Early Implementation PCTs.
- Two of the 20 successful PCTs selected from those invited to bid are: North East Lincolnshire Care Trust Plus and North Lincolnshire PCT
- Each of the successful PCTs has been awarded £150,000 in 2008/09 to help them deliver better local alcohol services.
- In addition, all the EI PCTs will be supported by the National Support Team (NST) which will visit them and advise.
- These extra resources will support the 20 EI PCTs in improving their services and their overall response to alcohol misuse.

BACKGROUND TO THE EARLY IMPLEMENTATION PROGRAMME

Invitations were sent to the 35 PCT Chief Executives, whose areas have the highest level of alcohol related hospital admissions (based on 5 years of admissions data) to invite them to apply to become an Early Implementation (EI) site for the Alcohol Improvement Programme.

To be selected as an EI PCT, PCTs were asked to demonstrate:

- a commitment to reducing alcohol related admissions by including an alcohol target within their local NHS Operational Plan and Local Area Agreement, with a challenging target to reduce admissions;
- a clear plan of action based on an assessment of local needs and a plan to evaluate the impact of interventions and treatments; and
- a willingness to invite the National Support Team (NST) on Alcohol to visit their area in 2008/09 or 2009/10 and a willingness to disseminate the learning from being an EI PCT to other PCTs.

LIST OF SUCCESSFUL EARLY IMPLEMENTATION PCTs

Newcastle PCT
 Middlesbrough PCT
 Heart of Birmingham PCT
 Knowsley PCT
 Manchester PCT
 Ashton, Leigh & Wigan PCT
 Warrington PCT
 Leicester City PCT
 Nottingham City PCT
 North Tyneside PCT
 Stoke-on-Trent PCT
 North Lincolnshire PCT
 South Birmingham PCT
 Newham PCT
 North East Lincolnshire Care Trust Plus
 Bolton PCT
 East Lancashire PCT

Darlington PCT

Oldham PCT

Blackpool PCT

Yorkshire and Humber: SHA assessment of services the area needs

Alcohol is one of the biggest population threats in Yorks and Humber, with over one third of adults drinking more than the recommended daily allowance, many with high levels of dependency. Focus groups in the area indicate that the risks associated with alcohol are not properly understood.

Key areas for action identified by the SHA are:

- The NHS in Y&H should improve screening and identification of people with alcohol use problems.
- PCTs should commission the systematic use of brief interventions to “industrialise” their use across NHS services.
- PCTs should commission a range of ‘tiered’ services to cope with people who present with different levels of alcohol dependency and ensure simple referral routes are accessible from screening points.
- PCTs should commission alcohol services separately from drugs misuse services as the evidence suggests that people with alcohol problems are more likely to use separate rather than shared services.
- The NHS should work with other organisations to reduce the accessibility of alcohol, including an increase in its price.

North East Lincolnshire investment in alcohol services

North East Lincolnshire PCT reports that it is investing in the following alcohol services to improve the health of its local population:

- Alcohol Prevention Programme Coordinator (Local Authority funded—£40K)—a specialist health promotion post within Public Health to work in schools and the community, and link in with the Alcohol and Violence Champion.
- Two alcohol outreach posts (CTP posts—£40K)—Attached to Drug and Alcohol Intervention Programmes and providing services to the partnership’s anti social behaviour, family intervention, domestic violence and neighbourhood safety teams.
- Community Alcohol Team (PCT Commissioned Service—£120K)—Three alcohol workers and administrative support have begun to provide identification and brief advice as well as extended interventions at A & E and in primary care.
- Specialist Alcohol Service (PCT Commissioned Service—£175K)—community based alcohol withdrawal (detoxification) service that provides ongoing medical and counselling support linked to the Community Alcohol Team.
- Specialist Young People’s Service (PCT Commissioned Service—£306K)—managed by Children’s Trust and the DAAT, providing all substance misuse treatment and support with a multi agency integrated team.
- In-Patient Detoxification (spot purchase—£80K). At present there are no local in- patient hospital facilities but negotiations are well advanced with the local acute trust hoping to develop such a service in 2009–10.
- Structured Day Programme (Commissioned Service—£100K) providing daily support to individuals recovering from alcohol misuse. Also provides assistance with accommodation, training, education and employment.

North East Lincolnshire PCT reports that it is investing in the following services to address crime related to alcohol misuse:

- Alcohol and Violence “Champion” (Police funded—£45K)—a police inspector post, initially Neighbourhood Renewal funded but now mainstreamed. The role is to coordinate criminal justice/trading standards/licensing/ publicity activity. That includes an ongoing policing operation aimed at the night time economy known as *Operation Nightsafe*, incorporating Nightsafe Marshalls; ongoing test purchase operations directed at under age sales; establishing licensing enforcement activity etc.
- Alcohol Intervention Programme (AIP) (Commissioned service—funded by Home Office (£68K) and Partnership (£60K)—£128K total)—The PCT is to become a Home Office pilot site for an AIP. The PCT Partnership had already found the funding to commence this service in the police custody suite but was then invited to apply for Home Office pilot status. This was granted on 18.8.08 but as the PCT was about to launch its own service, the HO pilot has been running since 1 September

2008. This will identify problem drinkers who are committing offences and offer brief and extended interventions and signposting to specialist treatment services, as well as addressing offending behaviour. It will offer pre and post sentencing options to the courts.

- Alcohol Treatment Requirements (ATRs) (Commissioned service—funded by Partnership—£50K)—The PCT was one of the first areas in the country to make this sentencing option available to the Courts.
- COVAID (Probation Service intervention—mainstream Probation—£45K). A Probation delivered intervention for the Control of Angry, Violent and Impulsive Drinkers, with links to ATRs and the AIP.
- Probation Service Brief Interventions (mainstream Probation delivery)—Humberside Probation Trust will pilot the mainstream delivery of brief advice to its clients, with referral into other alcohol services as needed.

Support services for all provided in North East Lincolnshire:

- CADES Training and Accreditation—(Partnership funded—£40K)—this free (or nominal charge) training and accreditation on alcohol and drug issues is available to the community and all local agencies. It provides credits towards a foundation degree.
- Service User Support Group (Volunteers—Partnership funded—£50K)— a very active service user group, is managed by an ex drug user and assisted by 11 volunteers. They offer outreach support, mentoring, signposting and numerous activities and therapies to drug and alcohol users, whether or not they have had contact with our treatment system.

Further information on the Alcohol Improvement Programme

- Some 99 PCTs have prioritised alcohol within their operating plans. These PCTs need information and support to deliver their plans effectively.
- The Alcohol Improvement Programme (AIP), launched by MSPH at the National Alcohol Conference in Nottingham on 5 November 2008, brings together all the relevant support PCTs need.
- The Alcohol Learning Centre is a comprehensive on-line resource at the heart of the Improvement Programme. It houses the support that PCTs need to plan and implement effective action to tackle the alcohol-related harm in their localities. (website at: www.alcohollearningcentre.org.uk).
- The ALC provides a wide range of local data and guidance materials for PCTs designed to help them to carry out accurate Joint Strategic Needs Assessments and to commission effective alcohol interventions.

SUPPORT MATERIALS AVAILABLE TO PCTs

The Alcohol Learning Centre materials include:

- *Local Alcohol Profiles for England (LAPE)* (published October 2007). Web-based resource to support Joint Strategic Needs Assessment the North West Public Health Observatory (NWPHO) has produced the first local alcohol profiles set covering a range of indicators ranging from binge drinking levels, through specific alcohol related diseases and alcohol related hospital admissions to crime attributable to alcohol, including violent crime and sexual offences.
- *Alcohol-related admissions trends data guidance and a trajectory planning tool* (published June 2008). DH provides quarterly and annual admissions trend data for every PCT against each of the conditions which are significantly (> 20%) attributable to alcohol. These data show existing trends in alcohol related ill-health for every PCT and provide a baseline against which PCTs can measure their delivery of the indicator.
- *Joint Strategic Needs Assessment* (published December 2007). Generic guidance which complements the statutory guidance on JSNA, *Creating Strong, Safe and Prosperous Communities*, provides tools for local partners undertaking JSNA. It describes the stages of the process, including stakeholder involvement, engaging with communities and recommendations on timing and linking with other strategic plans. It also contains guidance on using JSNA to inform local commissioning, publishing and feedback.
- *Models of Care for Alcohol Misusers (MoCAM)* (published 2005). Sets out best practice guidance for commissioning and delivering a planned and integrated local system of alcohol interventions. MoCAM describes a framework for planning and delivering alcohol interventions. By mapping existing services available in an area against the 4 tiers detailed in MoCAM, gaps in the range of interventions and the level of service capacity can be compared with the levels of locally identified need.

- *Review of the Effectiveness of Treatment for Alcohol Problems*. This review is a critical appraisal of the evidence base for the treatments available for people with alcohol problems. The review covers interventions ranging from simple advice and mutual aid to intensive specialist treatment. It was written to inform Models of Care for Alcohol Misusers (MoCAM).
- *The Hub of Commissioned Alcohol Practice and Policies (HubCAPP)*. A continually developing database of current practice to reduce alcohol harm. The database provides commissioners with examples of reliable and innovative practice across the country and the local policy levers which brought them into being. As the initiatives mature over time, it will be possible to show their efficacy so that they can be emulated elsewhere.

FORTHCOMING RESOURCE TO BE ADDED TO THE ALCOHOL LEARNING CENTRE

- Before the end of 2008, DH aims to publish *Joint Strategic Needs Assessment and Commissioning to address alcohol-related harm*. The document is set in the context of the World Class Commissioning competencies and will provide commissioners with guidance, tools and resources for assessing and tackling alcohol-related harm. Inter alia, it will direct commissioners to all the other support and documents available.

Memorandum submitted by Department of Health, Alcohol Know Your Limits

NATIONAL ALCOHOL HARM REDUCTION CAMPAIGN

The Department of Health launched its 'Safe. Sensible. Social.' alcohol strategy last year. The strategy sets out Government actions and commitments to combat excessive alcohol use, specifically its impact on health, crime and disorder.

THE NATIONAL CAMPAIGN

On 19 May the Government is launching a campaign to raise awareness of alcohol units and the health risks of regularly exceeding Government 'lower-risk' drinking levels. The campaign is driven, in part, by research and evidence that shows that:

- NHS admissions for alcohol-related illness are rising fast year-on-year.
- Between 15,000 and 20,000 premature deaths in England and Wales each year are associated with alcohol misuse
- There are over 10 million people drinking above the Government's lower-risk levels
- Most people drinking above lower risk levels are unaware of the potential health risks

A first phase of a national advertising campaign, will explain how many units there are in typical alcoholic drinks, and what are the lower risk levels of drinking. The second phase of advertising will draw attention to the health risks of regularly exceeding these lower risk levels.

The advertising will be supported by a new NHS website (www.nhs.uk/units). For those people who identify that their drinking is above lower risk levels and are interested in cutting down, there will be support available in the form of a self-help booklet and a telephone helpline.

YOUR SUPPORT AS A KEY HEALTHCARE PROFESSIONAL

As part of the campaign, the Department of Health has been working with leading clinical experts to help develop and test materials that will support you and your colleagues to be able easily and quickly to identify patients whose drinking is putting them at risk, as well as materials that will support you in providing them with advice on how to reduce their risks.

As a healthcare professional, your role is vital in supporting your patients to address this problem but the campaign also directs individuals to self-help programmes and other support, in recognition that this may be all that is needed for many.

This campaign forms a key element of a developing public health approach to this problem. It will assist the public to improve their own general health and well-being and it will also support you as health practitioners in contributing to this.

The Chief Medical Officer welcomes and supports this campaign, as do the Royal College of General Practitioners, Royal College of Nursing, Royal College of Physicians and Royal College of Psychiatrists; and I invite you to do the same.

MATERIALS TO HELP YOU

A number of materials will be freely available for you to use to coincide with the launch of the campaign. The following materials will be available on May 19th at: www.nhs.uk/alcoholstakeholders:

- A fact sheet—providing you and colleagues with general alcohol information including information about units and levels of risk.
- A quick-reference wall chart.
- A fold-out card for patients explaining recommended lower risk limits; and some tools and contacts for support, for those who decide to cut down.

In early July, The Department of Health will also be launching an e-learning training module for practitioners on the use of alcohol interventions and brief advice.

Thank you for your continued support. Please stay in touch with the campaign at www.nhs.uk/alcoholstakeholders.

Dr Will Cavendish
 Director of Health & Wellbeing
 Department of Health

ANNOUNCEMENTS AND PUBLICATIONS: 3 DECEMBER 2008

ANNOUNCEMENTS

New legislative powers to create a mandatory code of conduct

The Government intends to introduce a new mandatory code of practice which will set out compulsory licensing conditions for all alcohol retailers and will target irresponsible promotions and retail practices. The Government will seek to legislate for the power to impose a mandatory code for alcohol retail and will consult shortly on what measures to include in the new code.

The mandatory code will be enforced through the current licensing regime and will apply to all premises licensed to sell alcohol—including private members clubs. Any breach of the conditions will lead to a review of the licence (and possible loss of the licence).

Enforcement campaign

Under this crackdown on alcohol fuelled crime and disorder, Crime and Disorder Reduction Partnerships are being awarded a £3 million cash injection to target enforcement activities on specific alcohol-related problems in 190 areas across all police forces. An additional £1.5 million will be given to a number of priority areas to strengthen their ability to tackle alcohol related crime and disorder in their local area.

PUBLICATIONS

Consultation Report, Safe. Sensible. Social.—Consultation on Further Action

The report on the consultation, published by the Department of Health summarises the responses that were received to the consultation. It aims to provide a representative summary of all the responses, drawing out the key themes and messages:

Link: <http://www.dh.gov.uk/en/index.htm>.

University of Sheffield report: *The Effects Of Alcohol Pricing And Promotion*. This review by the School of Health and Related Research at Sheffield is a very detailed study, examining a wide range of policy options. (See Part A, Part B and Summary of Evidence). The Government will be evaluating these before deciding whether or not to act in this area:

Link: http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_4001740

Memorandum from Alcohol Concern

Following the publication of the National Audit Office value for money report examining alcohol related harms we understand that the Public Accounts Committee oral evidence session will look at this issue further on 12 November. Alcohol Concern, as the national agency on alcohol use, wanted to highlight to you what we believe to be the most important issues revealed by the NAO report.

1. Primary care trusts have to lead on the reduction of alcohol related harm. The NAO report showed that too often PCTs fail to communicate clearly with local delivery partners or partnerships such as the Drug and Alcohol Action Team or the Crime and Disorder Reduction

partnership. PCTs must therefore show clearer leadership and be directly accountable for reducing alcohol related harm and hospital admissions, even if delivery of services are devolved to local agencies.

2. At present, the Vital Signs Indicator within the NHS operating framework for reducing alcohol related hospital admissions is a Tier 3 target. To assist PCTs to better perform this role it is essential that the Indicator is elevated from a Tier 3 to a Tier 2 target. This would ensure that reducing alcohol related harm becomes a national priority for local delivery and would entail greater performance management by Strategic Health Authorities. This would put the priority to tackle alcohol related hospital admissions at the same level as ensuring that drug users are receiving effective treatment. This should be seen within the context of alcohol related problems costing the country £25 billion compared to the £5 billion caused by illicit drug use.
3. There are currently no clear guidelines about what constitutes a reasonable waiting time for those wishing to access specialist alcohol treatment. The Department of Health has recognised that the most effective way to reduce alcohol related hospital admissions is to ensure that dependent drinkers can access alcohol treatment. Alcohol Concern's research has show that drinkers can face waiting times of up to 12 months to access specialist services. As the NAO report mentions there is a target set for both America and Canada in terms of gaining access to treatment. To ensure that there is greater access to treatment there should be a benchmark for treatment access, so that those who require it are able to receive it. This would act as a lever for PCT funding to be made available to fund specialist alcohol services. Equally, as currently exists for problem drug users, there should be a minimum waiting time for those that want to access alcohol treatment, especially as tackling these problems are often time critical.

We welcomed the findings of the NAO report and hope that government will use it as an opportunity to put in place the systems and funding that will ensure that tax payers are not only getting value for money but are able to access the services they need.

11 November 2008

Memorandum from Pat Brazzier

RESPONSIBLE DRINKING MESSAGES

I understand from various press releases that Dr Will Cavendish has told the Public Accounts Committee that Diageo are one of the worst offenders when it comes to voluntary agreements on responsible drinking labelling.

I work in the Market Research business and specifically with Spirits and Wine. Perhaps Dr Cavendish should spend some time visiting retail establishments or visit websites relating to sensible drinking levels—it is totally misleading to inform the committee that Diageo are one of the worst offenders.

In fact “the worst offenders by far” with regard to “responsible drinking messages” are Supermarkets.

The **Social Responsibility Standards** were launched in November 2005—these standards included:

7.6 Siting of alcohol in the store

7.6.2 Alcohol is a key target for shop thieves, where practicable, it is best not to place alcoholic drinks near the entrance to the store.

7.7 Other measures

7.7.1 Retailers are encouraged to display information at each alcohol display area and at the point of sale regarding sensible drinking levels and sensible drinking messages.

In fact producers pay to have their brands (usually packs of beer) at the main entrance and in some cases on the tills in supermarkets and in almost all cases without any signs relating to age or sensible drinking levels.

Also outside the main area, supermarkets display alcohol brands and on some occasions have signs that relate to age but NEVER display signs relating to sensible drinking levels either on these displays or at the till. Only Tesco have signs relating to sensible drinking levels but only in some of the main aisles.

Some supermarkets are happy to place alcohol brands together with packaged water brands next to each other in the same aisle without any signs at all relating to age or sensible drinking messages. Under a previous Portman Group Code of Practice this would not have been allowed but this part of the Code was withdrawn from 1 March 2003. This part of the code included “displays should have signs to indicate that the products were specifically marketed as alcoholic and also signs to indicate that the products were for sale to over 18s only”.

I understand that the Irish Government is considering a change in policy which will mean food and alcohol products will be separated and that alcohol brands will have to be displayed in one place only. The aim is to end the impression that “alcohol is just another grocery product”.

Any “Code of Practice” does not work—all supermarket chains openly ignore “Codes of Practice”, they will only observe “The Law”.

During the last week my local Tesco store started to display Vodka and Alcopop brands together with packs of Anadin Extra.

I spoke to Boots and Weldricks and they were horrified as was the pharmacist working in the Tesco store.

Careline told me—“We are sorry that you find stocking Anadin Extra tablets in the alcohol aisle of the Tesco store—the placing of the tablets is entirely up to the retailers”.

I also spoke to my local Licensing Department and asked what their view would be if brands such as Johnnie Walker started to be displayed in the pharmaceutical aisles—their reply—“this would not be a problem”.

18 November 2008

Memorandum from the British Medical Association (BMA)

The British Medical Association welcomes the Public Accounts Committee’s forthcoming evidence session on “Reducing alcohol-related harm” (Wednesday 12 November 2008).

As you may be aware, the BMA published its report, *Alcohol misuse: tackling the UK epidemic*, on Thursday 21 February 2008.

In its report, the BMA calls for a targeted approach to tackling problematic levels of alcohol misuse in the UK. The BMA makes a number of recommendations in its report to reduce the burden of alcohol misuse and alcohol-related harm including:

- Higher taxes on alcoholic drinks whereby the increase should be proportionate to the amount of alcohol in the product.
- An end to irresponsible promotional activities like happy hours and two-for-one offers.
- The display of standard labels on all alcoholic products that clearly state alcohol units, recommended guidelines for consumption and a warning message advising that exceeding these guidelines may cause the individual and others harm.
- A reduction in the legal limit for the level of alcohol permitted while driving from 80mg/100ml to 50mg/100ml throughout the UK.

I enclose a copy of the report’s recommendations,² which the Committee may find helpful during the course of its inquiry. If you would like to see a full copy of the report, including an Executive Summary, please go to <http://www.bma.org.uk/ap.nsf/Content/tacklingalcoholmisuse>

November 2008

Letter from the Clerk of the PAC to Stephen Robertson, Director General, British Retail Consortium

QUESTIONS FROM THE COMMITTEE OF PUBLIC ACCOUNTS: BRITISH RETAIL CONSORTIUM ACTIVITIES AND VIEWS ON ALCOHOL HARM REDUCTION

The Chairman of the Committee of Public Accounts has asked me to write to you following the Committee hearing on alcohol harm on 12 November 2008. As you know, at the hearing the issue was raised of the degree of compliance with the voluntary agreement on labelling of alcoholic products with health information and subsequently, the Committee expressed an interest in hearing from the British Retail Consortium, as the representative body for supermarkets.

The hearing was of course some months ago and my colleagues have been in touch with you recently about the possibility of your attendance as a witness at a further Committee hearing to discuss this issue; however, the chairman has now decided that this matter is best addressed via correspondence. I am writing simultaneously to Diageo plc about the particular references to the firm which were made at the hearing, and more generally to seek the firm’s views on alcohol harm reduction.

The Committee would be interested to hear the Consortium’s views on why the implementation of the voluntary labelling agreement has been limited, whether compliance has increased in recent months (since the KPMG evaluation in June 2008) and what would be required for the agreement to be comprehensively and fairly adopted.

Beyond the immediate issue of labelling, the focus of this Committee’s hearing, based on the National Audit Office report, has been on tackling alcohol harm, primarily from a health perspective. This includes ways in which the NHS can bring about behaviour change, but of course the industry also has a key role to play in influencing individuals’ alcohol consumption. You will of course be aware that the government is

² Not printed here.

currently consulting on a proposed mandatory code of practice for alcohol retailers, *Selling Alcohol Responsibly*. The consultation also explores issues around pricing. This Committee would not want to prejudge the outcome of that consultation, but would be interested to hear your views generally on what would make the most difference in reducing alcohol misuse and promoting lower risk drinking, from your perspective as the representative body for many leading retailers of alcoholic products.

The National Audit Office report which formed the basis of the hearing, *Reducing Alcohol Harm: Health services in England for alcohol misuse*, can be found at http://www.nao.org.uk/publications/0708/reducing_alcohol_harm.aspx. The transcript of the Committee of Public Accounts hearing is available on the Committee's website, www.parliament.uk/pac.

24 June 2009

Letter from Stephen Robertson, Director General, British Retail Consortium

BRITISH RETAIL CONSORTIUM: ACTIVITIES AND VIEWS ON ALCOHOL HARM REDUCTION

The British Retail Consortium (BRC) is the trade association for retailers. Our members take a keen interest in these issues, recognising that the right to sell alcohol brings with it significant responsibilities. Our members account for approximately 80% of UK grocery sales and, therefore, have a significant share of alcohol sales in the off-trade.

The BRC welcomes the opportunity to respond on the issues of health labelling and alcohol harm reduction. Our members, as responsible retailers, are committed to making their contribution to tackling the alcohol culture in the UK. Through a number of voluntary initiatives they have demonstrated the role that retailers can play in tackling issues such as underage sales and increasing health information for consumers, but they recognise they are only one part of the solution. Alcohol problems in the UK will only be tackled by acknowledging it requires all to play their part; retailers, Government, parents and drinkers themselves and that a solution will not be found overnight.

ALCOHOL HEALTH LABELLING

Retailers have a long history of providing clear information to customers on health issues. They have led the way in Europe on the provision of such information on food products and they therefore have good understanding of how to communicate in this way with their customers and the benefits of using labelling to increase awareness among the public and give customers the information required to make their own, sensible choices. BRC members were happy to support the Department of Health's alcohol label when it was launched in 2007 and they have made significant progress since then in reviewing their lines and making the labelling changes required. Our six largest members, covering approximately 75% of the grocery market, made a commitment to the European Commission's Alcohol and Health Forum, that they would complete the rollout of the labeling change by the end of 2009, although the vast majority of products will be changed long before then. For reference, this covers 1,750 products in 7,720 stores.

We are in the process of assessing six month progress at the end of June, but our current figures show that 60% of products already carry the new label. The remaining products, which will be a small number for each of the six companies, will be on the slowest moving lines, where labelling changes are more infrequent and the products sell through slower.

Own brand alcohol lines are, of course, only part of the offer retailers sell. Customers in a typical supermarket will have the choice of branded and own brand alcohol. In some product lines, own brand alcohol has a greater share of the market than others (own brand wine, for example, will have a large market share, but own brand lager and beer is less popular). Retailers can only have responsibility for labelling their own products.

Retailers recognise that labelling is only one part of a health conversation with consumers. It needs to be supported by education and understanding, which members are also committed to, both individually through their own communication tools and via the Drinkaware Trust. This educational role is certainly one that Government can support. The main objective is to link the unit information on individual products to overall responsible consumption levels.

Although retailers continue to make rapid progress in changing labels to adopt the DH health label, we should not underestimate the problems involved and the logistical challenges.

Firstly, alcohol labels are not changed frequently. Typically, our members tell us they change alcohol labels every six years on average. Changing a label is a significant commitment as the technical detail needs to be checked, the artwork agreed and space found on the label to accommodate all the information. We estimate that changing a label can cost a company between £1,000–£10,000 depending on the complexity. This is a significant commitment if, as with major retailers, a company has hundreds of products that are affected.

Secondly, information required by customers on alcohol products does not change very frequently, unlike, for example, food. Usually a labelling change will incorporate various changes making it worthwhile and required. In the case of the DH alcohol label, it was only one element that needed to be changed and, in most instances, the unit information was already on the product, just not in the agreed format and with the additional information. This means companies may phase in adoption of the DH label over a lengthy period, incorporating other changes at the same time.

Finally, some alcohol products, such as specialist spirits, have a long shelf life, meaning even if the label is changed by producers it may take some time before consumers see it on products in a store.

REDUCING ALCOHOL HARM

We are currently consulting our members on the mandatory code and will be responding to the Home Office consultation accordingly. In basic terms, we do not believe more regulation is the way to address the alcohol problem in the UK. There are already sufficient powers in the Licensing Act to take action against irresponsible retailers.

Nor do we believe that focusing on the price of alcohol or promotions is the answer. There are many European countries where price is significantly lower than the UK that do not experience the problems we do. We already have some of the highest taxation in Europe and BRC figures show that alcohol prices have increased above inflation over the last 10 years, yet we still have problems, suggesting that price intervention is not the best way forward. A further problem with controls on pricing and promotion is it is a blunt instrument, it penalises the vast majority of the population who drink responsibly.

We believe the only way to tackle harm is by changing our alcohol culture. This relies on education, understanding the levels of sensible consumption, changing acceptance of drunkenness and helping communities tackle local problems.

In terms of education there are two areas that we believe are important. Firstly, it is important to reinforce messages on sensible consumption and potential harm at an early age. We support the guidance for children to parents which DCMS will be publicising in the Autumn. Several of our members will be working with DCMS to publicise the advice through their own health magazines. Parents have a key role to play not only supporting sensible messages but also recognising their own responsibilities. We know from the Government's own test purchasing figures that there has been a significant reduction in sales of alcohol by retailers and yet children are still obtaining alcohol. This means they are obtaining it from older peers or parents, who need to be reminded of their role in preventing children from abusing alcohol.

The second part of education is an improved understanding by drinkers of responsible levels of consumption. The Government is playing its role through its "know your limits" campaign, raising the awareness of typical unit levels in alcohol. Industry is supporting this through the Drinkaware Trust work. The wider coverage of the DH label, supported by information to remind consumers to check the label in the context of recommended daily limits, will help increase awareness of both units and sensible drinking levels and go some way to changing the UK's attitude to alcohol. This change however, will take time. The BRC believes it is essential that alcohol policy is a long term strategy as short term or "quick fix" solutions will not work.

We also need to change the belief amongst sections of the population that drinking to excess is acceptable. Again, the Drinkaware Trust will have a role in this, as will Government campaigns but we also need to ensure messages through the media are appropriate. The behaviour of celebrities and reality TV shows that reinforce drinking stereotypes can have an influence on drinkers. Just as the Government expects responsibility from retailers it should also expect this from those who are role models.

We also believe there should be more focus on partnerships at a local level to tackle problems in communities. BRC members, through the Retail of Alcohol Standards Group (RASG), have pioneered Community Alcohol Partnerships (CAPs). The first CAP was set up in St Neots, Cambridgeshire and it works by bringing together retailers, police, trading standards, local authorities and schools to work together to tackle underage sales and anti-social behaviour. This scheme has been extremely successful and resulted in:

- A 42% decrease in anti-social behaviour incidents in the St Neots area from August 2007 (pre-project) to February 2008 (post-project).
- A 94% decrease in under-age people found in possession of alcohol.
- A 92% decrease in alcohol-related litter at key hotspot areas.
- The changed enforcement activity was cost-neutral.
- A better relationship between retailers and enforcers.

CAPs are now being rolled out across the UK and a CAP officer has been recruited, paid for by those involved in RASG, to support their development. The schemes use local knowledge and are based on genuine partnership with a shared aim to tackle local problems. Although primarily set up to tackle under age drinking and associated problems they also have a role in educating children to respect not abuse

alcohol. The fact that the scheme is cost neutral demonstrates that local problems can be solved without increased legislation and excessive funding. The link below will take you to further information about the CAP scheme.

<http://www.wsta.co.uk/Community-Alcohol-Partnerships.html>

All those involved in alcohol policy must recognise that alcohol harm will not be tackled overnight, it will take years to change the culture around alcohol in the UK. Regulation of retailers and alcohol sales is only one part of the solution but it will not change culture. The culture will only change through an acceptance by parts of society that current abuses are unacceptable, for all of those with a role to accept their responsibility in educating the next generation of drinkers and for us all to understand the importance of safe drinking limits and taking responsibility for our own consumption.

2 July 2009

Memorandum from Corporate Relations Director, Diageo plc

I am writing to clarify Diageo's position on the issue of labelling following yesterday's evidence session on alcohol misuse.

We are disappointed at the comments attributed to Dr Will Cavendish. Diageo was the first company to unit label from 1999, and put responsible drinking reminders and other consumer information on product labels as early as 2005, in other words most of the elements of the voluntary scheme. Those elements of the scheme that have a strong evidence base we already comply with. We identified the problem of non-compliance well before the agreement was put to industry and we made it clear in public that we would be unable to comply with two aspects of the agreement. These two provisions the Department of Health should have mandated. Our position is therefore no surprise to the Department of Health and we have had several extensive discussions with them about it.

Diageo is fully committed to providing information to consumers to help them make informed choices about alcohol, and we recognise that labelling can play a role in this. We note, however, that labelling is just one of many ways in which alcohol information can be provided to consumers. Indeed, it will only be effective if it is a part of a broader package of alcohol information measures. It is essential to utilise a range of media to communicate basic, detailed and tailored alcohol information and advice to consumers—for example, marketing campaigns, targeted interventions, websites and other resources. That is why we have invested significant sums in our own nationwide "The Choice Is Yours" responsible drinking campaign, have supported The Portman Group since its creation and more recently, The Drinkaware Trust. Furthermore, we are making a significant contribution to an emerging industry wide social marketing partnership.

It seems somewhat random to identify Diageo as a problem, especially when that non-compliance is widespread. We have made constructive proposals that would see the five provisions of the voluntary scheme become mandatory. We have consistently asked the Government to make the scheme mandatory in order to avoid patchy compliance and consumer confusion. For Diageo to be identified as a problem is wholly misleading, unfair and deeply troubling. No other company has done as much to promote responsible drinking as we have. It is a travesty to find our name being abused in this way.

I would be happy to explain our position to the committee or indeed individually to members if a further session proved difficult to organise.

Ian Wright
Corporate Relations Director

13 November 2008

Letter from the Clerk of the PAC to Benet Slay, Managing Director, Diageo plc

QUESTIONS FROM THE COMMITTEE OF PUBLIC ACCOUNTS: DIAGEO ACTIVITIES AND VIEWS ON ALCOHOL HARM REDUCTION

The Chairman of the Committee of Public Accounts has asked me to write to you following the Committee hearing on alcohol harm on 12 November 2008. As you know, at the hearing the issue was raised of the degree of compliance with the voluntary agreement on labelling of alcoholic products with health information. Following references to Diageo in that context, your Corporate Relations Director, Mr Ian Wright, wrote the following day to the Committee setting out Diageo's position on this issue.

The hearing was of course some months ago and my colleagues have been in touch with you recently about the possibility of your attendance as a witness at a further Committee hearing to discuss this issue; however, the chairman has now decided that this matter is best addressed via correspondence. I am also writing to the British Retail Consortium as the representative body for supermarkets.

The Committee would thus be interested to hear Diageo's current position on compliance with the voluntary labelling agreement. In addition, the Committee would like to hear the firm's views on why the implementation of the voluntary agreement has been limited in the industry as a whole, and what would be required for the agreement to be comprehensively and fairly adopted.

Beyond the immediate issue of labelling, the focus of this Committee's hearing, based on the National Audit Office report, has been on tackling alcohol harm, primarily from a health perspective. This includes ways in which the NHS can bring about behaviour change, but of course the industry also has a key role to play in influencing individuals' alcohol consumption. You will of course be aware that the government is currently consulting on a proposed mandatory code of practice for alcohol retailers, *Selling Alcohol Responsibly*. The consultation also explores issues around pricing. This Committee would not want to prejudge the outcome of that consultation, but would be interested to hear your views generally on what would make the most difference in reducing alcohol misuse and promoting lower risk drinking, from your perspective as a leading producer of alcoholic products.

The Committee is of course aware of the evidence which you have provided to the Health Select Committee on these issues, for their recent enquiry into alcohol policy.

24 June 2009

Letter from Benet Slay, Managing Director, Diageo Great Britain

QUESTIONS FROM THE COMMITTEE OF PUBLIC ACCOUNTS: DIAGEO ACTIVITIES AND VIEWS ON ALCOHOL HARM REDUCTION

Further to your letter of 24 June 2009, Diageo is very pleased to submit further evidence to the Committee as it relates to compliance with the voluntary agreement on labelling, as well as wider views on tackling alcohol misuse.

As you are aware from previous correspondence with the Committee, Diageo has consistently called for a mandatory labelling scheme in the UK in order to avoid consumer confusion and ensure industry-wide application.

Diageo has long maintained that a co-regulatory solution is possible by amending the Portman Group code on Naming, Packaging and Promotion of Alcoholic Drinks to cover all 5 components of the voluntary agreement. By making compliance with the Code a condition of license under the Licensing Act 2003, it becomes mandatory for alcohol producers as well as retailers. Any product found in breach of the Code, would be made public by a "Retailer Alert Bulletin" and removed from sale. A retailer failing to do so would be in breach of license and subject to legal sanction.

This system has all the benefits of legislation (it is binding and ensures mandatory compliance) but because it is developed in partnership it avoids creating an excessive regulatory burden and other unintended consequences.

Since Diageo last corresponded with the Committee, significant progress has been made in moving towards such an arrangement. Following discussions with the Department of Health, Portman Group members have agreed to expand the Code to encompass at this stage three elements of labelling and will shortly be consulting further to ensure that any potential issues and opportunities are explored.

As evidence of our commitment to achieving this goal, Diageo has confirmed to the Portman Group that we will adopt all five elements of the labelling scheme. This is not an inconsiderable challenge as it will involve approximately 200 million cases of beer, wine and spirits. Any public support the Committee can give to this co-regulatory process would be desirable in helping bring it to fruition.

In addition to our written submission to the Health Select Committee, which the Committee has already seen, Diageo provided a submission to Government as part of its Safe, Sensible, Social Consultation, which outlines in detail our views on the most effective way to promote responsible drinking and tackle alcohol misuse. I attach the executive summary of this submission for the Committee's attention, and would be happy to answer any further questions you may have.

29 June 2009

Submission by Diageo plc to “*Safe. Sensible. Social: Consultation on further action*”

EXECUTIVE SUMMARY

Diageo welcomes the discussion on the UK’s relationship with alcohol initiated by the Government. We share the Government’s goal to promote responsible drinking and combat alcohol misuse. Diageo is therefore wholly committed to working in partnership to change our drinking culture for the long-term.

We agree with the Government’s analysis that there is no single, simple solution to alcohol misuse, and we fully endorse its objective of eliminating irresponsible behaviour—whether on the part of consumers, producers or retailers.

We believe that a responsibility matrix, defining appropriate roles for Government, industry, law enforcers, individuals and others, is essential to bring about the desired levels of change and to avoid placing the greater and unjustified burden of responsibility for alcohol misuse on the shoulders of the alcohol industry.

Any interventions introduced by Government must be targeted so as to impact the minority who misuse alcohol, and not to penalise the responsible drinking majority. Ultimately, this—rather than a whole-population approach—will deliver the desired changes to alcohol harm levels. Interventions must also be rooted in a strong and clear evidence base.

However, Government interventions must be considered in the context of enforcing the wide range of existing laws and regulations already available. We note with disappointment that these are wholly under-utilised.

Diageo’s response identifies three key proposals:

As a responsible company, Diageo believes that industry and Government should work together to root out all irresponsible retail promotions. We strongly believe that a system of co-regulation for retail promotions is the most appropriate and effective approach to do this. Under co-regulation, the Government and the alcohol industry draw up standards together, which are strictly monitored and enforced, within the industry, by Government through existing laws and regulations (the Licensing Act) and by a body such as The Portman Group.

We also advocate a co-regulatory approach for labelling/enabled through legislation, again under the guardianship of The Portman Group, to ensure that consumers are given information to help them make informed choices about alcohol. This would ensure that all drinks containers carry the same information.

We believe that industry can play an important role in changing consumer attitudes to alcohol by working more closely with Government, the Drinkaware Trust and others to form a social marketing partnership. This would see greater sharing of knowledge and setting of common performance measures for campaigns to tackle alcohol harm. We believe that such a partnership, which would draw on the model adopted by the Government and the food industry to tackle obesity, would be a significantly stronger alternative to the alcohol advertising “end frame” option proposed in the consultation.

In implementing policy, care must be taken that there are no unintended negative consequences, which either diminish the effectiveness of the policy or create unexpected problems in other areas. The Government has shown that it is sensitive to the needs of industry, society, authorities and individuals, and we would hope that any firm policy proposals that emerge from this consultation will be backed by rigorous impact assessments, against which the consequences of the policies can be assessed.

We are concerned, however, that there are unintended consequences that will arise from some of the proposals outlined. Firstly, an end frame on advertising would have little or no impact on consumer attitudes or behaviour and has, as yet, an unquantified economic impact on the alcohol industry and importantly other industries such as broadcasting.

Secondly, “blanket” actions taken which drive a 10% reduction in total alcohol consumption, as identified in the Department of Health’s impact assessment, will inevitably have a negative impact on Treasury revenues. In addition to this, there is no proven link that a reduction in alcohol consumption will lead to a reduction in alcohol-related harm, the ultimate objective of Government and industry alike.