HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Alcohol treatment services, HC 1001

Thursday 2 March 2023

Ordered by the House of Commons to be published on 2 March 2023.

Watch the meeting

Members present: Dame Meg Hillier (Chair); Olivia Blake; Dan Carden; Mr Jonathan Djanogly; Nick Smith.

Gareth Davies, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-132

Witnesses

I: Clare Taylor, Chief Operating Officer, Turning Point and Vice-Chair, Collective Voice; Professor Dame Carol Black, author, independent review of drugs; and Sir Ian Gilmore, Chair, Alcohol Health Alliance.

II: Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; Jonathan Marron, Director General, Office for Health Improvement and Disparities, DHSC; and Alice Wiseman, Director of Public Health, Gateshead Council, and Board Member and Alcohol Policy Lead, Association of Directors of Public Health.

HOUSE OF COMMONS

Report by the Comptroller and Auditor General

Alcohol Treatment Services (HC 1129)

Examination of witnesses

Witnesses: Clare Taylor, Professor Dame Carol Black and Sir Ian Gilmore.

Q1 **Chair:** Welcome to the Public Accounts Committee on Thursday 2 March 2023. Harmful drinking has a detrimental impact on drinkers and their loved ones, as we know. It also costs the national health service about £3.5 billion a year to treat. About a decade ago, alcohol treatment services were moved to local authorities, but since then we have seen a drop in funding for those services—obviously there are other pressures on local authorities—but an increase in the number of people admitted to hospital or, sadly, dying for alcohol-related reasons.

Today, we have a double-handed session. Our first panel are experts in their field. We will be talking about how things are working on the ground. In our second session, we will move on to question the senior civil servants responsible for this area of policy and the Association of Directors of Public Health. I welcome our witnesses on the first panel: from my left to right, Clare Taylor, the Chief Operating Officer for Turning Point and Vice Chair of Collective Voice; Professor Dame Carol Black, known to many, author of an independent review of drugs for the Government; and Sir Ian Gilmore, the Chair of the Alcohol Health Alliance, but wears many other hats as well. When you first speak, if you could explain what you do, that will be helpful for those listening. To kick off, will you describe the current state of the provision of alcohol treatment services? Please, also explain exactly what you do and what the role of Collective Voice is as well.

Clare Taylor: Collective Voice is a charitable organisation working to promote effective treatment and recovery services. I also work for Turning Point, a national treatment provider of drug and alcohol treatment services.

As to what we are experiencing at the moment, we are noticing an increase in the number of people coming into treatment for support with alcohol use, at a time when there has been considerable disinvestment in funding of services. We are also noticing increased acuity of people coming into treatment, particularly with liver damage, requiring additional support.

We know that when people do come into treatment, it can be effective—almost 60% of people coming into treatment leave successfully. As for waiting times, people are seen within three weeks, on average. However, from the recent National Audit Office Report last week, we know that a significant number of people are not in treatment. I think only 18% of

those who might be dependent are accessing treatment services, so significant demand is not being met.

Professor Dame Carol Black: At the moment, I am the independent adviser to the Government on combating drug misuse. In my independent review on drugs, the treatment element and what I recommended were, I hoped, going to help those dependent on alcohol as well, because drugs and alcohol services are commissioned together. I said in my report—it was true of drugs and alcohol—that the system was broken and I could not see how it could get much worse in many ways. I said that we were starting from a very low base and that it would take several years to turn it around.

I hoped that of the 50,000 new places that come with my review, 20,000 would be for alcohol-dependent people, but the real challenge is how you deliver that treatment. Often, alcohol patients find it quite difficult to go to drug treatment centres. A lot of nuance is needed around the way you deliver services; more attention needs to be paid to the special requirements of an alcohol-dependent person, both in the community treatment and when they need secondary care. I think I helped a bit, but there is more to do.

Sir Ian Gilmore: I am a physician by background. I specialise in liver disease. I have worked at the Royal Liverpool Hospital for 40 years and I have seen a lot of patients come through, not just those with alcoholrelated liver disease. If any patient has a problem that can be pinned on alcohol, that tends to be pushed towards our service.

In a sense, I am a late convert to a public health approach, because I

have spent years pulling drowning people out of the water without walking upstream to see why they were falling in. I think the penny has finally dropped. It dropped when I was president of the Royal College of Physicians and I set up the Alcohol Health Alliance. We had a handful of charities and third sector organisations; we now have over 60, and it has been absolutely spectacular watching that grow.

One of our priorities has always been alcohol treatment services, and that remains so. One of the frustrations is that we know it works—as Clare tells us, it not only works, but saves money. For every pound invested, you get £3 back straightaway and £26 over 10 years; those are reliable data. It works, but at the moment it is not being allowed to work—this in the face of NHS pressures which we know it could help. One in 20 hospital admissions are alcohol-related and a staggering 40% of ambulance time is taken up with alcohol-related problems, so we need the treatment services to work.

Chair: Thank you. I am going to ask Dan Carden MP to start the questioning.

Q2 **Dan Carden:** I start by declaring my interests to the Committee. People will know that I have long campaigned on this issue. I am the MP named in the National Audit Office Report as having asked the NAO to carry out this briefing.

Sir Ian, can I start with you? I thought one of the most shocking statistics in the NAO Report was that deaths relating specifically to alcohol had risen by 89% between 2001 and 2021. Over that 20-year period, how have you seen alcohol harm change and impact people?

Sir Ian Gilmore: As you imply, it has just got progressively worse. It has been particularly frustrating, I think, not having had any national alcohol strategy for more than 10 years now. The one that we did get previously was, sadly, not evidence-based and really didn't have the levers or the goals and targets to allow us to really make a difference. I have been involved in alcohol strategies for more years than I care to remember. We have been really fighting for a strategy ever since.

It has also been frustrating in the last decade to see the funding go down for treatment services. I absolutely realise that there were benefits in moving public health into local city councils, but that gap has undoubtedly allowed the money to be raided—for very reasonable priorities, but raided none the less. Funding has been a real disappointment.

Integration of services across the piece has also suffered. I think alcohol care teams in hospitals are one of the bits of good news, if you like—there is still a long way to go, but most patients coming into hospital will get seen and assessed. The problem is they go out with a handful of leaflets and appointments. First of all, about a third don't even remember what they have been told because they have an alcohol-related brain injury. As you know, we are starting an aggressive outreach project in Liverpool, with charitable funding, to try to deal with that. But even those who know what they are being told often fall through the cracks in the services because the signposting, the training of alcohol workers in the community, and the links with the charitable sector and organisations such as AA are not good. The vulnerable, the homeless and the poorest in society seem to be falling through the gaps, and we have evidence of that.

I don't want to talk for too long, but the final issue I have to raise is workforce. Addiction psychiatry is a dying speciality; if we let it die, we will regret that for generations. The training posts have gone down from something like 60 to four—don't quote me on the exact number, but it will die if we don't do something about it. So many of these patients—70% of those entering treatment—have mental health issues that need to be addressed, not just by an alcohol worker with a clipboard but by someone with expertise in mental health. That is one of our priorities.

Q3 **Dan Carden:** Dame Carol, alcohol was out of scope of your independent review, but the Government insist that the 10-year drug plan, "From harm to hope", will improve alcohol treatment outcomes. Does the drug strategy adequately deal with alcohol harm or is something else needed?

Professor Dame Carol Black: I certainly think it begins to deal with it. As I said, you have 20,000 new places. The real challenge, as I said to Dame Meg, is how you get alcohol-dependent people early in their journey to go to treatment centres, because they often feel stigmatised and don't want to be there with a drug-dependent person. So you need to think about the delivery of the service very carefully. You could use GP services and outreach more.

I have started the journey. Do I think it is enough? It is neither enough on alcohol nor enough on drugs, but we need to show the Treasury that with the money we have got, we can improve both the alcohol and drug treatment services such that we can make a case in the next spending review.

On the immediate things that you could do, I think we should remind our drug partnership boards that they have a duty to alcohol-dependent people. The outcomes framework has alcohol in it and perhaps we should stress that a little more. ICSs have equality fund money and we have been trying to engage the ICSs, both for drugs and alcohol, because they could be supportive partners. So you have those two options that you could put pressure on immediately.

I suppose you are indirectly asking me if I think an independent review of alcohol would be helpful. You would learn more, of course, but you know so much already. You would have to weigh it up. It takes at least a year to do an independent review, often longer—say 15 months. You are better placed to judge than I am, but where we are in the political cycle would give you challenges. Of course, an independent review gives you an independent voice, although I am not sure how valuable that is; I like to think it is valuable.

An independent review would not be out of scope for me, but I think you would have to ask yourself how much value you would get at this point in time. There are some immediate things we should do, such as make every local council and drug partnership board aware of their duty in the treatment sector to alcohol-dependent people.

Q4 **Dan Carden:** Dame Carol, you were dealing with illicit drugs. Here we are talking about a drug that is the most harmful but also legal. What additional challenges do you think that presents?

Professor Dame Carol Black: Of course that presents you with a challenge, because many people like and enjoy a drink without it doing them any harm. The challenges you have to think about are about what our prevention strategies are, how we get to young people in particular, and the advertising that is available to young people. I think you do have to think about minimum unit pricing and licensing. If people drink, we

want them to drink responsibly. Are the regulations sufficient? I think that is for you, as politicians, to decide.

Q5 **Dan Carden:** On that point, Sir Ian, how harmful is alcohol? You are a liver specialist; how harmful is alcohol?

Sir Ian Gilmore: There are over 100 illnesses associated with alcohol. The one that people know about is cirrhosis of the liver, but what people do not know is that alcohol is strongly linked to seven cancers, two of which are particularly common: breast cancer and colon cancer. The evidence is that there is no safe limit. Clearly, the less you drink the lower the risk, but any alcohol does slightly increase your risk. Of course, everything in life carries risk, and patients who want to avoid risk by lying in bed will get deep vein thrombosis—nothing is safe. When we looked at and recommended units of alcohol, 14 units a week equated approximately to a one in 100 chance of dying of an alcohol-related disease. Most people drinking less than 14 units would accept that as a reasonable risk. We cannot say any more that alcohol in moderation is safe, but the risks are relatively low.

Q6 **Dan Carden:** Alcohol Health Alliance has great expertise in these areas. I am sure today we will focus on treatment, commissioning and all the issues relating to the national health service and local authorities. How important is the public health strategy? I am thinking of the availability of alcohol and the marketing—those types of things.

Sir Ian Gilmore: Prevention, or harm reduction, is the most important part. We certainly do not want to ignore those who have been caught up in the problem already, which is why treatment services are one of our priorities in the AHA. None the less, if you want to make an impact, there is no doubt that you need to go upstream. Price first, then availability and marketing—those are the three big drivers. There is international evidence that would break the benches here with its weight. As Dame Carol said, we could do an independent review, but in a sense we have got the evidence. Public Health England produced a wonderful paper in *The Lancet* in 2017 enumerating all the evidence on the benefits of a strategy of prevention. I really think it is time to push Government into a strategy.

Q7 **Dan Carden:** One final question from me to Clare. The National Audit Office briefing says that around 18% of dependent drinkers access treatment. Why do you think that is?

Clare Taylor: There are probably multiple reasons. One is the stigma around accessing support for alcohol. One is that the lack of investment has probably led to an over-focus on drugs in combined integrated services, and we need to redress that. As Dame Carol said, some of the additional funding will help with that. I think we need to do more across primary care in identifying people who are drinking problematically. We need to work on the prevention, as Sir Ian said, and early identification of people with problems, so we can see them in structured treatment services sooner.

Q8 **Nick Smith:** Well done to Mr Carden for initiating this Report; it is really important. To our witnesses, does minimum unit pricing work? How much of an impact does it make?

Chair: Who are you directing that to?

Nick Smith: Probably to Sir Ian first.

Sir Ian Gilmore: The first thing to say is that there will never be final data, but people will go on looking at the results. A Scottish department is looking at this, and will produce a report later this year, probably not much before Christmas. I would say that about a dozen studies have come out, and 11 out of the 12 have shown a real benefit. There has been a lot of publicity given to one study that came out recently, which said that heavily dependent drinkers did not cut down their drinking, but seemed to move money from other things, such as food, into drink. That was a highly selected group of heavily dependent drinkers who were accessing treatment. That was at one end of the spectrum, and in a sense you would not expect a big impact on them, although if you could reduce their drinking from, say, 2 litres of Scotch a day to 1 litre, you would help them.

The evidence from Scotland is that the minimum unit price does target the heaviest drinkers. The heaviest drinking households showed the biggest reduction in consumption, and hospital admissions and deaths are down. There is very strong evidence of the benefit, and we will have evidence coming from Wales. We have evidence from Canada of a very closely related way of tackling price: a floor price. They have seen a health benefit. I think it is something we should do. It has somehow got a bit of a bad name in Westminster in the last year or 18 months. We have not been going on about it, but there is no doubt that prices are the single most important thing. MUP is very good because it targets the heaviest drinkers; the non-dependent heavy drinkers are targeted.

We should not forget duty; there is a duty review on at the moment. Duty in real terms has dropped way back, so that in real terms, alcohol is two or threefold cheaper than it was, say, 40 years ago. The two things are complementary. We should look at and rationalise duty. At the moment, the system is not rational. Products should be taxed according to alcohol

content, and they are not. Duty gets frozen every Budget, and we do not see the rationale for that. Duty and MUP side by side are the most powerful ammunition we have.

Q9 **Nick Smith:** I have one more question, Chair. I am not sure who is the best person to ask. Sir Ian, you talked about handing out materials to people at your alcohol services. I think you said that one third of them have alcohol-related brain injury and therefore could not understand what services they needed to seek. That seems a really thorny issue. Is there good work addressing that? It is a really tricky thing.

Sir Ian Gilmore: That is a very good question; I could bore you on it for an hour. It has been a Cinderella subject within alcohol and harm, but we are tackling it in Liverpool and one or two other places. The problem is that the cause is complex because alcohol is directly toxic to the brain in large doses. Also, people who are alcohol-dependent fall over a lot and get head injuries. They tend to smoke more than average and get arteriosclerosis—a hardening of the arteries—so the mental impairment is multifactorial. There are good studies on this.

The issue is worth concentrating on, because this is one of the few forms of dementia that is reversible. About one third of people with alcoholrelated brain injury return virtually to normal if they keep away from alcohol. One third make some improvement, and one third do not improve at all. Those are good odds when you compare them to those for other causes of dementia. As I say, we are setting up a pilot study, funded by the Oglesby Trust in Manchester, which looks at an outreach system that captures these people. They go home, and the project supports them and the family. We expect that to make a significant difference.

Q10 **Olivia Blake:** I want to ask Dame Carol and Sir Ian about the trend for younger people not to drink as much. Should we be encouraged by that trend? Is it already impacting services? Are you seeing fewer people in your services?

Sir Ian Gilmore: Yes, it is encouraging. It is not unique to this country; it is an international trend. I think the reasons are not fully understood, but we should welcome it. However, we need to remind ourselves that alcohol is still the biggest single factor in deaths in men between 15 and 49. That is a stark statistic. I haven't got the figures in front of me, but the percentage of 11-year-olds who had been drunk in the previous month was remarkably high, so it still goes on. There is improvement, but as young people are improving, the middle-aged and older population are a worry. They often have more disposable income.

I remember the president of the Intensive Care Society telling me that ITU beds had been blocked by older people falling down the stairs when going to bed at night when they were not fully compos mentis. Of course, older people have other comorbidities that make alcohol more harmful, and that was the group we saw causing more problems during covid lockdown than

young people. One group seems to improve a bit, and another group seems to get worse.

Professor Dame Carol Black: During my review, one of the most worrying features was the deterioration in treatment for young people with addiction. I documented that it was, if anything, worse than what had happened to adults, so we have a long way to go on both drugs and alcohol. Given the money that local authorities will now have—this is certainly in the guidance that they have received—we need to think what we most need to provide for young people who have an addiction. They do not find the normal treatment centres particularly attractive. Very often, they require far more psychosocial input. As you probably know—Ian has referred to it—the treatment workforce has been decimated, whether that is psychologists, mental health nurses or addiction psychiatrists. All parts of the treatment service workforce have really been deteriorating.

There is a real need to say, "What do young people with either alcohol or drug addiction need in order to go to and stay in treatment?" At the moment, there is quite a barrier. You see this with young students from university who may have an addiction need. The services are just not geared and welcoming to young people, and it is a really important point.

Q11 **Olivia Blake:** Moving on to commissioning, what impact does not knowing what the public health grant will be have on ability to plan services? It is probably best to ask Ms Taylor that. We do not know what next year's grant will be.

Clare Taylor: No, and that does have a significant impact on planning, particularly as one of our priorities is to build up the workforce and recruit more specialist staff to the sector. That is very difficult to do, because it takes time, so that does have an impact.

It was announced last week that, on the back of the Dame Carol Black review and the drug strategy, the additional OHID funding has been guaranteed for another two years. That is helpful, but it would be helpful for the sector in general to have a longer-term, stable commitment to funding to allow for better planning.

Q12 **Dan Carden:** Carrying on the theme of commissioning, the Report says that over the last seven years, there was a 27% drop in spending at local authority level. In 2012, commissioning was taken from the national health service and given to local authorities. What challenges does that present? Do any of our panellists think that there should be a change in where alcohol and drug services are commissioned?

Clare Taylor: It is difficult to compare regimes because of the disinvestment there has been over the last 10 years and the changes in external circumstances. There is certainly an argument for it being sat in public health, due to the wider impact of alcohol use and misuse. What is really important is the financial investment in treatment, and for that to be ringfenced so that it can be protected. There should also be continued

investment in quality commissioning standards, so that there is goodquality planning at local level, regardless of where commissioning sits.

Q13 **Dan Carden:** What are the challenges to do with having mental health services commissioned by the national health service and drug and alcohol services commissioned at local level?

Clare Taylor: There are still issues with integration; offering comprehensive services for people who have drug and alcohol problems and mental health problems is still challenging. There are some areas of really good practice, where combined teams work with people with cooccurring conditions, but the integration landscape is not perfect. A lot more can be done. Dame Carol's report recommended that we provide better mental health support for people in addiction services.

Professor Dame Carol Black: You will recall that my review asked the King's Fund to give us advice, and to look at the problem of where commissioning should sit. There is no perfect answer. I recommended that it stay with the local authorities because of all the additional needs that a drug or alcohol-dependent person has—needs for not only mental health and trauma support, but housing. Safe housing is very important for alcohol-dependent individuals. Enabling them to return to work, or at least to move towards the world of work, is important. Social care is important. I felt that, in a way, local authorities had not had a fair chance. After they took over the services, there was a year-on-year reduction in the public health grant. Drug and alcohol services took one of the greatest hits, because local authorities had so many other responsibilities to spend their money on.

The extra money that came from my review is ringfenced. That was not necessarily the most acceptable outcome for local authorities, but I felt that it was really important that it went to drug and alcohol treatment services. We need to look very carefully at our commissioning standards to see whether they are adhered to. You will recall that when I published my review, we were still in the throes of covid. The NHS is a very pressurised service, and I did not think that giving the extra money back to the NHS—considering where the NHS is at the moment—was a wise thing to do; I felt that the issue would probably be fairly low on their priority list. This does, however, require local authorities to now step up to the plate and deliver for us.

Dan Carden: Sir Ian?

Sir Ian Gilmore: I defer to my colleagues on commissioning.

Q14 **Dan Carden:** Could I ask you, then, about alcohol care teams in hospitals? I think they started out in Liverpool—it had one of the first. The Government promised to roll them out to 25% of the most in-need areas. Do you know if that has been done? Could you talk about the important role of alcohol care teams in hospitals?

Sir Ian Gilmore: I don't think that has been completed. It is certainly not enough; there needs to be a step change in funding. If you have one or two nurses working Monday to Friday, nine to five, that is hardly the peak time for alcohol-related problems, so we really need a seven-day service as a minimum. A 24-hour service is possibly too much to ask for at the moment, but certainly only a minority of trusts are able to provide that seven-day service, which is a real priority. My understanding, from talking to OHID, is that they have not yet got that money rolled out.

Q15 **Olivia Blake:** Do you think the covid-19 pandemic has had a lasting impact on people coming into services? You mentioned acuity being much higher. Do you think that has been a major factor?

Sir Ian Gilmore: We have certainly seen alcohol-specific deaths rise markedly, and they have not yet come down. Even if this is only a temporary blip, the economic consequences are really large. The Institute of Alcohol Studies recently produced a report that we can get for you, which shows that the economic impact is really quite significant. Of course, if it is not a blip but a sustained rise, that will be even more economically damaging.

It is a very interesting area, and there is quite good evidence that moderate drinkers often drank less during lockdown, but those who were already problematic put their foot on the accelerator and drank more. That is why a study from King's College Hospital showed a marked rise in admissions of people with advanced liver disease. You do not get advanced liver disease in three months, so they were already on the edge of the cliff. The increase in consumption pushed them over, so that they presented with more advanced disease. The mortality rate was higher. As happens with so many other conditions, people were reluctant to present to hospital and presented late. Plus there is the fact that they had started drinking more when they were already in a dangerous position.

Q16 **Olivia Blake:** Do you think that because the services are not part of the NHS, they might miss out on recovery funding or transformation funding that other NHS services might get as a result of the pandemic?

Sir Ian Gilmore: Very much so. I am no expert in the wider field, but I think we will see that the indirect impact of the covid pandemic will have caused more harm than the direct effect of the virus, and alcohol is a good example of that.

Q17 **Mr Djanogly:** My question is for Clare Taylor. What more, if anything, should local directors of public health do to improve alcohol treatment services?

Clare Taylor: There is something around partnership working; more integrated working across primary and secondary care and the specialist drug and alcohol treatment services would certainly be welcome. There is the need to continue with the investment that we have talked about, and

to look at how services can work together more, and at people, not problems—that whole integrated approach.

We need to come back to encouraging people to access treatment sooner, and to look at national and local campaigns around stigma and access to treatment and support. The additional investment will help. So too would defining a specific, alcohol-only treatment offer for people just using alcohol. That is certainly something that we are trying to do in our community services, and want to do more of with the additional investment.

Q18 **Mr Djanogly:** You brought up quite a lot of issues there. To what extent do we need better communication between local and national services, and the Department of Health?

Clare Taylor: From a local perspective, there is good communication with the Office for Health Improvement and Disparities; that is where my experience lies. There was good communication throughout the pandemic, when Dame Carol completed her review, and when the national drug strategy was launched.

Professor Dame Carol Black: As you probably know, we have a central Combating Drugs Unit, which would be concerned with alcohol from a treatment perspective. There is great determination to keep the centre and the local linked through the national outcomes framework and through commissioning. I think there are much better relationships. In the ministerial group, there is the Home Office, Health, Housing, DWP and Education.

Chris Philp chairs the ministerial group, and I have been really impressed. For a Home Office Minister, he is incredibly well informed about treatment and recovery, and is doing his very best to make sure that they are integrated. I have never seen such good cross-Government working. This is a wicked cross-Government problem, but I am very encouraged by what has happened at the centre, and the absolute intention to ensure good central-local relationships.

We have a senior responsible officer in every locality. You could ring them up and ask them where their alcohol services are. We have a list of their names. There is someone locally who has responsibility for this. I think central-local is better than I have ever seen it, but one needs to keep one's foot on the pedal.

Q19 **Chair:** Figure 12 on page 27 of the NAO's Report lists all the local authorities, not by name but by take-up of alcohol treatment services. The median is 18%, but that rises to more than 40%. It stands below 10% in a number of areas. Ms Taylor and Dame Carol, could you point to areas of exemplary work? Well, if it is only at 40%, that is perhaps not exemplary, but where are the best areas in the country for doing this work? Are there any examples you can give us? I should stress that we

have had some extremely good and useful evidence from many people, and I thank them for that.

Clare Taylor: I cannot give a specific example of an area. We probably did in our written submission. As you said, it varies; there are multiple factors. I have lots of areas of good practice where alcohol services are being delivered.

Chair: Well, if you think of something afterwards—

Clare Taylor: Yes.

Professor Dame Carol Black: I think you are going to be able to question one of the areas in the next session: in Alice's area—I have visited it—there is very good practice. There are many areas now trying very hard to improve, but you will have the opportunity a little later to ask.

Q20 **Nick Smith:** Ms Taylor, how do you encourage people to access services earlier?

Clare Taylor: That comes down to the joint work across primary care and looking at prevention, early identification of people who are drinking in excess, and then ensuring that there are effective pathways into treatment services when they are required and that treatment services are tailored to specific needs. It is continuing to work on how accessible services are in terms of how we work within communities as well as within our specialist services, so that we have more of a presence and are more easily accessible for people.

Q21 **Chair:** Dame Carol, Clare Taylor very specifically says that we should have separate alcohol strands. You touched on that in your opening remarks. Are you saying that we should have separate treatment for alcohol and drugs, and that they should always be separated?

Professor Dame Carol Black: No, I wasn't saying that at all. I do think, though, that there are differences between what happens to a drugdependent person and an alcohol-dependent person, and we need to be sure within any treatment protocols that we have met the needs of that particular addiction. I am not an expert in alcohol, but it certainly seems to me that in complex cases of alcohol addiction, all the support that is needed there is insufficient at the moment. I think prevention is insufficient. We have slightly different problems in drug addiction. There is some evidence, and some people would tell you, that the alcoholdependent person has possibly lost out to the drug-dependent person in the treatment arena, and they shouldn't. One would want to see both dependencies treated to the highest possible standard. We have a long way to go for both.

Clare Taylor: May I just clarify that I do not think there need to be separate commissioned services? I think there needs to be a separate offer that is distinct for alcohol-only clients.

Q22 **Chair:** Thank you for clarifying that. I want to go to you again, Ms Taylor—perhaps the other witnesses will briefly contribute, too. We know that there are therapeutic communities where people can get support, and there is some discussion in the Report about how that is provided. The NHS has a track record of referring people with obesity or weight problems, for instance, to Weight Watchers and those sorts of privatesector organisations that already do this. We have AA for alcoholics. Ms Taylor, you are directly providing some of these services, but do you think that there is a space to go where there is already a functioning structure? Does that work for the people you are seeing, or are they coming to you because they haven't managed that route?

Clare Taylor: No, I think the role of peer-led recovery, whether it is Alcoholics Anonymous, SMART Recovery or other organisations, is integral in offering recovery support. For some people, that is all they might need; for others, it can be a continued relationship, with fellowships that people have for life once they have completed the 12-step programme. They are a really valuable part of a recovery-orientated system that do not just complement structured treatment but, for some people, can provide the treatment and support they need.

Professor Dame Carol Black: You perhaps remember from my review that I highlighted the paucity of really structured recovery programmes. Ed Day, our recovery champion, is working very hard on improving the recovery offer with the Department of Health and Social Care and OHID. I think that, whether you are alcohol dependent or drug dependent, having available an ongoing place of recovery that you can be part of is important. So many drug and alcohol-dependent people will tell you they are in recovery for life, so we really need to improve those structures. I

made it clear in my report that they were inadequate. We need to value peer support workers much more than we did. I found they were often treated as second-class citizens and often not paid. That is a really important area for us to improve in the treatment arena and to make part of an offer. Not everybody goes to AA, so we want a variety of things, but recovery communities are crucial.

Sir Ian Gilmore: Something that is allied to treatment and which has not come up so far is in-patient services. The numbers of in-patient beds have plummeted over recent years.

Chair: Yes, we have had shocking evidence about that. In Durham, I think they had one bed.

Sir Ian Gilmore: That's right. A patient who wants to come off alcohol and wants to be detoxified, but who has had, say, fits on previous occasions, is not safe to do that anywhere than other than under medical supervision.

Q23 **Olivia Blake:** Dame Carol, do you feel that there is sufficient support for carers and families around alcohol-dependent people? Should that be more of a focus for commissioners?

Professor Dame Carol Black: You can always think, when you have done a report, of the things that you should have done better. I did not do very much in my report about families. That has been pointed out to me. For both alcohol dependency and drug dependency, support for families and carers is crucial and should not be forgotten, so yes.

Clare Taylor: I absolutely agree. The impact of alcohol use on families and children is significant, as we have spoken about. There is much more we can do to support families, who, in turn, can support people into recovery, in terms of sustaining recovery. There are some examples of really good practice and interventions—such as the five-step families model—that can be really effective in supporting families.

Sir Ian Gilmore: I will just add that supporting families is really worthwhile, because people who are dependent with a supportive family have a better outcome in treatment than those who do not have that family support.

Q24 **Nick Smith:** Sir Ian, you talked about there being insufficient beds. What is the effect of that for people with alcohol problems?

Sir Ian Gilmore: It means that these patients are often left bouncing around the community, trying to access services that could and should be delivered—and, actually, would be delivered much more economically and efficiently—in an in-patient scenario.

Q25 **Nick Smith:** When you say "bouncing around", can you give me an example of that from your experience?

Sir Ian Gilmore: Particularly homeless people. I think if I was sleeping out in winter in Liverpool, I would be using alcohol to numb the pain. They are certainly a group, and there are other deprived people. We have not really dwelled on the inequalities issue, but it is well known that alcohol harm is seen much more in the lower quintiles of the socioeconomic groups. So I think this is about people who are without family support, often homeless, who need a period of in-patient stabilisation and then to be moved on to a more controlled environment. There are some wonderful charities around that take patients, but they do not have the medical support to get them started.

Q26 **Dan Carden:** There are well over a million admissions to hospital each year related to alcohol, yet only 23% of people who are referred to alcohol treatment come from health services. Are people being missed? Is an opportunity being missed to address alcohol issues when people are admitted to hospital?

Sir Ian Gilmore: I am sure there are. I wrote a paper back in, I think, 1977 or 1978 saying how rarely junior doctors took in alcohol history. You

still see the dreaded phrase "alcohol: social" in medical records. There are some very sociable people around.

The short answer is yes. There are real problems in hospitals and there is still a stigma. They are seen as revolving-door patients in A&E departments. That is partly because they do not see the ones who do not come back. Nobody chooses to be alcohol dependent—it is not a happy life. We need to do much more to inculcate staff in hospitals and in primary care that this is an illness; it does need the same commitment and cannot just be dismissed as someone's own fault, which, sadly, still happens. Either they do not identify it or they do not follow up and do something about it.

Chair: Thank you all very much indeed. It feels such a short time to try to extract your enormous expertise. The transcript of this session and the next will be up on the website, thanks to our colleagues at *Hansard*, in the next couple of days. It goes up uncorrected, so if you feel that something you said has not been recorded quite right, please let us know. We will produce a report on this probably just after the Easter recess—around that time. You are very welcome to stay for our next session. I just want to record again our thanks to not just you but those who have written in with very useful evidence from across a range of areas. Thank you very much indeed.

Examination of witnesses

Witnesses: Sir Chris Wormald, Jonathan Marron and Alice Wiseman.

Chair: Welcome back to the Public Accounts Committee on Thursday 2 March 2023. We are now on to our panel of Government experts, who I

will briefly introduce. We have Sir Chris Wormald, who is well known to this Committee. He is the permanent secretary at the Department of Health and Social Care. Jonathan Marron, also a frequent flyer, is director general of the Office for Health Improvement and Disparities at the Department of Health and Social Care. I swear, Mr Marron, that every time you are in front of us you have a different title and a different set of responsibilities. It feels like you keep taking more into your empire.

We are delighted to welcome Alice Wiseman, who has travelled all the way from Gateshead today, so thank you very much for that. Ms Wiseman is the director of public health for Gateshead Council and board member and alcohol policy lead for the Association of Directors of Public Health. Responsibility for alcohol treatment moved to local authorities in around 2012, just over a decade ago. We are really pleased to have you here as well.

I will hand straight over to Mr Dan Carden MP, who has a declaration to make at the beginning.

Q27 **Dan Carden:** Thank you, Dame Meg. I refer the Committee to my entry in the Register of Members' Financial Interests. I think people know that I have a long-standing interest in these issues—personal and professional.

Can I start with you, Jonathan Marron? The NAO Report sets out the scale of harm caused by alcohol to the national health service, the wider economy and public health, yet it states on page 15: "There is…no specific policy on the prevention and treatment of alcohol harm". How difficult does that make your job?

Jonathan Marron: The harm that alcohol causes is well recognised in the public health community, clinically—Sir Ian and Dame Carol spoke about it eloquently just in the previous session—and, indeed, in Government. We have been very concerned about not only the harm caused, but the access to treatment. As set out in the NAO Report, access to treatment started to decline from about 2014-15. PHE, the predecessor to OHID, worked on this in the late teens, and we saw some stabilisation of services at that stage.

Of course, following Dame Carol's drugs review, which looked at drug and alcohol treatment services as a whole, we have seen very significant investment going into those services. There has been a significant increase to date and, of course, there are far more increases to come, so I am confident that we will see better access to higher-quality treatment.

Dame Carol was very modest about her report in her comments earlier. She has really achieved two things: a significant expansion over the next two to three years in access to alcohol and drug treatment—correcting, perhaps, the slide that we have seen in the previous 10 years—but also really serious investment in the quality of those services. We are looking for another 800 mental health and clinical professionals to enter those services, meeting some of the quality questions that Sir Ian was raising. I think, actually, we should be in a much, much better position.

The Government has been very clear in setting out a strategy for alcohol treatment, and indeed the NHS long-term plan is very clear on the NHS's contributions through the establishment of alcohol treatment services. The promise is 47 by the end of 2023-24. That will reach the hospitals in the areas with the 25% highest need. So far, we have got 22 fully operational, with their full workforce, and we expect to complete that.

Q28 **Chair:** So you're halfway there.

Jonathan Marron: Yes.

Q29 **Dan Carden:** I appreciate that you are hopeful for the future, but I don't think the evidence we have in front of us paints that picture. It shows that deaths have risen year on year; deaths have risen a remarkable 89% over 20 years, and every year we see record numbers. I have to say again that there isn't a Government strategy. There was a strategy in 2012. That was then dropped. There was a strategy promised in 2018 or 2019. We see the evidence of the harm and the fact that it is increasing;

where is the strategy? Do you want politicians to give you a strategy to deal with this harm?

Jonathan Marron: We have very clear actions in place to tackle the harm and to improve treatment. We have set those out. They are in different documents. Actually, the Secretary of State for Health is very conscious of the need to pull together our strategies and be clear about how we are making a difference, so he announced—it was last month, I believe; if I have got the date wrong, I'm sorry—a major conditions strategy, which we will now work on, to bring together both the treatment effects and the prevention policies that are needed to tackle some of our major conditions. Sir Ian talked about cancer. There is also coronary heart disease; a significant component is driven by alcohol and high levels of alcohol consumption. That will give us a chance to set out something much broader about how we tackle the burden of disease in this country both through better treatment and by getting upstream and doing more prevention. I hope it will give us a much broader canvas to set out what the Government is trying to do.

Sir Chris Wormald: I should say first that we welcome the NAO Report—we agreed it—and we welcome this hearing and the light it shines on an exceptionally important issue.

The question of strategies is one that I and my Secretary of State debated with your sister Committee, the Health and Social Care Committee, across a range of things. There is a school of thought that says that if something is important, you publish a bespoke strategy about it. That is not the policy that this Government is following. It is focusing on what it can practically do, which I know is going to be the majority of the hearing and is the majority of the Report.

That is for a number of reasons. One is the getting on with actually doing things, as opposed to publishing strategies, but there is also a recognition—we see this across a range of areas—that individuals are not defined by conditions. In this particular case—I am sure Alice will talk about some of this later—very frequently somebody with a drug problem also has an alcohol problem, and vice versa. We were discussing the major conditions strategy with your sister Committee. A large number of people have more than one condition. We have been shying away from saying, "Here's a problem and here's the bespoke strategy to deal with that specific problem."

Q30 **Dan Carden:** That is not quite right, is it? The alcohol strategy was promised in 2019 and then it was dropped. That is slightly different from what you are saying.

Sir Chris Wormald: As I say, the Government at this time is focused very much on the proactive things that we can do—

Q31 **Chair:** The Government has changed its mind from 2019.

Sir Chris Wormald: Yes. As I say, there is a school of thought in Government, and it is perfectly reasonable—

Chair: Let's just call a spade a spade. The Government was going to have an alcohol strategy and it has decided not to.

Sir Chris Wormald: We published the drugs strategy, which also covers the money that goes into alcohol support, and we are getting on with it.

Q32 **Dan Carden:** You link alcohol to drugs and mental health and other things. We have a drugs strategy. Alcohol causes more harm in this country than illicit drugs. Can you explain why we would have a drugs strategy but not an alcohol strategy?

Sir Chris Wormald: This is what I was coming on to. The services—I am sure that Alice will talk about this—are very frequently the same, as are the people. The Government did publish a drugs strategy along with the additional money, which covers both drugs and alcohol services and is a very significant investment. The Government is now focused, with its partners, on actually doing stuff to improve both the quality of the service—that has always been quite high, although it has areas where it can be better—and crucially, as you alluded to in your introduction, access to those services. The Government's big focus in these areas is access to the services and then how good the service is when we get it. There is a

long debate, as you know—

Q33 **Dan Carden:** We are short of time today, so I will try to rush through some questions. Alice Wiseman, you are on the ground delivering and commissioning some of these services. We spoke in the earlier session about the fact that only 18% of dependent drinkers actually access treatment. What is your experience of people suffering with alcohol problems actually being able to access treatment?

Alice Wiseman: There is a big issue that starts with people even being able to acknowledge that there is a problem. The problem is so widespread in our communities that, often, somebody who has a problem with alcohol will look next door and see somebody who is drinking at the same level that they are drinking at. It is a really normalised product. One of the biggest challenges is people accepting that they have a problem in the first place.

I also think that there is a real issue with stigma. There is a theory that you have to be able to drink responsibly, but, actually, the idea of being able to use a drug responsibly is a really interesting concept. So people who then have a problem with alcohol feel a sense of shame as a result of not being able to use that drug responsibly when, actually, it is the product that is harmful rather than the individual, who is the recipient.

They are two major issues. Other issues that were picked up on in the earlier session were about treatment pathways. We did a big healthcare

needs assessment in the north-east and north Cumbria with our NHS workforce. Our NHS workforce are also part of our community, so the problems that we have with drinking are problems that we potentially have across our workforce. So when asking questions about alcohol use, when somebody is presenting for a different condition, that tends to mean that people think, "Oh, they are the same as me, so I will not necessarily provide that referral." So there is an issue about workforce development to ensure that people get referred into services.

They are the major issues. Once people get to a service—actually, the majority of our service users are self-referrals, and they are often supported self-referrals. So they are supported by a health professional, for example, but they are making the contact themselves, because we know at that point that they are really ready for that level of support, and they are really successful. I was looking at the successful completions just for my local area and something like 68% of people who accessed the service managed to have a successful treatment completion. That is not within a year—sometimes it takes longer, and, as Dame Carol said, it is a chronic condition, so there is sometimes relapsing as well.

Q34 **Dan Carden:** Could I ask you about information and awareness? The north-east and the north-west top the scales in terms of harm. You commission Balance North East. Could you explain a bit about what Balance does to tackle this problem?

Alice Wiseman: We as directors of public health in the north-east recognise that tackling it on an area-by-area basis on its own with just treatment will never work. What we need is a broader programme. There are economies of scale. We work across seven local authority areas, and each director of public health provides commissioning. What Balance does for us is develop the evidence base and ensure that we are responding to the evidence coming in internationally and from across the country. We have already talked about the work going on in Scotland.

Balance also enables us to do mass media campaigns. For example, at the moment we are running a campaign in the north-east to ensure that our population understand the link between alcohol and cancer. People understand that there are issues with liver disease, but they often neglect the fact that there are significant challenges with other issues.

Balance also does work for us so that we can understand our public perceptions—so we can understand what the public actually think about the measures that we are taking on alcohol and whether they think we are doing enough or should be taking further steps. For example, I think that about 80% or 90% of our population think that we should be doing more to protect children from alcohol marketing. That is a helpful bit of information to have, so that we can start to think about our policy response at the local level and at the subregional or potentially regional level.

Q35 **Dan Carden:** Sir Chris, back to you. We know from a lot of the evidence given to the Committee that some of the most impactful changes can be on the price of alcohol, availability, labelling, and information and awareness. What role does the Department of Health have in that? There is good practice there from Balance.

Sir Chris Wormald: I will ask Jonathan to comment on the details, which he is much closer to than me. Your question is very pertinent. We own the overall policy and part of the regulatory framework around this, so we are part of that debate. Alice's answer has already demonstrated this, but we then need to leave space for people who understand their local areas and the specific issues in a specific place or region. We leave them with enough freedom to do what they need to do. The local and national balance is very important.

There is, of course, a public debate on all the issues that you raised—none of those questions about the right thing to do is uncontested in this space. The role of the Department and Ministers is the absolute classic one: to listen to those debates, to balance up the various health, social and economic consequences of particular courses of action, and to decide where the public interest lies. However, they are not straightforward debates, and there is not a nice algorithm to tell us the right answer. That is very definitely the Government's job—it is a classic ministerial role to do that balancing up of where the public interest is and what the right approach is—but the answers to those questions are not straightforward at all, as I am sure you and the Committee are well aware.

Jonathan Marron: To add further detail to Chris's answer, clearly the alcohol treatment services are within our responsibility—those provided both by the NHS through the Secretary of State and by the local authority ones, the public health ones. We are clearly responsible for that, and we are overseeing the roll-out of the additional money that came following Dame Carol's report to secure those services.

On the broader questions, obviously a lot of Departments are involved. We try to pull together the evidence, to be clear what we know internationally and what has been demonstrated to work—the PHE reports mentioned earlier were produced by many of the people now working for OHID—and we take that into discussion with other colleagues. Part of bringing PHE into the Department of Health and Social Care is that it has opened doors to much more frank conversations with officials in other Departments. Clearly, the regulation of alcohol is with the Home Office, not the Department of Health. Advertising policy is with DCMS, and we work closely with both those Departments. Again, Dame Carol was giving her views on the excellent joint working on drugs, and we can build on that in this wider area.

Sir Chris Wormald: The other one I should have added is that the Department and, in particular, the chief medical officer have a role in advising the public, as well as advising Government on the issue. That is

our other important departmental role, but done as a piece of clinical advice, as opposed to a piece of ministerial policy.

Q36 **Dan Carden:** In 2021, I think, the Government promised a consultation on alcohol and calorie labelling. Did that ever start?

Jonathan Marron: It has not yet started. We are still looking at our policies on labelling overall and our policies on calorie and food labelling more generally. DEFRA is another Department that is interested and has a set of responsibilities for food labelling. That work is ongoing; quite a lot has happened since 2019, but it is something that we need to get round to.

Q37 **Dan Carden:** When we see the level of harm that alcohol is causing, and with deaths rising, do you think it is right that the public have more information about a bottle of orange juice than they do about a bottle of alcohol?

Jonathan Marron: With alcohol labelling, we started with being really clear about units and the harm caused.

Q38 **Dan Carden:** You wouldn't even see the ingredients or calories in alcohol.

Jonathan Marron: I think units and harm are a reasonable place to start. There is a debate to be had about whether, as we look at our obesity policies overall, we should be much clearer about the calorie content of alcohol.

Q39 **Dan Carden:** What about the link between alcohol and cancer? Should we have this consultation, and is there a reason why it has not happened?

Jonathan Marron: We continue to work on our labelling policies for nutrition, and how that should relate to alcoholic drinks. As you know, the regulatory regime that has been in place for some years excludes alcoholic drinks from food nutrition labelling. That is one of the things we would look at. It is a former EU piece of legislation that is currently carried over on to the statute book. Obviously, there will be opportunities to look at that again as we work through EU legislation.

Sir Chris Wormald: Of course, there are not very many products that come with a personal view from the chief medical officer written on them about their use. We do treat alcohol very differently from the vast majority of products, correctly.

Q40 **Dan Carden:** There is less information on a bottle of alcohol than on a bottle of orange juice.

Sir Chris Wormald: Yes, but you won't find on a bottle of orange juice Sir Chris Whitty's views on how it should be drunk. That is clearly a very big thing.

Q41 **Chair:** It is in quite small print, I can imagine.

Sir Chris Wormald: But it is also extremely well known and debated what the chief medical officer's advice on alcohol is.

Chair: It is not about you. I don't think there is any need to be defensive in the Department.

Q42 **Dan Carden:** I don't think tens of thousands of people die each year from drinking orange juice.

Sir Chris Wormald: I am saying it is a completely appropriate thing. I am not disagreeing with any of the points the Committee has made—they are very important points. Of course, labelling is extremely important. The key bit here is the causation between the Government taking action and if that action affects what you are pointing to.

Q43 **Dan Carden:** The consultation was promised.

Sir Chris Wormald: Jonathan set out the position on that.

Q44 **Dan Carden:** I had an Adjournment debate on this a few years ago. Is it a ministerial decision?

Chair: You have just highlighted five Departments that have some input into this. Perhaps you could answer Mr Carden's question about whether that is part of the problem.

Jonathan Marron: We are working on views on labelling for food and alcohol more generally.

Q45 **Dan Carden:** No, a consultation was promised.

Jonathan Marron: In 2019.

Q46 **Dan Carden:** Numerous times. Why has it not started?

Jonathan Marron: Since 2019, in the Department of Health and Social Care we have had other things that we have spent a lot of our time focusing on. That has definitely slowed down the delivery of some areas of policy.

Q47 **Dan Carden:** Can we expect to see it start this year, as it has been promised—unless someone is going to reverse the decision?

Jonathan Marron: I don't have a start date for a consultation, but we are working on nutrition labelling more generally, and this is one of the issues that we will consider.

Q48 **Dan Carden:** Could I ask you or the Minister to write to me after this Committee?

Chair: It sounds like this may be coming into the policy end of it, so we might want to take the issue up with Ministers, or maybe Mr Carden can do that. Thank you—we will come back to it.

Q49 **Nick Smith:** Mr Marron, do you think having a drugs strategy will improve health outcomes for people with drug problems?

Jonathan Marron: The work Dame Carol did on drug and alcohol treatment was very helpful. It really showed some of the problems, which the NAO has so effectively put in its Report, and it has led to very significant investment in improving those services. Undoubtedly, that is the case.

The wider drugs strategy, of course, has a whole range of other things in it, including how we tackle the availability of illegal drugs. Again, we know they are damaging to health.

Nick Smith: That sounds like a yes.

Q50 **Chair:** So it has helped. You welcome Dame Carol's work—she is sitting behind you, I should say.

Jonathan Marron: We are very grateful for Dame Carol's work. I think we will see a transformation of services.

Chair: So the answer to Mr Smith's question is yes.

Q51 **Nick Smith:** Ms Wiseman, you talked about a marketing strategy to emphasise the relationship between alcohol misuse and cancer in your region, and that sounded interesting. Could you tell us whether it has been effective?

Alice Wiseman: It is actually the second time we have run this campaign because of the impact that it had the first time. We do the public perceptions survey; we asked the public what they understood the risks were with alcohol, and a very small proportion of the population understood that there was a link between alcohol and cancer. It was about 10%, if I remember rightly. Following the campaign, it increased only to 20%, so it still did not reach the whole population, but certainly there was greater awareness in the north-east of the link between alcohol and cancer than there was before the original campaign. That is why we are running it again now. We are doing that with some support from the ICS, so our local ICS—

Q52 **Chair:** Integrated care system.

Alice Wiseman: Sorry, integrated care system. The NHS has also invested in it as a result of the evaluation.

Q53 **Nick Smith:** It sounds like it has been good at raising awareness of the issue. Do you know if it has had an impact on signposting and getting people to take up services to support them?

Alice Wiseman: No, I am not able to talk about the link between it and accessing treatment services. What we are trying to do with that campaign is, at a population level, ensure that people have an understanding of the harm that they are causing themselves, whether they are drinking once a

week, twice a week, multiple times or if they are addicted. That is the point that we are trying to raise with the public: alcohol is not a safe product. The less you drink, the lower your risk is, but, even at any level, there is a risk of cancer. Women are more likely to have breast cancer, for example, if they are heavier drinkers. It is really important that our community know that, so that they can consider what they are doing.

I also think it enables us to gather and gain public support for some of the wider measures that we need. Certainly, learning from tobacco, it was when we started to understand the link between tobacco and cancer that we started to get much more public support for some of the wider measures.

Q54 **Olivia Blake:** Sir Chris, we just heard from witnesses that money seems to be being directed away from alcohol dependence to drug dependence. Is that because there is a drugs strategy nationally?

Sir Chris Wormald: I do not think that, in the last few years, that is the case. The NAO Report set out very clearly the investment patterns and there is no denying that these services have been under considerable pressure. What we are seeing and hope to see in future is spending on both drugs and alcohol going up. We do not prescribe—

Q55 **Chair:** In which period of time are you talking about it going up?

Sir Chris Wormald: Up from the investments we have made in the drugs strategy, which is— **Chair:** It is £533 million.

Sir Chris Wormald: Yes, over the next three years. We wish to see increased investment in both of those objectives. We do not centrally prescribe what the "correct" split is for the reasons that Alice has already explained: those need to be local decisions based on local demography and local challenges. There should be a recognition, as I said before, that there is quite a large number of people who need both alcohol and drug support simultaneously.

Q56 **Chair:** Ms Wiseman, that £533 million does not fill the gap by which it has gone down since it came over to local government. Is that right?

Alice Wiseman: It is an incredibly welcome funding stream; I am not looking a gift horse in the mouth.

Q57 **Chair:** You are sitting next to the permanent secretary—you are going to say that—but it does not take you back to where you were.

Alice Wiseman: It takes us back almost to where we were, but not quite yet.

Olivia Blake: In real terms.

Alice Wiseman: I think the other point that is a real challenge at a local level is not just the cuts to the public health grant, but the cuts to the wider local government grant, because, actually, that impacts on the

wraparound services that enable people to build social capital, which enables them to get into recovery and then successfully recover. We heard talk earlier about the importance of not just housing, but employment support.

Jonathan Marron: May I add a few points? The NAO have very clearly set out the reductions in alcohol treatments from about 2013-14; I think it is about 16%. It is set out in the Report. If you were to look at opiate treatments over a slightly longer time—you have to go back to 2010-11—they have been falling slowly for a long time. Again, it is about a similar reduction through to the period of about 2017-18, so both services have fallen.

Q58 **Olivia Blake:** But deaths from alcohol are rising.

Jonathan Marron: Can I come back to that? I think you will find that the long-term trends show that we have seen a reduction in both these services over the last 10 years or so. Investment from the drug strategy will allow us to turn those figures around.

Chair: It begins to bring it back up to where it was. Yes, we got that.

Jonathan Marron: I am tempted not to talk about figure 9 in the NAO Report because I know that the split between alcohol reporting and drug reporting in local authority accounts is not the most reliable, and the NAO has put warnings in the Report. However, if we look at figure 9, spend on alcohol, helpfully put into current prices, is roughly stable over this period, but spend on drugs falls. Some of that will be misreporting—there is some of that in there—but I do not think there is great evidence that we have moved away from alcohol to fund drugs, although it is very clear that we have reduced the services here, and we are now correcting that.

Sir Chris Wormald: As I say, the funding set out in the NAO Report is not in doubt. It is quite clear there are difficult decisions and pressures in these budgets, and then an upturn, but then, whatever the quantum, on the question of who is best placed to take the decisions about what the right mix of services will be, we are very clear that that is best done by people who understand those areas.

Chair: We can see the chart. We know money has gone down, then a bit of money has gone in that gets up not quite to the level it was before. We can go round and round the houses on this, but that is a simple summary.

Q59 **Olivia Blake:** We must not forget as well that money does not adequately represent productivity. Ms Wiseman, do you agree with the previous witnesses about that money direction moving away from alcohol dependence to drug dependence as a priority?

Alice Wiseman: We are looking at the money we are getting in as being for treatment services for addition. That is the way I am viewing it locally. Certainly, because we have an integrated service, we are able to do that. We provide a different offer for people with alcohol dependence, so that

they don't have to come into the main service if they choose not to. Actually, all the money goes in and it just depends on whether the person presents with an alcohol or opioid dependence. It is much more individually led as opposed to driven. We monitor numbers and there are more people in treatment services with opiate addiction than with alcohol addiction.

Sir Chris Wormald: To be clear, my point is that that is the right way to take decisions.

Chair: We completely get that. We have done recent work on integrated care services and the Committee thinks that devolution can be great when it works well.

Q60 **Olivia Blake:** We have an average of only 18% of alcohol-dependent people in services at this minute. Looking at the national focus on alcohol, do you feel the structural changes at Public Health England have had any impact on the national focus?

Sir Chris Wormald: I will ask Jonathan to comment. The first answer is that it is very early to be able to tell, because obviously we only made the changes quite recently. The point of the changes was to ensure that we had one organisation, UKHSA, whose sole organisational focus was on health security and protection and on infectious diseases, and a second organisation, OHID, whose sole focus and expertise was in the area of health improvement. The purpose of the change was to ensure that we had an organisation with a single focus on those issues. Hand on heart, can I say it has worked yet? It is much too early to tell. I love the work OHID and UKHSA do—I would say that—but could I, hand on heart, say we could point to some improvements in outcomes? You wouldn't expect that yet, if I am absolutely honest. Jonathan, would you like to add to that?

Jonathan Marron: This is one of the areas where, even when we were the Department of Health and PHE, we were trying really hard to work together, so in some ways the advantages of bringing PHE in are not so noticeable. However, Dame Carol was talking about the Government structures earlier, and Rosanna O'Connor, my director of addiction, who was the PHE director in this space, is actually in Government meetings now, so we are in the heart of the conversation, which I think is helpful. It was pleasing to hear Clare talk about the good communication with OHID that remains. We were worried about that, but we have managed to deal with it.

Q61 **Chair:** Keep your eye on that ball, then; we know what happens when it becomes less focused.

I want to ask about the £533 million, which we have discussed. There was talk on the earlier panel about ringfencing, and this is one of the problems—why it has drifted away. I think you said, Ms Wiseman, that you wanted to see this ringfenced, and that is obviously all for alcohol

and drugs. In your area, have you taken some of the money that has been allocated especially for alcohol services?

Alice Wiseman: We are just combining it into one pot dealing with addiction, but it is really good to have it protected. It is not just protection of the new moneys that are coming in; it is actually protecting the old moneys as well. There was an audit taken around how much is being spent on drug treatment systems. If you take any out of that, you also lose some of the national money, so there is an incentive for local areas to invest. It has never been a problem for me in Gateshead, but I know that colleagues across the country welcome that as a way of making sure that treatment services are appropriately funded.

Q62 **Chair:** That is interesting. Mr Marron and Sir Chris, was that from you or the Treasury? Who made that happen? It is quite a clever way of stitching policy into delivery.

Jonathan Marron: I think it is a really deliberate set of steps to ensure that the very significant investments that are being made in drug and alcohol treatment services are indeed made in drug and alcohol treatment. It gives lots of people much more confidence that they can make significant investments, and that they will see the outcomes that they wanted when making those decisions, so I think this is a good way of going about ensuring we get delivery.

Q63 **Chair:** Are you monitoring centrally what proportion is spent on drugs and alcohol?

Jonathan Marron: Yes.

Chair: You cannot always completely separate—we get that—but where you can.

Jonathan Marron: We always call it by an acronym, so let me do it slowly. The National Drug Treatment Monitoring System —NDTMS—has significant data on all treatment across local authorities for both system and, indeed, sub-categories of them, so we have really rich data on what people do.

In terms of the new money, we have asked for very detailed plans on delivery and what local authorities will deliver for the extra £500 million over the three years, so we have very clear sets of commitments on both the number of people in treatment and, indeed, additional staff. To come back to some of the points raised, I think that increasing the number of staff to improve the quality of the treatment is the other part of this strategy, as well as just having more people come through services. We've got all of that, and it is very helpful.

Q64 **Chair:** There is at least £80 million a year between 2022-23 and 2024-25; you are going to recruit people, Ms Wiseman, but you don't know whether you will still have the money to pay them after 2025.

Alice Wiseman: No, and we did not know the amount that we were getting for next year until last week. I still don't know the public health grant for 1 April, so at the moment we are taking risks in the local authority, in that we are going forward with our commissioned services, recruiting the staff we need and hoping that we get the outcome that we need from the Government announcement.

Q65 **Nick Smith:** Ms Wiseman, tell us more about what that means for the workforce and for holding on to the expertise and passion that people clearly bring to this important area. Tell us what happens on the ground when you know that you have a budget for just a few weeks ahead.

Alice Wiseman: It is incredibly challenging, because even if we are providing assurances to staff that we will protect it, if the money did not come in, staff are very aware that they would not have a job for the next year and that there would be redundancies. At times, you lose really good people, and that is not just in our provider services; it is in our commissioning services as well. It is the same in public health teams without having that real guarantee. People have permanent contracts, but there is always that risk of redundancy coming, so people tend to move on to more secure positions. I certainly think that has been the issue over the last decade, and it is part of the reason why, across the country, there is variable expertise and experience in terms of both commissioning and providing.

Jonathan Marron: We have committed to the next two years for the drugs money. It will not solve all the problems but it is a small step.

Chair: From Whitehall, two years seems like a long time, and you have to rate success, but on the ground that means that someone does not know if they have a job for more than two years, and that it is difficult to recruit. We know the different perspectives. I am sure that is a great achievement for you, but it is really challenging on the ground, and that is what we are talking about at the moment.

Q66 **Dan Carden:** Sir Chris, can you tell us why the public health grant for 2023-24 has not been announced yet?

Sir Chris Wormald: That is a question for Jonathan.

Jonathan Marron: As I think you will understand, we have had a series of challenging and robust decisions to make on funding for the NHS and local government over this year. We are making the final decisions on the public health grant and I expect to have it out shortly. I know it is very late, but actually it is not unusually late: over the last three years, we have allocated it on 7 February, 16 March and 17 March. I am not excusing anything—

Q67 **Dan Carden:** As you heard from Alice, that is not a good way to be running things, is it?

Jonathan Marron: I think local government do an excellent job of managing their services with the level of uncertainty that our annual budgets bring.

Chair: It is a very regrettable delay.

Q68 **Dan Carden:** Mr Marron, the last calculation of the cost of alcohol harm to the NHS was made back in 2012—I imagine that came about as part of the alcohol strategy—and the cost to the NHS was calculated to be £3.5 billion. Are there any plans to consider the cost of alcohol harm to the NHS now, 11 years on?

Jonathan Marron: There are two things here. First, there is obviously the research on the different elements of it. Significant parts of those costs are in early death, particularly to the economy, and then—

Q69 **Dan Carden:** It would be good to know—wouldn't it?—the exact impact and cost to NHS services of alcohol. Is that something you are going to find out?

Jonathan Marron: We have not gone back and done the detailed research again. I can uplift the numbers for inflation.

Q70 **Dan Carden:** Could you do that in your job, or do we need a Minister to make that decision? I would think it is a clinical— **Chair:** It is just data collection.

Jonathan Marron: If we looked at the £21 billion for the total costs of alcohol that was estimated in 2012 in today's money, it is £25 billion. I could give you the individual answer for the NHS, but what I have not done is updated the—

Q71 **Dan Carden:** That is different from looking at the actual cost clinically, and looking through the NHS.

Sir Chris Wormald: The straight answer to your question is that it is a ministerial decision for the Department to commission research.

Chair: It is a ministerial decision—really?

Sir Chris Wormald: To commission research, yes.

Q72 **Chair:** Does the £21 billion include things like crime? We had some good evidence from the Durham police and crime commissioner.

Jonathan Marron: Yes, the £21 billion includes the impacts on productivity, which is largely driven by early death, unfortunately, and on health and crime.

Q73 **Dan Carden:** Alice Wiseman, we know that alcohol harm does more damage in the most deprived communities. There is actually an alcoholharm paradox, whereby more deprived communities can drink

lower quantities of alcohol yet the harm can be greater. Can you explain that? Does the funding that you receive reflect the harm?

Alice Wiseman: I don't think there is a complete explanation of it, but you are right that communities that consume less alcohol can experience greater levels of harm. In the most deprived communities they have five times the number of liver deaths that they have in the most affluent communities. That cuts across the board. A whole range of issues sit within that in terms of the wider impact of deprivation, the impact on people's lives and the issues that we know our most disadvantaged communities face more generally. As a layer on top of that, alcohol just adds further to the challenges faced by our most disadvantaged communities.

Q74 **Dan Carden:** Can I ask you about licensing decisions? A few months back I asked the Levelling Up Secretary a question about being able to use public health as a determinant factor in licensing. How important could that be, especially in more deprived communities?

Alice Wiseman: Public health is a responsible authority, so I already make representations on licensing applications locally if I think there are risks, but currently I have to tie them back to different aspects of harm. For example, if I know that a licensee has tried to sell alcohol to an under18-year-old, I can go in on the protection of children. If I know that there is a lot of antisocial behaviour in an area, I can use that as a lever. But currently I am not able to talk to the local licensing committee about the public health data and say to them, "This is an area where we have a high number of ambulance call-outs or hospital admissions, so we shouldn't be looking at an additional licence or additional hours in this area."

Q75 **Dan Carden:** Mr Marron, what can be done about that? Is it a ministerial decision?

Chair: It is a DLUHC decision.

Sir Chris Wormald: It is a matter of law, how licensing works.

Jonathan Marron: It is with the Home Office, so it would be a Home Office decision. We often call it HALO—health as a licensing objective. I think Alice and her colleagues among the directors of public health have been very clear that they think it would be an effective way to tackle some of these harms. That debate goes on within Government.

Sir Chris Wormald: And it is ultimately a decision for Parliament, as I said.

Q76 **Dan Carden:** Alice, can I come back to you? There is often a crossover between the need for alcohol treatment and the need for mental health services, with mental health services being in the NHS and alcohol services being at the local authority level. I have heard anecdotally, many

times, that people can be refused mental health treatment on the basis of their alcohol use disorder, and vice versa—refused alcohol treatment on the basis of their mental health issues. Is that something you are aware of?

Alice Wiseman: Yes. I talk to my colleagues across the country on regular occasions about the fact that people are excluded from services because their substance misuse is seen to be not under control sufficiently for them to be able to benefit from a mental health assessment or a mental health intervention.

I know that around two thirds of people who access alcohol dependence treatment require mental health services and we do have improving arrangements, I think, across the country as a result of some of the investment with the mental health transformation funding, looking at really trying to embed mental health practitioners within the drug treatment services, so that we can stop pushing people around. I think Dame Carol Black talked about it as co-occurring conditions, and that is how we should be treating it. We wouldn't say to somebody who was diabetic that we cannot offer them a service until their diabetes is under control, so it is something that we need to tackle.

We did our healthcare needs assessment in the north-east of England, and I have to say that our OHID colleagues led on a lot of that. In terms of our arrangements with our local regional teams, I just want to say that they are really good. Actually, we were not able to get data from mental health services, because although when they do an initial intervention with somebody, maybe for IAPT, they do ask them about alcohol, it is not recorded anywhere in a way that can be reported. So it was really hard for us to tell. One of the recommendations to our local services was to start collecting that data better so that we can have a better understanding of what is happening on the ground.

Dan Carden: It can't be right, can it?

Sir Chris Wormald: I will add two things. Obviously, at the level of an individual patient, who gets what service is a clinical decision, and I do not think anyone would challenge that.

Chair: We know that the structures make a difference as to what clinicians will decide.

Sir Chris Wormald: Yes. I was also going to pick up on a point that Alice made earlier. We very often talk about integrated care systems as if they are bringing together health and social care; bringing public health to the table in the way that Alice described earlier and having a forum where you can debate those questions and come to a proper answer is part of the point of having ICSs.

Certainly, in some of my conversations with ICSs the data-matching point has come up. I have seen people do this live on the board: "Here is the

ambulance data, here is the mental health data and here is the public health data. Put it all together and what does that tell us about how we need to organise services?" There are ICSs having those conversations all over the country—it sounded like yours was one of them, Alice—and that is a fantastic thing and is the way into your question.

Q77 **Dan Carden:** But it leaves the risk of a postcode lottery, doesn't it? I am interested to know what your view is on people being—

Sir Chris Wormald: I will do postcode lotteries—

Dan Carden: Should it be possible to exclude someone from mental health treatment based on their alcohol use?

Sir Chris Wormald: As I say, at an individual level—

Chair: We know; we have heard you say that. It is the structures that make the difference.

Sir Chris Wormald: Yes. The problem with "postcode lottery" arguments is that they lead to people who sit in London telling people like Alice how they should organise their services and what they should spend their money on in a place that we may have visited but certainly don't understand. Now, of course there is a—

Q78 **Chair:** But you do have a role—to look at variation and see why it is there.

Sir Chris Wormald: Yes, we have a role in good practice and frameworks; NICE, as the owner of clinical advice and practice, obviously has a very big role and all that, but it has to leave that space for people like Alice to say, "I understand my community and this is the right answer," even if it is a different answer to Dorset, Tower Hamlets or Cumbria, or other places that have different demographics and different economies, as it were. That can lead to local differentiation, which you can call a postcode lottery, but I think what we are describing in this case is a good thing, not a bad thing.

Q79 **Chair:** We are not going to get into the whole issue of postcode lotteries. They can be a good thing; we know that. They can also be a bad thing.

Sir Chris Wormald: It is only because you raised the question.

Q80 **Dan Carden:** Can I ask Alice to come back in on this? It is an incredibly difficult issue.

Chair: Do you want to bring in Mr Marron first? It might be better to do it that way round.

Jonathan Marron: We agree that this is an incredibly difficult issue. We are also concerned, and Dame Carol pointed it out in her report as well. We are working with NHS England on an action plan for drug, alcohol and mental health services to see whether we can do things nationally with better practice guidance to try to help move this forward.

Obviously, the extra money will help significantly in both mental health and drug and alcohol services, but we should do more here. The policies ought to mean that no door is closed, so the idea that people are being turned away from the wrong service is not right.

Alice Wiseman: It would be fantastic if every person accessing the treatment service was given a mental health assessment at the front end, and it was determined what level of support they were able to access at that stage. But Jonathan is right. The door should remain wide open, so that at the point where they are able to access further treatment, they aren't sat back on a waiting list. They should be straight through the door into accessing that treatment.

One challenge is that you often get somebody who is able to reduce their consumption to such an extent that they would benefit from treatment, but by the time they are able to access the treatment—

Chair: They're at the back of the queue.

Q81 **Dan Carden:** I have one more question about residential rehabilitation. We have heard the woefully low numbers of people who are able to access residential rehabilitation. Is there a policy—a belief—in terms of the numbers that we should be trying to achieve?

Jonathan Marron: There is. We are specifically concerned about inpatient detoxifications. As part of the money that has been made available, £10 million has been ringfenced for exactly that. In 2022-23, we have ambition to get an extra 1,800 people through in-patient treatment.

Q82 **Dan Carden:** Is that NHS detox as opposed to residential rehabilitation commissioned by local authorities?

Jonathan Marron: It is in-patient detox, so that number will be both. I could find out the breakdown and write to you, but I don't have it here.

Q83 **Dan Carden:** Ms Wiseman, residential rehabilitation would be commissioned at local authority level. Is that right?

Jonathan Marron: This is turning into local government, so it is local authority.

Alice Wiseman: The focus we have had on resources so far has been on in-patient detox. We are very short of provision in the north-east. I know that other parts of the country are short as well. We worked together as local authorities because we have that history of doing that, so we could commission something together that was a bit more substantial than what we have had previously. So that's great.

The other point is that, in the absence of provision for residential rehab, local areas have developed a range of different models. For example, in Gateshead we run a community rehab model. It is the same in that people

come every day for six months and they go through the full 12-step programme.

For some people it is better, because they are able to get well in the community in which they continue their recovery journey. That is particularly true for women and men who have children. So we are working on other models. I guess the challenge is ensuring that we are able to capture those figures in the right way, because they don't necessarily hit all the triggers of the National Treatment Agency box.

Q84 **Dan Carden:** It is great for people who get in there, isn't it? What I have seen all too much of is people who don't get a place because there isn't the funding to pay for it. People often go and look for bursaries from charitable organisations. How much need is out there that is not being dealt with?

Alice Wiseman: We definitely have the same challenge with residential rehab. It is incredibly expensive. It is incredibly cost-effective, so there are definite financial benefits from providing it. There isn't anywhere to send anybody in the north-east at the moment. Our provider that was in the north-east a few years ago went out of business. If we send people, we have to send them further afield to other parts of the country. We have provided a local response to the problem so that we can still give people the same offer, albeit without the residential aspect. I must say, we do have accommodation linked to it if people need accommodation.

Q85 **Chair:** We heard interesting evidence from Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. It highlighted that for detoxification, in some areas there is only one available bed at any point in time between several local authority areas. That is for detoxification, not residential rehabilitation, but I think we get the point.

Alice Wiseman: Yes, that's right.

Chair: We have heard some very useful evidence.

Q86 **Nick Smith:** Just a quick follow-up from that set of questions. Ms Wiseman, why haven't you got anywhere in the north-east for people to get that specialist detoxification support?

Alice Wiseman: Nobody was interested in providing the service, because we did not have a secure funding base for it. When we looked at provision of the funding, we only had a year's worth of guaranteed funding, so we worked with our local trust. North of the river, we used Cumbria, Northumberland, Tyne and Wear mental health trust. We had a couple of beds in one of the other acute hospitals and one further down in Teesside for the rest of the region.

Q87 **Nick Smith:** I have a quick question for Mr Marron. There has been a lot of data flying around this morning. I think you said that the cost of alcohol misuse, big picture, had gone up from £21 billion in 2012 to £25 billion now. Did I get that right?

Jonathan Marron: Yes. We took the 2012 study. We had not redone the rates. We simply took the costs that we calculated then, applied them to today's money, and it is £25 billion. As Mr Carden points out, we should look again at a proper estimate. It has probably gone up. We have seen more liver disease over that period.

Q88 **Chair:** It is a classic spend-to-save argument, isn't it, which I know the Treasury is not always keen to hear.

Jonathan Marron: That £25 billion is already a significant sum. Although it would go up if we redid it—

Chair: Spend to save, let alone the harm on individuals and their communities.

Sir Chris Wormald: I will defend my Treasury colleagues, since you raise it.

Chair: I should never fly that flag. It is a mandarin's job to defend his colleagues.

Sir Chris Wormald: And some serious arguments. As you know, the Treasury is always concerned about whether you get the save. My Treasury colleagues—I expect Marius will confirm this—are very interested in the economic effects of all this. Who does it take out of the workforce? We have a very productive—

Chair: We might be analysing the spend to save.

Sir Chris Wormald: Exactly. I will finish my point regardless. We have a very constructive debate with our Treasury colleagues about these matters.

Chair: I am sure Mr Bowler and his colleagues are listening and will give you a pat on the back or something. Mr Jonathan Djanogly is next.

Q89 **Mr Djanogly:** That leads me on perfectly to talking about alcohol in the workplace. Looking at the 2012 figures, one third of the £21 billion—£7 billion—was from lost productivity through unemployment and sickness. I suppose that £7 billion is now larger. Do we know how many functioning alcoholics are in employment? Do we know how many are being summarily dismissed? Do we have those figures? Do we know what impact this is having in practice? Can you put it in more useful terms?

Jonathan Marron: Can I take a couple of steps back? Those numbers relate to the impact of both illness primarily caused by alcohol—liver disease and those things—and also the secondary effect. Ian talked earlier about cancer and heart disease. About 40% of the total impact is on the contribution that alcohol makes to heart disease.

Although it is true that dependent drinkers will be a significant part of those numbers, the 1.7 million people who drink at higher risk and the 8.2 million people who drink at increasing risk will also be contributing, given

their increased likelihood of having cancer. It is a much broader range of harms than just dependent drinkers.

Q90 **Mr Djanogly:** So you are saying that the £7 billion is not anything to do with the impact on employment status. You are saying it is an additional health implication for the NHS.

Jonathan Marron: We look at the burden of disease that we believe alcohol contributes to. We pull up the costs to the NHS. The productivity costs are both an estimate of sickness and absence, but also, importantly, early death. People who are dying early partly due to their alcohol consumption are, I think from memory, about 40% of that estimate.

There is a significant impact if people simply are not in the workforce, which is a problem for the economy—and much more important for themselves, their families and loved ones, obviously. Of the people who have significant alcohol or dependent drinking, we have higher sickness rates. I am happy to come back with more detail.

Q91 **Mr Djanogly:** Yes; I am not currently getting a feeling that this is an area the Government know much about. Let me turn it around. What, from your point of view, is the role of the employer in dealing with alcoholism in the workplace? Do you expect them to interact with your services, or do you expect them to go to the private sector? What do you expect them to do?

Jonathan Marron: When we look at our evidence, the dependent drinkers and the harm are highly concentrated in the lower socio-economic groups, so the contribution that employers might make to that harm is probably smaller. I know there are employers that have good offers and work with some of the wider voluntary sector providers, and that is all to be encouraged.

We have worked with DWP at the other end: people who are out of work. The scheme that we are committed to rolling out nationally is putting employment advisers into services, so that as you receive your alcohol treatment, you also get independent placement support. That has proven quite effective at getting people back into work. We are trying to work on the people who are falling out and on whether we can get them back in.

We have some much broader conversations going on with the CBI about the general role of employers in supporting a healthy workforce, and how they can increase their productivity by retaining people in work. Alcohol is part of that conversation, but we are also thinking about smoking, obesity and mental health in a much broader sense.

Sir Chris Wormald: As a straight answer to your question, we don't set a national expectation on employers. Obviously, what one might expect of a very large employer will be very different from an SME.

Q92 **Mr Djanogly:** If an employer comes to you, what happens?

Alice Wiseman: If it is a person who needs to be referred into treatment services, they can be referred into treatment services and supported by their employer. We have some great examples where employers have done exactly that.

Q93 **Mr Djanogly:** Do you encourage that?

Alice Wiseman: Yes, we have a scheme in the north-east called the Better Health at Work Award. Through that, we provide training to employers. It is based on whether they will engage with us, so there is variation, but employers that engage with us do a whole range of things, not just on alcohol. Making sure they have the pathways right for people to move into alcohol treatment should they need it is part of it.

Sir Chris Wormald: Just to be clear, our approach is persuasion and discussion, not regulation and rules.

Q94 **Chair:** There is a cost to the economy, as Mr Djanogly just highlighted.

Sir Chris Wormald: Yes.

Q95 **Mr Djanogly:** There is indeed. I was interested to hear Mr Marron say that it is mainly in the lower demographic. Funnily enough, when we discussed this among ourselves, we were saying that it is in the more manual jobs where there would be immediate dismissal, whereas with the more professional jobs, people can stay as functioning alcoholics more easily. That doesn't really tie in with what you said, Mr Marron.

Jonathan Marron: I was making the broader point that if you look at our communities, the places with the most deprivation have much higher levels of alcohol harm than places with much lower deprivation. Your observation may well also be quite accurate in how it affects individuals in work. I don't think we have done much specific work on that.

Q96 **Chair:** There is a bigger health and safety risk if you are a rail worker, a driver or whatever, than if you are at a desk, so there is the dismissal point.

Sir Chris Wormald: Exactly. If you look at those industries that ban alcohol, as a number of rail jobs do, it is exactly as Mr Djanogly says.

Q97 **Mr Djanogly:** But it would be fair to say, Sir Chris, based on what you said, that because it is a voluntary relationship, the state doesn't really know what the problem is in the workforce.

Sir Chris Wormald: No, and we have the classic balance: we could go out into business and do a lot of information collection and all those things, but all those things are a burden to business. Therefore, we have taken the approach that we have, which recognises that employers are very different and that it is a voluntary activity.

You could take a different approach, but there are swings and roundabouts to that more statist approach to how we work with people. We would

rather persuade people that it is not only in the nation's and the individual's interest, but in the business's interest, to be talking to people like Alice about what they can do for their workforce, both to be good people and on productivity grounds. That is our approach.

Q98 **Mr Djanogly:** You see the problem here. It is a third of the problem, and we are saying, "We don't really know what the problem is."

Sir Chris Wormald: I have set out some of the swings and roundabouts in the decision making, and we are taking that approach. Could you take a much more state-directed approach? Yes, you could, but there are obvious downsides to that.

Chair: We have aired the issues, and obviously there is no definitive answer at this point. Thank you very much.

Q99 **Olivia Blake:** I want to ask a quick question to Mr Marron about whether there has been any assessment of, or any data collected on, the costs to councils and outcomes for children of social care associated with alcohol.

Jonathan Marron: We certainly have data on the number of children we think are affected. I don't have any costs data with me to hand, but I could come back on that question. We have definitely been worried about numbers, and we are there, so I am sure we have some estimates.

Q100 **Olivia Blake:** I appreciate that. In your view, how well do local authorities commission services?

Jonathan Marron: Look, I think local government does a great job of commissioning public health services, broadly. As the report shows, there is variation. In these services in particular, we have produced through OHID a set of commissioning guidelines to try to give more support to people.

We work with individual authorities through our regions and through the teams overseeing the new grants. I think we are working quite hard to try to spread good practice. There is lots of great practice out there. As with all services, we have variation and I am hoping the focus and additional investment will improve performance across the board.

Sir Chris Wormald: The one to add is that completion rates have stayed very stable even with the budget pressures. So nationally, it looks like local authorities have done a very good job of keeping the quality up for the services that are provided—

Q101 **Chair:** For those who get it in the first place.

Sir Chris Wormald: For those who get it. I think others have observed that there are a number of specialist services that have been under pressure, so obviously there are quality effects, but the general quality for people who get the service has held up quite well.

We worry, and I think this is true of our local government friends as well, about those access questions, which is partly what is available and, as Alice was saying earlier, who comes forward. They are higher up our worry list than the quality of services when you get them, although of course you always have to be worried about the quality. Is that fair, Alice?

Alice Wiseman: Yes, it is down to the way that you commission your services and the contracts you have, but not just the contracts you have—the relationships that you have with local services are important. There is variation across the country, as you would expect, but I know that colleagues in public health teams are working incredibly hard to make sure that those contracts are right and I guess this additional investment and the additional data collection will mean that there will be a bit more consistency.

Certainly, in our region our OHID colleagues supported us with the healthcare needs assessment, which included an audit of our local community services and our acute services. That is an example of the type of work that we are collaborating on to try to ensure that there is consistent good practice across our area.

Q102 **Olivia Blake:** Is there anything else that the Department could be doing to support you locally to achieve your aims?

Alice Wiseman: Within the treatment space, or do you mean more broadly?

Olivia Blake: Just around alcohol-related harm, in general—in the services. Is there anything more that could be forthcoming?

Alice Wiseman: I would love to see exactly the same as we have seen for the drugs work—that there would be an independent review and an alcohol strategy. I think Sir Ian said this at the beginning—at the moment, we are pulling people out of the river, rather than stopping them falling in in the first place.

The things that will make the greatest difference are not the things that are on the table for discussion today, around price, promotion and availability. Unless we get into that space, we are going to be continuing to tackle a challenge and having limited resources to be able to respond to it.

Q103 **Olivia Blake:** That is very helpful, thank you. Mr Marron, you mentioned the new commissioning advice. How are you monitoring the impact that is having? Do you know if you are seeing an improvement with that advice being available?

Jonathan Marron: Through the NDTMS system, we have good information, on numbers in treatment, on completion rates and indeed we are looking closely at the numbers of people employed. One of the things that we are really keen that the new money does is to start to reintroduce health professionals to these services.

We have seen a decline, as Ian talked about earlier, in both the clinical psychiatrists but also mental health practitioners. We are monitoring all of that through a set of plans that we have agreed with local government, and we will continue to do that over the next three years. I think we have got good plans and visibility on performance and that should give us great confidence as we roll out the expenditure—the £500 million that comes over these three years.

Q104 **Olivia Blake:** How do you cascade the practice through from the centre?

Jonathan Marron: We have tried to do some things in terms of guidance. Obviously, the commissioning guidance is already out. We are working on some clinical guidelines; actually, as a four-nations task, we are trying to agree across all four on, say, "This is what clinical good practice looks like." I think that will be helpful in giving people a reference. As Alice has described, OHID works with both individual local authorities and groups of local authorities to drive good practice, and we will continue to do that. At the other end, where there are concerns, we have been able to have conversations with individual DPHs or councils to have some challenge in the system.

Q105 **Olivia Blake:** Ms Wiseman touched on this, but what are you doing from the centre to help to narrow health disparities, tackle preventable risk and improve public health and alcohol-related harm?

Jonathan Marron: The treatment plans we have in place are our attempt to tackle those in need with significant investments, and significant increases in both the numbers in treatment and the range of specialist services available. We have heard a lot today, as I am sure you have in your evidence, about the decline in specialist services, which we are trying to correct. That is our broader challenge, and we are working much more broadly on what we think the drivers of health risk are and how we can reduce disparities in health. The levelling-up White Paper recommits to the manifesto commitment to increasing healthy life expectancy by five years by 2035 and to reducing disparities. Clearly, that is an enormous task; it will require both healthcare and more up-front preventive services, some of which have been introduced in this conversation.

Q106 **Olivia Blake:** Ian mentioned that there seems to be a massive reduction or dying off in addiction psychiatry. He referred to some figures, which he wasn't quite sure of—

Chair: It was from 60 to 4, wasn't it?

Olivia Blake: Yes. I am not sure that he was confident in those figures, but obviously that is a concern, given the other mental health issues we have heard about. How is the central Department working to improve that?

Jonathan Marron: We are working with Health Education England, which sets out the training requirements for clinical professionals, to produce a 10-year plan for drug and alcohol treatment services. The focus is on

ensuring that we get those professionals back in. We think the new funding made available might bring back people who left the services as jobs were not available. Of course, in the longer term, we will need to train more psychiatrists and mental health workers, IAPT-style—a broad range of people, so that members of the public entering alcohol treatment services get the support, including high-quality medical support, that is needed alongside other interventions.

Q107 **Olivia Blake:** Ms Wiseman, the public health grant has obviously decreased. What other services do you see most regularly competing with alcohol treatment?

Alice Wiseman: When we look at the health needs of a population such as the one that I serve in Gateshead, there are significant challenges, particularly around the issue of inequalities, which you raised. Tobacco harm is still really high on our agenda, and is half the reason for the difference in life expectancy, so that is certainly a challenge to the spending and the grant. Our nought-to-19 services, our health visitors and our school nursing are critical to ensuring that every child has the best start in life, so you are making decisions on those issues. In Gateshead, we are focusing our resources on those services, but as a result, we have had to focus them away from things such as obesity services. That was partly because of the lack of evidence base for some of the weight management programmes; we decided to prioritise those things that had greater evidence. Those are the kinds of decisions we are making locally regularly. We have the highest number of children in care that we have had in my entire time in Gateshead, and I have been there almost 10 years. All the pressure on families is resulting in increasing demands for our health visitors and school nursing.

Q108 **Dan Carden:** I want to return to the question Olivia asked about supporting local authorities when it comes to preventable risk. Your answer was about treatment. Balance North East runs public health awareness campaigns, and the evidence shows there is a greater public understanding of the link between alcohol and cancer in the north-east, which I think is linked to that work. What lessons are you learning from that, and have you considered national public awareness campaigns?

Jonathan Marron: We do run a set of national public awareness campaigns. There is quite a lot of work going on about mental health, trying to help people to understand the broader things that drive good mental health. We have been active on smoking, and remain so, and on obesity. Interestingly, the public have really accepted that smoking drives cancer significantly. That has been very effective in helping people change behaviour, and perhaps change policies around smoking. I don't think the public have quite as clear an understanding of the harms of either alcohol or obesity, so it is interesting to think about how we raise awareness and what we might do—

Q109 **Chair:** Do you have a budget for it?

Jonathan Marron: We spend, I think, around £30 million on public health campaigns.

Q110 **Chair:** But who chooses where it goes? Is that a ministerial decision?

Jonathan Marron: We agree it with the Minister.

Q111 **Chair:** But you make recommendations, so what are you recommending? What's the balance between smoking and alcohol?

Jonathan Marron: The things we have been focused on recently have been obesity, smoking, mental health, and then take-up of screening campaigns and some of the other, more NHS-focused—

Q112 **Chair:** Do you monitor the impact of it, so that if you spend a certain amount of money over the next—

Jonathan Marron: Yes, we know the impact of each of our campaigns, both more broadly and the impact on people picking up on the campaign. Some have been really successful. Just one you will have heard of is Couch to 5k. That is one of ours; everybody knows that one.

Chair: One that Government came up with in Whitehall and everyone has heard of—a rare success!

Sir Chris Wormald: The only thing I would add is that if you follow the data, it's a very dynamic thing. Smoking is a very interesting case study. Obviously, smoking rates have fallen a lot. The smoking that is left is very geographically and demographically concentrated. Basically, the big, national campaigns that most people have accepted become less and less effective, and the local targeting of very specific communities becomes much more effective, over time. There isn't a single, straight answer; it's quite dynamic. As we have discussed, alcohol is obviously not at the same point of maturity as smoking.

Q113 **Dan Carden:** Isn't the difference this? We have had a tobacco plan. We have action on gambling, and I think a duty is going to be placed on gambling companies to fund health projects related to that. We have had action and plans on obesity. We have had the independent review on drugs. Why is alcohol, when it causes so much harm, left without a strategy?

Sir Chris Wormald: We have debated that already. I would say that each of the conditions that you have described is very different, and what you do to affect them is very different. I wouldn't want to set up a false equivalence by making it alcohol versus gambling.

Q114 **Dan Carden:** Isn't the truth that we do not know, because we are not calculating the cost of the harm caused by alcohol to the NHS or across the economy? There is no review on the price and availability of alcohol. You are not even telling the public what is in their alcoholic drinks, and the fact that alcohol harm is linked to cancer and various other diseases.

Really, whereas we have seen action taken on tobacco, gambling and obesity, on alcohol we are keeping the public in the dark. We are not doing anything to tackle the harms that the industry, both in this country—

Sir Chris Wormald: Obviously, and as you will have heard from our answers throughout this hearing, that is not a case we accept.

Q115 **Dan Carden:** Well, throughout the hearing, we are concentrating on treatment—on what is being done at that end of things. We are not concentrating on the public health messaging and prevention.

Sir Chris Wormald: As Mr Marron has described, we do indeed do a lot in that area. Of course, what works and does not work on alcohol is a very well researched issue indeed. In some of the areas you mention, as I said earlier, what the right approach is is highly contested, both politically and between different experts. Just take one of the examples you gave: alcohol pricing, on which Scotland has obviously made a big move. The results of that are currently unclear. From the evidence available so far—obviously, it's quite early—the impact is quite different on different groups. These are contested areas, which my colleagues in OHID debate and—

Q116 **Chair:** We are not talking about individual areas; I think Mr Carden is talking about the wider strategy.

Sir Chris Wormald: As I say, I don't think there is very much difference between us and the Committee when it comes to focus and things that need to be done. We do not accept that there is no action on alcohol. We have described, and the NAO Report describes, an enormous amount of action. You would prefer it to be pulled together into a strategy. We have set out that the Government's view is, "Actually, let's get on with the things that we know work, and with spending the money." Well, that is a difference between us, clearly, but on the vast majority of these things—

Q117 **Chair:** I think we'd want to see outcomes, which we will come to.

Sir Chris Wormald: Exactly, but we want the things done that we know work, and where it is unclear whether things work, we want to follow the data and research.

Q118 **Chair:** On prevention, perhaps we can bring in Ms Wiseman, because she is on the frontline, and possibly at the cutting edge as well.

Alice Wiseman: I am going to politely disagree with you, Chris.

Sir Chris Wormald: That's fine; you're allowed.

Alice Wiseman: I think the evidence on what we need to do to tackle alcohol is really robust and clear. We are several decades behind where tobacco is, but we have an opportunity to really make some strides in this area and protect populations. I do not just mean populations who require addiction treatment; I am talking about the wider population, and the children growing up in families where people are drinking to excess.

The evidence coming out from Scotland, which Sir Ian referred to, is good: there is that 3.5% reduction in off-trade sales per adult; a 7% sustained reduction in household consumption; reductions in household expenditure; and the lowest volume of pure alcohol sold in 26 years. In comparison, England is going in the opposite direction, with a consumption rise.

For me, minimum unit price is not a silver bullet; we need all the things mentioned: we need alcohol duty, which was also referred to, a minimum unit price, and restrictions on marketing—and we certainly need to protect children from exposure to alcohol marketing. It is not good that our 10year-olds are able to name alcohol brands because they are plastered over the fronts of their favourite football team. It is not good enough, and we really could take robust action in that space.

Thinking about availability, we have far too much available alcohol. When I was growing up, you had to go down a special aisle in the supermarket to access alcohol, and you were not allowed if you were under 18. Nowadays, it is on the end of the aisle selling the "back to school" resources for kids, so they are selling it alongside the return to school things. There is so much more that we can do in that space.

I am really concerned about no-alcohol and low-alcohol advertising, because if you look at those alcohol adverts, all it is doing is product placement. It looks like beer—it looks exactly the same as beer—and it is saying to people that it is normal to drink beer. If you look at the advertising for that, there is one with a pregnant woman drinking a bottle of beer, and a guy driving a car. Those are circumstances in which people should not be drinking at all. They are using that as product placement. That is a space that we have to get into, and that is why an independent review on this would be really important.

Chair: Thank you. That was very passionate. I have more questions, but I will hand back to Mr Carden for now.

Q119 **Dan Carden:** We have talked about the harm to an individual's health. As MPs, I think we all see and learn about the harm to society. Can you talk a little about the link to domestic violence, people losing their employment, the statistics on children with parents who are alcoholics, and the impacts we see across society?

Alice Wiseman: Locally, we have data on looked-after children and why they have been taken into care. There is what they call the toxic trio: substance misuse, mental ill health and domestic abuse. It is a mix of all those things that is leading our children into care, but think of all those children who are not quite in care, but are living in families where they experience some of those difficulties.

Children who experience four or more adverse childhood experiences are much more likely to become addicted to substances and to contemplate suicide in later life; a whole range of poor outcomes come with that. There

is a generational issue, and if we do not seek to address it, the next generation of young people will come through with various challenges.

In Gateshead, one in 56 women reported a domestic violence episode in the last year. I know that that is not unique, and that they are largely alcohol-related and alcohol-driven. Sadly, we see a spike in alcohol-related domestic abuse as a result of a negative outcome in a football match, for example, and we know that that is fuelled by alcohol. It is having a massive impact on families, individuals and our communities. Coming as I do from the north-east, I could not sit here without talking about some of those challenges, because they are in front of me every day.

Q120 **Dan Carden:** Hearing that, Mr Marron, what work is being done across Government? This is not just a matter for the Department of Health. It affects criminal justice, society and communities. What work are you doing with other Departments?

Jonathan Marron: We continue to work with our colleagues across Whitehall on the impacts of alcohol, and indeed on a whole range of other behavioural-related factors that have impacts on health. Our aim is to have those discussions, put options in front of Ministers and look for ways that we can make reductions. Many of the things that we are now talking about are clearly matters of policy for our Ministers to take decisions on. We continue to have discussions on those.

Q121 **Olivia Blake:** Following on from what you were saying, Ms Wiseman, about the impact on families, do you feel that the public health grant is set up in a way that allows you to commission and prioritise work that focuses on families, carers and, importantly, children in households where there is alcohol dependence?

Alice Wiseman: I guess the challenge we have in local government is the funding that we have across the board. Because we all sit on the same organisation, the opportunity is absolutely there. I work daily with my director of children's services to consider our offer to families. In Gateshead, I am responsible for community safety as well as public health, so I am the lead on the domestic abuse work in my service area. There are different set-ups on different councils, but there are definitely opportunities for us to look together at our nought-to-19 services to ensure that they work in that way.

One of the opportunities that we are pleased about is the work on family hubs. We were one of the areas with additional resourcing for family hubs, and that has brought a whole range of professionals together to look at the needs of our families and how we can co-locate some of our resources—not just from a local authority perspective, but from the broader health perspective, with midwifery and mental health services as well.

Q122 **Olivia Blake:** Sir Chris, having heard all that, and also about the impact of adverse experiences in later life, do you think that there is more that the Department could do to prioritise this within these budgets?

Sir Chris Wormald: There is always more you can do, to state the obvious. The Government are making significant new investment, as we have said. People will argue about whether that is enough or too much, and about the relative priorities. From Alice's evidence, I would pick out, first, that it is good that we argue about this stuff. I hope that you have seen that there is no defensiveness or groupthink around these issues; there are proper debates about the right way forward, based on data, evidence and professional contact. That is what we should do in this area. Secondly, the cross-service nature, which most Committee members pointed to, of what you have to do to tackle these areas—many of them not in health—is absolutely central.

Chair: It is a wicked issue, as has been said.

Sir Chris Wormald: Alice described how she works with the rest of her local authority; that is why this responsibility was moved to local government. That, of course, creates a rough edge with the NHS and a lot of services.

Q123 **Chair:** We see the logic, but the problem is that the funding went. We could go round that house again.

Sir Chris Wormald: We focus on what we can achieve for the quantum available. You can obviously achieve more with a different—

Q124 **Chair:** The quantum went down, and it has now just gone up. We can go round and round. However clever a mandarin you are, you cannot deny that.

Sir Chris Wormald: I have at no point denied that.

Chair: Okay, but it is your whole way of expressing it.

Sir Chris Wormald: What I am saying is that the debate is: whatever the quantum is, how do we best spend it, so that you get the best outcomes? I think what you have seen is the kind of data-driven professional debate.

Chair: I think we agree that it is a very good practice.

Dan Carden: But I think we are lacking the data, aren't we? What you perhaps need is some ministerial direction.

Chair: I will bring in Mr Carden in a minute, but Mr Smith has a quick question.

Q125 **Nick Smith:** I have one point, then a question. The first is to say how good the Department of Health's public health awareness raising is. I really value Couch to 5K at Parc Bryn Bach in Tredegar.

Sir Chris Wormald: There is a "but" coming very quickly, isn't there, Mr Smith?

Chair: Take the positives where you can.

Sir Chris Wormald: I was going to say, "We will take it, but there is a very big 'but' coming."

Nick Smith: No, there isn't. There will be hundreds of people involved in the Parc Bryn Bach Couch to 5K initiative this spring. It will finish on 8 July to celebrate the 75th anniversary of the NHS, when hundreds of people will graduate and really enjoy that fantastic initiative. Thumbs up to the Department of Health for that, and please do more of it, Mr Marron.

To pick up on the point made by Ms Blake and Sir Ian about psychiatrists and addiction, and the crash in the number of people being trained—we hear it is from 60 to four—that is an appalling situation. You did give an answer, but I thought it was very short and insufficient. Why has it happened? What are you going to do about it? It is terrible.

Chair: Mr Marron—on workforce planning.

Jonathan Marron: We absolutely agree that we need access to the full range of professionals, including addiction psychiatrists. The additional investments we are making available will fund those posts, and we are working with HEE to ensure that we are training the right numbers of people.

Q126 **Chair:** How long will it take to train them?

Jonathan Marron: New psychiatrists obviously take a very long time to train, as you are aware.

Q127 **Chair:** So you are losing ones who are already psychiatrists, presumably?

Jonathan Marron: We have two things happening quicker than that. First, we are confident that there are people who previously worked as addiction psychiatrists but moved to other posts in the NHS who would be keen to come back. Also, you can add modules on addiction later in the training programme, so that it is not at the start. That way, people can train on addiction later and then move through; we are looking at that as well. Of course, our demand for psychiatrists in general is also driving up, as we spend more money on mental health, so we are working with HEE on what our strategy will be for the workforce over the next 10 years, and on ensuring that addiction psychiatry is clearly as much part of that as other elements are.

Q128 **Dan Carden:** We are short of time, so I have one last question. Budweiser believes that harmful drinking can be prevented by the health services, public services and the alcohol industry. What role do you see for the alcohol industry?

Jonathan Marron: We are not in the same position as we are with the tobacco industry; the harms caused there are so clear, and the WTO has a treaty under which we simply do not talk to the tobacco industry.

With alcohol, there are advantages to us having conversations with the industry and understanding what our opportunities are to ensure appropriate marketing, and to ensure that lower-strength alcohols are available more frequently. On all those things, the Government need to be clearer on where the boundary is and where regulation is required. That would then be a matter for the Government, not for the industry.

Chair: We had a fairly clear idea of Ms Wiseman's view earlier. As tempted as I am to bring you back in for a second bite, Ms Wiseman, I think we heard your views very clearly about supermarkets and advertising. Is there anything else, Mr Carden?

Q129 **Dan Carden:** Are there formal processes by which the alcohol industry meet with you or inform policies?

Jonathan Marron: I do not think we have any formal processes. Certainly I have no ongoing action with them. If there were issues to discuss, I would do so. We promised in 2019 to look at having more no-alcohol and low-alcohol products available in both the off-trade and the on-trade. We will be talking to the industry about whether that is possible and what might make that happen. That is a sensible way to do that. In the same way, we talked to the supermarkets about obesity.

Q130 **Dan Carden:** You met the alcohol industry—

Jonathan Marron: I have had no meetings with the alcohol industry.

Sir Chris Wormald: But to be clear, yes, the Department would.

Q131 **Dan Carden:** So on alcohol labelling, for instance, would they have been part of those discussions—the shelved alcohol labelling consultation?

Chair: Perhaps we are straying a little bit.

Jonathan Marron: It is some years ago that the last decision on alcohol labelling was made, but I am sure—

Q132 **Chair:** All I would observe is that trying to find zero-alcohol beverages in the alcohol aisle has been very difficult. No member of staff ever knew where they were. It is now a little easier.

Ms Wiseman, we do not have time to go into how you convinced your staff that what they thought was normal drinking was not. If you could write to us about that, with specific examples of how you did that education programme, it would be really helpful.

Alice Wiseman: Yes.

Chair: We need to end the sitting here. It is a fascinating discussion that is hugely important to individuals and their families, communities, the

economy and, as Ms Wiseman has very passionately laid out, the health and wellbeing of a generation.

The transcript of this session will be published on our website uncorrected in the next couple of days—thank you to our colleagues at *Hansard*—so do have a look at that. We will be a producing a report, likely after the Easter recess. Thank you for your time.