AHA Organisation Response: Change NHS Consultation (November 2024)

Please confirm the name of your organisation

The Alcohol Health Alliance.

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

The Alcohol Health Alliance is a coalition of 65 organisations, from healthcare bodies and medical Royal Colleges to treatment providers, charities and research organisations, working to tackle alcohol harm in the UK.

As a significant cause of preventable death and ill-health, we strongly recommend the 10 year plan has commitments on alcohol.[1] We are also calling more widely for the Government to commit to a new national alcohol strategy in light of the rising (and concerning) rates of national alcohol harm, and the resulting impacts on services, public finances, and wider society. A cross-government strategy would ideally reduce population-level alcohol consumption to reduce overall harms, alongside driving more preventative policies and pathways to tackle alcohol harm at an earlier stage.

Our asks for the 10-year Health Plan include:

1. **A bolder acknowledgement of, and commitment to tackle, the impact of alcohol harm on our health services**
2. **Better early intervention and prevention measures around alcohol**
3. **Greater understanding of links between alcohol use and mental health difficulties, including links between alcohol use and suicide, with services better able to support patients presenting with dual diagnosis/co-occurring conditions**
4. **Greater rollout of Alcohol Care Teams, particularly given that ACTs ease pressures in other core NHS services such as A&E**
5. **Alcohol as an increased priority in health services, with support to screen, intervene and refer**
6. **Ring-fenced funding for (and enhanced access to) alcohol treatment services, addressing workforce gaps, and ensuring adequate alcohol-related specialists**
7. **Finally, a 10 year plan must be aligned with other national policies that we know will reduce alcohol harm.**

Further details under each of these asks are set out below.

1. A bolder acknowledgement of, and commitment to tackle, the impact of alcohol harm on our health services.

- Decisions on healthcare priorities are hugely contextual. Given the steep rise in both alcohol-specific and alcohol-related health harms since the last NHS plan, this new national context

[1] OHID (2022). Local Profiles for England – Mortality due to alcohol

necessitates a fresh approach and firmer commitments on alcohol as its impact on public health and healthcare services has escalated. We would recommend alcohol as a greater health priority within this new 10 year plan than it has been previously. A 2023 Public Accounts Committee inquiry into Alcohol Treatment Services also provided key recommendations for health services around alcohol[2].

- Reducing alcohol harm would impact directly on almost all of the Government's 5 Missions, including: helping to drive productivity and economic growth through a Health is Wealth approach; reducing serious violent crimes where alcohol is a factor; reducing health inequalities and therefore breaking down barriers to opportunity; and reducing NHS pressures from preventable illnesses and the biggest killers.
- We fully support and endorse the Medical Council on Alcohol's recent report 'The need for a health system response to alcohol-related harms', and call on the Government to address and implement its recommendations in the 10 year plan. The report can be accessed here: https://m-c-a.org.uk/wp-content/uploads/2024/11/Core-Document-The-Need-for-a-Health-System-Response-to-Alcohol-Related-Harms-FinalVersion.pdf
- Alcohol is a small molecule which can permeate into every organ of the body, including the brain. Although it is widely available in society, and drunk at some level by approximately 80% of adults in the UK, it is now well established that there is no 'safe' level of alcohol consumption,[3] and that the physical and mental health harms caused by alcohol increase (at different rates) with the amount consumed.[4]
- Alcohol harm skyrocketed during the pandemic, placing increasing burdens – and costs – on healthcare services. Between March 2020 and March 2021, there was a 58.6% increase in the proportion of respondents drinking at increasing risk and higher risk levels.[5] Modelling has indicated that if alcohol use does not return to pre-pandemic levels there could be an additional 150,000 cases of nine alcohol-related diseases, and up to 10,000 additional deaths by 2035, costing the NHS £1.2 billion.[6] UCL's Alcohol Toolkit Study shows that unfortunately we are far from returning to 2019 levels of higher-risk drinking, and deaths have already increased at a faster pace than the modelling predicted.[7]
- The latest available data indicates that in 2022, for the third year in a row, alcohol-specific deaths have continued to reach record highs across the UK, up 33% from 2019. In England, 7,912 deaths in 2022 were wholly a result of alcohol.[8]

2. Better early intervention and prevention measures around alcohol.

- The impact of alcohol on healthcare services cannot be overstated. This spans emergency services such as ambulances, A&E departments and wider hospital admissions, as well as presentations to primary care services such as pharmacies and GP practices, and other impacted health services such as those for cancer, heart, liver and gastrointestinal treatment.
- To reduce pressures and waiting lists in these areas, a new 10 year plan should first reflect an understanding of the widespread impact of alcohol on these services

[2] Public Accounts Committee (2023) Alcohol Treatment Services
[3] World Health Organization. (2023) No level of alcohol consumption is safe for our health. (January 4, 2023). Accessed August 19, 2024. https://www.who.int/europe/news/item/04-01-2023-no-level-of-alcohol-consumption-is-safe-for-our-health
[4] Rehm J, Gmel GE, Gmel G, et al. (2017) The relationship between different dimensions of alcohol use and the burden of disease—an update. *Addiction*. 2017;112(6):968-1001. doi:10.1111/ADD.13757
[5] Public Health England (2021) Monitoring alcohol consumption and harm during the COVID-19 pandemic: summary.
[6] Boniface, S., Card-Gowers, J., Martin, A., Retat, L., and Webber, L. (2022) The COVID hangover: Addressing long-term health impacts of changes in alcohol consumption during the pandemic. Institute of Alcohol Studies and Health Lumen.
[7] UCL, Alcohol in England, Alcohol Toolkit Study (accessed August 2024).
[8] Office for National Statistics (2024) Alcohol-specific deaths in the UK: registered in 2022.

- Almost 40% of ambulance time is estimated to be spent dealing with alcohol-related incidents.[9] The latest figures indicate that there were almost 980,000 hospital admissions where the primary reason or a secondary diagnosis was linked to alcohol – more than 1 in 20 of all hospitalisations.[10] The annual cost of alcohol to NHS England is currently estimated by the Institute of Alcohol Studies to be £4.9 billion[11]
- Alcohol use is the biggest risk-factor for early mortality, ill-health and disability among 15 to 49-year-olds,[12] and the fifth biggest risk-factor across all ages.[13] Playing a causal role in more than 200 different diseases and injuries, alcohol is linked to seven cancers, including two of the most common (breast and bowel).[14] Tackling alcohol harm would in the long term reduce wider alcohol-related harms including cancers, liver disease, and cardiovascular disease. Better screening and early detection for these conditions would also help to save lives, particularly where somebody is identified as at-risk through their alcohol use
- 78% of alcohol-specific deaths are due to alcohol-related liver disease (ARLD). Many of those accessing alcohol services are at high risk of developing cirrhosis and may have undetected ARLD. Yet non-invasive tests for liver fibrosis (i.e. transient elastography and enhanced liver fibrosis testing) are not widely embedded in high-risk community services including alcohol services. Earlier ARLD detection can stimulate changes in drinking behaviour and save lives.
- We would support additional resources and appropriate training for early intervention steps such as brief interventions, as well as signposting/referrals to specialist services and treatment pathways. This should be practised in any healthcare setting that somebody presenting with alcohol difficulties is seen in with a 'no wrong door' approach.

3. Greater understanding of links between alcohol use and mental health difficulties, including links between alcohol use and suicide, with services better able to support patients presenting with dual diagnosis/co-occurring conditions.

- We are calling for more focus on, and a better understanding of, treatment for those experiencing both alcohol and mental health difficulties.
- Alcohol dependence often co-occurs with other mental and physical health conditions, and the complex relationship between these must be accounted for in effective treatment provision. Individuals with a mental health condition concurrent with problematic alcohol use also experience a greater burden of physical illness, further highlighting the need for timely and integrated treatment.[15]
- 44% of people in Community Mental Health Treatment and 85% of people in alcohol treatment have a dual diagnosis of a mental health problem along with a substance use problem.[16] In 2020/21, English hospitals had over 227,000 admissions for mental and behavioural disorders due to alcohol use – this accounted for 25% of all alcohol-related hospital admissions.[17]

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[9] IAS (2015). Alcohol's impact on emergency services
[10] NHS Digital (2022). Statistics on Alcohol, England 2021
[11] IAS (2024) The cost of alcohol harm in England
[12] VizHub - GBD Results (2019). Global Health Data Exchange, Institute for Health Metrics and Evaluation, University of Washington.
[13] OHID (2022). Local Alcohol Profiles for England
[14] WHO (2018). Fact sheets: alcohol.
[15] Gomez, K. U. et al. (2023). The clustering of physical health conditions and associations with co-occurring mental health problems and problematic alcohol use: a cross-sectional study.
[16] Weaver T, et al. (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *The British Journal of Psychiatry*.
[17] NHS Digital. (2022). Statistics on Alcohol, England 2021.

- Research has found a close relationship between alcohol, suicide, and self-harm: those who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population.[18] Over half of hospital presentations for self-harm involve alcohol use.[19]
- Despite this known relationship, and the prominence of dual diagnosis, treatment for each condition is often dependent on a patient recovering from one condition first.[20]
- Research has shown that treatment for alcohol problems and mental health problems must happen in parallel to improve outcomes.[21] There are significant barriers to integrating these services, including insufficient funding, workforce shortages, and stigma.[22]
- There are common risk factors for alcohol use disorders and mental health problems e.g., exposure to traumatic events or childhood adverse events or genetic/environmental risks.[23] This means there is an ability to identify key at-risk persons and to intervene at an earlier stage through better data sharing and referral mechanisms.

4. Greater rollout of Alcohol Care Teams, particularly given that ACTs ease pressures in other core NHS services such as A&E

- We believe that every acute hospital must have an Alcohol Care Team, and would welcome a firm commitment to this in the 10 year plan.
- Alcohol Care Teams (ACTs) are teams of specialists, mainly located in acute UK hospitals. There is clear evidence that they reduce acute hospital admissions, readmissions and mortality, improve the quality and efficiency of alcohol care, and have 11 key evidence-based, cost-effective and aspirational components.[24]
- ACTs are a proactive way to drive down hospital readmissions, and can bridge the gap between secondary and community care.[25] They can also bring about a culture change in how people with alcohol problems are treated in key parts of the NHS such as A&E. ACTs are cost-effective across all four elements of alcohol-related harm: crime and social disorder, families and family networks, the workplace, and health.[26] Implementation of an alcohol specialist nurse service in Nottingham improved the health outcomes and quality of care for detoxification and alcohol-related cirrhosis patients, resulting in a saving of 36.4 bed days per month in detoxification patients and a reduction in bed days used in the cirrhotic group from 6.3 to 3.2 days per month.[27]
- Although there has been an increase in the number of trusts in England with an alcohol specialist nurse service, many hospitals are not resourced to provide the optimal seven-day service, [28] which is estimated to save £179,000 per annum per 100,000 population.[29] To provide a seven-day service, trusts should have a minimum of four nurses, with liver and mental health expertise.[30]
- The NHS Long Term Plan set aside £27 million to support the implementation of specialist ACTs in 25% of hospitals with the highest rates of alcohol-dependence related admissions,

[18] Samaritans. (2022). Insights from experience: alcohol and suicide.
[19] Ness, J. et al. (2015). Alcohol use and misuse, self-harm and subsequent mortality: an epidemiological and longitudinal study from the multicentre study of self-harm in England. *Emergency Medicine Journal.*
[20] Care Quality Commission (2015) Right here, right now: People's experiences of help, care and support during a mental health crisis.
[21] Foulds J. A., et al. (2015) Depression in patients with alcohol use disorders: Systematic review and meta-analysis of outcomes for independent and substance-induced disorders. *Journal of Affective Disorders*.
[22] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.
[23] Goodwin, L. (2022). AHA Seminar Session: Alcohol harm and ethnicity.
[24] Moriarty, K. (2019). Alcohol care teams: where are we now? *Frontline Gastroenterology*
[25] Moriarty, K. (2019). Alcohol care teams: where are we now. *Frontline Gastroenterology.*
[26] Ibid.
[27] Ryder, S. D. et al (2010). Effectiveness of a nurse-led alcohol liaison service in a secondary care medical unit. *Clinical Medicine*.
[28] Williams, R. et al. (2017). New metrics for the Lancet Standing Commission on Liver Disease in the UK. *Lancet*.
[29] NICE (2016) Quality and Productivity Case Study: Alcohol Care Teams: reducing acute hospital admissions and improving quality of care.
[30] Ibid.

estimated to prevent 50,000 admissions over five years.[31] The implementation of this plan thus far is unclear, and the delivery aim of 25% hospitals falls far short of a national roll out.

- In addition, overlaps or conflicts in project responsibility can hinder successful technology project completions from end to end. For example, funding to establish Alcohol Care Teams was initially provided by NHS England for the 25% of hospitals most in need of this service. Once set up and established, future funding responsibility for these ACT's was set to transfer to ICB's/local commissioning authorities, and NHSE funding for the project would be moved on to establish the next wave of hospital ACTs. However, local budget pressures meant that a) some areas simply could not maintain ACTs without continued NHSE funding, and b) that future rollouts of ACTs in the next wave of the project therefore could not commence due to the allocated project funding being used to prevent existing ACTs from being discontinued (rather than establishing new ones).

5. Alcohol increased as a priority in health services, with support to screen, intervene and refer

- NICE quality statements have reinforced two principles that would help to integrate care. Firstly, 'everyone's job' indicates that both commissioners and service providers should be responsible for providing services for people with a dual diagnosis or complex needs. Secondly, 'no wrong door' underlines that service providers should not turn away people with co-occurring conditions and that treatment for any of the conditions should be available at every point of contact, known as Making Every Contact Count.[32]
- Identifying, assessing and supporting people who are facing issues with alcohol and other drugs (including those around a person using substances) should be seen as a 'core business' of all health and social care services - though each would contribute in their own way.
- Even where a community NHS trust is not the main provider of community alcohol treatment, they should have in-house expertise in substance use, and be clear on how to link into wider support services. Similarly, GPs should feel confident and willing to screen and support people using alcohol, including supporting the prescribing for alcohol detox. This should not be a postcode lottery, as it is at the moment, where individual practices (and practitioners) can choose whether or not to support alcohol interventions such as detoxes.

6. Ring-fenced funding for (and enhanced access to) alcohol treatment services, addressing workforce gaps, and ensuring adequate alcohol-related specialists

- The alcohol treatment landscape is complex and covers a broad range of community and in-patient services provided by the NHS, voluntary sector and private sector. We encourage the 10 year plan to recognise the importance of charities and community organisations as healthcare and treatment providers alongside NHS services treating alcohol harms.
- *We also urgently call for announcements to be made on the next Drug Strategy funding cycle, to prevent local services needing to commence redundancy consultations and close services.*
- Treatment outcomes are directly linked to funding. Alcohol treatment provides very good value for money: in England, every £1 invested in alcohol treatment is predicted to yield £3 of social return, increasing to £26 over 10 years.[33]Every 5% reduction in yearly spending on

[31] Hansard (2020). Response to Written Question, UIN 91927.
[32] NICE. (2019). Coexisting severe mental illness and substance misuse.
[33] PHE (2018). Alcohol and drug prevention, treatment and recovery: why invest?.

alcohol treatment is associated with an extra 60 alcohol-related hospitalisations per 100,000 people in the population.[34]

- The most recent figures suggest there are 602,391 adults with alcohol dependence in need of specialist treatment in 2018/19. With only 107,428 in treatment for alcohol in 2020/21, this means over 80% of adults are not receiving the help they need. Almost two thirds of those starting treatment for alcohol were self-referred, indicative of a lack of referrals through the health and social care system, and thus more is needed to improve pathways into alcohol treatment.
- Since 2015/16, the overall public health grant has effectively been cut by 28% per person in real terms and now stands at £3.6bn, equivalent to just 2.2% of the NHS England budget.[35] The amount local authorities reported spending on drug and alcohol services fell by 27% in real terms from 2014–15 to 2021–22.[36] Despite recent increases as a result of the government's 10-year drug strategy,[37] spending has still not matched 2014-15 levels, and is not sufficient to tackle the massive unmet need for alcohol treatment.[38] There is also no forward plan for this funding currently in place.
- This has led primarily to the reduction in workforce (across commissioning, strategy development and implementation, and service delivery), leading to insufficient resources to develop services, improve pathways, increase harm reduction work, and weaker system partnership working. Compounding this issue, is the short-term and late notice of annual funding amounts, which in turn limits the ability of local authorities to secure the necessary workforce, in time, or on a sustainable basis.[39]
- Cuts have also meant fewer specialist addictions psychiatrists, clinical psychologists, and nurses, and a greater reliance on doctors without specialist training and volunteers with limited training, increasing pressure elsewhere in the NHS and the wider system. Dame Carol Black's independent review of drugs found that the number of training places for addiction psychiatrists has plummeted from around 60 to around 5, meaning there is little to no capacity to train the next generation of specialists. Even with additional funding, there is therefore a lot of work to do to build up capacity and expertise in the market.[40]
- There is also an issue with funding pots not being joined up – even within the NHS. So it is difficult to spend money that saves expenditure in the longer term if a pot of money used for a cost saving initiative would impact a different pot of money to the one funding it. As healthcare impacts from early intervention, prevention and treatment can cut across multiple departments, this makes cost saving initiatives difficult to carry out in practice.

7. Finally, a 10 year plan must be aligned with other national policies that we know will reduce alcohol harm

- Alcohol treatment provides an essential service (as well as wider health interventions). It is effective and it provides good value for money. However, it is only one part of the holistic, evidence-based approach to alcohol harm that is needed from the Government. As a witness to the independent Alcohol Harm Commission noted "we'll never treat ourselves out of this situation we're in … we have to start with prevention."[41]

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[34] Roberts,E., et al. (2020) 'The relationship between alcohol related hospital admission and specialist alcohol treatment provision across local authorities in England since passage of the Health and Social Care Act 2012'
[35] The Health Foundation (2024) Options for restoring the public health grant.
[36] National Audit Office (2023) Alcohol treatment services.
[37] DHSC and the Home Office (2021). Largest ever increase in funding for drug treatment
[38] National Audit Office (2023) Alcohol treatment services.
[39] Limb, M (2023). Public health: Delay in confirming budgets for 2023-24 is harming the public, says leader. *BMJ*
[40] Dame Carol Black (2020) Review of Drugs: Executive Summary.
[41] Dr Helen McAvoy, Institute of Public Health in Ireland, cited in Alcohol Harm Commission (2020) 'It's everywhere' – alcohol's public face and private harm

- Preventative policies limit the burden on treatment services. Population-level measures to limit the affordability, availability and promotion of alcohol have been recommended as cost-effective by Public Health England (now the Office for Health Improvement and Disparities)[42] and the World Health Organization.[43]
- Increasing alcohol duty is one of the most cost-effective measures to tackle alcohol harm, reduce cancers and deaths, as well as providing other public health benefits such as reducing obesity.[44] Reducing the availability of alcohol through licensing regulations is also beneficial. The relaxing of licensing restrictions led to an increasing alcohol-related overnight attendance in a London hospital[45], and in Scotland alcohol-related hospitalisations, deaths and crime rates are directly linked to the density of licensed premises.[46]
- Exposure to alcohol marketing encourages children and young people to start drinking at an earlier age and engaging in riskier drinking habits,[47] and can also trigger relapses in those with alcohol dependence. Alcohol marketing restrictions reduce the overall burden on health services by bringing down alcohol consumption. Several European countries already have alcohol marketing restrictions in place, especially around sports sponsorship by alcohol companies, including France, Norway and the Republic of Ireland.[48]

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Challenges:

- Healthcare funding is currently concentrated on hospitals as that's where those who didn't get early intervention/prevention or care in the community end up presenting. This creates an imbalance in the funding, and therefore service provision potential and capacity, for community services.
- It is unclear that hospitals are proactively screening people for issues with alcohol and other drugs. Current funding models do not encourage hospitals to look for these opportunities in all cases, and different patient screening/data collection on admission can actually punish hospitals practising proactive screening by indicating worse harm rates in comparison to those not proactively screening.
- There is also a lack of understanding on how to identify and effectively refer patients into support in the community. Ambulance and hospital staff can often see the same patients readmitted to hospital on a regular basis. A community referral to specialist local alcohol services (that are also geographically easier for patients to access) would provide better care and reduce repeat presentations to hospital.
- Challenges in referrals are partly about technology - where different case management systems don't talk to each other - but also about working across different specialties, departments and organisations in and outside of hospital to better use referral pathways.

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[42] PHE. (2016). The public health burden of alcohol: evidence review.
[43] WHO. (2017). Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases.
[44] Kilian et al. (2021). Modelling the impact of increased alcohol taxation on alcohol-attributable cancers in the WHO European Region. Ananthapavan, J. et al. (2020). Priority-setting for obesity prevention-The Assessing Cost-Effectiveness of obesity prevention policies in Australia (ACE-Obesity Policy) study.
[45] Newton, A. et al. (2007). Impact of the new UK licensing law on emergency hospital attendances: a cohort study. Emergency Medicine Journal.
[46] Alcohol Focus Scotland and Centre for Research on Environment, Society and Health (2018). Alcohol Outlet Availability and Harm in Scotland. Glasgow: Alcohol Focus Scotland.
[47] Jernigan, D. et al. (2017). Alcohol Marketing and Youth Consumption: A Systematic Review of Longitudinal Studies Published Since 2008. *Addiction*.
[48] Institute of Alcohol Studies (2020) Alcohol and Marketing

- If different datasets were linked, healthcare professionals would be more able to spot patterns of service use that predict future issues, and care could be more integrated and therefore both effective and efficient. At present, it is not clear that each part of the health and social care system will be aware if an individual has a substance use issue or is being treated for it, as this would require sharing of data both across the NHS and beyond (as most substance use treatment is provided outside of the NHS, with 80% of the workforce in the field employed in the third sector).
- Stigma can also prevent people seeking early care in the community, before becoming unwell enough to need hospital treatment. Recent British Liver Trust survey results show that 49% of liver patients have experienced stigma from healthcare professionals and almost 1 in 3 patients have been prevented from seeking or receiving support due to stigma[49]

Enablers:

- More joined up/integrated systems that allow cross-system referrals both within and outside NHS services.
- Proactive – and nationally consistent – screening at the point of presentation into hospitals (particularly for those experiencing frequent hospital admissions) would enable services to identify a) those at risk, and b) provide opportunities for further investigation where other factors may suggest a higher likelihood of other conditions despite no symptoms. For example, liver disease is a silent killer that often doesn't have any symptoms in the early stages. Hospital admission rates for liver disease have risen by almost 80% over the last decade alone. Sadly three quarters of cirrhosis patients are diagnosed in A&E when it's too late for effective treatment or intervention.
- Better diagnostic tools available in community services would enable more identification to happen in local settings at an earlier stage, making treatment interventions more successful and cost effective.
- For example, in June 2022, NHS England launched a major drive to accelerate earlier detection of liver cancer by harnessing innovative technology. A network of 12 mobile trucks were deployed to high-risk communities to deliver Community Liver Health Checks in alcohol recovery services, food banks, diabetes clinics, sexual health clinics, GP practices and homeless shelters to perform quick, non-invasive scans (FibroScans) to test for inflammation or scarring. As of the end of July 2024, the programme has delivered over 66,000 FibroScans and referred over 4,700 people into six-monthly ultrasound surveillance for liver cancer. We are calling for this good practice to be expanded and rolled out nationwide.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Challenges:

- Currently there are many different systems, both within and outside of the NHS, and these do not link together. Linking takes place on a very variable local basis, with different areas having made different levels of progress, including contrasting datasets and data items, with varying uses for the systems (e.g. Aggregate analysis or individual patient care).
- There are also some areas where relatively basic, existing technology is not applied as widely as it could or should be. For example, outside of the NHS, substance use treatment

[49] British Liver Trust (2022) https://britishlivertrust.org.uk/stigma-survey-results/

prescribing has to be done by paper - which is both less efficient and less safe than electronic prescribing. This is because the electronic facility is only set up for GPs prescribing controlled drugs, not the systems used within substance use treatment (which are themselves required and approved by DHSC as part of the national requirements for substance use treatment).

- When not ringfenced, vital funding for technology projects risks being redistributed due to unplanned budget overspends on critical/acute care, delaying vital digital upgrades that would vastly improve patient care and outcomes.
- Digital technology such as apps enabling people to monitor and reduce their alcohol intake offer some benefits to users, however some of these apps are funded by organisations with funding links to the alcohol industry (such as DrinkAware). Recent research showed that some apps presented significant misinformation to consumers on product risks.[50]

Enablers:

- Funding for technology and innovation should be increased and ringfenced, to protect budgets for technology projects that would significantly increase patient care from being reallocated to plug holes in healthcare budgets
- Systems should be better aligned (or at the very least, compatible with each other and able to share data more easily) to enable consistency in care and appropriate multi-agency referrals across treatment pathways
- Better technology/digital systems and joining up data in case management systems would mean healthcare professionals could spot patterns of service use that might predict the development of a longer-term problem. This is both more beneficial to patient outcomes and to the overall treatment cost for that individual.

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Challenges (spotting illnesses earlier):

- Better training and awareness of alcohol harm and alcohol-related conditions is key. We need to ensure that all professionals in the health and social care system see the use of alcohol and other drugs as a key part of their role, and feel confident in screening, supporting and referring people who use substances.
- There is also a key element related to stigma and culture: the issues with alcohol and other drugs deter people from seeking support as it is not always seen as a legitimate issue for which people can reasonably ask for help. The dominant ideas of alcohol and alcoholism in our society mean that people using substances often do not identify themselves as having a problem until quite late in the progression of their illness.
- Existing legislation can perpetuate this stigma: those experiencing difficulties with alcohol are not protected under the current Equality Act because of an exclusion clause on alcohol within the act (due to alcohol harm still being viewed as 'self-induced'). Sufferers are also not usually able to be detained under the Mental Health Act (as they are deemed to have capacity as soon as they sober up) even when their actions are causing significant harms to themselves and potentially risking their own life. Changing laws and processes to protect those who are vulnerable as a result of their alcohol use, and to enable services to divert

[50] Roy-Highley, E., Körner, K., Mulrenan, C., and Petticrew, M. (2024) Dark patterns, dark nudges, sludge and misinformation: alcohol industry apps and digital tools. *Health Promotion International.*

those in crisis into treatment, would reduce patient stigma and greatly assist early intervention efforts.

- There is a lot that could be done to identify those with a treatment need who are not presenting to traditional health and care settings. Data and technology would help significantly with this. For example, a 2021 report from the Parliamentary Advisory Council for Transport Safety found that 17% of drink driving offences were caused by a repeat offender, and that drink drivers (particularly reoffenders) were significantly more likely to have alcohol issues and mental health issues than other drivers.[51] Sharing data between other blue light services such as police forces to identify at-risk drinkers and offer brief interventions and treatment access/referrals would not only reduce drink driving injuries (and deaths) presenting to hospitals, but would also reduce drink driving reoffending. It could also enable appropriate alcohol treatment referrals to those needing it but not yet visible to healthcare services.
- As highlighted earlier, the lack of funding and long-term support for the alcohol treatment sector, with treatment outsourced to local authorities but with inadequate budget to meet local needs, means many go into acute care services such as hospitals at a later stage, putting additional pressures on NHS secondary care services.

Challenges (tackling the causes of ill health):

- In terms of prevention, it is essential the Government recognise the hugely detrimental impact of health harming industries (such as tobacco, alcohol and unhealthy food and drinks) on population health. Government regulation is vital in driving producers of health harming products towards healthier formulations (where possible) or to drive the most damaging products (such as white cider) out of the market altogether, whilst improving public health, recovering public finances and taking some pressures off health and public sector services
- We are calling for a comprehensive alcohol strategy that addresses these factors in order to address the growing crisis of alcohol harm in the UK.

Enablers (spotting illnesses earlier):

- Better workforce training and awareness of alcohol harm and alcohol-related conditions
- Legislation and language that perpetuates stigma around alcohol use disorder and difficulties with alcohol more generally should be reviewed and revised, to reduce stigma and to encourage greater understanding around alcohol harm
- Early identification both within and outside of NHS services is key to identifying and addressing treatment need at an early stage.

Enablers (tackling the causes of ill health):

- Population wide measures which regulate the affordability, availability and marketing of alcohol are proven to be more effective than individual behaviour change in reducing overall disease burdens and addressing health inequalities.

Q5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in:

[51] PACTS (2021) Drink Driving: Taking Stock, Moving Forward

Quick to do, that is in the next year or so

- Announce Drugs Strategy funding decisions to enable substance use services to continue operating and to secure substance use service provision. Alongside this, setting out longer finance cycles for these services, with future allocations confirmed much further in advance, to enable more security for the sector and its workforces
- Enable electronic prescribing for controlled drugs through community prescribing outside of GP systems
- Improve consumer information around alcohol harms (such as links to common cancers such as breast and bowel) with public health campaigns (for example, Balance North East's 'Alcohol is Toxic' campaign which was well-received regionally, impactful, and featured key NHS clinical spokespersons in the region[52])
- Provide clear information to consumers on which digital apps to help monitor and reduce alcohol intake are free from industry influence/misinformation
- Introduce regulations to mandate certain information on alcohol labels including established health risks such as links between alcohol and cancer. We would also want to see labels include warnings on drinking alcohol during pregnancy, the CMOs' low risk drinking guidelines, unit and calorie information, and a full list of ingredients as standard for all alcohol products
- Introduce screening tools in community settings such as FibroScan technology, to allow local services the ability to detect illnesses and conditions at an earlier stage
- Introduce Minimum Unit Pricing to drive down sales of cheap, high strength alcoholic drinks that cause the most harm, alongside a public health levy to divert additional revenue from the policy away from alcohol producers or retailers and back into alcohol treatment services.
- Extract health-harming industries from the policymaking processes to regulate their own products, recognising that the industry is not a good faith actor and will always put profit before public health
- Reintroduce the alcohol duty escalator to ensure duty rates keep pace with inflation and to drive down harmful consumption rates.

In the middle, that is in the next 2 to 5 years

- A new national alcohol strategy to provide a renewed long-term vision and roadmap for tackling alcohol harm at a national level
- Ensure all hospitals have an Alcohol Care Team, with 7-day access
- Require key health and social care services to have training, screening and referral pathways for those presenting with alcohol difficulties - and monitor delivery of this (e.g. through Alcohol Care Teams in acute trusts), alongside improving workforce training to include alcohol harm and treatment
- Update GP and pharmacy contracts to include substance use provision as standard
- Upgrade technology for NHS providers and other external commissioned service providers to ensure that data can be more easily shared between agencies, particularly where somebody's alcohol use is of concern and requires further assessment and specialised intervention.

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Long term change, that will take more than 5 years

- Encourage wider cultural change around the use of alcohol and other drugs to reduce stigma and problematic use
- Introduce robust policies that restrict the prolific industry marketing of health-harming products including alcohol, unhealthy food and drinks, and vapes.