National Audit Office

DEPARTMENT OF HEALTH

Reducing Alcohol Harm: health services in England for alcohol misuse

LONDON: The Stationery Office
£14.35

Ordered by the
House of Commons
to be printed on 27 October 2008

SUMMARY

1 For a significant and growing number of people in England, alcohol consumption is a major cause of ill-health. More than 10 million people (31 per cent of men and 20 per cent 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. Hospital admissions for the three main alcohol-specific conditions (alcohol-related liver disease, mental health disorders linked to alcohol and acute intoxication) more than doubled in the 11 years between 1995-96 and 2006-07 from 93,459 to 207,788, although this is in the context of a general rise in admissions of about a third over the same period. There were 8,758 deaths from alcohol-related causes in the UK in 2006, twice as many as there were 15 years before.

2 The Department of Health **(the Department)** estimated in July 2008 that alcohol misuse costs the health service in the order of £2.7 billion per year. Such misuse also imposes wider costs on society, such as crime and disorder, social and family breakdown and sickness absence. The total annual cost of alcohol misuse to the UK economy has been calculated by the Cabinet Office at up to £25.1 billion.

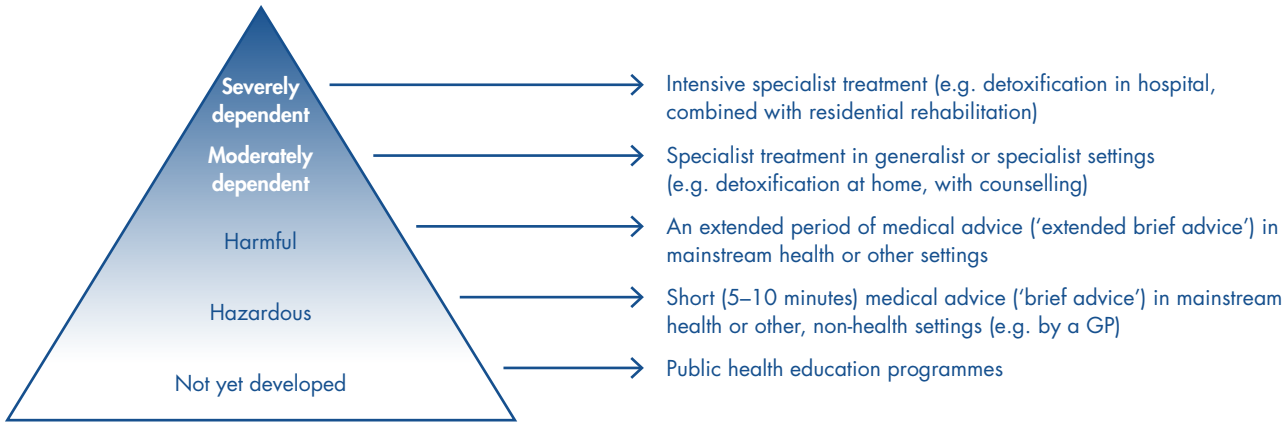
3 The World Health Organization has identified four levels of alcohol misuse, which the Department uses in its alcohol strategies and guidance. These range from 'hazardous' drinking (above recommended limits), through to 'severely dependent' alcohol misuse, which requires intensive specialist treatment **(Figure 1)**.

In England, it is estimated that 18 per cent of the adult population (7.6 million) are drinking at 'hazardous' levels; another seven per cent (2.9 million) are showing evidence of harm to their own physical and mental health, including approximately 1.1 million people who have a level of alcohol addiction (dependency). The health service offers different types of services for these groups, ranging from simple measures to provide information and raise awareness to acute clinical or mental health interventions for severe cases.

4 Dependent drinking can have many causes, including family history, psychological factors such as anxiety or depression, the addictive pharmacology of alcohol, and the environment in which people live. For others who drink alcohol above the guidelines, at 'hazardous' and 'harmful' levels, alcohol misuse may be due to habit, lifestyle, lack of awareness of the health effects and an absence of obvious symptoms.

5 The Department has in recent years emphasised the importance of prevention and public health measures, particularly in the *Choosing Health* White Paper (2004) and in Lord Darzi's review of the future of the NHS, *High Quality Care for All* (June 2008). In keeping with that aim, there has been a National Alcohol Strategy in place since 2004, aiming to encourage a more sensible drinking culture and reduce the burden of alcohol harm on society and the economy. In 2007 Government reviewed progress and set out the next stage of its National Alcohol Strategy in the report *Safe. Sensible. Social*, led jointly by the Department and the Home Office. The Strategy emphasises the importance of early interventions such as 'brief advice' (see box), which have been shown to reduce alcohol consumption by people who are drinking more than sensible amounts, but have not developed a dependency on alcohol.

1 The range of alcohol treatments and interventions



Source: Adapted from Broadening the Base of Treatment for Alcohol Problems, Institute of Medicine, 1990

NOTES

Individual drinkers may move between categories of alcohol problem over time and the boundaries between categories are not clear-cut. Likewise, the treatments are indicative and may, in some circumstances, be appropriate for the other categories of alcohol problem.

Severely dependent: may have withdrawal fits (delirium tremens: e.g. confusion or hallucinations usually starting between two or three days after the last drink); may drink to escape from or avoid these symptoms.

Moderately dependent: likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking.

Harmful: showing clear evidence of alcohol-related problems.

Hazardous: drinking applies to anyone drinking over the limits recommended by the Department.

Not yet developed: people who currently have no level of alcohol misuse.

Brief advice

'Brief advice' is the term used for short, structured advisory interviews, provided when questions about a patient's drinking habits have identified that there is misuse. The advice is provided by a 'competent practitioner' such as a GP, nurse or trained non-medical professional, in about five to ten minutes. Typically, the advice given includes the risks a patient is running by drinking too much, setting goals to reduce alcohol consumption, and providing written materials such as advice leaflets. Brief advice has been shown to be effective in reducing hazardous and harmful drinking, as well as being cost-effective. In September 2008 a new Directed Enhanced Service was announced, providing an additional incentive of £8 million for GPs to undertake identification and brief advice with newly-registered patients. This will begin in April 2009.

6 Beyond the immediate health benefits to individual citizens, a greater focus on prevention also means that the costs of later, often more complex treatment are avoided, providing important savings to the NHS. By supporting early interventions on alcohol misuse, such as 'brief advice', the Department and the National Health Service (NHS) may avoid or reduce the costs of later, more intensive and specialist support for people who develop dependency or suffer from an alcohol-related illness.

7 In April 2008, for the first time, alcohol misuse became the subject of a cross-departmental Public Service Agreement (PSA), with the Department of Health a partner in delivering the new PSA 25 on alcohol and illegal drugs, led by the Home Office. The PSA will be monitored annually until 2011 and includes a performance indicator for the Department to bring down the rate of increase of alcohol-related hospital admissions. In turn, the Department is encouraging the local NHS commissioning bodies, Primary Care Trusts (PCTs), to include this indicator in their operational plans.

8 In this context, the National Audit Office has undertaken a study to evaluate:

- the arrangements for planning and commissioning health services for alcohol misuse (Part 2);
- measures to prevent alcohol misuse, and to identify misusers and provide them with simple advice and help (Part 3);
- specialist services to treat misusers who are dependent on alcohol, including those who have a serious or longstanding dependence on alcohol (Part 4).

9 The report focuses on alcohol misuse and on health services, based on data gathered in early 2008. It concentrates on the role played by the NHS and its partners in delivering on the hospital admissions indicator of the PSA. The report excludes other influences and policy areas which impact on the PSA, such as those that affect the availability of alcohol (such as pricing and promotion, taxation and licensing) or which deal with crime, disorder and other social effects.

10 The report focuses on England. The administrations in Scotland, Wales and Northern Ireland are separately responsible for health issues, and have responded in different ways to the differing patterns of alcohol harm in their countries (Appendix 3). In Scotland, where alcohol-related harm is higher than in England, there are plans to invest approximately £120 million in tackling alcohol misuse over the three financial years from 2008-09. In Wales, a new strategy for tackling substance misuse, including alcohol, was launched on 1 October 2008. A Northern Ireland alcohol strategy was published in 2000 and a further strategy document covering alcohol and drugs was published in 2006.

Main findings

The current state of services

11 PCTs are now responsible for setting their own local health priorities, but our survey found that a quarter had not accurately assessed the alcohol problems in their area. Without such assessments, PCTs cannot know what services they should be providing, and cannot assess whether the services they commission are sufficient or cost-effective. All PCTs have ready access to the data held in the Local Alcohol Profiles for England, which are generally acknowledged to be the most reliable data available on local need, but around 20 per cent of PCTs do not make use of them, and around a quarter of PCTs surveyed for this report had not carried out their own local needs assessment for alcohol in the last few years. Since April 2008, however, PCTs are required to undertake together with local authorities a formal assessment (Joint Strategic Needs Assessment) of the future health and wellbeing needs of the local population as the basis for planning future services.

The role of Primary Care Trusts in addressing alcohol harm

PCTs are responsible for determining local health priorities and have control of the majority of NHS spending. PCTs are free to decide for themselves how much to spend on services to address alcohol harm. They have no specific requirement to provide any alcohol-specific services, but since April 2008 they have been able to choose to include an indicator for alcohol-related hospital admissions in their operating plans. PCTs and other local bodies, in particular Drug and Alcohol Action Teams, may commission a range of treatments and services to address alcohol harm from various providers, including GPs, hospitals and mental health trusts, voluntary and private organisations.

Drug and Alcohol Action Teams

These Teams are local partnerships of professionals from local authorities and other public bodies such as PCTs, the police, probation service, and from private and voluntary sector providers. Their role is to address drug and alcohol problems in the local area and they plan treatments and commission services from a range of providers in all sectors. Drug and Alcohol Action Teams are accountable primarily to the local partnerships of which they are part and evolved from Drug Action Teams. There are 149 Drug Action Teams and Drug and Alcohol Action Teams in England. In many areas Drug and Alcohol Action Teams have merged or work closely with community safety or crime reduction partnerships.

12 Many PCTs do not have a strategy for alcohol harm, or a clear picture of their spending on services to address it. Some 58 per cent of the PCTs responding to our survey had an alcohol strategy and 69 per cent were able to provide details of their expenditure on alcohol services. Where spending was known, it showed PCTs spent an average of £600,000 on commissioning alcohol services in 2006-07 (including, for example, the provision of brief advice from GPs, weekly alcohol clinics, or more involved specialist treatments). This expenditure represents a little over 0.1 per cent of a typical PCT's total annual expenditure of around £460 million. The wider general cost to the NHS of dealing with the consequences of alcohol misuse, ranging from the cost of ambulance services to acute surgical procedures such as liver transplants, is estimated by the Department to be in the order of £2.7 billion annually.

13 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 dependent users of illegal drugs and alcohol. They are not equipped to meet the needs of the much larger groups of 'hazardous' and 'harmful' alcohol misusers. The 2004 National Alcohol Strategy recommended that local Drug Action Teams should be encouraged, but not required, to extend their remit for commissioning and delivering treatment services to cover alcohol misuse for adults as well as drugs misuse (which includes under-age alcohol misuse). In 2004, around half of Drug Action Teams offered both drug and alcohol services. That figure has since increased to 81 per cent. Illegal substance use, however, remains Teams' overriding concern with their main source of funding (a budget of £385 million in 2006-07) ring-fenced for that purpose. Furthermore, many Drug and Alcohol Action Teams do not have the direct links with or experience in primary or acute (hospital) care to commission effective alcohol interventions in these areas.

14 Local provision of specialist services is not based on a good understanding of communities' needs and there are wide variations between localities. There is also much scope for better integration of hospital services with follow-on and support services, such as psychiatry or self-help groups, to improve recovery rates and prevent patients relapsing into their previous drinking patterns.

On the costs and benefits of programmes to address alcohol harm

15 The available evidence suggests that simple, often early interventions such as identification and brief advice can bring substantial savings by reducing the need for more intensive treatment later. Locally, however, opportunities to identify and advise people who are drinking above sensible levels are not being fully exploited. Alcohol screening questionnaires and the provision of brief advice offer a quick and effective means of identifying and engaging with those who are drinking above the guidelines but who may not realise the damage they are doing to their health. There is evidence indicating the cost-effectiveness of such interventions (Appendix 6). However, identification and brief advice is only sporadically provided by GPs and health workers, and rarely used in other parts of the health service, such as accident and emergency (A&E) departments where those suffering from the consequences of alcohol misuse are often present.

16 More specialist treatments, even though the cost is higher than for brief advice, have also been shown to be cost-effective, since they can also reduce the high costs of treating serious alcohol-related diseases. For example, specialist counselling and detoxification can reduce alcohol consumption, and may prevent liver damage worsening to the point where a liver transplant, typically costing £80,000, is needed. The Department recently commissioned an online system to collate details of local alcohol-related initiatives throughout England, known as the 'Hub of Commissioned Alcohol Projects & Policies' (HubCAPP). However, the programme is still in its infancy and its details have still to be communicated widely.

17 Since 2006, the Department has sought both to clarify its guidance on sensible drinking and to promote public health, through a series of new publicity campaigns. Research showed that the Department's guidelines are not fully understood by consumers, who tend to underestimate the amount of alcohol that their drinks contain. In response, the Department has funded a further campaign to raise public awareness of alcohol units in drinks, which started in May 2008. The public health campaigns ('Know Your Limits'), which were initially aimed at binge drinking and will cost the Department more than £6 million in 2008-09, have followed good practice guidance for such publicity work. The Department did not set measurable goals for the intended impact of these campaigns but aims to continue to track reported consumer awareness and behaviour change.

The new Public Service Agreement

18 The new PSA performance indicator on alcohol-related hospital admissions gives PCTs an incentive to address alcohol harm, but it has limitations and carries risks. While the indicator will measure alcohol harm and its consequences for the health service, it may not act as a clear incentive to PCTs to provide, for example, brief advice. Evidence suggests that the indicator will be responsive to provision of specialist services and early interventions (although it is also sensitive to other policies such as programmes to restrict availability and to reduce alcohol-related crime and disorder, which are not covered by this report).

19 While the majority of PCTs have chosen to include the new alcohol-related performance indicator in their operating plans, or in a Local Area Agreement, more than a third have not. In areas with relatively low levels of alcohol harm and more pressing health priorities it may be appropriate for PCTs not to adopt the indicator, but such decisions need to be based on sound evidence. PCTs' operating plans and Local Area Agreements are the direct means by which the Department can influence action locally on alcohol services and secure progress towards the PSA. As a positive development, almost all (46 of 50) of the PCTs showing the highest rate of alcohol-related hospital admissions, have included the new indicator in their operating plan and for many of these (32), the indicator is also included in the corresponding Local Area Agreement. Where Local Area Agreements do not include the alcohol indicator even though it is in the PCT's operating plan, PCTs will have to work harder to gain local partners' support for work such as the promotion of sensible drinking.

20 Regional oversight of the NHS's response to alcohol misuse has to date been limited. The creation of a new network of Regional Alcohol Offices in autumn 2008 aims to strengthen the influencing role of Strategic Health Authorities and Regional Directors of Public Health and to provide opportunities for sharing best practice between PCTs. The Department has committed £2.7 million per year for three years from 2008-09 for Regional Alcohol Offices with dedicated Regional Alcohol Managers, to support commissioners in delivering the PSA. Regional Directors of Public Health will assess whether planned activity is both realistic and reflects local need, and will check performance by PCTs against local targets annually.

Conclusion on value for money

21 Where they could provide a figure in response to the NAO survey, PCTs reported spending on average approximately £600,000 on services directly intended to address and reduce alcohol harm. Some PCT expenditure will be on services such as brief advice, which are judged generally to be cost-effective; although PCT expenditure on alcohol services as a whole cannot be comprehensively demonstrated to be so. Overall, therefore, there is scope to secure better value for money from PCT expenditure on alcohol services, which is not usually based on a clear picture of need or of the likely results. Our survey found that local strategies are lacking, or inadequate, in many areas and service delivery is fragmented, with resources allocated based on an incomplete picture of need. Service provision has, as a consequence, varied widely, both in type and degree of provision.

22 The new PSA indicator on alcohol is a way of encouraging local NHS organisations to focus on alcohol harm. The adoption of the indicator locally is, however, optional. Therefore, the indicator has no direct accompanying sanctions or rewards for PCTs. However, the Department does plan to publish benchmarking information on all PCT performance indicators, including the alcohol indicator, annually.

23 There is evidence, however, that well-planned and targeted services can produce results which are good value for money. With an increased emphasis placed by the Department on the promotion of public health, NHS trusts need to understand how to translate this wider objective into practical, well-evidenced resourcing decisions. The evidence base on cost-effectiveness will be strengthened by forthcoming studies, including a study of brief interventions – the Screening and Intervention Programme for Sensible drinking – commissioned by the Department, and the National Institute for Health and Clinical Excellence (NICE) review of prevention, early identification and clinical guidelines for the management of alcohol misuse. The resulting recommendations are due to be published in 2009 and 2010 respectively, providing the NHS with additional tools to understand the relative cost-effectiveness of different services to reduce and prevent health harm from alcohol misuse.

Recommendations

a The contribution of the NHS and its partner organisations to measurable progress relies primarily on the actions of PCTs. Our evidence suggests that, to date, PCTs' planning and commissioning of health services to reduce alcohol harm have not been tailored to local needs. In 2009, at the end of the first year of the new PSA, Strategic Health Authorities should assess the progress made by PCTs in each region towards the PSA alcohol indicator, taking local action if agreed progress has not been made.

b While national systems collect detailed data on local patterns of alcohol misuse, some PCTs do not use these sources, and few PCTs collect information from their local partners to supplement these national datasets. The Department should provide a framework to allow PCTs to assess alcohol misuse within a PCT area; thus enabling regular reviews of performance by Strategic Health Authorities and Regional Directors of Public Health, and allowing PCTs themselves to compare their provision of alcohol services against peer PCTs with similar patterns of alcohol misuse.

c The new PSA indicator on alcohol needs to act as an incentive for PCTs to address effectively the alcohol misuse problems in their local area. To strengthen the rigour of PCTs' local prioritisation and commissioning decisions concerning alcohol, the Department should deepen and develop the evidence available to PCTs on the causes and forecast trends of alcohol-related hospital admissions and alcohol health costs. It also needs to develop further evidence for the link between the PSA alcohol indicator and early interventions.

d Historically, primary care data have not given a clear picture of alcohol misuse due to confusing 'codes' for recording diagnoses and interventions resulting in inconsistent recording of activity in primary care. New codes for identification, screening and brief advice were issued in May and October 2008, and the Department should set a review point to assess how effectively these codes are operating to generate accurate and comparable information.

e Currently there is no consistency in how the level and cost of alcohol services is recorded locally. To secure greater consistency, the Department should emphasise to PCTs the importance of following the guidance set out in the NHS costing manual. Strategic Health Authorities will be able to use this standard method to compare provision across their PCTs as part of their performance management of PCTs.

f Money spent on identification and brief advice can be cost effective, helping to pre-empt the need for more expensive services to treat longer-term alcohol harm, but currently such services are sporadic. The Department should explore the feasibility of providing PCTs with a toolkit to assess locally the relative costs and benefits of different services to tackle alcohol harm, particularly those that focus on early prevention. The toolkit should aim to show the effect that such preventive measures can have in reducing the need for specialist treatment in the future, based on existing guidance and the best available estimates of cost effectiveness.

g PCTs have often seen Drug and Alcohol Action Teams as the bodies primarily responsible for commissioning services to tackle alcohol harm. These Teams, however, focus on specialist treatment of illegal substance misuse. PCTs need to be clear about the purpose of funding they provide to Drug and Alcohol Action Teams, for example in commissioning specialist services. The majority of specialist alcohol treatments are provided by combined drug and alcohol services and so there is a risk that, without a clear specification, alcohol treatment could be overlooked. At a national level, the Department, working with the Home Office, needs to undertake a consultation with representatives of local commissioners in order to provide clear guidance on the remit and local accountability of Drug and Alcohol Action Teams in relation to alcohol, including how this fits within the Teams' existing accountabilities for illegal substance misuse. PCTs should also promote the commissioning of brief advice for the large body of hazardous and harmful drinkers, whether provided in general practice, A&E departments or other other parts of the public sector.

h Where PCTs do commission services, they rarely assess the quality of what is delivered. Regional Directors of Public Health and Strategic Health Authorities need to get PCTs to assess the quality of the services they commission against the Department's commissioning guidance, including *Models of Care for Alcohol Misuse, MoCAM* (2006) and criteria set out in the Department's World Class Commissioning programme.

i Our survey of PCTs showed that not all are working well with other public bodies – such as the police, prison and probation staff, and social services – to identify and help people who are misusing alcohol and whose health may be at risk. Such organisations are often well placed to identify alcohol misuse within those sections of the community that do not come into regular contact with the health service. PCTs should help educate and train NHS staff and agree with local partners outside the health service how they can be supported in developing skills to identify alcohol misuse.

j Currently there is no systematic means of promoting good evidence-based practice on alcohol harm across PCTs. Regional Directors of Public Health should develop a professional network of PCTs, Drug and Alcohol Action Teams and health care professionals with an interest in exploring and promoting new ways to tackle alcohol misuse. These networks should record details and outcomes of local alcohol-related interventions and treatments using the existing online database of alcohol initiatives (HubCAPP).