



Government Response to the  
House of Commons Health Select Committee  
Report of Session 2012-13:  
Government's Alcohol Strategy

Presented to Parliament by  
the Secretary of State for Health  
by Command of Her Majesty  
September 2012



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## Committee recommendations

- 1. The Committee shares concerns about the social impact of binge drinking but we believe it is also important to ensure that the Government's strategy recognises and responds to the evidence of an increasing health impact of excessive alcohol consumption (Paragraph 6)***
- 3. Alcohol misuse affects a large number of people. The current annual death rate from alcohol-related conditions is more than three times that for deaths in road accidents, and the cost to the NHS of treating such conditions is around 3% of its annual budget. The Government's strategy is a welcome attempt to address some of these problems in a coherent way (Paragraph 20)***

The Government agrees that the health impact of alcohol misuse is important and, in our view, the strategy does address alcohol-related health harm and risks to young people. The need to address public disorder and alcohol-related crime are prominent in the strategy, reflecting public concern on these issues. The strategy provides a coherent response to alcohol misuse, and policy proposals such as a minimum unit price, more local powers to control the density of licensed premises, including on the basis of local health considerations, banning multi-buy promotions in the off-trade, and local dedicated public health budgets will have an impact on health just as much as crime. Indeed, health experts who gave evidence to the Committee generally recognised that the strategy provides a comprehensive policy response, even where they may have concerns on particular points.

The strategy sets out the Government's ambitions with regard to alcohol and these clearly relate to tackling health harms as well as reducing crime and disorder. It further specifies six outcomes we want to see, and these include a reduction in the number of adults drinking above the NHS guidelines, and a reduction in the number of alcohol-related deaths, alongside the inclusion of alcohol related hospital admissions in the Public Health Outcomes Framework. All are clear measures of health outcomes.

- 2. The establishment of Public Health England provides an important opportunity to analyse the true public health impact of alcohol consumption and adopt a package of policy responses which is evidence-based, as well as being carefully calibrated and targeted. (Paragraph 8)***

4. ***The main focus of the strategy is the need to address public order issues. We agree that these are important, but we believe that the health impact of the misuse of alcohol is more insidious and pervasive; the remainder of this report therefore focuses on ways in which those harms to health can be addressed. (Paragraph 21)***

We agree that Public Health England will play a vital role in providing expert analysis, evidence and support to local areas on a range of public health issues, including alcohol misuse.

## Objectives and targets

5. ***The Committee believes it is important to ensure that the objectives of policy on alcohol are clearly stated and calibrated. The great majority of citizens enjoy alcohol without significant evidence of harm to their health. The Committee accepts that it is not possible to define a level of alcohol consumption which is, in any absolute sense, safe for all citizens at all times. We do not believe, however, that this conclusion should lead to disproportionate or heavy handed controls which are justified neither by public support nor evidence of proportionate health gain. (Paragraph 22)***

The Government agrees and we believe the alcohol strategy is consistent with this approach.

6. ***The Committee also believes that healthy societies expect all citizens, both corporate and individual, to exercise their individual freedoms in ways which respect the rights and interests of their fellow citizens and observe shared standards of responsible behaviour. It is part of the function of Government to stimulate, lead and if necessary regulate, in order to encourage the development of this culture. (Paragraph 23)***

We agree that it is an important role for Government to lead and stimulate the development of a healthier culture. We are regulating on pricing matters where only Government can act. We are supporting citizens to change their behaviours through Change4Life and local services. And through the Responsibility Deal, businesses are adopting standards of responsible behaviour.

7. ***The Committee believes that an Alcohol Strategy should be seen as part of a wider public health strategy, and should contain some key quantified, alcohol-specific objectives which will provide both a framework for policy judgements and an accountability framework. (Paragraph 27)***
8. ***We address in the report the issue of all local areas having an alcohol strategy, flowing from the national strategy but using local approaches to deal with local problems. It seems logical that Public Health England should oversee this process, given its overarching responsibility for public health matters. It also seems logical that Public Health England should devise the national measures against which the strategy can be tested. (Paragraph 28)***

It is for the Government rather than Public Health England, to set national objectives for public health, together with the Public Health Outcomes Framework.

It is important to note that, while not framed as 'targets' or 'quantified objectives', the ambitions set out at the start of the strategy are challenging, and cover all the main domains of harm. Achieving them would mean reversing the long term rise in alcohol-related harms of all types. They provide clear objectives and a framework to allow success to be judged at national level.

The Government agrees that Local Authorities should consider the need for a local alcohol strategy. Public Health England will have a vital role in advising local areas on their own strategies.

## What is 'safe'?

- 9. *Although we accept that it is a complicated issue, we regard a clearer, evidence-based definition of the health effects of alcohol consumption as fundamental to successful policy development in this area. The work of the Chief Medical Officer needs to be carried forward as a matter of urgency. Public Health England, acting independently of Government, then needs to use the outcome of the review as the basis for its promotion of public understanding of the issues, setting out the level at which harms are likely to result alongside sensible drinking guidelines. (Paragraph 36)***

The Government agrees on the importance of the review of the alcohol guidelines, being led by the Chief Medical Officer. Public Health England will be responsible for promoting public understanding of the issues and the guidelines.

## Binge drinking

- 10. *Despite some perceptions that binge drinking is largely a public order issue, the evidence presented to us suggests that it does contribute to some of the long-term health harms that have concerned us. We conclude that these health problems need to be addressed no less urgently than problems with public order and anti-social behaviour. (Paragraph 40)***

The Department of Health's written evidence to the Committee set out some of the evidence on the significant health harms, both short term and long term, due to binge drinking. The review of alcohol guidelines, being led by the Chief Medical Officer, will consider how to provide better advice for the public on this.

## Minimum unit price

- 11. *The Committee welcomes the Government's decision to introduce a minimum unit price for alcohol. Rather than relying on generalised statements about the effect of price on consumption, the Committee urges the Government to build its case for a minimum unit price by establishing direct links: between specific alcohol products and specific alcohol-related harms; between different levels of minimum unit price and the resulting selling prices for the products which are linked to alcohol-related harms; and the likely effect of different levels of selling prices for those products on demand for those products in the target range of households. (Paragraph 54)***
- 12. *Given the Government's decision to introduce a minimum unit price, the debate has been about the level at which it should be set – whether it should be 40, 45 or 50 pence – but the setting of a minimum unit price***

*will not be a one-off event. Once a minimum price is introduced, if it is judged to be successful, the level will need to be monitored and adjusted over time. A mechanism will need to be put in place in order to do this, but as yet there has been no indication from the Government of what it intends to do other than to consult on the price. One way of setting the level would be to establish an advisory body (there are a number of these already, dealing with a range of issues) to analyse evidence and make recommendations to Government. Whatever mechanism is chosen should be used when setting the initial level of the minimum unit price to ensure that from the beginning the price is clearly evidence-based. (Paragraph 55)*

- 13.** *If the minimum unit price in England were to be fixed at a different level to that in Scotland, we would expect the evidence supporting that decision to be set out clearly. This is another argument in favour of establishing a transparent mechanism for setting the price. (Paragraph 56)*
- 14.** *We recommend that there should be a "sunset clause" on any provisions for setting a minimum unit price for alcohol, and that a decision by Government to make a minimum price permanent should be taken following advice from the advisory body or other mechanism used to monitor and adjust the price during the initial period. (Paragraph 57)*
- 15.** *We have emphasised the need for the decision on minimum price to be evidence-based. The debate so far is based almost entirely on the work of the Sheffield Alcohol Research Group, though research from Canada has become available more recently. It is not a criticism of the integrity of that research to say that, if there is to be a minimum unit price, a more substantial evidence base needs to be developed in the future to help in the assessment of whether the minimum unit price is achieving the anticipated benefits. (Paragraph 58)*

The Government welcomes the Committee's support for a minimum unit price for alcohol. We agree that the issues the Committee raises are important. We have committed to introducing a minimum unit price for alcohol and will consult on the price level in the autumn. The Government's forthcoming consultation stage Impact Assessment will consider the impact of a range of minimum unit price levels on consumption, health harms and crime, and other factors such as impact on the Exchequer and business, based on the best available evidence. The Government will continue to develop the evidence base throughout the consultation process to ensure that the minimum price level is targeted, proportionate and effective in reducing harmful consumption.

The Government is clear that a minimum unit price should be effective over a sustained period and recognises that there are different ways by which this could be achieved, for example by linking the minimum unit price to inflation. This and other issues raised by the Committee, including a review clause, will be considered further as we move towards implementation of the policy.

## **Multibuys**

- 16.** *The evidence does not convince us that a ban on multibuys is either desirable or workable. The proposed minimum unit price will provide a floor price for the sale of alcohol, including discounted sales. The Committee supports*

***the principle of setting the minimum unit price at a level which is effective at reducing identified alcohol-related harm; it believes that an attempt to outlaw well-established and convenient retailing techniques for alcohol products, regardless of price level, would simply create opportunities for retailers to find innovative and newsworthy work-arounds which would invite ridicule and bring the wider policy objective into disrepute. (Paragraph 64)***

The Government has committed to consult on a ban on multi-buy promotions in shops and will consider the issues raised by the Committee, including the potential for benefits in addition to those from a minimum unit price. The Government will also review the current conditions within the Mandatory Code for Alcohol to ensure they are sufficiently targeting problems such as irresponsible alcohol promotions in pubs and clubs.

## **Challenging the industry to act responsibly**

- 18. *The Committee does not believe that participation by the alcohol industry in the Responsibility Deal should be regarded by anyone as optional – we regard it as intrinsic to responsible corporate citizenship. We welcome the willingness of the industry to address the harms that alcohol can cause – for example by tackling issues with licensed premises through the formation of a business improvement district – but we believe that it should be clear that the Responsibility Deal is not a substitute for Government policy. (Paragraph 76)***

We fully agree with the Committee and have made clear from the start that the Responsibility Deal is not a substitute for Government policy. Health bodies have generally recognised that the Government's alcohol strategy provides a comprehensive policy response to the issue of alcohol-related health harm. The Responsibility Deal is just one element of the strategy.

Over 125 companies, including all of the UK's main alcohol producers and retailers, have signed up to one or more of the alcohol pledges in the Responsibility Deal and adopted a core commitment to "foster a culture of responsible drinking, which will help people to drink within guidelines". The alcohol industry has responded enthusiastically to this challenge and we are pleased that the Committee recognises the need for industry to play its part in reducing harm from alcohol.

- 19. *It is for the Government, on behalf of society as a whole, to determine public policy and ensure that a proper independent evaluation of the performance of the industry against the requirements of the Responsibility Deal is undertaken. We recommend that such an evaluation is commissioned by Public Health England. We will be particularly interested to see the assessment of the effect of reducing the alcohol level in certain drinks. We do not believe that reducing the alcohol in some lagers from 5% to 4.8%, for example, will have any significant impact. If the industry does not bring forward more substantial proposals than this it risks being seen as paying only lip service to the need to reduce the health harms caused by alcohol. (Paragraph 77)***

We agree with the Committee that it is for Government to ensure a proper independent evaluation of the Responsibility Deal. The Department of Health has already taken action to ensure this. Its Research and Development Directorate

is overseeing an independent evaluation of the impact of elements of the Responsibility Deal. The first stage of that evaluation has been to scope what is feasible to achieve an effective research strategy that provides good value for money.

We believe the Committee may have underestimated the significant impact that reducing the alcoholic strength of drinks can have, particularly if this is sustained over time and if it represents a commitment from broad sectors of industry.

It is generally recognised that the average strength of alcoholic drinks, particularly in sectors such as wine, has increased in the UK over the last 40 years and that this has contributed a significant proportion of the rising levels of alcohol consumption that we have seen up to the middle of the last decade.

Even apparently small reductions in alcoholic strength can potentially have large impacts. A reduction in population level consumption of 1bn units per year would be a drop of around 2% in the number of units of alcohol sold. In a decade, this would result in almost 900 fewer alcohol related deaths each year as well as tens of thousands fewer hospital admissions and alcohol related crimes, and substantial savings to health services and crime costs.

Over 30 companies have already had their delivery plans published on the Responsibility Deal website. These outline commitments to reduce the strength of nearly 20 wines, beers and ciders as well as the launch of over 30 new lower alcohol products. As one example, a major company is proposing to make small changes to three of its core brands that should result in over 110 million units being taken out of the market over the course of a year.

The Government is introducing a number of incentives including, in March this year, changes to the duty rates for higher and lower strength beers.

International evidence suggests that the potential public health gains from encouraging these changes in alcoholic strength are substantial. For example, in Australia in the early 1980s differential tax rates for low (<3% abv) and full strength beers were introduced to promote consumption of lower-alcohol beer. Between 1980 and 2002, per capita consumption fell by 24% and lower strength beers now make up more than 20% of the total beer market.<sup>1</sup>

## Expectations within the Responsibility Deal

- 17. Messages contained in alcohol advertisements play an important part in forming social attitudes about alcohol consumption. The Committee believes that those involved in advertising alcoholic products should accept that their advertisements contain positive messages about their products and that these messages are supported by considerable economic power. If this were not the case it is not clear why shareholders should be content for their companies' resources to be spent in this way. Since it is true, however, it is important that the alcohol industry ensures that its advertisements comply in all respects with the principles of corporate social responsibility. Closer definition of these principles as they apply to alcohol advertising is a key objective of the Government's Responsibility Deal. (Paragraph 66)***

<sup>1</sup> ACNielsen (2006)

**20. *The Committee is concerned that those speaking on behalf of the alcohol industry often appear to argue that advertising messages have no effect on public attitudes to alcohol or on consumption. We believe this argument is implausible. If the industry wishes to be regarded as a serious and committed partner in the Responsibility Deal it must acknowledge the power of its advertising messages and accept responsibility for their consequences. (Paragraph 86)***

The Government would wish to distinguish reported public statements made on behalf of some in industry from the established basis of the system of co-regulation (CAP, BCAP, OFCOM & ASA) which recognises the potential for harm and the important role that the advertising codes therefore play in ensuring advertisements are responsible and do not encourage or condone irresponsible drinking. If there is evidence of problems caused by alcohol advertising in relation to consumer harm or protection of young people, then the independent regulators would have a duty to consider it fully and take appropriate action.

We agree with the Committee that it is important to seek to apply the principles of social responsibility to alcohol advertising. We believe the steps we have set out within the strategy are consistent with such an approach. We will:

- Work with the ASA and OFCOM to examine how alcohol adverts might not be shown during programmes 'of high appeal to young people'
- Work with the ASA to ensure the full and vigorous application of ASA powers to on-line and social media and work with industry to develop a scheme to verify people's actual ages which will apply to alcohol company websites and associated social media.
- Continue work through the Responsibility Deal to support the alcohol industry to market, advertise and sell their products in a responsible way and deliver the core commitment to 'foster a culture of responsible drinking, which will help people to drink within guidelines'

**21. *The industry will take a significant step down this road when it makes it clear that alcoholic products should not be marketed in ways which address audiences a significant proportion of whom are aged under 18, and cannot therefore legally purchase the product. (Paragraph 87)***

Under the ASA system, alcohol cannot be marketed to appeal to people under the age of 18. The CAP and BCAP codes specifically recognise the importance of ensuring alcohol advertising is responsible and in particular that children and young people are protected. They do this by including prescriptive rules on the placement and content of alcohol advertising additional to the general code provisions against misleading, harmful or offensive advertising. For example, the rules forbid advertisers from showing people drinking or behaving in an adolescent or juvenile way or reflecting the culture of people under 18. They cannot depict people who are, or appear to be under the age of 25. Scheduling and placement restrictions also mean that ads cannot be placed adjacent to programmes likely to appeal to audiences under 18 or (for non-broadcast ads) in a medium where more than 25% of the audience are under 18.

## Existing precedents

22. ***Advertising of alcoholic products on television is subject to rules which are relatively targeted and sophisticated. The Committee believes there is scope to apply these principles more widely – for example in cinemas – and recommends that this principle be reviewed in the context of the Responsibility Deal. Serious consideration should be given to reducing to 10% the proportion of a film's audience that can be under 18 and still allow alcohol to be advertised, or to prohibiting alcohol advertising in cinemas altogether except when a film has an 18 certificate. (Paragraph 91)***

The Government agrees with the Committee that the rules relating to advertising alcohol on television are relatively targeted and sophisticated. However, it is important to note that the current rules for cinema advertising are very similar in effect. The Cinema Advertising Association (CAA) pre-vets all alcohol advertising to ensure that they meet the CAP Code and BBFC rules on content and placement of ads. This means that alcohol advertising is only permitted around films where it is estimated that 75% or more of the audience is over 18 (based on profiling of the audience rather than its certificate). The CAA also goes beyond this in setting its own compliance criteria for alcohol ads.

We are not aware of evidence that a reduction from 25% to 10% in the proportion of cinema audiences under 18 where alcohol ads are permitted would be proportionate or reasonable, nor that this would provide better safeguards against harm.

We believe that to link a prohibition on alcohol advertising in cinemas directly to the age rating of films would be a blunt tool, not taking into account the reality that adult audiences often make up the large majority of audience in films given a PG or 12 certificate (recent examples include the *Best Exotic Marigold Hotel* and *The Artist*).

We intend to build on the current rules, working with the ASA and OFCOM, as we have set out in our strategy.

## Drinkaware

23. ***The Committee believes that it is right that the industry should support education and awareness campaigns about the harms that alcohol can cause, and doing so through a separate organisation such as Drinkaware seems appropriate in principle, but the independence of the organisation is vital. The value of this contribution is likely to be very limited if the campaigns it promotes are considered to be constrained by industry links. (Paragraph 96)***
24. ***We acknowledge that the Board of Drinkaware as presently constituted has a majority of non-industry Members, and we welcome that fact. Nevertheless, if Drinkaware is to make a significant contribution to education and awareness over the coming years its perceived lack of independence needs to be tackled, and as part of the review that is to be held this year the Committee recommends that further steps are taken to entrench that independence. (Paragraph 97)***

The 2009 Addendum to the original Drinkaware Memorandum of Understanding committed to a major audit and review of Drinkaware in 2012.

As an integral part of the audit, an independent review panel has been appointed. Sir Hugh Taylor, Chairman of the Guy's and St Thomas' NHS Foundation Trust and former Permanent Secretary at the Department of Health, is chairing the panel. Other members of the panel are:

- Professor Sir Ian Gilmore, Department of Medicine, University of Liverpool, Consultant and Royal Liverpool University Hospitals, and Chairman of the Alcohol health Alliance.
- Jeremy Beadles, Corporate Relations Director, Heineken UK and former Chief Executive of the Wine and Spirit Trade Association
- Ben Page, Chief Executive, Ipsos MORI

The panel's role is to provide assurance that the audit is comprehensive, takes on board the views of key stakeholders and other key experts and is properly independent.

Drinkaware's board of trustees currently consists of five members from the industry, five with a health or other professional interest in alcohol and three who have no professional interest in alcohol, including the chair. In addition, a medical panel advises on Drinkaware materials.

With its current governance and engagement with stakeholders, Drinkaware has achieved a high level of public awareness and its website now attracts over three million unique visitors a year.

The review will, however, consider whether Drinkaware's current governance and engagement with stakeholders operates in an appropriate and effective way to support its goals and activities through to 2020.

## Loi Evin

**25. *Although the precise terms of the Loi Evin reflect the circumstances of a different society at a different time, the Committee believes that the approach adopted in the French legislation merits serious examination in the English context. In particular the Committee recommends that Public Health England should commission a study of the public health effect which would be delivered in the UK by adopting the principles of Loi Evin; such a piece of work would provide a valuable reference point for the evaluation of the effectiveness of the Responsibility Deal which the Committee has recommended should also be undertaken by Public Health England. (Paragraph 101)***

The Department of Health has examined the evaluation of the *Loi Evin*<sup>2</sup>, commissioned and published in 2000 (in French only). This is a comprehensive study, which the Government took into account in developing the Government's alcohol strategy.

The *Loi Evin* was passed in 1991 and came fully into force in 1995. This law was

<sup>2</sup> 'La Loi relative a la lutte contre le tabagisme et l'alcoolisme', *Rapport d'évaluation*, Premier ministre, Commissariat general du plan, Conseil nationale de l'évaluation

in many ways the continuation of earlier measures. The official evaluation of the *Loi Evin* states that it can be misleading to make simple before 1995/ after 1995 comparisons. Earlier measures were:

- a legal ban on all alcohol advertising in sports grounds from 1975
- a voluntary ban on TV alcohol advertising agreed with TV companies from 1975
- this became a legal ban on TV advertising from 1987

The *Loi Evin* added to the 1987 law by:

- banning alcohol advertising in cinemas and on radio
- regulating the content of alcohol advertising in print and poster media – only factual and verifiable statements are permitted, the intention being to limit promotion of alcohol
- requiring a health warning on all alcohol advertising

The overall findings from qualitative research were that the *Loi Evin* and previous legislation played a positive part in creating healthier, better informed drinking norms in French society than had existed before the 1970s. But their impact cannot be fully quantified and disentangled from:

- social changes, notably the major shift since 1950 from manual and agricultural work to employment in white collar and service industries
- legislative changes which reduced alcohol licences by about 20% between 1954 and 1991
- the impact of extensive health education campaigns from the 1950s, aimed at the effects of parents' drinking on children and alcohol and pregnancy, and
- the role of the medical profession in raising awareness of the importance of alcohol for calorie intake as part of a general raised consciousness of the need for healthier diets, particularly among women.

The evaluation found that evidence for impact of the restrictions on under 18s' drinking was weak, and the trends from the late 1980s in France were for more young people to start consuming alcohol, with some rise in binge drinking patterns. The Department sees this area of weakness in the evidence as significant, given the importance of minimising under-age drinking and the need to ensure that alcohol advertising does not undermine this aim. Levels in France of under age drinking and risky behaviours such as drunkenness nevertheless were and remain well below UK levels.

It is evident from the evaluation that alcohol advertising remains extensive in France in the media where this is permitted, with overall alcohol advertising spend in the years before 2000 at about half UK levels. The lower costs of print and poster advertising suggest a still substantial volume. Overall alcohol advertising spend was little affected by the coming into force of the *Loi Evin* itself.

## Local responses

26. ***Birmingham is one example of local action that has been drawn to our attention during the inquiry, and it does demonstrate how local agencies can put together an effective action programme without the need for a substantial additional bureaucratic support structure. This model of local action, linking in with national priorities, makes sense as a pragmatic, practical way of addressing serious problems. As we recommended earlier in this report, Public Health England should use this model as the template for all local areas to address the various problems that alcohol causes in their communities, and to link local objectives to those at the national level. Central Government cannot direct a local area to address alcohol problems in a particular way, but the new public health structures, in which local authorities have a key role, should provide the opportunity to establish a national framework of local initiatives. (Paragraph 106)***

The Government agrees that there are areas such as Birmingham where local agencies are working together effectively to tackle alcohol harms. We expect Public Health England to work with its partners, including local authorities, to provide expert intelligence on effective local interventions. This will include sharing models of best practice such as Birmingham's.

## Treatment Services

27. ***We welcome the work which the Department is undertaking to provide an evidence base to allow commissioners to make informed decisions about which models of treatment provision are most effective in addressing the health issues caused by alcohol abuse. In particular commissioners need evidence about the most effective form of early intervention in order to reduce the number of avoidable hospital admissions which currently represent avoidable illness for patients and avoidable costs for taxpayers. The evidence we received suggested that the establishment of Alcohol Specialist Nurse services throughout the country is one of those measures. The fact that over 70% of the costs to the NHS of alcohol-related services was spent on hospital treatment demonstrates the scale of the opportunity to restructure services to achieve better outcomes. (Paragraph 117)***

The Department of Health provides guidance and information for commissioners about the interventions that evidence suggests will have the greatest impact on alcohol related health harm. This includes the establishment of Alcohol Liaison Nurses. The Government's alcohol strategy recognised the value of these services. Public Health England will also have a clear commitment to supporting local areas to join up services to tackle alcohol dependency holistically and look at innovative methods of delivering services.

The DH funded Alcohol Learning Centre is a one stop shop where commissioners can find guidance, data, tools and training resources to support them to commission effective interventions to respond to local need. The Department expects that in future Public Health England will provide local authorities with the best evidence available about the most effective services and interventions the local area could offer to address alcohol harm.



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