Public Health England

Protecting and improving the nation's health

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 27 April 2016
Sponsor	Kevin Fenton/Sir Derek Myers
Presenter	Rosanna O'Connor
Title of paper	**Alcohol Update**

1. Purpose of the paper

1.1 The purpose of the paper is to provide an overview of activity at PHE to prevent and reduce alcohol harm and describe the context within which our programme is operating.

2. Recommendation

2.1 The PHE Board is asked to:

a) **NOTE** this overview
b) **ENDORSE** the approach we are taking to inform policy.

3. Background

Current consumption levels

3.1 Alcohol consumption in England is measured through large scale surveys, usually conducted in private households. It is widely acknowledged that these surveys under-estimate population-level alcohol consumption, only reporting between 55% and 60% of consumption compared with actual sales.

3.2 The most recently published data on consumption is from the 2014 Health Survey for England. Eighty-two per cent of adults said that they drank alcohol and had done so in the last 12 months. Men were more likely than women to do so (85% and 79% respectively). The proportion of drinkers among men and women increases as neighbourhood deprivation decreases i.e. the highest rates are in the least deprived areas.

3.3 Per capita consumption of alcohol in the UK increased sharply and steadily in the second half of the 20th century. By 2005, per capita consumption was three times higher than in the 1950s. This rise was driven by increasing drinking amongst women, a move to higher strength products such as wine and spirits and increasing affordability of alcohol, particularly in the 1980s and 1990s. In 2013, an estimated 10.3 million adults (25%) were regularly drinking more than new CMO guidelines of 14 units of alcohol each week.

3.4 Over the past five to ten years, household surveys indicate a reduction in alcohol consumption at a population-level. Nonetheless, there is evidence from the Health

Survey for England that, at an individual-level, reduced consumption is more likely in those already drinking at lower-risk levels.

Summary of the latest data on harmful impact

3.5 Studies show a consistent relationship between alcohol-related harm (alcohol-related deaths and hospital admissions) and deprivation, with those in the most deprived areas much more likely to die or suffer an illness due to alcohol than those in the least deprived. However, studies also show that average consumption in deprived areas is generally similar or lower than in higher income areas.

3.6 Drinking alcohol is associated with over 200 preventable diseases and injuries. Excessive drinking also harms other people, causing family financial and emotional problems, is a major factor in road accidents, damages productivity at work and causes violence and disorder.

3.7 Mortality and admission rates for men are twice as high as the corresponding rates for women. Those aged between 40 and 64 have the highest rates of alcohol-related admissions for both males and females. By region, the highest rates for alcohol-related mortality and admissions are in the North West and the North East.

3.8 The National Health Service (NHS) spends £3.5 billion each year treating people with alcohol-related diseases and injuries. Overall, the cost to our society each year from alcohol-related harm is £21 billon.

Current Government policy on alcohol

3.9 The 2012 Alcohol Strategy intended to re-shape the approach to alcohol in England by influencing public behaviour.

3.10 Evidence tells us that the most effective way of achieving this is to target affordability, availability and the way in which alcohol is marketed, especially to young people. The government consulted on the introduction of a minimum unit price in 2013 but decided not to pursue implementation at that time, focusing instead on the promotion of local responses.

The new CMO guidelines

3.11 Earlier this year the UK CMOs published new guidelines on drinking levels. This included that both men and women are safest not to drink regularly more than 14 units per week, to keep health risks from alcohol to a low level and if you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol.

3.12 The Guidelines development group considered the global evidence on the effects of alcohol on health and length of life, with this newest evidence suggesting:

a) benefits for heart health are less and apply to a smaller group of the population than previously thought. The only group with a potential to have an overall significant reduction in risk of death in UK is women over the age of 55 (and only if drinking around 5 units a week or less);

b) there are adverse effects from drinking alcohol on a range of cancers – this was not fully understood in 1995 – and these risks start from any level of regular

drinking and then rise with the amounts of alcohol being drunk.

4. Position since March 14 Board discussion: the PHE alcohol programme

4.1 The PHE programme has developed substantially since the Board discussion in March 14 in which it was agreed that alcohol should be given greater prominence in PHE business planning.

4.2 As part of that in October 2014 PHE published From Evidence into Action which highlighted action on harmful drinking as one of the seven PHE priorities that have been driving PHE activities and plans. Our activities are wide ranging and include:

PHE Evidence Reviews

4.3 In June 2014, in the remit letter, the Minister for Public Health asked PHE to "provide advice about possible evidence-based solutions to reduce the public health impact of alcohol, guided by the best and latest scientific evidence".

4.4 The review of evidence has been undertaken in house, supported by an external expert advisory group, and is in the process of being written up in tandem with the peer review process.

4.5 The Review looks at consumption levels, harmful impact effectiveness of control policies. The following control policies are examined:

• Regulating price • Regulating availability • Regulating marketing	• Brief intervention and treatment • Information • Protecting public safety • Reducing drink-driving

4.6 A second Evidence Review has been commissioned by the Devolved nations and the Republic of Ireland public health network, chaired by Kevin Fenton. PHE is leading the collaboration to produce an Alcohol 'Harms to Others' report, on behalf of all the nations involved.

4.7 Surveys have been undertaken in all 5 geographies to gain a better understanding of impact and to ensure cross border consistency. The review, planned for publication later this year, will include the following areas:

- Harm to the unborn foetus
- Acts of drunken violence
- Vandalism
- Sexual assault
- Child abuse
- Abuse and neglect
- Domestic violence
- Road traffic accidents where individuals are injured by drunk drivers
- Reduced productivity at work
- Health burden carried by both the NHS and friends and family who care for those damaged by alcohol
- The impact on the NHS/social care/local government in relation to what

other services are reduced to in responding to the impact of alcohol related harm

The NHS: Prevention at Scale and NHS planning

4.8 The NHS Five Year Forward View, published in October 2014, laid out the critical importance of prevention at scale interventions for the long term sustainability of the NHS. We have worked closely with NHSE on the most cost effective alcohol interventions and in what way CCGs, acute trusts and primary care could make the most impact.

4.9 We have built on this work recently in providing examples and evidence in support of the placed-based CCG Sustainability and Transformation Plans. In addition, we have been ensuring that risk behaviours/reducing alcohol use and improving pathways into treatment is featured in the narrative and supports the 'Right Care' approach – particularly with regard the liver disease care pathway.

LA facing activity and support for local policy development and delivery

4.10 The responsibility for commissioning alcohol prevention and treatment interventions passed to local authorities in 2013 as part of the Health and Social Care Act changes. The budget for these activities is part of the wider public health grant.

4.11 We support a range of activities aimed at impacting positively for local communities, including supporting Directors of Public Health in their Responsible Authority role within the licensing act and working with national organisations through the Public Health and Licensing network; the widespread roll out of Identification and Brief Advice; the commissioning of effective evidence based provision, including timely access to alcohol treatment. This support also includes health marketing campaigns such as One You and previously Dry January.

5. Programme governance & resourcing

5.1 Our internal governance for the programme is strong though diffuse through the organisation. The programme has recently been internally audited with positive observations.

5.2 In 2015 PHE established the Alcohol Leadership Board to oversee and support the delivery of the PHE programme. Members include, statutory organisations, NGO's and the voluntary sector, OGD's attend as observers. The board is co-chaired by Professor Sir Ian Gilmore and Rosanna O'Connor.

5.3 A joint delivery framework for alcohol links the alcohol related priorities in the 'From evidence into action' document to actions across PHE undertaken by Health & Wellbeing (HWB), Chief Knowledge Officer (CKO), Centres and Communications & Marketing. The Health & Wellbeing (HWB) team act as co-ordinators for the Joint Delivery Framework.

5.4 Executive leadership for the programme sits under Professor Kevin Fenton, with the primary government department policy interface led by Rosanna O'Connor, Divisional Director for Alcohol Drugs and Tobacco (ADT).

5.5 Within the ADT division there are eight staff who are wholly employed to support the alcohol programme. There are many others within the division and other directorates that interface with or have direct responsibility for some aspects of the

programme – as alluded to in section 28. Resourcing is predominantly through Grant In Aid – as part of PHE permanent staffing and little programme funds have been allocated to alcohol in 2016-17 beyond a nominal amount to support the Alcohol Leadership Board.

6. How we measure our impact

6.1 Measuring our impact is a challenge given the multiplicity of levers we are trying to influence and the lack of direct relationship between our actions and the drinking behaviour we are trying to change.

6.2 At the highest level our ambition is to reduce the harm that alcohol causes. Our current proxy measure is alcohol related hospital admissions, which have largely remained stable for the last few years, although these national figures obscure increases in some geographic areas and within the female population. Falling rates would provide us with the most objective measure of our overall success – though the relationship is not as simple as our support for X intervention leads to a Y % reduction and we need to pay particular attention to variation within that by say geography, age or gender.

6.3 PHE action on alcohol sits within a much broader context of Government policy all of which contribute to alcohol harms much of which sits outside our responsibility.

6.4 For us to be confident that we are making an impact we do the following:

a) Measure ourselves against what we say we are going to do
b) Measure ourselves against what our stakeholders think about our actions
c) Measure ourselves against public participation in specific campaigns or that part of more general healthier living campaigns that relate to drinking
d) Measure the extent to which our publications are quoted or referenced in the media or in academic literature
e) Measure the extent to which access and outcomes of treatment for dependence improve
f) In addition we aim to make a direct link between our recommendations in the upcoming Evidence Reviews and a change in government policy.

7. Discussion

7.1 We welcome suggestions for active support from Board members of the findings of the Evidence Review, through their networks and contacts to ensure that it gets maximum exposure and to enhance its potential for impact on future policy.

7.2 We welcome any suggestions from the Board on how we could or should measure the impact of our current or future programme.

ANNEX A – PHE's Social marketing programmes