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Information Centre



Statistics on Alcohol

England, 2015

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This report may be of interest to members of the public, policy officials and other stakeholders to make local and national comparisons and to monitor the quality and effectiveness of services.

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- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

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Executive Summary

Main findings

In Great Britain:

- More than one in five adults (21 per cent) said that they do not drink alcohol at all in 2013. This has increased slightly since 2005 (19 per cent). Young adults (aged 16 to 24) were primarily responsible for this change, with the proportion of young adults who reported that they do not drink alcohol at all increasing between 2005 and 2013.
- The proportion of adults who binged^a at least once in the week before interview decreased from 18 per cent in 2005 to 15 per cent in 2013. Young adults were mainly responsible for the decrease in binge drinking, with the proportion that had binged falling by more than a third since 2005, from 29 per cent to 18 per cent.

In England:

- In 2013, 15 per cent of men and 20 per cent of women did not drink any alcohol in the last year; 63 per cent of men and 64 per cent of women drank at levels indicating lower risk of harm; 18 per cent of men and 13 per cent of women drank at an increased risk of harm and 5 per cent of men and 3 per cent of women drank at higher risk levels.
- In 2013, 39 per cent of pupils in years 7 to 11 said that they had drunk alcohol at least once. This continues the downward trend since 2003, when 61 per cent of pupils had drunk alcohol, and is lower than at any time since 1988, when the survey first measured the prevalence of drinking in this age group.
- In real terms, between 2010 and 2013 household spending on food and drink fell by 3.2 per cent and eating out expenditure by 5.6 per cent. Household spending on alcoholic drinks fell by 5.7 per cent over the same period, whilst that bought for consumption outside the home fell by 13.4 per cent.
- In 2013/14, there were an estimated 1,059,210 admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis (broad measure). This is 50,360 (5 per cent) more estimated admissions than 2012/13 (1,008,850) and 565,450 (115 per cent) more estimated admissions than 2003/04 (493,760). Of these:
 - The highest number of admissions, 511,260 (48 per cent of all admissions), were due to cardiovascular disease in 2013/14. This is 32,220 (7 per cent) more admissions than 2012/13 (479,040) and 337,100 (66 per cent) more admissions than 2003/04 (174,160).
- In 2013/14, there were an estimated 333,010 admissions where the primary diagnosis or alcohol-related external causes recorded in secondary diagnosis fields were attributable to the consumption of alcohol (the narrow measure). This is 7,150 (2 per cent) more estimated admissions than 2012/13 (325,870) and 96,240 (29 per cent) more estimated admissions than 2003/04 (236,770). Of these:

^a In line with the Government's Alcohol Strategy, men are considered to have binged if they drank more than eight units of alcohol on their heaviest drinking day in the week before interview and women if they drank more than six units.

- The highest number of admissions 74,330 (22 per cent) were due to cancer in 2013/14. This is 1,670 (2 per cent) more admissions than 2012/13 (72,660) and 11,440 (18 per cent) more admissions than 2003/04 (62,890).
- In 2014, 194,706 items were prescribed (in a primary care setting or NHS hospital). The majority of these 185,251 (95 per cent) were prescribed in a primary care setting (e.g. GP surgery, pharmacist or clinic). The Net Ingredient Cost (NIC) of these prescription items in 2014 was £3.43 million, which is an increase of £0.30 million since 2013 and more than double the NIC in 2004 of £1.52 million.
- In England, in 2013 there were 6,592 alcohol-related deaths. This is a 1 per cent increase from 2012 (6,495) and a 10 per cent increase from 2003 (5,984).

1 Introduction

This statistical report acts as a reference point for health issues relating to alcohol use and misuse by providing information obtained from a number of sources in a user-friendly format. It covers topics such as drinking habits and behaviours among adults (aged 16 and over) and school children (aged 11 to 15), drinking-related ill health and mortality, affordability of alcohol, alcohol related admissions to hospital and alcohol-related costs. The report contains previously published information and also includes additional new analyses.

The data within this report relate to England where possible. Where figures for England are not available, figures for England and Wales, Great Britain or the United Kingdom are provided.

[Chapter 2](#) reports on alcohol consumption among adults and children, looking at how much and how often people drink, drinking patterns among different groups, the type of alcohol consumed and the affordability of alcohol.

[Chapter 3](#) reports on adults' knowledge of alcohol and children's attitudes towards drinking, including their knowledge of measuring alcohol in units and awareness of the health risks of drinking.

[Chapter 4](#) looks at the health risks associated with alcohol misuse including the number of admissions to hospital related to alcohol and the number of deaths that are linked to alcohol. Information on prescription drugs used for the treatment of alcohol dependency is also included and the cost of alcohol misuse to the NHS is considered.

A brief explanation and a short review of the quality of each of the sets of statistics used in this publication have been included in [Appendix A](#).

2 Drinking behaviour among adults and children

2.1 Introduction

The information presented in this chapter relates to the drinking patterns of adults (aged 16 and over) and children (aged 11 to 15). A number of sources are used to describe drinking patterns, drinking among different groups in society, geographical patterns in the prevalence of drinking among adults and children, and expenditure on and affordability of alcohol.

The main source of data on drinking among adults is the Opinions and Lifestyle, Drinking Habits Amongst Adults Survey (OPN)¹ carried out by the Office for National Statistics (ONS). This is an annual survey covering adults aged 16 and over living in private households in Great Britain. The latest report OPN 2013² is based on the survey which ran from January to December 2013 and was released on 13 February 2015. It replaced the General Lifestyle Survey (GLF)³ in 2012 which used to be the source for a lot of the findings.

Average weekly alcohol consumption and maximum alcohol consumption estimates are presented in the Health Survey for England (HSE) 2013 – Trend Tables⁴.

Data on purchased quantities of alcohol are taken from the Living Costs and Food Survey (LCFS)⁷. Alcohol price and retail price indices data are taken from the ONS publication *Focus on Consumer Price Indices*⁹, while households' disposable income data are taken from the ONS publication *Household sector: Secondary Distribution of Income Account*⁶.

International comparisons on alcohol consumption are included in the report using data from the *Health at a Glance 2014*¹¹ published by the Organisation for Economic Co-operation and Development (OECD).

The *Smoking, drinking and drug use among young people in England in 2013* (SDD13)¹² report published by the HSCIC is the main source of data for drinking prevalence among children.

The NHS advises that men should not regularly drink more than three to four units of alcohol per day, and women should not regularly drink more than two to three units of alcohol per day. 'Regularly' is defined as most days in the week. Pregnant women are advised to avoid alcohol altogether. In the course of a week, men are advised to drink no more than 21 units, women no more than 14 to avoid the risk of alcohol-related harm. Drinking at these levels is defined as 'lower risk'. Adults who regularly drink more than these amounts are considered to be at 'increased risk'. Men who regularly drink more than eight units a day (or 50 units a week) and women who regularly drink more than six units a day (or 35 units a week) are considered to be at particular risk of harm, and are described as 'higher risk' drinkers. The current NHS guidelines (<http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx>) for sensible drinking are further described in Section 6.1.2 of the report HSE 2012⁵ and some information on guidelines and indicators used to measure consumption are described in [Appendix B](#).

2.2 Alcohol consumption

2.2.1 Drinking in the last week

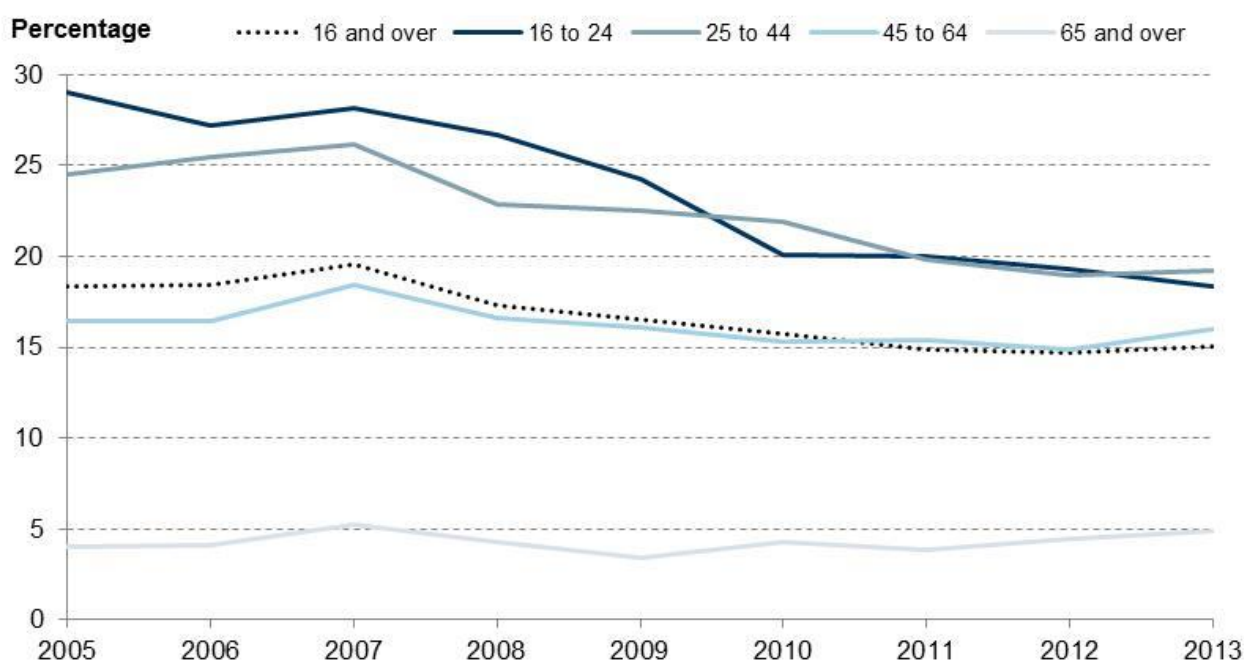
Respondents to the OPN 2013² were asked questions about their drinking in the week prior to interview.

In Great Britain in 2013:

- More than one in five adults (21 per cent) said that they do not drink alcohol at all. This has increased slightly since 2005 (19 per cent). Young adults (aged 16 to 24) were primarily responsible for this change, with the proportion of young adults who reported that they do not drink alcohol at all increasing between 2005 and 2013.
- The proportion of adults who binged^b at least once in the week before interview decreased from 18 per cent in 2005 to 15 per cent in 2013. Young adults were mainly responsible for the decrease in binge drinking, with the proportion that had binged falling since 2005, from 29 per cent to 18 per cent. [Table 2.1](#), [Figure 2.1](#)

For further information see OPN, Drinking Habits among adults 2013².

Figure 2.1 - Binge drinking amongst adults in Great Britain, by age, 2005 to 2013



Source: Opinions and Lifestyle Survey, General Lifestyle Survey and General Household Survey; Office for National Statistics. Copyright © 2015 Health and Social Care Information Centre. All rights reserved

2.2.2 Estimated weekly alcohol consumption

HSE 2013 trend table⁴ 10 presents estimated weekly alcohol consumption, by survey year, age and sex showing in 2013 in England:

- 15 per cent of men and 20 per cent of women did not drink any alcohol in the last year.

^b In line with the Government's Alcohol Strategy, men are considered to have binged if they drank more than eight units of alcohol on their heaviest drinking day in the week before interview and women if they drank more than six units.

- 63 per cent of men and 64 per cent of women drank at levels indicating lower risk of harm^c.
- 18 per cent of men and 13 per cent of women drank at an increased risk of harm^d.
- 5 per cent of men and 3 per cent of women drank at higher risk levels^e.

HSE 2012⁵ is the most recent report that contains a chapter dedicated to alcohol consumption. Chapter 6 presented findings on the consumption of alcohol in the last week, for England in 2012, including:

- Men were more likely than women to have drunk in the last week; 67 per cent of men and 53 per cent of women did so, including 18 per cent of men and 10 per cent of women who drank on five or more days in the week.
- Assessment of average weekly alcohol consumption over the last 12 months showed that 62 per cent of men usually drank up to 21 units a week and 61 per cent of women usually drank up to 14 units a week, the level of drinking defined as lower risk.
- Men and women in the highest equivalised household income quintile were most likely to drink at increased risk levels over the last 12 months (31 per cent of men, 25 per cent of women); those in the lowest two income quintiles were least likely to do so (19 per cent of men, 13 per cent of women). There was no equivalent pattern for higher risk drinking.

Other breakdowns of estimated weekly alcohol consumption are provided in the HSE 2012 report: age and sex; region and sex; equivalised household income and sex; Index of Multiple Deprivation (IMD) and sex.

2.2.3 Types of alcohol consumed

HSE 2012⁵, Chapter 6, Table 6.10 shows the types of drinks consumed on the day of maximum alcohol consumption in the last week. The key findings were as follows:

- The types of drink consumed on the day that men and women drank the most in the last week varied with age and sex. The majority of men had drunk normal strength beer, lager, cider or shandy (62 per cent); a third had drunk wine (33 per cent), and just over a fifth had drunk spirits (22 per cent). In contrast, the majority of women had drunk wine (64 per cent); a quarter had drunk spirits (26 per cent), and a fifth (19 per cent) had drunk normal strength beer, lager, cider or shandy.
- The proportions of men and women who had drunk normal strength beer, lager, cider and shandy declined with age. Among men and women, drinking spirits was most likely among those aged between 16 and 34 (particularly those in the youngest age group), and among men aged 75 and over. The proportion of men who drank wine increased with age.
- The proportions of women who drank wine also increased with age, levelling out at those aged 55 to 74, and decreasing in the oldest age group. The proportions who drank fortified wines and alcopops were each very small, but consumption of these was concentrated in particular age groups. 1 per cent of men and 4 per cent of women had drunk fortified wine, but this included 7 per cent of men and 20 per cent of women aged 75 and over. 2 per cent of both men and women had drunk alcopops,

^c Up to 21 units per week for men and up to 14 units per week for women

^d Between 21 and 50 units per week for men and between 14 and 35 units per week for women

^e More than 50 units per week for men and more than 35 units per week for women

but these were most likely to be aged 16 to 24 (14 per cent of young men, 10 per cent of young women).

2.3 Purchases, availability and affordability of alcohol

2.3.1 Purchases

The purchase of alcoholic drinks bought for consumption within the home in the United Kingdom (UK), as reported by the LCFS⁷, has increased overall since 1992 from 527 millilitres (ml) per person per week, peaking in 2003/04 at 792 ml per person per week. In 2012, this figure was 700 ml per person per week, a 33.0 per cent increase since 1992. Yorkshire and the Humber had the highest purchases of alcohol at 874 ml per person per week, 400 ml per person higher than the lowest level in London.

Some of the key findings of the LCFS 2013 covered in the *report Family Food 2013*⁷ also show that:

- In real terms, between 2010 and 2013 household spending on food and drink fell by 3.2 per cent and eating out expenditure by 5.6 per cent. Household spending on alcoholic drinks fell by 5.7 per cent over the same period, whilst that bought for consumption outside the home fell by 13.4 per cent. (LCFS 2013 Table 1.2)

2.3.2 Availability

Information on the volume of alcohol released for home consumption is collected by Her Majesty's Revenue and Customs and relates to the United Kingdom as a whole. The data on alcohol released for home consumption excludes personal imports (both legal and illegal)⁸.

2.3.3 Affordability

The Health and Social Care Information Centre (HSCIC) has routinely published a series of indices derived from ONS data in its *Statistics on Alcohol: England* reports. These include the alcohol price index (API), retail price index (RPI)⁹, relative alcohol price index (defined as API / RPI), real households' disposable income (RHDI) and the affordability of alcohol index (defined as RHDI / relative price index).

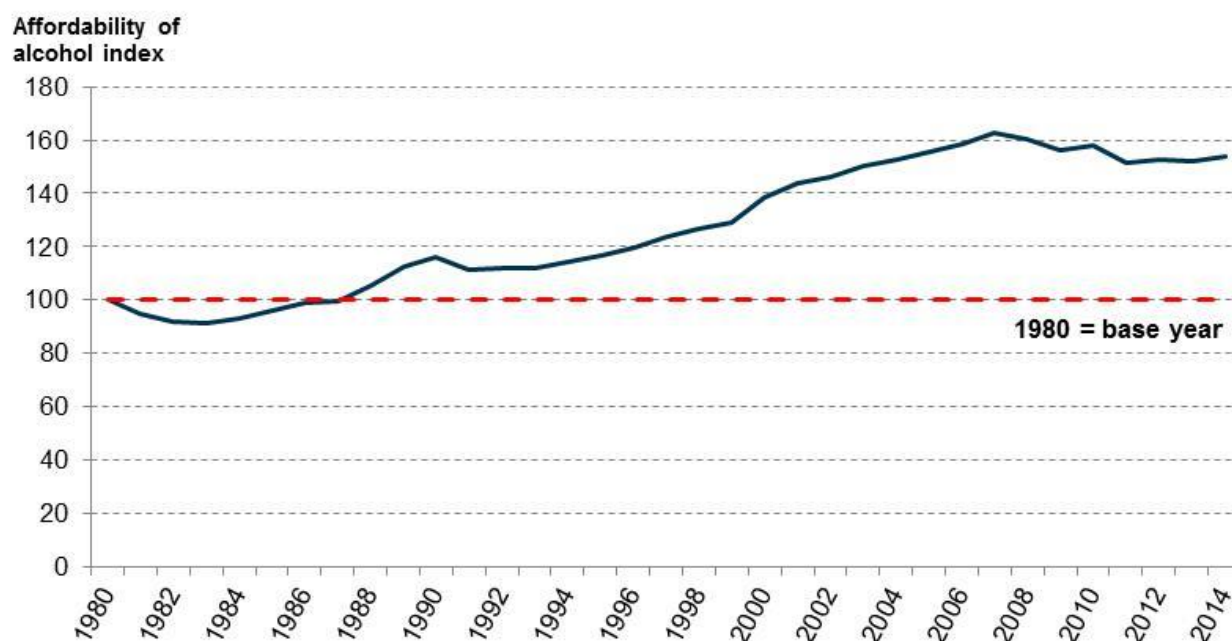
For information on the methodology see [Appendix A](#).

The alcohol price index used in the affordability index relates to a 'basket of alcoholic drinks' chosen by the ONS and provides an overall picture of the affordability of alcohol. It is not designed to measure the affordability of the cheapest alcohol, and neither is it designed to measure the affordability of pure alcohol. It is intended to be used as a national measure – its relevance at an individual level will depend on the extent to which an individual's choice of drinks match the drinks included in the measure.

In the UK, prices of alcoholic drinks, as measured by the alcohol price index [Table 2.2](#):

- Have increased more than the retail price index since 1980 (an arbitrarily chosen base year).
- Between 1980 and 2014 the price of alcohol increased by 23.2 per cent more than retail prices generally (Alcohol price index relative to Retail price index).
- Real household disposable income per adult (adjusted) increased by 89.4 per cent over the same period.
- Alcohol in 2014 was 53.8 per cent more affordable than it was in 1980, highlighting the overall trend of increasing affordability over the period [Figure 2.2](#).

Figure 2.2 - Alcohol affordability index in the United Kingdom: 1980 to 2014



Sources: Alcohol Price and Retail Prices (all items) Indices: derived from Focus on Consumer Price Indices (Codes: CBAA, CBAB, CHBD, CHAW). Office for National Statistics. Real Households Disposable Income from the UK Economic Accounts (Code NRJR). Office for National Statistics.
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2.4 Alcohol consumption and socio-economic variables

2.4.1 Economic activity status

OPN, Adult Drinking Habits in Great Britain, 2013², Table 7 shows variations in alcohol consumption by socio-economic classification status in Great Britain:

- A higher proportion of those in routine and manual occupations (20 per cent) were teetotal than intermediate occupations (17 per cent) and managerial and professional occupations (12 per cent).
- Of those who drank alcohol in the last week and, on the heaviest drinking day, exceeded 8 units for men, and 6 units for women, 31 per cent were in routine and manual occupations; 27 per cent in intermediate occupations and 27 per cent in managerial and professional occupations.

2.4.2 Other socio-economic variables

OPN, Adult Drinking Habits in Great Britain, 2013 also show variations in alcohol consumption in Great Britain by:

- Income (Table 5).
- Level of education (Table 6).
- Relationship status (Table 8).
- By age and whether a person lives alone (Table 9).
- By sex and whether dependent children live in the household (Table 10).
- Smoking status (Table 14).

2.5 Drinking and pregnancy

OPN, Drinking Habits in Great Britain, 2013², Table 12 shows that in Great Britain:

- Pregnant women were more than three times as likely to be teetotalers as other women (72 per cent vs. 22 per cent). Pregnant women were also less likely to have drunk in the week before interview. Fewer than 1 in 10 pregnant women drank in the week before interview compared with more than 5 in 10 of those who were not pregnant or unsure.

Information on drinking during pregnancy is also collected as part of the Infant Feeding Survey (IFS), the latest survey being *Infant Feeding Survey 2010*¹⁰. The main focus of the survey is the prevalence of breast feeding, however the new mothers interviewed are also asked about their drinking behaviours before, during and after pregnancy.

IFS 2010, table 11.26 shows that in England, of the women who drank before pregnancy:

- 48 per cent gave up (33 per cent in 2005) while they were pregnant
- 47 per cent (62 per cent in 2005) said they cut down on the amount drank
- 2 per cent reported no change or drank more (4 per cent in 2005) to their drinking patterns.

Further details are provided within Chapter 11 of the IFS 2010 report.

2.6 Geographic patterns of alcohol consumption

2.6.1 International comparisons

The Organisation for Economic Co-operation and Development (OECD) report *Health at a Glance 2014*¹¹ includes data on alcohol consumption among adults across different countries.

In the OECD report Figure 2.2.1 shows Alcohol consumption for the population aged 15 and over in 2012 (or the nearest year available from the countries reported upon).

Figure 2.2.2 in the OECD report shows Trends in alcohol consumption, selected EU countries, 1980-2012.

- The EU region has the highest alcohol consumption in the world. Measured through monitoring annual sales data, it stands at slightly over 10 litres of pure alcohol per adult on average across EU member states in 2012 (OECD 14, Figure 2.2.1). Lithuania, Estonia and Austria reported the highest consumption of alcohol, with 12 litres or more per adult. At the other end of the scale, southern European countries (Italy, Malta, Greece, and Cyprus) along with Nordic countries (Norway, Iceland, and Sweden) have relatively low levels of consumption, with 6 to 8 litres of pure alcohol per adult. In the United Kingdom alcohol consumption is 10.6 litres^f.
- Although average alcohol consumption has gradually fallen in many European countries over the past three decades, it has risen in some others. There has been a degree of convergence in drinking habits across the European Union, with wine consumption increasing in many traditionally beer-drinking countries and vice versa. Major wine-producing countries such as Italy and France have seen their alcohol

^f Alcohol consumption is defined as annual sales of pure alcohol in litres per person aged 15 years and over. The methodology to convert alcohol drinks to pure alcohol may differ across countries. Official statistics do not include unrecorded alcohol consumption, such as home production.

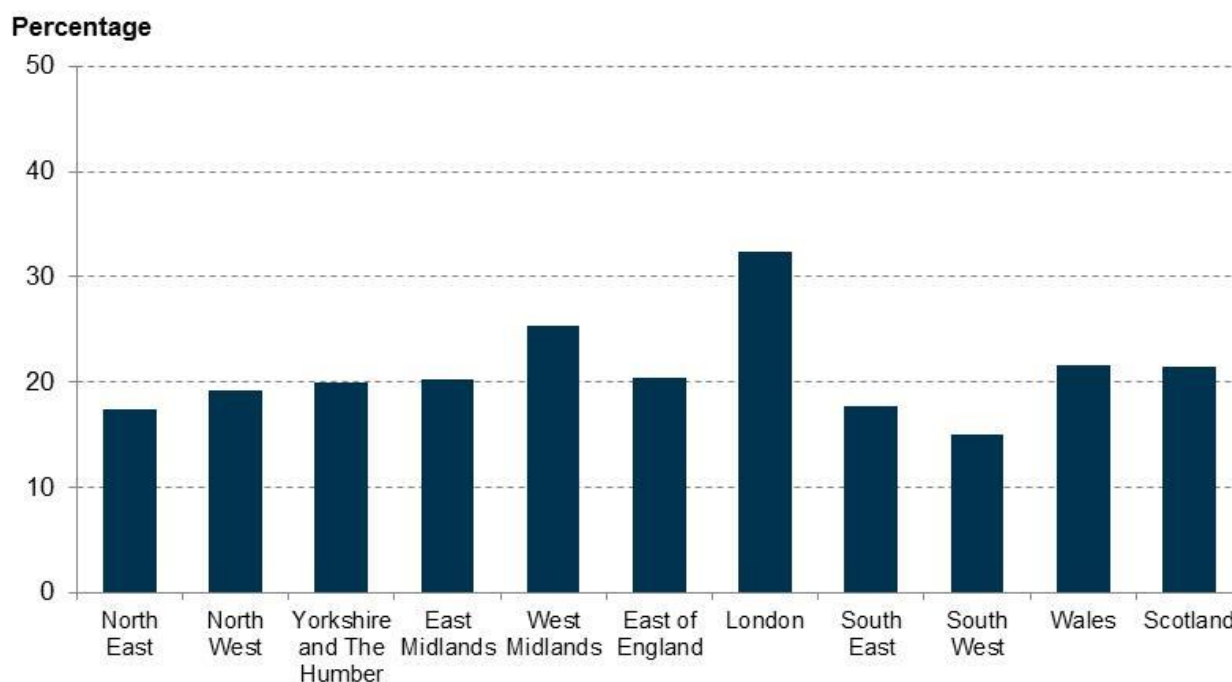
consumption per capita fall substantially since 1980 (OECD 14, Figure 2.2.2). On the other hand, alcohol consumption per capita has increased at least slightly in some Nordic countries (e.g., Sweden and Finland), although it still remains below the EU average. Alcohol consumption remained unchanged since 1980 in the United Kingdom, the Czech Republic and Turkey.

2.6.2 Alcohol consumption by region

OPN, Adult Drinking Habits in Great Britain, 2013² contains data on alcohol consumption by region in Table 11 and this is also shown in figure 2.3 below.

- In 2013 almost one in three adults living in London (32 per cent) said they were teetotallers. This was considerably higher than the Great Britain average of 21 per cent, and higher than the proportion in any other single region of Great Britain [Figure 2.3](#). Although it is difficult to attribute regional differences to any single factor, London is the most ethnically diverse region⁹ of the UK and has a lower than average population age of just 33. Both of these factors may play a part in London having a higher than average number of teetotallers.

Figure 2.3 - Proportion of adults who are teetotallers, Great Britain, by region, 2013

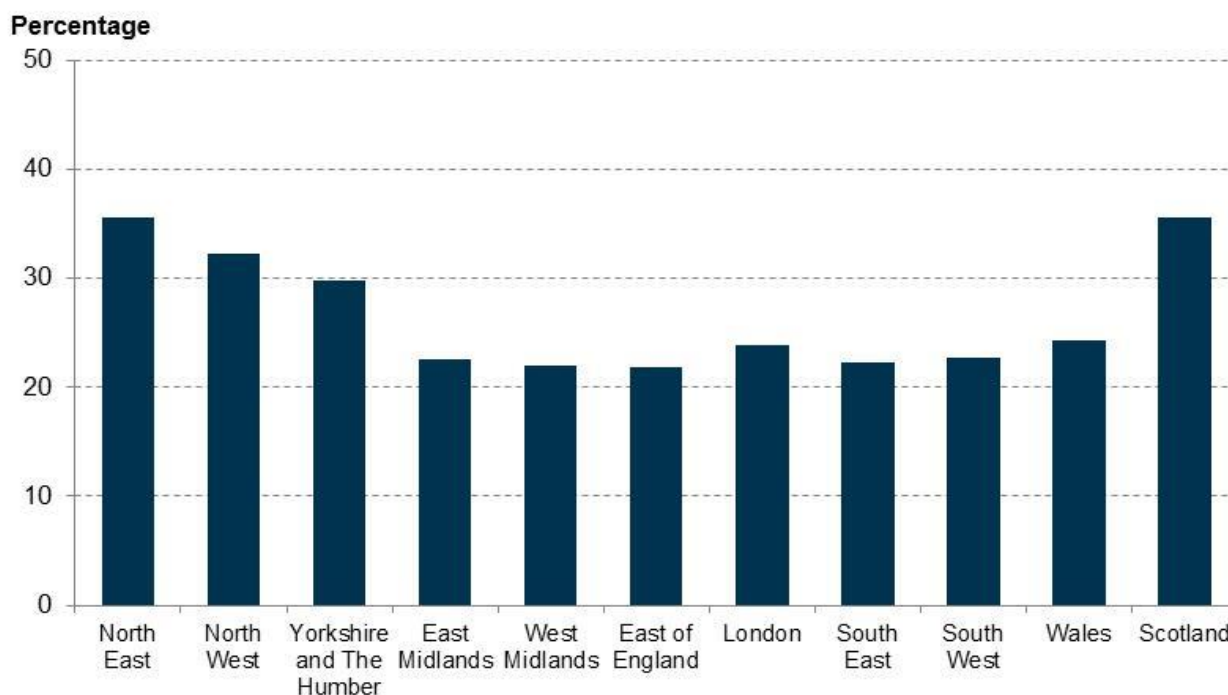


Source: Opinions and Lifestyle Survey, Office for National Statistics
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⁹ http://www.ons.gov.uk/ons/dcp29904_291554.pdf

- Drinkers (defined as those who drank in the week before interview) in the north of England and in Scotland were most likely to have binged^h. Around a third of drinkers in these regions had binged, compared with less than a quarter of those in other parts of Great Britain. However it is difficult to explain these regional differences with any particular factor. [Figure 2.4](#)

Figure 2.4 - Binge drinking amongst those who drank, Great Britain, by region, 2013



Source: Opinions and Lifestyle Survey, Office for National Statistics
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HSE 2012⁵, Table 6.7 shows the maximum alcohol consumption on any day in the last week by region and sex. Among adults who had drunk alcohol in the last week, the proportions that were defined as being binge drinkers varied between regions:

- Among men who had drunk in the last week the proportion who had drunk more than 8 units in one day was lowest in the London (24 per cent) and highest in the North East (45 per cent). Among women, the proportion that drank more than 6 units on at least one day varied between 15 per cent in the South West and 37 per cent in the North East.

^h The Government's Alcohol Strategy defines binge drinkers as men who report exceeding eight units of alcohol on their heaviest drinking day in the week before interview, and women who report exceeding six units.

2.7 Drinking among children

The Smoking, drinking and drug use among young people in England in 2013 (SDD13)¹² report chapter 4 contains information on drinking in children aged 11 to 15 in secondary schools in England.

The key findings for 2013 are:

- 39 per cent of pupils said that they had drunk alcohol at least once. This continues the downward trend since 2003, when 61 per cent of pupils had drunk alcohol, and is lower than at any time since 1988, when the survey first measured the prevalence of drinking in this age group.
- Boys and girls were equally likely to have drunk alcohol. The proportion of pupils who had drunk alcohol increased with age from 6 per cent of 11 year olds to 72 per cent of 15 year olds.
- 9 per cent of pupils had drunk alcohol in the last week. This proportion has also declined since 2003, when it was 25 per cent.
- The proportions of pupils who drank alcohol in the last week increased from 1 per cent of 11 year olds to 22 per cent of 15 year olds.
- Around three quarters (74 per cent) of pupils who drank alcohol in the last week did so on one day only.
- Pupils who drank alcohol in the last week drank a mean of 8.2 units of alcohol, the lowest average amount since 2007, when the current method of calculating units was introduced. Boys and girls drank similar amounts.
- Most pupils who drank alcohol in the last week had consumed more than one type of alcoholic drink.
- Boys drank 63 per cent of their intake of alcohol in the form of beer, lager or cider. Of the remainder, most was drunk in the form of spirits (16 per cent) or alcopops (13 per cent). Girls' intake was more diverse, being divided more evenly between beer, lager and cider (30 per cent), wine (25 per cent), spirits (22 per cent) and alcopops (20 per cent).

2.7.1 Regional comparisons of drinking among children

The report SDD12¹³ contains the most recent regional data and presents drinking estimates by the nine English regions in Chapter 6 based on 2011 and 2012 data combined.

SDD12, Table 6.3 shows the proportion of pupils who have ever drunk alcohol by region and sex. Table 6.4 shows the proportions of pupils who drank alcohol in the last week by region and Table 6.5 shows mean consumption of alcohol by pupils who drank in the last week, by region and sex.

- The proportion of pupils who drank alcohol was lower in London than anywhere else; 31 per cent of pupils in London had ever drunk alcohol, and 7 per cent had drunk in the last week.
- Outside London, the proportion of pupils who had ever drunk alcohol ranged from 36 per cent in the West Midlands to 51 per cent in the North East, and the same pattern was seen for drinking alcohol in the last week.

Similar regional variations were found in the analysis of data for the report SDD2011¹⁴.

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3 Knowledge and attitudes to alcohol

3.1 Introduction

The information presented in this chapter relates to adults' knowledge and awareness of alcohol and children's attitudes to drinking.

There are three sources used, The Office for National Statistics (ONS) Omnibus Survey Report *Drinking: adults' behaviour and knowledge in 2009*¹ which ran biannually but is now discontinued. The last report was published in 2009 using data collected from 2008/09. The survey report presented results from questions about drinking over several years, allowing comparisons to be made over time. The survey used a small sample size and asked respondents about knowledge and attitudes. The survey provided Great Britain level data.

*The Heath Survey for England 2007*² (HSE07) asked questions of people's knowledge and attitudes towards alcohol. It used a larger sample size and different population sample to the Omnibus survey report. There have been more recent HSE reports; however these have not had the same focus on knowledge and attitudes so the 2007 data remains the most recent.

In general, the HSE07 estimates levels of knowledge to be slightly higher than the Omnibus survey report on drinking. As the two surveys are of different populations, ask slightly different questions and cover different geographies, it is expected that estimates are slightly different.

The report *Smoking, drinking and drug use among young people in England in 2012* (SDD12)³ is the main source of data for attitudes to drinking for children (aged 11 to 15). The focus of this annual publication alternates year on year, between smoking and drinking (SDD12) and drugs in 2013 (*Smoking, drinking and drug use among young people in England in 2013*⁴).

3.2 Adults knowledge and attitudes to alcohol

3.2.1 Knowledge of Units

Advice on the amount people should drink has to be provided in such a way that it applies to the wide range of different types of alcohol people may drink, which can have very different alcohol content. Advice on drinking is therefore given in terms of units, and for people to be able to monitor how much they drink, they need to understand what is meant by a unit of alcohol, and how many units different drinks contain. Drinking guidelines are available in [Appendix B](#).

Drinking: adults' behaviour and knowledge in 2009¹ Chapter 4, table 4.1 shows that:

- When asked whether they had heard of measuring alcohol consumption in units, 90 per cent of respondents said that they had. This has steadily increased from 79 per cent in 1997.
- Men and women were equally likely to have heard of alcohol units and the increase in knowledge since 1997 has occurred among both men and women.
- On the whole, the more people drank, the more likely they were to have heard of units: 95 per cent of those with the highest average weekly consumption (22 units and over for men and 15 units and over for women) had heard of units, compared with only 71 per cent of those who did not drink at all.

In HSE07²:

- Most adults (92 per cent of men and 89 per cent of women) had heard of units; this was most common among adults aged between 35 and 64.

3.2.2 Awareness of Units and Alcohol Content

The 2009 Omnibus survey asked respondents if they knew the alcohol content of the drinks they had consumed. Results presented in chapter 4 and tables 4.4 to 4.9 show that:

- Those who frequently drink a particular type of alcohol at least once a week were aware of its alcohol content.
- Those who drank beer and those who drank wine at least once a week were much more likely to know how many units were in that drink, than were those who seldom drank these drinks.
- About a third (31 per cent) of frequent beer drinkers and a sixth (17 per cent) of frequent wine drinkers were not aware of the number of units in what they were drinking.
- Differences according to frequency of consumption were much less marked for those who drank spirits and fortified wine.

The survey report also asked respondentsⁱ whether or not they kept a check on the number of units they drank and results are presented in chapter 4, tables 4.10 and 4.11

- 13 per cent of respondents said that they kept a check on the number of units they drank.

Although men were more likely than women to drink heavily they were not more likely to keep a check in terms of units on how much they drank – overall,

- 12 per cent of men and 14 per cent of women who had heard of units did so.
- Women who did keep a check on units were more likely to do so on a weekly basis (6 per cent) than on the daily basis (2 per cent) suggested by the government's current advice on sensible drinking. There was no difference among men.
- The percentage of people who kept a daily or a weekly check on the number of units drunk has remained similar over the period covered by the surveys varying between 11 per cent and 16 per cent between 1997 and 2009.
- Among men who had heard of units, those who drank less than 10 units a week were less likely than others to keep a daily or weekly check on the number of units drunk. Among women, those who drank less than 1 unit a week were least likely to keep a check.

In HSE07, results showed that:

- Accurate knowledge of the content of different drinks in units varied with age, being highest among 25 to 54 year olds.

It was also related to what people actually drank.

- Seventy seven per cent of men and 73 per cent of women who had drunk wine on the day they drank most in the last week said correctly that a 125 ml glass of wine contained one or two units, compared with 65 per cent of men and 60 per cent of

ⁱ Not all respondents who drank each type of drink knew how many units were contained therein, that the likelihood of them keeping an accurate check was, in some cases, low

women who had not drunk wine on the day they drank most in the last week (though they may have drunk wine on other days).

A similar, though less marked pattern was seen for beer and spirits. Further information can be found in HSE07, Chapter 7.

Information on government recommendations for consumption can be found in [Appendix B](#).

3.3 Children's attitudes to drinking alcohol

In *Smoking, drinking and drug use among young people in England in 2012* (SDD12)³ pupils aged 11 to 15, were asked about their attitudes to drinking alcohol, including their perceptions of parents' views on drinking alcohol and being drunk.

The key findings are:

- Whether pupils drink or not was strongly influenced by the behavior and attitudes of their families. Pupils were more likely to drink alcohol if someone they live with does: 83 per cent of pupils whose households did not include anyone who drank had never themselves drunk alcohol, compared with 30 per cent of pupils who lived with three or more drinkers.
- Similarly, pupils who thought their families didn't like them drinking were less likely to have drunk alcohol than those who thought their families didn't mind if they drank. 87 per cent of pupils who felt that their parents would disapprove had never drunk alcohol, compared with 28 per cent of those who thought that their parents wouldn't mind as long as they didn't drink too much.
- The proportion of pupils who think it is OK for someone of their age to drink alcohol has fallen in recent years. In 2012, 28 per cent of pupils thought that it was OK for someone of their age to drink once a week compared with 46 per cent in 2003.
- Pupils' beliefs about why people of their age drink alcohol varied according to whether or not they have drunk alcohol themselves. Pupils who have never drunk alcohol were more likely than those who have to think that people of their age drink because of social pressures: to look cool in front of their friends or because their friends pressure them into it.
- Pupils who have drunk alcohol were more likely than non-drinkers to believe that people of their age drink to be sociable with friends or because it gives them a rush or buzz.

The report SDD12 also includes findings on patterns of drinking, where pupils get alcohol, beliefs and attitudes about drinking alcohol, sources of information that pupils found helpful, and personal and school characteristics associated with having drunk alcohol in the last week.

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4 Drinking-related costs, ill health and mortality

4.1 Introduction

Alcohol misuse can cause serious harm to a person's health. This chapter presents information on:

- The prevalence of hazardous, harmful and dependent drinking.
- The proportion of drinkers who had discussed drinking with a health professional.
- The estimated number of alcohol-related hospital admissions.
- Drugs prescribed for the treatment of alcohol dependence.
- The number of deaths from causes directly related to alcohol consumption.
- The estimated cost to the NHS of alcohol misuse.

4.2 Hazardous, harmful and dependent drinking

Chapter 9 of the report *Adult Psychiatric Morbidity in England - 2007, Results of a household survey*¹ (APMS2007) presents prevalence estimates of hazardous and harmful drinking, and of alcohol dependence in the adult general population. Findings from this survey are summarised below. It should be noted that a survey of the household population such as this is likely to under-represent dependent adults, who are more likely to be homeless or in an institutional setting. Moreover, problem drinkers who do live in private households may, like problem drug users, be less available, able or willing to participate in surveys.

Hazardous drinking is a pattern of alcohol consumption carrying risks of physical and psychological harm to the individual. Harmful drinking denotes the most hazardous use of alcohol, at which damage to health is likely. One possible outcome of harmful drinking is alcohol dependence, a cluster of behavioural, cognitive, and physiological phenomena that typically include a strong desire to consume alcohol, and difficulties in controlling drinking.

Hazardous and harmful drinking was measured using the AUDIT (Alcohol Use Disorders Identification Test). Alcohol dependence was assessed using the SADQC (Severity of Alcohol Dependence Questionnaire, community version).

- The prevalence of hazardous drinking identified by APMS 2007 was 24.2 per cent (33.2 per cent of men, 15.7 per cent of women). This included 3.8 per cent of adults (5.8 per cent of men, 1.9 per cent of women) whose drinking could be categorised as harmful. In men, the highest prevalence of both hazardous and harmful drinking was in 25 to 34 year olds, in women in 16 to 24 year olds.
- The prevalence of alcohol dependence was 5.9 per cent (8.7 per cent of men, 3.3 per cent of women). For men, the highest levels of dependence were identified in those between the ages of 25 and 34 (16.8 per cent), for women in those between the ages of 16 and 24 (9.8 per cent). Most recorded dependence was categorised as mild (5.4 per cent), with relatively few adults reporting symptoms of moderate or severe dependence (0.4 per cent and 0.1 per cent respectively).
- The prevalence of alcohol dependence was lower for men in 2007 than in 2000, whereas it remained at a similar level in women.
- Alcohol dependence was more common in white men and women than in those from minority ethnic groups. There were no significant variations in the prevalence of

dependence by region or income. However, the likelihood of being a hazardous drinker did vary between regions.

- 14 per cent of alcohol dependent adults were currently receiving treatment for a mental or emotional problem. Dependent women (26 per cent) were more likely than dependent men (9 per cent) to be in receipt of such treatment.

Full details and further breakdowns are available in chapter 9 of the report *Adult Psychiatric Morbidity in England - 2007, Results of a household survey*¹ (APMS2007).

4.3 Discussion of drinking with health professionals and specialist treatment

4.3.1 Discussion of drinking with health professionals

The ONS Omnibus Survey 2009² is still the most-up-to-date source of information on discussion of drinking with health professionals.

Respondents to the Omnibus Survey 2009 were asked if, in the last year, they had had any discussions about drinking with their General Practitioner (GP), someone else at the surgery, another doctor or any other medical professional.

Omnibus Survey 2009, Tables 4.17 to 4.19 show:

- 10 per cent of male drinkers and 7 per cent of female drinkers had had such discussions in the last year, the majority of these with their GP. This question was first asked in 2000, and the proportions having such discussions have changed little since then.
- Although it appeared that older men were more likely than younger men to have discussed drinking with a health professional, the difference was not statistically significant due to a small sample size. There were no significant differences by age among women.
- Those with the higher weekly alcohol consumption were more likely than other drinkers to have discussed their drinking with their GP or other medical person in the last year. However, these results should be interpreted with caution because some drinkers may have altered their drinking.

4.3.2 Specialist alcohol treatment

From April 2008, the National Treatment Agency for Substance Misuse started collecting and monitoring data on specialist alcohol treatment, requiring providers of specialist treatment for alcohol misuse to submit data to the National Drug Treatment Monitoring System (NDTMS), which has been in existence since 2004. The NDTMS provides an on-going published dataset on specialist alcohol and drug treatment in England.

The NDTMS is now managed by Public Health England and the latest report *Alcohol Treatment in England, 2013-14*³ has the following key findings:

- 114,920 adults (18 and over) received alcohol treatment in 2013-14, up from 109,683 the year before.
- 80,929 adults started treatment during the year, up from 75,773 in 2012-13.
- Despite the increase in numbers entering treatment, 93 per cent of people waited less than three weeks to start treatment, up from 89 per cent in 2012-13.
- 43,530 people successfully completed their treatment, up from 40,908 in 2012-13.

4.4 Alcohol-related hospital admissions

This section presents information on Finished Admission Episodes (referred to here as hospital admissions) with diseases, injuries and conditions that can be attributed to alcohol consumption.

Estimates of the number of alcohol-related hospital admissions have been calculated by applying alcohol-attributable fractions (AAFs) to the number of hospital admissions. AAFs take account of patient age, sex and diagnosis to estimate the number of admissions attributable to alcohol consumption.

AAFs were developed by the North West Public Health Observatory (now part of Public Health England (PHE)). More information on AAFs can be found in [Appendix A](#).

PHE also publish information on alcohol related admissions in the Local Alcohol Profiles for England (LAPE)^{4,5} using the same methodology to estimate the number of alcohol-related hospital admissions but a different standardisation methodology to calculate the number of admissions per 100,000 head of population. The figures presented in this report have been standardised to the England population whereas the figures published by Public Health England used the European Standard population. Therefore standardised rates differ slightly.

There are two different measures used for alcohol related admissions:

- **broad** measure - derived by summing the alcohol attributable fraction associated with each admission based on the diagnosis most strongly associated with alcohol out of all diagnoses (both primary and secondary).
- **narrow** measure - is constructed in a similar way but counts only the fraction associated with the diagnosis in the primary position or alcohol-related external causes recorded in secondary diagnosis fields.

The “broad” measure is a better indicator of the total burden that alcohol has on health services as it takes more account of secondary diagnoses than the “narrow” measure. However, since secondary diagnosis fields have become better populated over time, this impacts upon time series comparisons for the “broad” measure. Consequently, the “narrow” measure is a better indicator of changes over time.

Fuller definitions of the broad and narrow measures can be found in the [Glossary of terms](#).

The Department of Health have developed an alcohol-related admissions indicator for inclusion in the Public Health Outcomes Framework⁴. Currently the preferred option is for an indicator which estimates alcohol related admissions based on primary diagnoses or alcohol-related external causes recorded in secondary diagnosis fields (narrow measure).

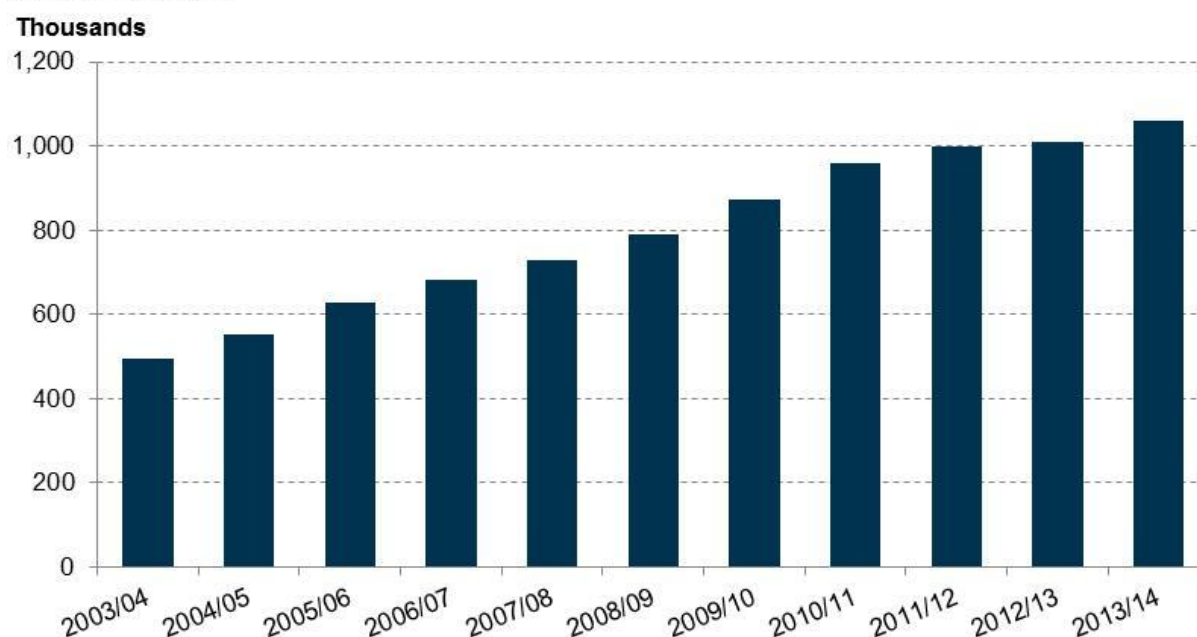
4.4.1 Alcohol-related admissions based on the broad measure (primary and secondary diagnoses) - admissions relating to wholly and partially attributable conditions combined

In 2013/14, there were an estimated 1,059,210 admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis (broad measure). This is 50,360 (5 per cent) more estimated admissions than 2012/13 (1,008,850) and 565,450 (115 per cent) more estimated admissions than 2003/04 (493,760). [Table 4.1](#) and [Figure 4.1](#)

Around half of the change from 2012/13 was due to an increase in the number of admissions where the primary or secondary diagnosis code related to a hypertensive disease.

The change from 2003/04 will be partly due to improvements in recording of secondary diagnoses.

Figure 4.1 - Number of alcohol-related NHS hospital admissions in England, where a primary or secondary diagnosis (broad measure) was wholly and partially attributable conditions combined, 2003/04 to 2013/14



Sources: Hospital Episode Statistics admissions data and attributable fractions from Public Health England
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Of the estimated alcohol related admissions (broad measure):

- The highest number of admissions 511,260 (48 per cent of all admissions) were due to cardiovascular disease in 2013/14. This is 32,220 (7 per cent) more admissions than 2012/13 (479,040) and 337,100 (194 per cent) more admissions than 2003/04 (174,160). Cardiovascular disease as a percentage of all admissions was 47 per cent in 2012/13 and 35 per cent in 2003/04. [Table 4.1](#)
- The second highest number of admissions 204,450 (19 per cent) were for mental and behavioral disorders due to alcohol in 2013/14. This is 5,850 (3 per cent) more admissions than 2012/13 (198,600) and 107,620 (111 per cent) more admissions than 2003/04 (96,830). Mental and behavioral disorders due to alcohol as a percentage of all admissions was similar in 2012/13 and 2003/04 (20 per cent for both years). [Table 4.1](#)
- Males were more likely to be admitted to hospital with alcohol related diseases, injuries and conditions than females, with 65 per cent of the overall admissions being male patients in 2013/14. [Table 4.2](#)
- In all age groups males had a higher number of admissions than females with the exception of those aged Under 16, where males accounted for 2,590 admissions and Females 3,080 admissions. [Table 4.2](#)
- In 2013/14, there were 1,970 alcohol-related hospital admissions per 100,000 head of population in England. Compared to 1,890 alcohol-related hospital admissions per 100,000 head of population in 2012/13 [Table 4.3](#)
- Male alcohol-related hospital admissions per 100,000 head of population in England were 2,580 in 2013/14 and 2,480 in 2012/13. The corresponding rate for females was 1,370 in 2013/14 and 1,310 in 2012/13. [Table 4.3](#)

- Rate of alcohol-related admissions varied regionally from 2,480 per 100,000 head of population in North East Region to 1,580 admissions per 100,000 head of population in South East Region in 2013/14. Regional variation was similar in 2012/13 with 2,500 admissions per 100,000 head of population in North East Region and 1,500 admissions per 100,000 head of population in South East Region. All rates are age and gender standardised, to allow meaningful comparisons. [Table 4.3](#)

The mid-2013 population estimates were used to derive age-group and gender specific rates for each area. The age and gender standardised rate is obtained as a weighted sum of the age group and gender specific rates, where the weights are the proportion of the England population in each age and gender group.

4.4.2 Alcohol-related admissions based on the broad measure - admissions relating to wholly attributable conditions only

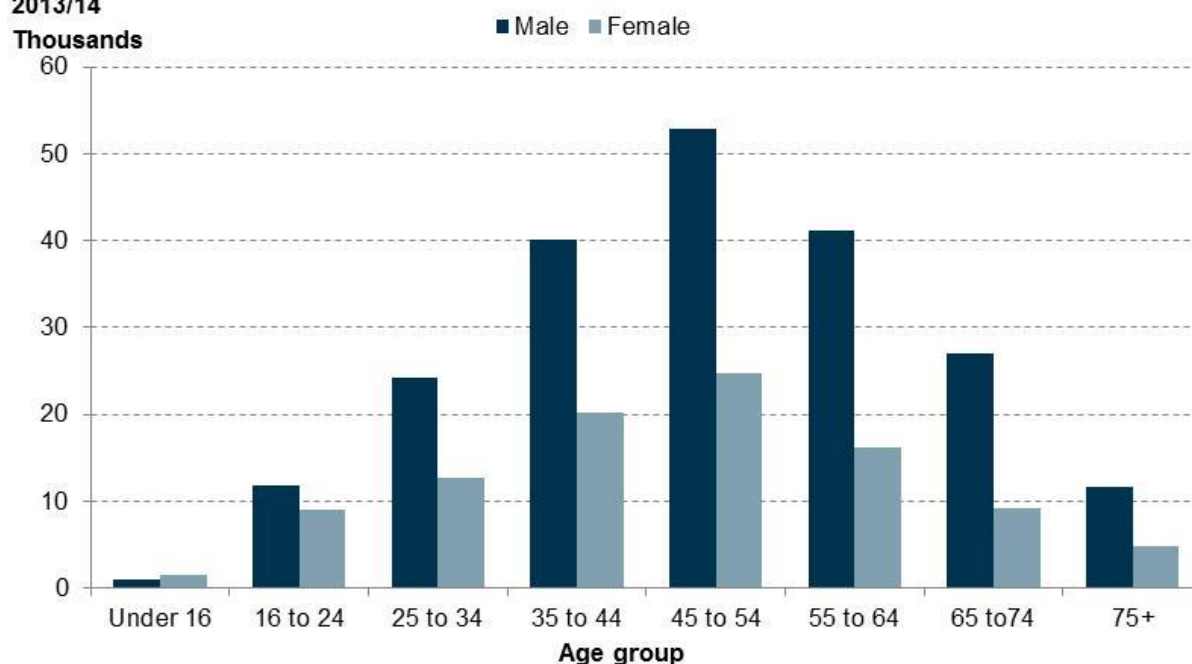
Out of the estimated 1,059,210 alcohol-related admissions in 2013/14: [Table 4.1](#)

- 307,710 (29 per cent) were for diseases or injuries that were wholly attributable to alcohol consumption or 'alcohol-specific' (i.e. with an attributable fraction of 1). This is 10,700 (4 per cent) higher than 2012/13 (297,010 admissions) and 154,880 (101 per cent) higher than 2003/04 (152,820 admissions).
- Mental and behavioral disorders due to the use of alcohol (ICD-10 code F10) were the most common alcohol-related diagnosis, accounting for around two-thirds of wholly attributable admissions (204,450). An increase of 5,850 (3 per cent) since 2012/13 (198,600 admissions) and 107,620 (111 per cent) since 2003/04 (96,830 admissions).
- 53,310 (17 per cent) admissions were for alcoholic liver disease (ICD-10 code K70). An increase of 2,800 (6 per cent) since 2012/13 (50,510 admissions) and 24,730 (87 per cent) since 2003/04 (28,580 admissions).
- 35,620 (12 per cent) of wholly attributable admissions were for the toxic effects of alcohol types which are common in alcoholic drinks (ICD-10 codes T51.0, T51.1 and T51.9). An increase of 1,750 (5 per cent) since 2012/13 (33,870 admissions) and 17,240 (94 per cent) since 2003/04 (18,380 admissions).

Among the different age groups: [Table 4.2](#) and [Figure 4.2](#)

- 45 to 54 year olds had the highest number of admissions where the primary or secondary diagnosis was wholly attributable to alcohol for both males and females (52,890 and 24,680 respectively).
- In all age groups males had a higher number of admissions than females with the exception of those aged Under 16, where males accounted for 890 admissions and females 1,470 admissions.

Figure 4.2 - Number of alcohol-related NHS hospital admissions in England, where a primary or secondary diagnosis (broad measure) was wholly attributable to alcohol by gender and age group, 2013/14



Sources: Hospital Episode Statistics admissions data and attributable fractions from Public Health England
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4.4.3 Alcohol-related admissions based on the broad measure - admissions relating to partially attributable conditions only

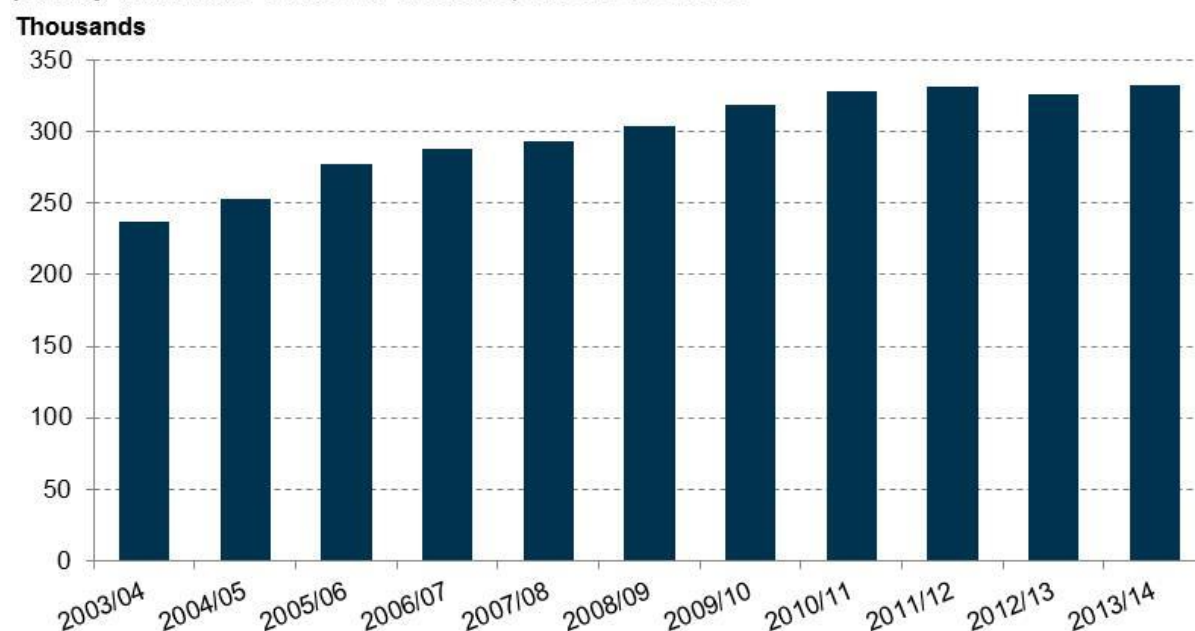
Of the 1,059,210 estimated alcohol-related admissions in 2013/14: [Table 4.1](#)

- 751,500 admissions (71 per cent) were for reasons that are partly attributable to alcohol consumption (i.e. the attributable fraction associated with the diagnosis (either primary or secondary) most strongly associated with alcohol consumption was less than 1). This is 39,660 (6 per cent) higher than 2012/13 (711,840 admissions) and 410,570 (120 per cent) higher than 2003/04 (340,940 admissions).
- Cardiovascular disease (ICD-10 codes I10-I15, I47-I48, I60-I62, I69.0-I69.2, I63-I66, I69.3-I69.4 and I85) had the highest number of admissions in this category with 511,260 (68 per cent). This is 32,220 (7 per cent) more than 2012/13 (479,040 admissions) and 337,100 (194 per cent) more than 2003/04 (174,160 admissions). Hypertensive diseases accounted for 85 per cent of cardiovascular disease in 2013/14, 84 per cent in 2012/13 and 78 per cent in 2003/04.
- Cancer (ICD-10 codes C00-C15, C18-C22, C32 and C50) had the second highest number of admissions in this category with 86,650 (12 per cent). This is 3,140 (4 per cent) more than 2012/13 (83,510 admissions) and 18,340 (27 per cent) more than 2003/04 (68,310 admissions).

4.4.4 Alcohol-related admissions based on the narrow measure (primary diagnosis or external cause code in secondary diagnosis fields) - admissions relating to wholly and partially attributable conditions combined

In 2013/14, there were an estimated 333,010 admissions where the primary diagnosis or alcohol-related external causes recorded in secondary diagnosis fields were attributable to the consumption of alcohol (the narrow measure). This is 7,150 (2 per cent) more admissions than 2012/13 (325,870) and 96,240 (41 per cent) more estimated admissions than 2003/04 (236,770). [Table 4.4](#) and [Figure 4.3](#)

Figure 4.3 - Number of alcohol-related NHS hospital admissions in England, where a primary diagnoses or external cause codes in secondary diagnosis field (narrow measure) was wholly and partially attributable conditions combined, 2003/04 to 2013/14



Sources: Hospital Episode Statistics admissions data and attributable fractions from Public Health England
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Of the estimated alcohol related admissions (narrow measure):

- The highest number of admissions 74,330 (22 per cent) were due to cancer in 2013/14. This is 1,670 (2 per cent) more admissions than 2012/13 (72,660) and 11,440 (18 per cent) more admissions than 2003/04 (62,890). Cancer as a percentage of all admissions was 22 per cent in 2012/13 and 27 per cent in 2003/04. [Table 4.4](#)
- The second largest number of admissions 73,620 (22 per cent) were for unintentional injuries in 2013/14. This is 760 (1 per cent) less than 2012/13 (74,380 admissions) and 22,500 (44 per cent) more than 2003/04 (51,120 admissions). Unintentional injuries as a percentage of all admissions were 23 per cent in 2012/13 and 22 per cent in 2003/04. [Table 4.4](#)
- Males were more likely to be admitted to hospital with alcohol related diseases, injuries and conditions than females, with 62 per cent of the overall admissions being for males and 38 per cent for females in 2013/14. [Table 4.5](#)
- In all age groups males had a higher number of admissions than females with the exception of those aged Under 16, where females accounted for 2,380 admissions and males 1,840 admissions. [Table 4.5](#)
- In 2013/14, there were 620 alcohol-related hospital admissions per 100,000 head of population in England. Compared to 610 alcohol-related hospital admissions per 100,000 head of population in 2012/13 [Table 4.6](#)
- Male alcohol-related hospital admissions per 100,000 head of population in England were 780 in 2013/14 and 770 in 2012/13. The corresponding rates for females were 460 in 2013/14 and 450 in 2012/13. [Table 4.6](#)
- Rate of alcohol-related admissions varied regionally from 810 per 100,000 head of population in North East Region to 500 admissions per 100,000 head of population in South East Region in 2013/14. Regional variation was similar in 2012/13 with 820

admissions per 100,000 head of population in North East Region and 490 admissions per 100,000 head of population in South East Region. All rates are age and gender standardised, to allow meaningful comparisons. [Table 4.6](#)

These rates were standardised in the same way as the rates for the broad measure.

4.4.5 Alcohol-related admissions based on the narrow measure (primary diagnosis plus external cause code in secondary diagnosis fields) - admissions relating to wholly attributable conditions only

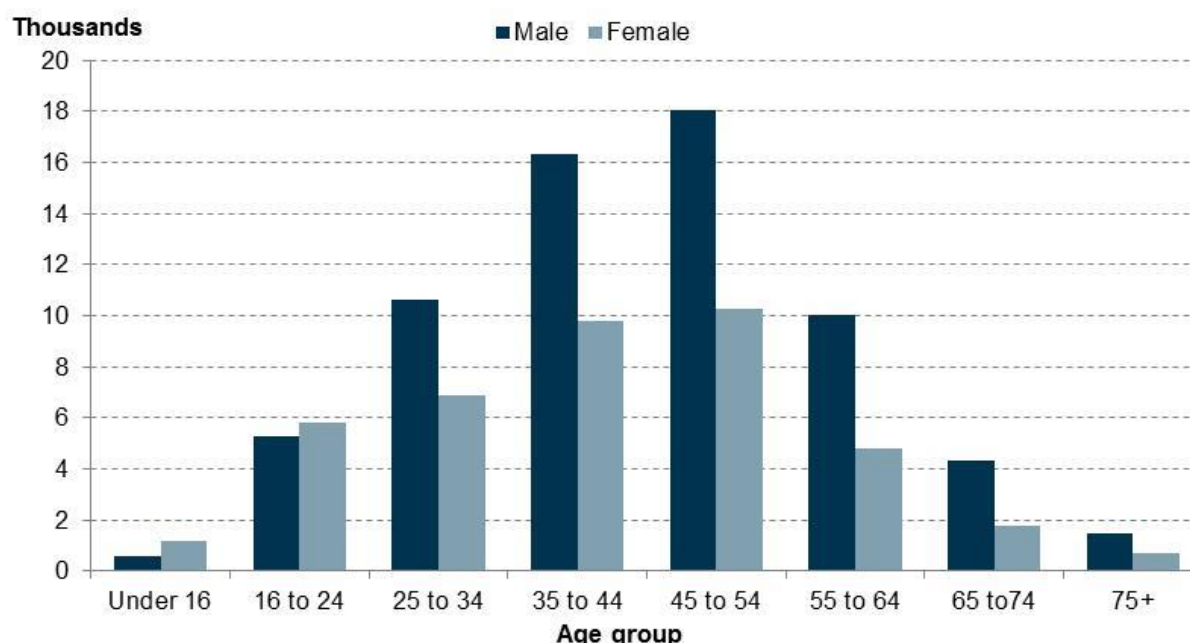
Out of the estimated 333,010 alcohol-related admissions in 2013/14: [Table 4.4](#)

- 107,820 (32 per cent) were for diseases or injuries that were wholly attributable to alcohol consumption or 'alcohol-specific' (i.e. with an attributable fraction of 1). This is 4,660 (5 per cent) higher than 2012/13 (103,160 admissions) and 40,330 (60 per cent) higher than 2003/04 (67,490 admissions).
- Mental and behavioral disorders due to the use of alcohol (ICD-10 code F10) were the most common wholly attributable alcohol-related diagnosis, accounting for 43 per cent of wholly attributable admissions (46,120). An increase of 1,820 (4 per cent) since 2012/13 (44,300 admissions) and 14,370 (45 per cent) since 2003/04 (31,750 admissions).
- Around 16,450 (15 per cent) admissions were for alcoholic liver disease (ICD-10 code K70). An increase of 250 (2 per cent) since 2012/13 (16,200 admissions) and 4,210 (34 per cent) since 2003/04 (12,240 admissions).
- 950 (less than 1 per cent) of admissions were for the toxic effects of alcohol types which are common in alcoholic drinks (ICD-10 codes T51.0, T51.1 and T51.9). A decrease of 110 (10 per cent) since 2012/13 (1,060 admissions) and a decrease by 430 (31 per cent) since 2003/04 (1,390 admissions).
- Other wholly-attributable conditions accounted for 44,300 (41 per cent) of admissions. An increase of 2,700 (6 per cent) since 2012/13 (41,600 admissions) and 22,190 (100 per cent) since 2003/04 (22,110 admissions).

Among the different age groups: [Table 4.5](#) and [Figure 4.4](#)

- 45 to 54 year olds had the highest number of admissions where the primary diagnosis or alcohol-related external causes recorded in secondary diagnosis fields was wholly attributable to alcohol for both males and females (18,050 and 10,280 respectively)
- In most age groups males had a higher number of admissions than females with the exception of those aged under 16 (580 admissions for males and 1,150 admissions for females) and those aged 16 to 24 (5,270 admissions for males and 5,800 admissions for females).

Figure 4.4 - Number of alcohol-related NHS hospital admissions in England, , where a primary diagnoses or external cause codes in secondary diagnosis field (narrow measure) was wholly attributable conditions by gender and age group, 2013/14



Sources: Hospital Episode Statistics admissions data and attributable fractions from Public Health England
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4.4.6 Alcohol-related admissions based on the narrow measure (admissions relating to partially attributable conditions only)

Of the 333,010 estimated alcohol-related admissions in 2013/14: [Table 4.4](#)

- 225,190 admissions (68 per cent) were for reasons that are partly attributable to alcohol consumption (i.e. the attributable fraction associated with the primary diagnosis or external cause codes in secondary diagnosis fields was less than 1). This is 2,490 (1 per cent) higher than 2012/13 (222,700 admissions) and 55,910 (33 per cent) higher than 2003/04 (169,290 admissions).
- Cancer (ICD-10 codes C00-C15, C18-C22, C32 and C50) had the highest number of admissions in this category with 74,330 (33 per cent). This is 1,670 (2 per cent) more than 2012/13 (72,660 admissions) and 11,440 (18 per cent) more than 2003/04 (62,890 admissions).
- Unintentional injuries had the second highest number of admissions in this category with 73,620 (33 per cent). This is 760 (1 per cent) less than 2012/13 (74,380 admissions) and 22,500 (44 per cent) more than 2003/04 (51,120 admissions).

4.5 Prescribing

Information on prescription items for the treatment of alcohol dependence are presented from Prescription Services⁶, a division of the NHS Business Services Authority (NHS BSA) by the HSCIC.

The two main drugs prescribed for the treatment of alcohol dependence in primary care settings and in NHS hospitals in England are Acamprosate Calcium (Campral) and Disulfiram (Antabuse). In May 2013 a new drug Nalmefene (Selincro) was launched.

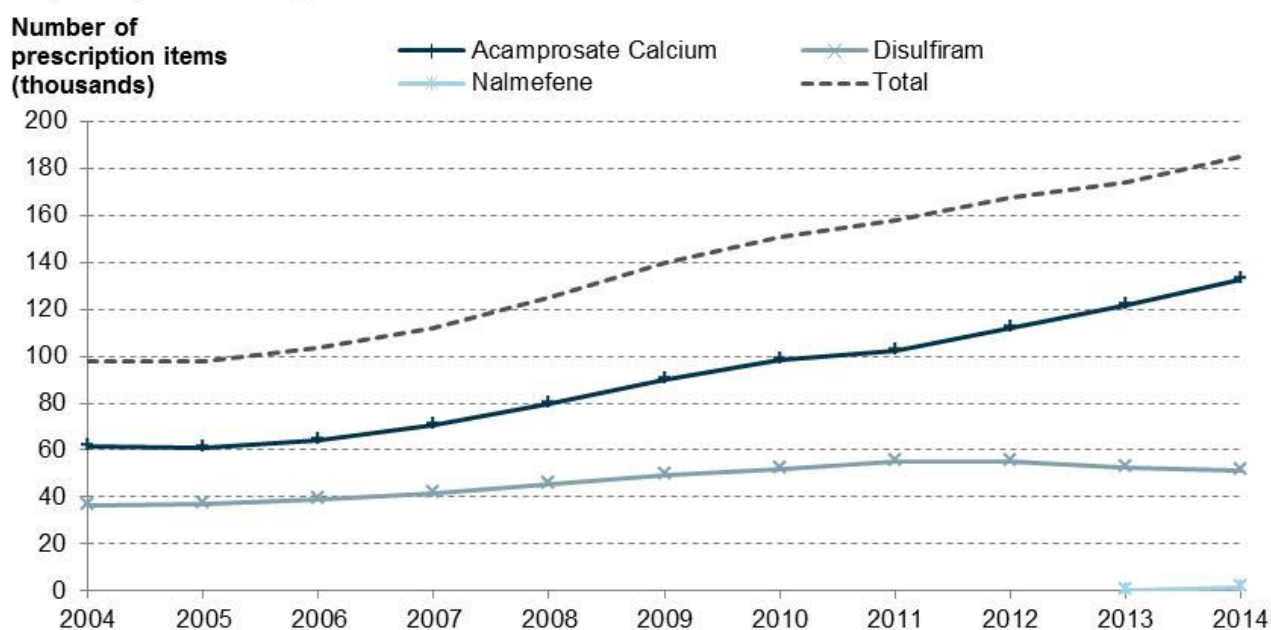
Presented here are data on prescription items and Net Ingredient Cost (NIC) for drugs used to treat alcohol dependence. Prescription items give a measure of how often a prescriber has decided to write a prescription for the treatment of alcohol dependence. The number of

items is not a good measure of the volume of drugs prescribed as different practices may use different durations of supply. The NIC is the basic cost of a drug as listed in the Drug Tariff or price lists; it does not include discounts, dispensing costs, prescription charges or fees.

Alcohol dependency prescription items shows:

- 194,706 items were prescribed (in a primary care setting or NHS hospital) in 2014 for the treatment of alcohol dependency and dispensed in the community.
- The majority of these 185,251 (95 per cent) were prescribed in a primary care setting (e.g. GP surgery, pharmacist or clinic). This has gradually increased from 89 per cent in 2006.
- Overall, there has been a steady increase 86,625 (80 per cent) in the number of items prescribed in the last 10 years.
- The Net Ingredient Cost (NIC) of these prescription items in 2014 was £3.43 million, which is an increase of £0.30 million since 2013 and more than double the NIC in 2004 of £1.52 million. The introduction of Nalmefene in 2013 will have contributed slightly to the increased cost. However, the majority of the increase is attributable to the increase in the number of items being prescribed as the average NIC per item in 2014 was £18 which is the same as it was in 2005.
- 71 per cent of the three main drugs prescribed for the treatment of alcohol dependency are for Acamprosate Calcium. This proportion has increased from 62 per cent in 2004, although the number has risen considerably from 66,863 to 137,596 in 2014.
- Nalmefene which has only been available on prescription since May 2013 accounts for less than 1 per cent of the items prescribed in 2014. [Tables 4.7](#) and [4.8](#), [Figure 4.5](#)

Figure 4.5 - Number of prescription items for the treatment of alcohol dependency prescribed in primary care in England, 2004 to 2014



Source: Prescribing Analysis and Cost Tool (PACT) from NHS Prescription Services of the NHS Business Services Authority. Health and Social Care Information Centre
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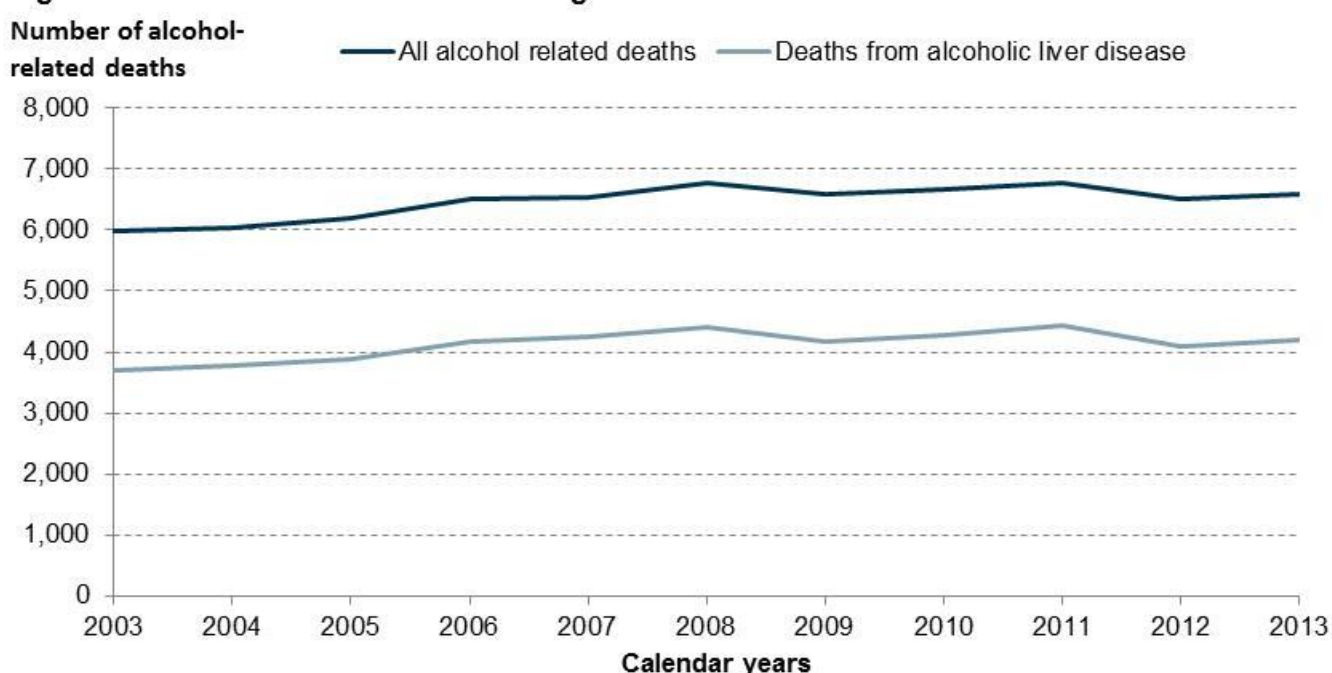
4.6 Deaths related to alcohol consumption

Alcohol misuse can be directly related to deaths from certain types of disease, such as cirrhosis of the liver, and in some cases, may be associated with other causes of death, such as strokes.

Table 4.9 shows the number of alcohol-related deaths in England, by gender, 2001 to 2013 using the National Statistics definition. The National Statistics definition of alcohol-related deaths only includes those causes regarded as being most directly due to alcohol consumption. It does not include other diseases where alcohol has been shown to have some causal relationship, such as cancers of the mouth, oesophagus and liver. For further information see the 'Definition' section of *Alcohol-related deaths in the United Kingdom, registered in 2013*⁷ by the Office for National Statistics (ONS). The historical figures in Table 4.9 have been revised and the figures vary very slightly from those published before. This is due to ONS changing the methodology to exclude non-resident deaths that were registered in England and the maximum effect per condition is 7 registered deaths.

- In England, in 2013 there were 6,592 alcohol-related deaths. This is a 1 per cent increase from 2012 (6,495) and a 10 per cent increase from 2003 (5,984).
- The number of male deaths increased from 4,232 in 2012 to 4,332 in 2013 and the number of female deaths decreased from 2,263 in 2012 to 2,260 in 2013. Both years were higher than the 3,968 male deaths and 2,016 female deaths in 2003.
- The most common alcohol-related death was alcoholic liver disease which accounted for 64 per cent (4,190) of all alcohol-related deaths in 2013. This proportion has remained fairly stable for the last ten years (between 62 and 66 per cent). Figure 4.6
- The number of deaths from alcohol-related fibrosis and cirrhosis of the liver were also high accounting for 22 per cent (1,438) of deaths in 2013.

Figure 4.6 - Alcohol-related deaths in England 2003 to 2013



Source: Alcohol-related deaths by individual cause of death and sex, in UK constituent countries, deaths registered 2001 to 2013. ONS

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Public Health England produces estimates of the number of alcohol-related deaths. These estimates are higher than the ONS figures since they include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls.

Further data and resources are available on the *Local Alcohol Profiles for England* website⁵.

4.7 Cost to the NHS

In 2004, *The Alcohol Harm Reduction Strategy for England*⁹ set out the then government's strategy for tackling the harms and costs of alcohol misuse in England. A follow up report was published in 2007 titled: *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*¹⁰.

The estimated cost of alcohol harm to society is £21 billion per year. Information on estimated cost to the NHS of alcohol misuse shows that it costs £3.5 billion every year, which is equal to £120 for every taxpayer. These estimates are presented in the evidence paper to the House of Commons Health Select Committee on the Government's Alcohol Strategy¹¹. The cost of £3.5 billion is an updated figure to the one given in 2008 when the then government produced a report, *The cost of alcohol harm to the NHS in England*¹² where it estimated that the cost of alcohol harm to the NHS in England was £2.7 billion (in 2006/07 prices). These updated estimates take into account increases in unit costs as well as more recent and accurate data on alcohol consumption and harm.

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Appendix A: Key sources

- Alcohol attributable fractions (AAFs)
- Affordability data
- Health at a glance , Organisation for Economic Co-operation and Development (OECD)
- Health Survey for England (HSE)
- Hospital Episode Statistics (HES)
- Infant Feeding Survey (IFS)
- International Classification of Diseases and related health problems (ICD)
- Living Costs and Food Survey (LCFS)
- Local Alcohol Profiles for England (LAPE)
- Mortality statistics
- Opinions and Lifestyle Survey (OPN)
- Prescription data
- Smoking, Drinking & Drug Use among Young People in England (SDD)

Most of the sources referred to in this publication are National Statistics. National Statistics are produced to high professional standards set out in the Code of Practice for Official Statistics¹.

Not all statistics in this publication are National Statistics some are Official Statistics, whilst others are neither. All are included to provide a fuller picture. Official Statistics should still conform to the Code of Practice for Official Statistics, although this is not a statutory requirement. Unless otherwise stated, all sources contained within this publication are considered robust.

Alcohol attributable fractions (AAFs)

Alcohol attributable fractions (AAFs) are used to calculate the number of hospital admissions attributable to alcohol. They were developed by North West Public Health Observatory (NWPHO) which is now part of Public Health England (PHE).

NWPHO led a review of the methodology used to estimate alcohol related admissions took place in 2012¹³. As a result of this the following changes have been made:

Revised alcohol attributable fractions are used to estimate the number of alcohol-related hospital admissions.

The alcohol-related diagnoses reported on, have been revised.

The previous measure based on primary diagnosis only has been revised to use alcohol-related primary diagnoses or alcohol-related external causes recorded in secondary diagnosis fields.

Within this publication, two main measures of alcohol related admissions are presented:

A broad measure is derived by summing the alcohol attributable fraction associated with each admission based on the diagnosis most strongly associated with alcohol out of all diagnoses (both primary and secondary).

A narrow measure which is constructed in a similar way but counts only the fraction associated with the diagnosis in the primary position or alcohol-related external causes recorded in secondary diagnosis fields.

The “broad” measure is a better indicator of the total burden that alcohol has on health services as it takes more account of secondary diagnoses than the “narrow” measure. However, since secondary diagnosis fields have become better populated over time, this impacts upon time series comparisons for the “broad” measure. Consequently, the “narrow” measure is a better indicator of changes over time.

Within each of these measures, the data is broken down into admissions that are wholly and partially attributable to alcohol.

Tables 4.1 to 4.3 show the number of hospital admissions based on the broad measure; Tables 4.4 to 4.6 show the number of hospital admissions based on the narrow measure.

Methodology

The number of alcohol-related admissions uses indicators for alcohol-related illnesses to determine the proportion of a wide range of diseases and injuries that can be attributed to alcohol.

Some conditions such as “Mental and behavioural disorders due to use of alcohol” or “Accidental poisoning by and exposure to alcohol” are felt to be solely due to alcohol so have an AAF of 1.

Other conditions such are only partially attributable to alcohol so have an AAF of less than 1. For example “Malignant neoplasm of oesophagus” has an AAF which varies from 0.38 for women aged 75+ to 0.63 for men aged 45 to 64.

External causes can also be attributable to alcohol and for example, “Assault” has an AAF which varies from 0.02 for women aged 75+ to 0.18 for men aged 45 to 54.

AAFs are assigned to HES^j data on admitted patients (inpatients) where at least one of the conditions known to be associated with alcohol consumption is in either the primary or one of the 19 secondary diagnosis positions.

- Where there is more than one alcohol-related condition among the diagnostic codes the condition with the largest fraction is used.
- Where there are two or more codes with the maximum attributable fraction, the code from the earliest position is used.

This method is employed to avoid double counting of the admission episodes related to alcohol and therefore each episode contributes to one cell in the table. The total number of alcohol-related admissions is arrived at by summing up the number of episodes counted against each alcohol-related condition.

Further information on the methodology can be found on the LAPE website².

^j HES is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere

Standardisation methodology

Age and gender standardisation is applied to the number of admissions per 100,000 head of population so that local areas can be compared more easily. The standardisation process adjusts the demographic profile of each local area so they all contain the same proportion of each age and gender combination. Therefore, any observed differences will not be due to the different age/gender composition of the area.

The latest available England population figures are used for standardisation. Therefore, the standardisation process effectively adjusts the observed rate to be the rate that would have occurred in the subject population if it had the same age profile as England.

PHE use the European Standard population for standardisation in their Local Alcohol Profiles for England (LAPE) so their figures will differ from those published in this report.

The following age bands have been used for standardising:

- Under 16
- 16 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75+

These are the same groups as used for calculating the AAFs.

Affordability data

Publications used to produce these figures include *Price Indices and Inflation*³, *Economic and Labour Market Review*⁴ and the *Mid-Year Population Estimates*⁵.

The *retail prices index (RPI)* shows how much the prices of all items have changed compared with the base price (100 in 1980).

The relative alcohol price index is calculated by dividing the alcohol price index by the retail prices index and multiplying by 100.

$$\text{relative alcohol price index} = \left(\frac{\text{alcohol price index}}{\text{retail prices index}} \right) * 100$$

This shows how the average price of alcohol has changed since the base year (1980) compared with prices of all other items. A value greater than 100 shows that the price of alcohol has increased by more than inflation during that period.

Adjusted real households' disposable income is an index of total households' income, minus payments of income tax and other taxes, social contributions and other current transfers, converted to real terms (i.e. after dividing by a general price index to remove the effect of inflation) which tracks, exclusively, changes in real disposable income per capita.

The adjusted real households' disposable income index is obtained by carrying out the following 2 steps;

1. Calculate real households' disposable income index / total number of UK adults aged 18 and over.
2. Rebase the resulting series so that 1980 = 100 per cent.

Affordability of alcohol gives a measure of the relative affordability of alcohol, by comparing the relative changes in the price of alcohol, with changes in households' disposable income per capita over the same period (with both allowing for inflation).

The alcohol affordability index is calculated by dividing the adjusted real households' disposable income index by the relative alcohol price index and multiplying by 100.

$$\text{alcohol affordability index} = \left(\frac{\text{adjusted real households' disposable income index}}{\text{relative alcohol price index}} \right) * 100$$

If the affordability index is above 100, then alcohol is relatively more affordable than in the base year, 1980.

Health at a Glance, Organisation for Economic Co-operation and Development (OECD)

Health at a Glance 2014⁶ offers the most comprehensive source of comparable statistics on health and health systems across OECD countries. It is an essential tool for health researchers and policy advisors in governments, the private sector and the academic community, to carry out comparative analyses and draw lessons from international comparisons of diverse health care systems. It is used in Chapter 2 on Drinking behaviour in Adults and Children.

Health Survey for England [NS]^k

The *Health Survey for England (HSE)*⁷ is an annual survey, monitoring the health of the population which is currently commissioned by the Health and Social Care Information Centre (HSCIC), and before April 2005 was commissioned by the Department of Health. The HSE has been designed and carried out since 1994 by the Joint Health Surveys Unit of the National Centre for Social Research (NatCen) and the Department of Epidemiology and Public Health at University College London Medical School (UCL). All surveys have covered the adult population aged 16 and over living in private households in England. Since 1995, the surveys have also covered children aged two to 15 living in households selected for the survey, and since 2001 infants aged under two have been included as well as older children. Trend tables are also published each year updating key trends on a number of health areas.

Each survey in the series includes core questions and measurements such as blood pressure, anthropometric measurements and analysis of saliva and urine samples, as well as modules of questions on specific issues that vary from year to year. In some years, the core sample has also been augmented by an additional boosted sample from a specific population subgroup, such as minority ethnic groups, older people or children.

^k National statistic

Hospital Episode Statistics

Hospital Episode Statistics (HES) is a data warehouse containing details of all admissions to NHS hospitals in England. NHS hospital admissions in England have been recorded using the HES system since April 1987. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contains details of all NHS outpatient appointments in England as well as detailed records of attendances at major A&E departments, single specialty A&E departments, minor injury units and walk-in centres in England. HES data is available from 1989-90 onwards.

HES data are classified using *International Classification of Diseases (ICD)*⁸. A finished admission episode (FAE) is the first period of inpatient care under one consultant within one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Please note that admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

The primary diagnosis is the first of up to 20 (14 from 2002-03 to 2006-07 and 7 prior to 2002-03) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was admitted to hospital. As well as the primary diagnosis, there are up to 19 (13 from 2002-03 to 2006-07 and 6 prior to 2002-03) secondary diagnosis fields in Hospital Episode Statistics (HES) that show other diagnoses relevant to the episode of care.

Infant Feeding Survey [NS]¹

The Infant Feeding Survey (IFS)⁹ covers the population of new mothers in the United Kingdom, and was carried out every 5 years between 1975 and 2010. The main aim of the survey was to provide figures on the incidence, prevalence and duration of breastfeeding and other feeding practises. The survey also collected information on the smoking and drinking behaviours of women before, during and after pregnancy.

International Classification of Diseases and related health problems (ICD)

The tenth revision of the ICD codes (ICD-10)⁸ is the latest in a series of classifications started in 1993. It provided a standardised way of collecting data across the health system.

Deaths in England and Wales were classified using ICD 10 for 1999, and 2001 onwards. Hospital Episode Statistics (HES) have been classified using ICD 10 for 1995/96 onwards.

Living Costs and Food Survey [NS]¹

In 2008 the Expenditure and Food Survey (EFS) was renamed as the Living Costs and Food Survey (LCFS)^{10,11} when it became part of the Integrated Household Survey (IHS) run by the Office for National Statistics (ONS). The Expenditure and Food Survey (EFS) was formed by bringing together the Family Expenditure Survey and the National Food Survey (FES and NFS). The LCFS provides data on food purchases and expenditure. Historical estimates based on NFS are available from 1940 to 2000.

¹ National statistic

Local Alcohol Profiles for England (LAPE)

The LAPE tool presents data for 26 alcohol-related indicators in an interactive tool, which helps local areas assess alcohol-related harm and monitor the progress of efforts to reduce this. The data can be accessed on the LAPE website².

Mortality statistics [NS]^m

The Office for National Statistics (ONS) produces annual statistics on numbers of deaths by cause in the United Kingdom (UK) by individual cause and sex, in UK constituent countries¹².

Deaths in the UK with an underlying cause regarded as being alcohol-related according to the National Statistics definition were extracted from the mortality databases at ONS (for England and Wales, GROS (for Scotland), and NISRA (for Northern Ireland).

The data in this report only includes deaths for conditions which are wholly attributable to alcohol. The mortality data published in LAPE by PHE also includes deaths from conditions which are partially attributable to alcohol, based on the same methodology as that for alcohol-related hospital admissions (see previous section).

Alcohol-related deaths registered in England by gender, 2001 to 2013 is presented in Chapter 4 of this report – Drinking-related costs, ill-health and mortality.

Omnibus Survey, Drinking: Adults' behaviour and knowledge report

This biannual survey asked respondents about their drinking behaviour and knowledge. The results were presented in the ONS Omnibus Survey Report *Drinking: adults' behaviour and knowledge* which provided information on alcohol consumption, knowledge of units of alcohol and guidelines and where people buy alcohol.

The ONS Omnibus Survey Report *Drinking: adults' behaviour and knowledge in 2009*¹⁴ was the last report in the series and was published in 2009 using data collected from 2008/09.

Opinions and Lifestyle Survey

In 2012, the survey vehicle for collecting drinking data changed from the General Lifestyle Survey (GLF) to the *Opinions and Lifestyle Survey (OPN)*¹⁵. The OPN uses the same initial approach to sampling as the GLF. That is, a random sample of addresses is drawn from the Postcode Address File (PAF). Initially, a sample of postcode sectors is drawn, and from within those, a list of addresses is chosen. The design means that every address and every person in Great Britain has an equal chance of selection. The PAF is ordered by region and other socio-demographic indicators provided by the census. Ordering the PAF helps to ensure the sample represents the general population of Great Britain.

^m National statistic

Prescription data [NS]ⁿ

Information on prescription items prescribed in primary care settings in England is produced using Prescribing Analysis and Cost Tool (ePACT). The ePACT system covers prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Prescriptions written in England but dispensed outside England are included. Prescriptions written in hospitals/clinics that are dispensed in the community, prescriptions dispensed in hospitals and private prescriptions are not included in PACT data.

Hospital prescription information is taken from the Prescription Cost Analysis (PCA) system, and is based on a full analysis of all prescriptions dispensed in the community i.e. by community pharmacists and appliance contractors, dispensing doctors, and prescriptions submitted by prescribing doctors for items personally administered in England. Also included are prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England. The data do not cover drugs dispensed in hospitals, including mental health trusts, or private prescriptions.

The differences between PCA and ePACT are that:

1. PCA includes prescriptions prescribed by dentists.
ePACT does not include prescriptions prescribed by dentists.
2. PCA includes prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England.
ePACT includes prescriptions written in England but dispensed in England and those dispensed outside England.

Prescriptions are written on a prescription form known as FP10 and each single item on the form is counted as a prescription item. Net Ingredient Cost (NIC) is the basic cost of a drug. It does not take account of discounts, dispensing costs, fees or prescription charges income.

The prescription data included in this report are not routinely available¹⁶. Sub-national or primary care data may be available on request from Prescription Services. National data with a wider coverage is available from the Health and Social Care Information Centre.

Smoking, Drinking and Drug use among Young People in England [NS]ⁿ

Smoking, Drinking and Drug Use Survey among Young People in England in 2013 (SDD13)¹⁷ is the latest in the series of surveys of secondary school children in England which provides the national estimates of the proportions of young people in school years 7 to 11 (who are mostly aged 11 to 15) who smoke, drink alcohol or take illegal drugs. The first survey in the series was carried out in 1982 and since 1998 the survey has included questions on drinking and drug use as well as smoking.

As well as these core measures, questionnaires since 2000 have included more detailed questions, with the focus alternating between smoking and drinking in one year and drug use the next. The focus in 2013 was on drug use and therefore 2012 was the last year to focus on smoking and drinking, and this report reflects that.

The questions measuring drinking in the last week are regularly updated to reflect changes in the drinks market and the list of example brands is updated annually.

Information from the SDD reports can be found in [Chapter 2](#).

ⁿ National statistic

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Appendix B: Cross-departmental policies

The NHS advises that¹:

- Adult women should not regularly drink more than 2 to 3 units of alcohol a day.
- Adult men should not regularly drink more than 3 to 4 units of alcohol a day.
- Pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to minimise the risk to the baby they should not drink more than 1-2 units of alcohol once or twice a week and should not get drunk.
- After an episode of heavy drinking, it is advisable to refrain from drinking for 48 hours to allow tissues to recover.

The Government's Alcohol Strategy

The Alcohol Strategy 2012² is targeted at harmful drinkers, problem pubs and irresponsible shops. It addresses both health and social harms describing coordinated actions across Government, including a strong package of health measures. The Strategy sets ambitions to reduce the number of people (i) drinking above the NHS guidelines (ii) 'binge drinking' and (iii) the number of alcohol related deaths as well as other ambitions, such as to see a change in behaviour where people think it is not acceptable to drink in ways that could cause harm to themselves or others.

Public Health Responsibility Deal

Under the previous Government the Public Health Responsibility Deal was launched in March 2011 to challenge businesses and other organisations to help people drink within the lower-risk guidelines. Around 125 companies signed up to alcohol pledges.

Under the previous Government, the drinks industry committed to voluntarily remove 1 billion units of alcohol from people's drinks. They removed 1.3 billion over just two years.

Reducing the strength of alcohol in people's drinks is expected to contribute, at no cost to the public purse, to a significant decrease in alcohol harm.

Under the previous Government, six new alcohol commitments were agreed in July 2014, including one to no longer sell cans with more than 4 units of alcohol and one to not sell house wines in pubs that are over 12.5 per cent ABV. Pubs and shops committed to voluntarily display unit and health information. Ipsos MORI, found that over a quarter of respondents saw a British Beer and Pub Association (BBPA) information image; over two in five 18-24 year-olds saw at least one BBPA image; over a quarter saw something similar, but different, to BBPA materials; more than half those seeing different materials also saw BBPA materials.

Improving Information

Clear and easily understood information is central to ensuring that everyone is aware of the lower-risk guidelines and the risks of drinking above the guidelines, as many people who drink do not realise how much they are drinking.

The Government asked Dame Sally Davies, the Chief Medical Officer, to oversee a review of the alcohol guidelines, to ensure these are founded on the best science and so that the guidelines help people at all stages of life to make informed choices about their drinking.

The review is underway and we expect that the consultation on new guidelines will take place from the autumn.

Under the previous Government, alcohol producers committed to display on bottles and cans, unit content, CMO lower-risk guidelines and a warning about drinking when pregnant. The independent report from Campden BRI found that:

- 79.3 per cent of labels provided all three elements correctly (meeting the commitment).
- 92.8 per cent provided correct pregnancy information; compared to just 18 per cent six years ago.
- 87 per cent had correct unit content; and
- 82.8 per cent had correct lower-risk drinking guidelines.
- 57.1 per cent of the labels which contained the three required compliant elements were assessed as easily visible, to have a font size or font / background colour combination that did not affect legibility and were presented according to the best practice grouping and were clear.

Drinkaware is a charitable organisation which aims to get people to think differently about alcohol. Their entire focus is on getting people to understand the harm it can do to their health, their families and those around them.

It currently receives over £5 million funding, primarily from the alcohol industry but is an independent charity with a board that is appointed on merit and through open competition.

Drinkaware has an extensive website providing detailed information about alcohol harm and provide web based tools and apps that help people check how much they are drinking, how much it is costing them and how many calories are in their drinks. The tools offer advice on the levels of risk for an individual's drinking and ongoing support to reduce their drinking if an individual asks for it (i.e. the full World Health Organisation AUDIT is used as a web based identification and brief advice tool).

In 2014 more than 8.3 million people visited the Drinkaware website, 40 per cent more than in 2013. More than 1 million people completed AUDIT and 100,000 people have downloaded the Drinkaware app since its launch in August 2014.

Licensing

Under the previous Government legislation via the Police Reform and Social Responsibility Act 2014 was passed to overhaul the Licensing Act 2003 and to rebalance in favour of local communities. These reforms give the police and licensing authorities more local powers to shape their night-time economies and to tackle irresponsible premises, particularly those selling alcohol to children. Local health bodies are now Responsible Authorities under the Licensing Act and allow them to make a fuller contribution to reducing acute harms from alcohol.

Evidence suggests that increased outlet density is linked to alcohol-related harms. Under the previous Government views were sought as part of a consultation by the Home Office in 2012/13, on the introduction of a new density power that would enable licensing authorities to consider local health harms specifically when introducing Cumulative Impact Policies.

Public Health England are working actively to support Local Alcohol Actions Areas interested in developing local data and evidence to support further consideration of this policy. This work concluded in March 2015.

Pricing

Under the previous Government views were sought on a number of measures set out in the Alcohol Strategy, including proposals to tackle the availability of cheap alcohol, in a consultation published by the Home Office in 2012/13.

Sales of alcohol below the level of duty plus VAT were banned in May 2014, meaning it is no longer legal to sell a can of ordinary lager for less than around 40 pence.

A wide range of evidence was provided on Minimum Unit Price (MUP) throughout the consultation, and this was considered alongside updated modelling by the University of Sheffield.

- In England, although the introduction of MUP was anticipated in the 2012 Strategy a decision was taken in 2013 not to introduce MUP but instead to keep it under review.

Alcohol Interventions

The Department of Health is supporting the NHS to put in place high quality services to prevent mitigate and treat effectively alcohol-related health harm. The relevant services range from identification and brief advice to specialist services to treat dependent drinkers. From April 2013, the Department of Health has funded the inclusion of an alcohol risk assessment in the NHS Health Check; so that people will be given brief advice to help them cut down if they need to. The support given will depend on the individuals' needs and might involve some brief advice or a referral to specialist alcohol service(s), if needed.

Local action

Public Health England (PHE) is the Executive Agency of the Department of Health with the role of supporting local authorities responsible for public health. PHE provides data, evidence and support to local authorities and NHS partners to enable them to reduce the harmful impact from alcohol in local communities.

PHE also encourages greater use of effective interventions, such as brief interventions, alcohol interventions in secondary NHS care and the treatment of dependent drinkers.

Reducing alcohol harm is one of PHE's seven priorities and we are implementing a programme to support people and services to implement changes. Over the next eighteen months, PHE are:

- Using alcohol as the trailblazer for a new whole system approach that establishes what works and is clear on the return on investment, enabling government, local authorities and the NHS to invest with confidence in evidence based policies, prevention and treatment interventions.
- Producing an independent report for government on the public health impacts of alcohol and on evidence-based solutions.
- Producing a framework on liver disease outlining public health actions to tackle liver disease, including alcohol.
- Expanding the Healthier Lives web tool: This now includes the Public Health Outcomes Framework 2.18 indicator on alcohol admissions and figures for waiting times and completions from alcohol treatment.
- Continuing to set out the evidence base for the introduction of a minimum unit price for alcohol.
- Considering the evidence for the inclusion of health as a licensing objective.

From April 2013, upper tier and unitary local authorities have received a ring-fenced public health grant. This includes funding for alcohol misuse prevention and treatment.

Health and Wellbeing Boards will bring together councils, the NHS and local communities to understand local needs and priorities expressed in the Joint Strategic Needs Assessment (JSNA). In addition, they develop a joint Health and Wellbeing strategy, which sets out how they will work together to meet these needs. The boards promote integration of health and social care services with health-related services like criminal justice services, education or housing. This helps join up services around individual's needs and improve health and wellbeing outcomes for the local population.

References

1. Change for Life website accessed May 2014
<http://www.nhs.uk/Change4Life/Pages/drink-less-alcohol.aspx>
2. Alcohol Strategy Policy Paper, Home Office. 23 March 2012
<https://www.gov.uk/government/publications/alcohol-strategy>

Appendix C: Further Information

Readers may also find the following organisations and publications useful resources for further information on alcohol:

Alcohol Concern

This organisation seeks to help people through information and guidance; help professionals through training, projects and research.

<http://www.alcoholconcern.org.uk/>

Drinkaware

Drinkaware is an independent charity supported by voluntary donations from the drinks industry and from major UK supermarkets. They work to reduce alcohol misuse and harm in the UK.

<https://www.drinkaware.co.uk/>

Her Majesty's Revenue and Customs (HMRC)

HMRC is the new department responsible for the business of the former Inland Revenue and HM Customs and Excise.

www.hmrc.gov.uk/

Home Office – Research and analysis series

Home Office research and analysis covers the following areas: alcohol, crime, counter terrorism, drugs, crime, migration and policing.

<https://www.gov.uk/government/organisations/home-office/about/research>

National Institute for Health and Clinical Excellence (NICE)

The NICE has taken on the functions of the Health Development Agency to create a single excellence-in-practice organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health:

<http://www.nice.org.uk/guidancemenu/lifestyle-and-wellbeing>

NHS Choices – Drinking and alcohol

This site shows users how many calories are in alcohol and how this impacts on weight gain.

<http://www.nhs.uk/livewell/alcohol/Pages/Alcoholhome.aspx>

Public Health England Alcohol Learning Resources

On these pages you can find training resources for healthcare and social care professionals delivering services in the alcohol harm reduction field.

<http://www.alcohollearningcentre.org.uk/eLearning/>

Office for National Statistics (ONS)

Information about National Statistics can be found at:

<http://www.ons.gov.uk/ons/index.html>

Appendix D: How are the statistics used?

Users and uses of the report

From our engagement with customers, we know that there are many users of the Statistics on Alcohol report. There are also many users of these statistics who we do not know about. We are continually aiming to improve our understanding of who our users are in order to enhance our knowledge on what the uses of these data are via recent consultations and feedback forms available online. Below is listed our current understanding of the known users and uses of these statistics. Also included are the methods we use to attempt to engage with the current unknown users.

Known Users and Uses

Department of Health (DH) - frequently use these statistics to inform policy and planning. The Public Health Outcomes Framework was published in January 2012 which sets out the desired outcomes for public health and how these will be measured. The Department of Health publishes policies such as Harmful Drinking (23 March 2013) and can be found via this link: <https://www.gov.uk/government/publications/2010-to-2015-government-policy-harmful-drinking>

Public Health England frequently use these data for secondary analysis.

Media - these data are used to underpin articles in newspapers, journals, etc. For example, the following articles appeared in response to the 2014 version of this report:

BBC News – “Prescription drugs to treat alcohol top £3m”

<http://www.bbc.co.uk/news/health-27618247>

Channel 4 News – “Drinking vs smoking - which is worse?”

<http://www.channel4.com/news/alcohol-label-warning-harm-tobacco-graphic-quiz>

Daily Mail – “Sharp fall in under-11s rushed to hospital for alcohol problems but parents are still worried about teen drinking”

<http://www.dailymail.co.uk/news/article-2707310/Drop-number-alcohol-related-visits-A-E-children.html>

Public - all information is accessible for general public use for any particular purpose.

Academia and Researchers - a number of academics cite the Alcohol data in their research papers.

NHS - frequently use the reports and tables for analyses, benchmarking and to inform decision making.

Public Health Campaign Groups - data are used to inform policy and decision making and to examine trends and behaviours.

Ad-hoc requests – the statistics are used by the Health and Social care Information Centre (HSCIC) to answer Parliamentary Questions (PQs), Freedom of Information (FOI) requests and ad-hoc queries. Ad-hoc requests are received from health professionals; research companies; public sector organisations, and members of the public, showing the statistics are widely used and not solely within the profession.

Unknown Users

This publication is free to access via the HSCIC website <http://www.hscic.gov.uk/lifestyles> and consequently the majority of users will access the report without being known to the HSCIC. Therefore, it is important to put mechanisms in place to try to understand how these additional users are using the statistics and also to gain feedback on how we can make these data more useful to them. On the webpage where the publication appears there is a link on the right-hand side to a feedback form which the HSCIC uses to capture feedback for all its reports.

The specific questions asked on the form are:

- How useful did you find the content in this publication?
- How did you find out about this publication?
- What type of organisation do you work for?
- What did you use the report for?
- What information was the most useful?
- Were you happy with the data quality?
- To help us improve our publications, what changes would you like to see (for instance content or timing)?
- Would you like to take part in future consultations on our publications?

Any responses via this form are passed to the team responsible for the report to consider.

We also capture information on the number of web hits the reports receive, although we are unable to capture who the users are from this. Statistics on Alcohol 2014 generated approximately 27,472 unique web hits (for the report and associated files) between its publication date of 29 May 2014 and 27 May 2015.

Glossary of terms

1. **Acamprosate Calcium (Campral)** – a drug used to treat alcohol dependency which helps restore chemical balance in the brain and prevents the feelings of discomfort associated with not drinking, therefore reducing the desire or craving to consume alcohol.

2. **Attributable conditions**

Wholly – where all cases can be ascribed to alcohol consumption and so have an alcohol fraction of one.

Partly – where some, but not all cases can be ascribed to alcohol consumption and so have an attributable fraction of less than one.

3. **Binge drinking** – In line with the Government's Alcohol Strategy, men are considered to have binged if they drank more than eight units of alcohol on their heaviest drinking day in the week before interview and women if they drank more than six units.

4. **Conditions**

Acute – symptoms appear and change or worsen rapidly.

Chronic – develops and worsens over an extended period of time.

5. **Diagnosis fields**

Primary – the main condition treated or investigated during the relevant episode of healthcare and where there is no definitive diagnosis, the main symptom, abnormal findings or problem.

Secondary – all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.

6. **Disulfiram (Antabuse)** – a drug used to treat alcohol dependency which produces an acute sensitivity to alcohol resulting in a highly unpleasant reaction when the patient under treatment ingests even small amounts of alcohol.

7. **Frequent drinking** – This is classified as those who drank on five or more days in the week before interview.

8. **Measures**

Broad measure – derived by summing the alcohol attributable fraction associated with each admission based on the diagnosis most strongly associated with alcohol out of all diagnoses (both primary and secondary).

Narrow measure – is constructed in a similar way but counts only the fraction associated with the diagnosis in the primary position or alcohol-related external causes recorded in secondary diagnosis fields.

The estimates calculated based on the broad measure are felt to give a better estimate of the number of admissions to hospital caused or affected by alcohol consumption at a particular time or place and hence the pressure put on the health system, rather than a measure of admissions directly caused by alcohol. In some of the cases where an admission episode contains an alcohol-related condition in a secondary diagnosis field but not the primary diagnosis field, the condition may not have been a causal factor leading to the admission. Rather, it may be a complicating factor and affect the care that is given to the patient, potentially making treatment more costly.

However, comparisons over time can be misleading as increases may be partly due to the improvement in recording of secondary diagnoses.

Information based on the narrow measure provides a less complicated picture of trends in alcohol-related admissions over time, although it gives an incomplete picture of admissions resulting from or affected by alcohol consumption. This is because in some cases, the secondary diagnoses will have been a contributing factor to the admission to hospital. This is particularly true of external causes of admission such as accidents and violence, which are never recorded as a primary diagnosis, but some of which can be attributed to alcohol.

Within each of these measures, the data can be broken down into admissions that are wholly and partially attributable to alcohol, according to the required purpose.

9. Nalmefene (Selincro) – is the first medicine to be granted a licence for the reduction of alcohol consumption in people with alcohol dependence. It helps reduce the urge to drink in people accustomed to large amounts of alcohol, but does not prevent the intoxicating effects of alcohol.

10. Teetotal – Teetotallers are those who said that they do not drink alcohol at all.

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