



Statistics on Alcohol: England, 2012



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Author: Health and Social Care Information Centre, Lifestyles Statistics.

Responsible Statistician: Paul Eastwood, Lifestyle Statistics Section Head

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Contents

Contents	4
Executive Summary	6
Introduction	6
Background	6
Main findings:	7
Overview	9
Introduction	9
Definitions	9
Main findings:	10
2 Drinking behaviour among adults and children	13
2.1 Introduction	13
2.2 Alcohol consumption	15
2.3 Purchases, availability and affordability of alcohol	17
2.4 Types of alcohol consumed	19
2.5 Alcohol consumption and socio-economic variables	20
2.6 Alcohol consumption and demographic characteristics	21
2.7 Geographic patterns of alcohol consumption	22
2.8 Drinking among children	24
References	26
List of Tables	28
3 Knowledge and attitudes to alcohol	45
3.1 Introduction	45
3.2 Adults knowledge and Attitudes to Alcohol	45
3.3 Knowledge of drinking limits	46
3.4 Children's attitudes to drinking alcohol	47
References	49
List of Tables	50
4 Drinking-related costs, ill health and mortality	59
4.1 Introduction	59
4.2 Hazardous, harmful and dependent drinking	60
4.3 Discussion of drinking with health professional and specialist treatment	61
4.4 Alcohol-related hospital admissions	61
4.5 Prescribing	66
4.6 Deaths related to alcohol consumption	67
4.7 Costs to the NHS	68

References	70
List of Tables	72
Appendix A: Key sources	87
Appendix B: Cross-Departmental policy 2011/12	110
Appendix C: United Kingdom Statistics Authority Assessment of the Statistics on Alcohol: England publication	114
Appendix D: Editorial notes	116
Appendix E: Further information	117
Appendix F: Update on the Public User Consultation	123
Appendix G: Quantification of the impact of changes in recording practices of secondary diagnoses on national alcohol related admission (ARA) estimates	129

Executive Summary

Introduction

This statistical report acts as a reference point for health issues relating to alcohol use and misuse, 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 new analyses are mainly obtained from the Health and Social Care Information Centre (HSCIC) Hospital Episodes Statistics (HES) system, and prescribing data. The report also include up to date information on the latest alcohol related government policies and ambitions and contains links to further sources of useful information.

The data in this report relates to England unless otherwise specified. Where figures for England are not available, figures for England and Wales, Great Britain or the United Kingdom are provided.

Most of the data contained in the report have been published previously including information from the HSCIC, Department of Health, the Office for National Statistics, Her Majesty's Revenue and Customs and the Department for Environment, Food and Rural Affairs. Some of the data presented here for the first time at England level have been previously published at Great Britain (GB) level.

The report also includes information on prescription drugs used for the treatment of alcohol dependencies showing the volume and costs of prescription items dispensed in primary care settings and in NHS hospitals.

Background

Government recommendations at the time of publication are that adult men should not regularly drink more than 3-4 units of alcohol a day and adult women should not regularly drink more than 2-3 units a day and after an episode of heavy drinking, it is also advisable to refrain from drinking for 48 hours to allow tissues to recover. A number of sources collect information on the number of units drunk in an average week and the amount drunk on the heaviest drinking day in the last week. Neither of these indicators precisely measure consumption against the recommendations, therefore in this compendium, we will refer to the information as it is collected, rather than compare the data with recommendations.

Main findings:

Drinking behaviour among adults and children

In England, in 2010:

- There has been a long-term downward trend in the proportion of adults who reported drinking in the week prior to interview. In 1998 75% of men and 59% of women drank in the week prior to interview compared to 68% of men and 54% of women in 2010
- 13% of secondary school pupils aged 11 to 15 reported drinking alcohol in the week prior to interview in 2010 compared with 18% of pupils in 2009 and 26% in 2001.

Knowledge and attitudes to alcohol

- There has been a fall in recent years in the proportion of pupils who think that drinking is acceptable for someone of their age. In 2010 32% thought it was okay for someone of their age to drink once a week compared to 46% in 2003. Similarly 11% of pupils thought that it was OK for someone of their age to get drunk once a week compared to 20% who thought that in 2003

Drinking related costs, ill health and mortality

In England:

Estimates of the number of alcohol-related admissions to hospital are calculated using a method developed by the North West Public Health Observatory (NWPHO) which takes information on patients' characteristics and diagnoses from the Hospital Episode Statistics (HES) www.hesonline.nhs.uk, together with estimates for the proportion of cases of a particular disease or injury that are caused by alcohol consumption (known as alcohol-attributable fractions (AAFs)). Within this publication, two main measures are presented:

- a broad measure, which 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); and
- a narrow measure, which is constructed in a similar way but counts only the fraction associated with the diagnosis in the primary position.

The attributable fractions represent the likelihood that the condition is the result of alcohol consumption, rather than the likelihood that the admission is the result of alcohol consumption. The figures based on all diagnoses give an 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. Information based only on primary diagnoses allow an uncomplicated picture of trends in alcohol-related admissions over time although will provide an incomplete picture of admissions resulting from or affected by alcohol consumption (as in some cases, the secondary diagnoses will have contributed to the admission to hospital).

This method is currently subject to a public consultation, led by the NWPHO working with the Department of Health and the Health and Social Care Information Centre. The

consultation was launched on 31 May 2012, and will run for 12 weeks. Full details can be found on the NWPFO website: www.lape.org.uk

- In 2010/11 there were 198,900 admissions where the primary diagnosis was attributable to the consumption of alcohol (the narrow measure). This is a 2.1% increase since 2009/10 when there were 194,800 admissions of this type and a 40% increase since 2002/03 when there were around 142,000 such admissions.
- In 2010/11, there were 1,168,300 alcohol related admissions to hospital based on the broad measure (primary and secondary diagnoses). This is an increase of 11% on the 2009/10 figure (1,056,900) and more than twice as many as in 2002/03 (510,700). Comparisons over time in the broad measure are complicated by changes in recording practices over the period. In order to estimate the trend once changes in recording practices are accounted for, a method to adjust the national figures has been devised which is presented in Appendix G. Adjusted figures show a 49% increase from an estimated 783,300 in 2002/03 but a 3% decrease from 1,208,100 in 2009/10.
- In 2011, there were 167,764 prescription items for drugs for the treatment of alcohol dependency prescribed in primary care settings or NHS hospitals and dispensed in the community. This is an increase of 4.7% on the 2010 figure (160,181) and an increase of 63% on the 2003 figure (102,741).
- The Net Ingredient Cost (NIC) of these prescription items was £2.49 million in 2011. This is an increase of 3.3% on the 2010 figure (£2.41 million) and an increase of 45% on the 2003 figure (£1.72 million).

Overview

Introduction

This statistical report acts as a reference point for health issues relating to alcohol use and misuse, 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 new analyses are mainly obtained from the Health and Social Care Information Centre (HSCIC) Hospital Episodes Statistics (HES) system, and prescribing data. The report also include up to date information on the latest alcohol related government policies and ambitions and contains links to further sources of useful information.

The data in this report relates to England unless otherwise specified. Where figures for England are not available, figures for England and Wales, Great Britain or the United Kingdom are provided.

Most of the data contained in the report have been published previously including information from the HSCIC, Department of Health, the Office for National Statistics, Her Majesty's Revenue and Customs and the Department for Environment, Food and Rural Affairs. Some of the data presented here for the first time at England level have been previously published at Great Britain (GB) level.

The report also includes information on prescription drugs used for the treatment of alcohol dependencies showing the volume and costs of prescription items dispensed in primary care settings and in NHS hospitals.

Definitions

Government recommendations at the time of publication are that adult men should not regularly drink more than 3-4 units of alcohol a day and adult women should not regularly drink more than 2-3 units a day and after an episode of heavy drinking, it is also advisable to refrain from drinking for 48 hours to allow tissues to recover. A number of sources collect information on the number of units drunk in an average week and the amount drunk on the heaviest drinking day in the last week. Neither of these indicators precisely measure consumption against the recommendations, therefore in this compendium, we will refer to the information as it is collected, rather than compare the data with recommendations.

Hazardous drinking is defined as a pattern of drinking which brings about the risk of physical or psychological harm. Harmful drinking, a subset of hazardous drinking, is defined as a pattern of drinking which is likely to cause physical or psychological harm.

Substance dependence is defined by the International Classification of Diseases and related health problems (ICD-10) as a cluster of behavioural, cognitive and physiological phenomena that can develop after repeated substance use.

Main findings:

Drinking behaviour among adults and children

In England, in 2010:

- 17% of men and 10% of women (aged 16 and over) reported drinking an alcoholic drink on five or more days in the week prior to interview and 9% of men and 5% of women reported drinking every day during the previous week.
- There has been a long-term downward trend in the proportion of adults who reported drinking in the week prior to interview. In 1998 75% of men and 59% of women drank in the week prior to interview compared to 68% of men and 54% of women in 2010
- 35% of men drank over 4 units on at least one day in the week prior to interview and 28% of women drank more than 3 units on at least one day in the week prior to interview. 19% of men reported drinking over 8 units and 12% of women reported drinking over 6 units on at least one day in the week prior to interview.
- The average weekly alcohol consumption for all adults was 15.9 units for men and 7.6 units for women.
- 26% of men reported drinking more than 21 units in a typical week. For women, 17% reported drinking more than 14 units in a typical week.
- 13% of secondary school pupils aged 11 to 15 reported drinking alcohol in the week prior to interview in 2010 compared with 18% of pupils in 2009 and 26% in 2001.
- 45% of pupils said they had drunk alcohol at least once compared with 51% in 2009 and 61% in 2003.
- Pupils who drank in the last week consumed an average of 12.9 units
- The overall volume of alcoholic drinks purchased for consumption outside the home has decreased by 44% from 733 millilitres (ml) of alcohol per person per week in 2001/02 to 413 ml per person per week in 2010. This reduction is mainly due to a 52% decrease in the volume of beer purchases from 623 ml to 299 ml per person per week over the same period.

Knowledge and attitudes to alcohol

- There has been a fall in recent years in the proportion of pupils who think that drinking is acceptable for someone of their age. In 2010 32% thought it was okay for someone of their age to drink once a week compared to 46% in 2003. Similarly 11% of pupils thought that it was OK for someone of their age to get drunk once a week compared to 20% who thought that in 2003

Drinking related costs, ill health and mortality

In England:

Estimates of the number of alcohol-related admissions to hospital are calculated using a method developed by the North West Public Health Observatory (NWPHO) which takes

information on patients' characteristics and diagnoses from the Hospital Episode Statistics (HES) www.hesonline.nhs.uk, together with estimates for the proportion of cases of a particular disease or injury that are caused by alcohol consumption (known as alcohol-attributable fractions (AAFs)). Within this publication, two main measures are presented:

- a broad measure, which 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); and
- a narrow measure, which is constructed in a similar way but counts only the fraction associated with the diagnosis in the primary position.

The attributable fractions represent the likelihood that the condition is the result of alcohol consumption, rather than the likelihood that the admission is the result of alcohol consumption. The figures based on all diagnoses give an 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. Information based only on primary diagnoses allow an uncomplicated picture of trends in alcohol-related admissions over time although will provide an incomplete picture of admissions resulting from or affected by alcohol consumption (as in some cases, the secondary diagnoses will have contributed to the admission to hospital).

This method is currently subject to a public consultation, led by the NWPFO working with the Department of Health and the Health and Social Care Information Centre. The consultation was launched on 31 May 2012, and will run for 12 weeks. Full details can be found on the NWPFO website: www.lape.org.uk

- In 2010/11 there were 198,900 admissions where the primary diagnosis was attributable to the consumption of alcohol (the narrow measure). This is a 2.1% increase since 2009/10 when there were 194,800 admissions of this type and a 40% increase since 2002/03 when there were around 142,000 such admissions.
- Of these 76% (150,900) were due to conditions which were categorised as chronic, 1% (1,200) were for conditions categorised as acute and 24% (46,800) were for mental and behavioural disorders due to alcohol.
- Overall in 2010/11 more males than females were admitted to hospital with a primary diagnosis of a condition attributable to alcohol (120,000 and 78,800 admissions respectively).
- In 2010/11, there were 813,600 hospital admissions with a primary diagnosis of a disease that can be caused by alcohol consumption. Overall, 198,900 (24%) of these were estimated to be attributable to alcohol consumption. This accounts for 1.3% of all hospital admissions.
- 5.8% (54,400) of all admissions with a primary diagnosis of circulatory disease and 2.3% (36,500) of all admissions with a primary diagnosis of cancer were attributable to alcohol consumption. In addition, 1.7% (29,800) of admissions with a primary diagnosis of diseases of the digestive system were estimated to be alcohol related.
- In 2010/11, there were 1,168,300 alcohol related admissions to hospital based on the broad measure (primary and secondary diagnoses). This is an increase of 11% on the 2009/10 figure (1,056,900) and more than twice as many as in 2002/03 (510,700). Comparisons over time in the broad measure are complicated by changes in recording practices over the period. In order to estimate the trend once changes in recording practices are accounted for, a method to adjust the national figures has been devised which is presented in Appendix G. Adjusted figures show a 49% increase from an estimated 783,300 in 2002/03 but a 3% decrease from 1,208,100 in 2009/10.

- The age and sex standardised number of alcohol related admissions based on primary and secondary diagnoses per 100,000 population varied among Strategic Health Authorities (SHAs). The rate varied from 2,597 and 2,425 admissions per 100,000 population in North East SHA and North West SHA respectively, to 1,335 admissions per 100,000 population in South Central SHA.
- In 2011, there were 167,764 prescription items for drugs for the treatment of alcohol dependency prescribed in primary care settings or NHS hospitals and dispensed in the community. This is an increase of 4.7% on the 2010 figure (160,181) and an increase of 63% on the 2003 figure (102,741).
- The Net Ingredient Cost (NIC) of these prescription items was £2.49 million in 2011. This is an increase of 3.3% on the 2010 figure (£2.41 million) and an increase of 45% on the 2003 figure (£1.72 million).
- In 2011 302 prescription items per 100,000 population were dispensed for alcohol dependency. Among SHAs the North West SHA had the highest number of prescription items per 100,000 population (517) and London SHA had the lowest (138)
- In 2010, there were 6,669 deaths directly related to alcohol. This is a 1.3% increase on the 2009 figure (6,584) and a 22% increase on the 2001 figure (5,476). Of these alcohol related deaths, 64% (4,275) died from alcoholic liver disease.
- In 2008 it was estimated that the cost of alcohol related harm to the NHS in England was £2.7 billion in 2006/07 prices.

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 for drinking prevalence among adults is the General Lifestyle Survey (GLF), formerly known as the General Household Survey (GHS) and published by the Office for National Statistics (ONS). This is a national survey covering adults aged 16 and over living in private households in Great Britain. The latest GLF report *Smoking and drinking among adults, 2010*¹ is based on the survey which ran from January to December 2010. A wide range of topics are covered in the GLF to provide a comprehensive picture of how we live and the social change we experience. Each year there are questions on alcohol consumption and drinking habits in the week prior to interview and in some years there are questions on average alcohol consumption in a typical week during the last 12 months.

Following consultation with users, the ONS has decided that the GLF will not continue in its current format after January 2012. Full details are available from the ONS website in the 'Response to the future of the GLF survey consultation' document:

<http://www.ons.gov.uk/ons/about-ons/consultations/closed-consultations/2011/the-future-of-the-glf-survey/index.html>

Questions on drinking (except average weekly alcohol consumption) will instead be included in the new ONS Opinions and Lifestyles Survey. Average weekly alcohol consumption will be included in the Health Survey for England for 2011 and 2012. Further information on the consultation and an assessment of the possible impact the change in data source may have, can also be found on the ONS consultation page.

Data on adults' drinking behaviour and knowledge is collected as part of the ONS Omnibus Survey. The Omnibus Survey provides information on the types of alcohol consumed and weekly consumption for adults. The Omnibus Survey is currently discontinued so information from the last publication, *Drinking: Adults' behaviour and knowledge in 2009*² continues to be included in this chapter.

Data on purchased quantities of alcohol are taken from the Living Costs and Food Survey (LCFS)³ (formally known as the Expenditure and Food Survey (EFS)). The LCFS is commissioned by ONS and the Department for Environment, Food and Rural Affairs (DEFRA), and is a continuous household survey that provides data on weekly expenditure on and purchase quantities of alcoholic drinks consumed both within and outside the home. In 2008, the LCFS became part of the Integrated Household Survey (IHS), with DEFRA having responsibility for the Family Food Module of the LCFS.

Data on alcohol price and retail price indices are taken from the ONS publication *Focus on Consumer Price Indices*⁴, while households' disposable income data are taken from the ONS publication *Household sector: Secondary Distribution of Income Account*⁵.

For the first time this year international comparisons are included in the report. Data on international alcohol consumption is taken from the *Health at a Glance 2011*⁶ published by the Organisation for Economic Co-operation and Development (OECD) in 2011.

The *Smoking drinking and drug use among young people in England in 2010*⁷ (SDD10) report published by the Health and Social Care Information Centre (HSCIC) is the main source of data for drinking prevalence among children. This report contains results from an annual survey of secondary school pupils in years 7 to 11 (mostly aged 11 to 15). Overall 7,296 pupils from 246 schools in England completed questionnaires in the autumn term of 2010.

This year information on drinking prevalence among young people, by Government Office Region (GOR) is taken from *Smoking, drinking and drug use among young people in England: Findings by region 2006-2008*⁸ published by the HSCIC. Data from the SDD surveys from 2006 to 2008 were combined to produce for the first time drinking prevalence estimates at GOR level.

In 2010 the design of the SDD sample changed from that used in previous years. In 2010, the sample was stratified by Strategic Health Authority (SHA); within each SHA an equal number of schools were sampled. This new methodology is intended to enable more up-to-date analyses by region than was possible with the previous sample design.

The change in sampling methodology was designed to produce results comparable with previous years' surveys. In 2010, some key survey estimates, while continuing established trends, showed greater than expected change from 2009 (for example, estimates of the prevalence of drinking alcohol). Detailed analysis was undertaken to assess whether these were due in part or whole to the change in sampling methodology, the application of weights or the school response rate (which was 6 percentage points lower in

2010, than in 2009). The analysis did not find any evidence to suggest that they were (see [Appendix B](#) of the report). Future data will be needed to establish how the results from 2010 fit into longer term trends. For further details of the sample design, see [Appendix A](#) of the report.

2.1.1 Updated methodology for converting volumes drunk to units

Estimates of alcohol consumption in surveys are given in standard units derived from assumptions about the alcohol content of different types of drink, combined with information from the respondent about the volume drunk. From 2006 the GLF (then GHS), and from 2007 the Omnibus survey, introduced an improved method of converting volumes of alcohol drunk into alcohol units. This was due to new types of alcoholic drinks being introduced, the increase in the alcohol content of some drinks and the fact that alcoholic drinks are now sold in more variable quantities than before.

In the GLF 2008, a further revision in methodology was introduced for calculating the units of alcohol for wine. Respondents were asked whether they had consumed small (125 ml), standard (175 ml) or large (250 ml) glasses of wine. It is assumed that a small glass contains 1.5 units of alcohol; a standard glass contains 2 units and a large glass 3 units. This is different from 2006 and 2007 when it was assumed that all respondents drank from an average size (170 ml) glass containing 2 units. In the GLF, the updated method made little difference overall, but has slightly reduced the proportion of women exceeding 3 units on their heaviest drinking day in the week before interview. Further details of the updates in methodology are supplied in [Appendix A](#).

2.1.2 Drinking guidelines

Drinking guidelines and indicators used to measure consumption are described in [Appendix B](#) and used throughout this chapter.

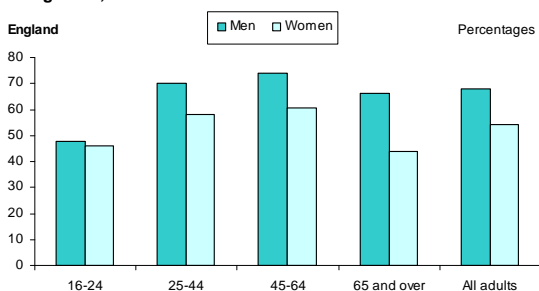
2.2 Alcohol consumption

2.2.1 Drinking in the last week

Respondents to the GLF were asked questions about their drinking in the week prior to interview. In England, in 2010, 68% of men and 54% of women (aged 16 and over) reported drinking an alcoholic drink on at least one day in the week prior to interview. Men were more likely to drink on more days of the week than women, with 17% reporting drinking on five or more days compared with 10% of women. Similarly, men were more likely than women to have drunk alcohol every day during the previous week (9% compared with 5%).

[Figure 2.1](#) shows how the proportion of adults who reported drinking in the last week varied by age. Those in the youngest and oldest age groups (16 to 24 and 65 and over) were less likely than those in the other age groups (25 to 44 and 45 to 64) to report drinking during the previous week. Less than half (44%) of women aged 65 and over reported drinking alcohol during the previous week, compared with 66% of men in this age group.

Figure 2.1 Proportion of adults who drank in the last week, by age and gender, 2010

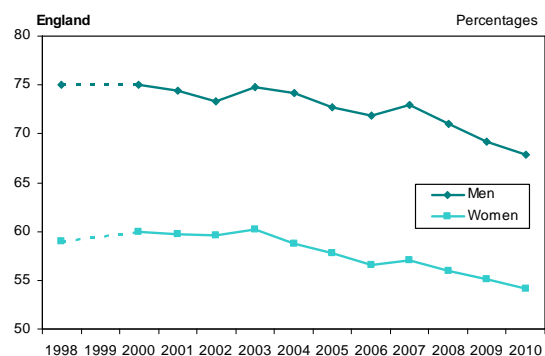


Source: General Lifestyles Survey 2010, Office for National Statistics (ONS)
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Those aged 65 and over were more likely than any other age group to have drunk on every day of the previous week; for example, 17% of men and 10% of women aged 65 and over had drunk every day during the previous week, compared to 2% of men and less than one percent of women aged 16 to 24 ([Table 2.1](#)).

There has been a long-term downward trend in the proportion of adults who reported drinking in the week prior to interview. In 1998, 75% of men and 59% of women drank in the week prior to interview compared to 68% and 54% respectively in 2010. Similarly, the proportion of adults drinking on 5 or more days in the previous week has also decreased since 1998; in 1998 24% of men drank on 5 or more days in the previous weeks, compared to 17% in 2010, the equivalent figures for women were 13% and 10% respectively ([Table 2.2](#) and [Figure 2.2](#)).

Figure 2.2 Proportion of adults who drank in the last week, by gender, 2000 to 2010



Data for 1999 is unavailable therefore the trend line shown for this year is an estimate only.

Source: General Lifestyles Survey 2010, Office for National Statistics (ONS)
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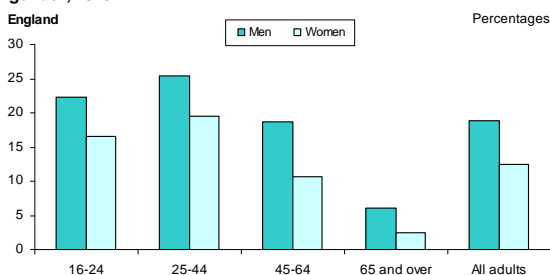
2.2.2 Heaviest drinking day in the last week

In 2010, the proportion of adults who reported drinking more than 4/3 units (men who drank more than 4 units and women who drank more than 3 units) on at least one day during the week prior to interview was higher for men (35%) than it was for women (28%). Those aged 65 and over were less likely than respondents in the other age groups to exceed 4/3 units on at least one day in the

last week (21% of men and 11% of women).

Men were also more likely than women to report drinking more than 8/6 units (men who drank more than 8 units and women who drank more than 6 units) on at least one day in the week prior to interview (19% and 12% respectively). The proportion of adults reporting drinking over 8/6 units on at least one day in the previous week was greatest among the 25-44 age group among men (25%) and women (20%). This is compared with 6% of men and 2% of women aged 65 and over. There has been a pronounced change in women aged 16 to 24 drinking over 6 units on at least one day in the previous week, decreasing from 24% in 2009 to 17% in 2010. This fall should be treated with caution due to the small sample size for this age group (Table 2.2 and Figure 2.3).

Figure 2.3 Adults whose maximum daily amount of alcohol in the last week was more than 8 units (men) or 6 units (women), by age and gender, 2010



Source: General Lifestyle Survey 2010, Office for National Statistics (ONS)
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Respondents who said they drunk alcohol in the week prior to interview in the 2010 GLF were asked on what day of the week they had drunk the most. Saturday was reported to be the heaviest drinking day among adults (29%), followed by Sunday (23%) and then Friday (14%) (Table 2.3).

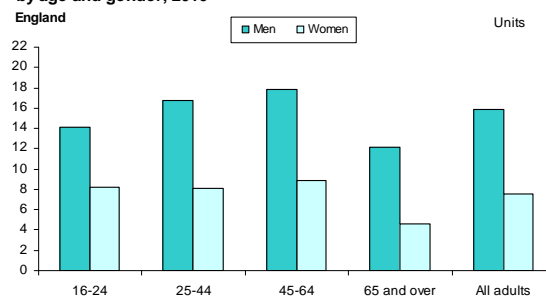
2.2.3 Average weekly consumption

In 2010, respondents to the GLF were asked questions about the different types of alcoholic drinks they had consumed and the usual amount and frequency of consumption for each type of drink over the last 12 months. From this information

average weekly alcohol consumption for all adults was derived.

Table 2.4 shows that the average weekly consumption of alcohol over the 12 months prior to interview was recorded at 15.9 units for men and 7.6 units for women. When looking at the variation between age groups, the average weekly consumption of alcohol over the 12 months prior to interview among men ranged from 12.2 units for those aged 65 and over to 17.9 units for those aged 45 to 64. For women, the number of units ranged from an average of 8.9 units for those aged 45 to 64 to an average of 4.7 units a week for those aged 65 and over (Figure 2.4).

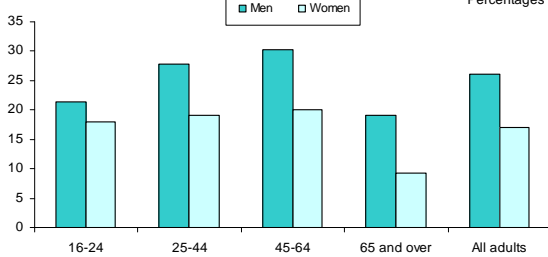
Figure 2.4 Average weekly units of alcohol consumed by adults, by age and gender, 2010



Source: General Lifestyle Survey 2010, Office for National Statistics
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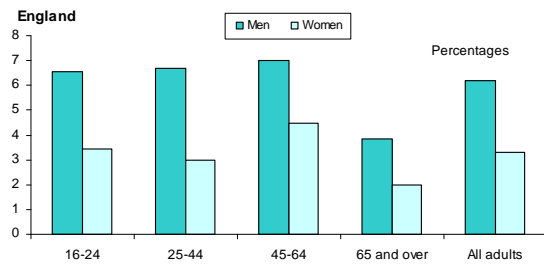
In 2010, 26% of men reported drinking over 21 units in an average week and 17% of women reported that their average weekly consumption was over 14 units. The proportion of people reporting drinking more than 21/14 units (men who drank more than 21 units and women who drank more than 14 units) in a week was lower in the oldest age group for both men and women (19% of men and 9% of women aged 65 and over) (Table 2.4 and Figure 2.5).

Figure 2.5 Adults whose average weekly alcohol consumption was more than 21 units (men) or more than 14 units (women), by age and gender, 2010
England



Source: General Lifestyle Survey 2010, Office for National Statistics (ONS)
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Figure 2.6 Adults whose average weekly alcohol consumption was more than 50 units (men) or more than 35 units (women), by age and gender, 2010
England



Source: General Lifestyle Survey 2010, Office for National Statistics (ONS)
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For men who usually drink in excess of over 21 units per week, around three quarters (74%) reported consuming more than 4 units on at least one day in the last week and just under half (45%) reported drinking more than 8 units on at least one day in the week prior to interview, showing that men who drank more than 21 units a week tended to have higher daily consumption.

For women a similar pattern exists. Those whose average consumption exceeded 14 units a week were more likely to exceed 3 units on at least one day in the previous week with three quarters (77%) reporting drinking over 3 units and 42% drinking more than 6 units on at least one day in the previous week (Table 2.6).

The 2010 GLF also reports on men who drank over 50 units in an average week and women who drank over 35 units in an average week. In England, in 2010, 6% of men reported drinking over 50 units a week on average and 3% of women reported drinking over 35 units in an average week.

Men aged 65 and over were less likely to drink over 50 units than any other age group. There was little variation between any other age groups. Women in the 65 and over age group were also the least likely to drink over 35 units in a week (2%). Again there was little variation between the other age groups (Table 2.4 and Figure 2.6).

2.3 Purchases, availability and affordability of alcohol

2.3.1 Purchases

Purchases of alcoholic drinks bought for consumption within the home in the UK, as reported by the LCFS (named EFS prior to 2008), have increased overall since 1992 from 527 ml per person per week, peaking in 2003/04 at 792 millilitres (ml) per person per week with figures fluctuating since. In 2010 this figure was 762 ml per person per week, a 45% increase since 1992. Purchases of cider and perry and wine showed the largest increase between 1992 and 2010 compared to other types of drink. Consumption of cider and perry has increased by 69% from 47 ml per person per week to 79 ml and wine consumption has increased by 66% from 152 ml to 252 ml. It should be noted that alcopops didn't really exist pre 1997.

The overall volume of alcoholic drinks purchased for consumption outside the home has decreased by 44% from 733 ml per person per week in 2001/02 to 413 ml per person per week in 2010. This reduction is mainly due to a 52% decrease in the volume of beer purchases from 623 ml to 299 ml per person per week over the same period (Table 2.7).

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). Although this data is not presented in this report it is available at;

<https://www.uktradeinfo.com/Statistics/Pages/TaxAndDutyBulletins.aspx>

2.3.3 Affordability

The 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), 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).

Since the publication of *Statistics on Alcohol: England 2010*, the HSCIC has worked with key customers to investigate the scope for making methodological improvements to the way the affordability of alcohol index is derived. The Institute of Alcohol Studies (IAS) produced a research paper⁹ proposing a number of adjustments to the affordability index produced by the HSCIC. One of these proposed adjustments was implemented in the *Statistics on Alcohol: England, 2011*¹⁰ report and as a result, the revised Real Households' Disposable Income (RHDI) index now tracks, exclusively, changes in real disposable income **per capita**. Previously, the RHDI index tracked changes in the total disposable income of all households and was not a per capita basis. This had the implication that changes in the RHDI index over time were, in part, due to changes in the size of the population and not exclusively due to changes in real disposable income per capita. The RHDI index feeds into the affordability of alcohol index, and so this was also affected.

The adjustment was carried out using ONS mid-year population estimates of the adult population aged 18 and over, and was applied to all years in the index (1980 onwards). The adjusted RHDI index was then carried forward to produce an adjusted affordability of alcohol index. For further information on the methodology see [Appendix A](#).

The unadjusted RHDI index and the unadjusted affordability of alcohol index (as used in *Statistics on Alcohol: England 2010* and prior publications) are presented alongside the revised indices for comparability purposes in the *Statistics on Alcohol: England 2011*¹⁰ report ([Table 2.8](#) and [Figure 2.6](#)).

Further views on the affordability measure, in particular to the revision made in 2011 and the further proposed amendments contained within the IAS research paper, were sought during the Lifestyles Compendia Publications public consultation in 2011:

http://www.ic.nhs.uk/webfiles/Work%20with%20us/consultations/Lifestyles_Statistics_Compedia_Publications_Consultation_Review_Outcome.pdf

The RHDI index used to construct the affordability of alcohol index, even though now adjusted in the way described earlier, is still subject to some debate in relation to other matters as described in the IAS paper. The source of the RHDI index is an ONS series known as *Economic Trends (Code NRJR)*. NRJR is closely related to a separate National Accounts ONS series known as *Gross Disposable Income (Code QWND)* which relates to all households in the UK and is defined in detail by ONS in *UK National Accounts Concepts, Sources and Methods*, <http://www.ons.gov.uk/ons/rel/naa1-rd/national-accounts-concepts--sources-and-methods/1998-release/index.html>

Whereas QWND is presented in current prices (i.e. values appropriate to the year for which they are presented), NRJR is adjusted for inflation, hence the 'Real' in 'Real households' disposable income'.

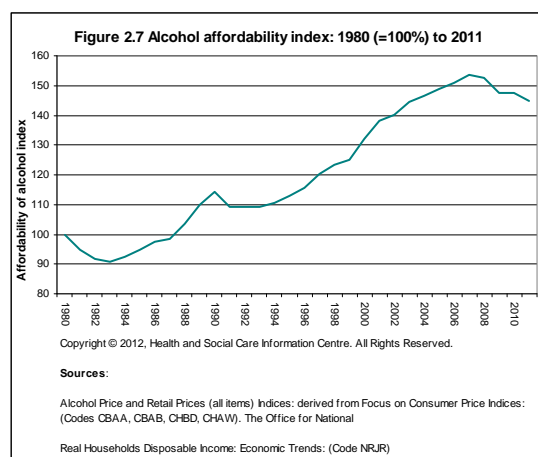
The concerns raised related to the detailed treatment of owner-occupier mortgage interest payments and imputed rent. Both are still being considered.

All responses received were in favour of the adjustment made in the 2011 report to calculate on a per capita basis. We intend to continue performing this adjustment going forwards. Further work will be necessary in the future to consider the further amendments to the index, including investigating whether an alternative source of data is more appropriate to measure disposable income, or whether to apply the adjustments proposed by IAS to the existing measure. From initial discussions with ONS it appears the adjustments would be beneficial or an alternative source of data on household disposable income could be used which may not have the limitations of the existing RHDI index. We will aim to examine this in the future, subject to resources, meantime like last year, the methodology underpinning the affordability index is an interim measure that may be refined if deemed necessary upon completion of further enquiry. (See [Appendix C](#) for further details of the responses received via the public user consultation).

Based on this interim measure, in the UK, prices of alcoholic drinks, as measured by the alcohol price index, have increased more than the retail price index since 1980 (an arbitrarily chosen base year). Between 1980 and 2011 the price of alcohol increased by 24% more than the retail prices generally. However, real households' disposable income per adult (adjusted) increased by 79% over the same period. Using the most recently available data, alcohol in 2011 was 45% more affordable than it was in 1980, highlighting the overall trend of increasing affordability over the period ([Table 2.8](#) and [Figure 2.7](#)).

This alcohol price index used in the affordability index relates to a 'basket of alcoholic drinks' chosen by the ONS. It therefore 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.



2.4 Types of alcohol consumed

The 2009 Omnibus Survey, *Drinking: Adults' behaviour and knowledge in 2009*² reports on the average weekly alcohol consumption in Great Britain, by recording how many pints, glasses, measures or bottles/cans of different types of alcoholic drink the respondent would usually consume on any one day in the past 12 months and how often each type of drink is usually consumed. From this information average weekly alcohol consumption is broken down into the number of units consumed by alcohol type.

There were marked differences in the drink preferences of men and women. Compared with men, women were proportionately less likely to drink beers and more likely to drink wine, fortified wine, spirits and alcopops. In terms of amounts drunk, even though women drink much less than men overall, they drank more units of wine (5.4 units for women and 4.0 units for men). Women's beer consumption was much lower than men's

(an average of 1.9 units compared with 9.3 units).

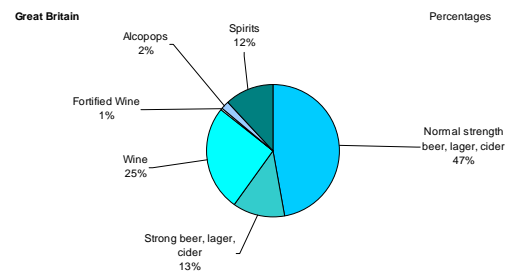
Beers were the most popular drink among men of all ages, but decline with increasing age as a proportion of total alcohol consumed, from 68% of the alcohol consumed by those aged under 25 to 43% of that consumed by those age 65 and over. Most of this variation is contributed by strong beer, lager and cider, which accounted for 23% of the units consumed by young men aged 16 to 24 but only 8% of alcohol drunk by men aged 65 and over.

The amount of spirits as a proportion of men's total consumption was highest among those aged 16 to 24 (19%) and 65 and over (18%). The amount of wine as a proportion of total consumption was highest among men aged 45 and over (32% of 45 to 64 year olds and 35% of those aged 65 and over).

The pattern of women's drinking in relation to age was slightly different to that of men. Among women aged 16 to 24, spirits were the most popular type of drink, followed by wine. Among older women, wine was by far the most popular alcoholic drink in women aged 45 to 64; wine accounted for 70% of average weekly alcohol consumption. The amount of fortified wine as a proportion of women's total consumption was highest (9%) among those aged 65 and over.

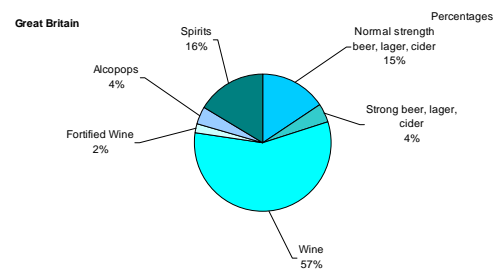
The consumption of alcopops showed the opposite association with age, accounting for a greater proportion of young people's alcohol consumption compared with that of older people: alcopops accounted for 16% of the alcohol consumption of women aged 16 to 24 compared with less than half a per cent for those aged 65 and over (Table 2.9, Figures 2.8 and 2.9).

Figure 2.8 Proportion of average weekly units accounted for by each type of drink among men, 2009



Source: Drinking: Adults' behaviour and knowledge in 2009, Office for National Statistics (ONS)
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Figure 2.9 Proportion of average weekly units accounted for by each type of drink among women, 2009



Source: Drinking: Adults' behaviour and knowledge in 2009, Office for National Statistics (ONS)
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2.5 Alcohol consumption and socio-economic variables

2.5.1 Socio-economic classification

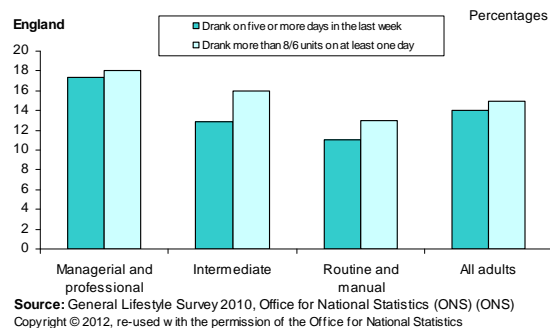
The GLF collects and reports on a variety of socio-economic variables and drinking behaviours are reported against a number of these.

Households in England where the household reference person was classified as managerial or professional had the highest proportions for both men and women who had an alcoholic drink in the last seven days (76% and 65% respectively), while men and women in routine and manual households had the lowest (61% and 45% respectively). There was a similar pattern in the proportions drinking on five or more days in the previous week. For example, 17% of adults in managerial and professional households had an alcoholic drink on five or more days in the past week compared

to 11% of adults in routine and manual households.

Overall the proportion of adults exceeding 4/3 units on at least one day in the last week was greater in managerial and professional households (37%) than in routine and manual households (26%) and the proportion exceeding 8/6 units was also greater in managerial and professional households (18%) than in routine and manual households (13%) (Table 2.10 and Figure 2.10).

Figure 2.10 Adults drinking in the last week by socio-economic classification, 2010



2.5.2 Economic activity status

Table 2.11 shows information on drinking among adults of working age (men aged 16 to 64 and women aged 16 to 59). Among men, those in employment were most likely to have drunk alcohol during the previous week – 73% had done so compared to 49% who were unemployed and 53% who were economically inactive. Working men were more likely than economically inactive men to have drunk more than 4 units on any one day in the last week - 42%, compared with 28%. Working men were also more likely to have drunk more than 8 units on one day – 25% compared with 14% for economically inactive men. Lower levels of drinking among economically inactive men are probably due in part to the large proportion of men in this group who are aged 60 to 64.

Among women, 64% of those who were working, 45% of those who were unemployed, and 41% of those who were economically inactive had drunk alcohol in

the previous week. Working women were more likely than the economically inactive to have drunk more than 3 units on one day – 38% compared with 24%. Working women were also more likely than economically inactive women to have drunk more than 6 units on one day – 19% compared with 10% (Table 2.11).

2.5.3 Household income

Table 2.12 presents information on drinking among adults by gross weekly household income. As the level of income increases, the proportion of men and women who drank alcohol in the previous week and drank more than 4/3 units on any one day also increases.

In households with a gross weekly income over £1,000, 79% of men and 70% of women reported drinking in the previous week, and 48% of men and 42% of women reported drinking over 4/3 units on at least one day. In households with a gross weekly income of £200 or less, only 57% of men 39% of women reported drinking in the previous week and only 28% of men and 16% of women reported drinking more than 4/3 units on their heaviest drinking day.

The proportion of adults who drank more than 8/6 units on at least one day in the previous week in households with a gross weekly income over £1,000 was nearly three times that of households with a gross weekly income of £200 or less (25% and 9% respectively).

2.6 Alcohol consumption and demographic characteristics

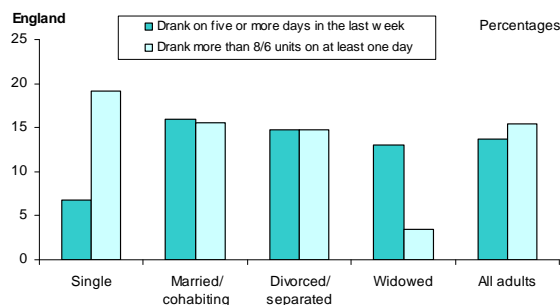
2.6.1 Drinking and marital status

Examining drinking by marital status showed that married people (including those cohabiting) were more likely to have drunk in the week prior to interview (66%)

compared to those who are single, divorced/separated or widowed (52%, 57% and 43% respectively).

Married/cohabiting men and women were also the most likely to report drinking on five or more days in the previous week (16%) whilst single adults were the least likely (7%) (Table 2.13 and Figure 2.11).

Figure 2.11 Adults drinking alcohol in the last week by marital status, 2010



Source: General Lifestyle Survey 2010, Office for National Statistics (ONS) Copyright © 2012, re-used with the permission of the Office for National Statistics

The proportion of single people and married or cohabiting people drinking more than 4/3 units a day was the same at 33%. In contrast however, a greater proportion of single people than married or cohabiting people reported drinking more than 8/6 units; 19% of single adults compared with 16% of married or cohabiting adults; widowed adults were the least likely to report drinking more than 8/6 units on their heaviest drinking day (4%) (Table 2.13).

2.6.2 Drinking and ethnicity

Information on ethnicity is not included within the GLF 2010 report. However, the *Statistics on Alcohol: England 2007*¹¹ publication included some information which combined data from the GHS 2001 to 2005 for Great Britain in order to facilitate analysis by ethnic group. This analysis found that respondents from Pakistani or Bangladeshi origin in Britain were less likely to have drunk in the week prior to interview (5% and 4% respectively) compared to those recording their ethnicity as White British or White Other (68% and 67% respectively).

Model-based estimates produced by the HSCIC showing prevalence of drinking among ethnic groups at a sub national level between 2003 and 2005 are available from the Neighbourhood Statistics website¹².

2.6.3 Drinking and pregnancy

Information on drinking during pregnancy is collected as part of the Infant Feeding Survey (IFS), the latest survey being *Infant Feeding Survey 2005*¹³. 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.

Key findings from the IFS show that in 2005 in the United Kingdom (UK), of the women who drank before pregnancy, 34% gave up while they were pregnant and 61% said they drank less during their pregnancy while 4% reported no change to their drinking patterns.

The percentage of all mothers in the UK who drank during pregnancy, decreased from 61% in 2000 to 54% in 2005. Based on those mothers who drank before pregnancy, there has been an increase in the percentage of mothers who gave up drinking while they were pregnant, from 30% in 2000 to 34% in 2005.

Further details are provided within Chapter 10 of the IFS 2005 report. The *Infant Feeding Survey 2010* report is provisionally due for publication by the HSCIC in September 2012.

2.7 Geographic patterns of alcohol consumption

2.7.1 International Comparisons

In 2011 the Organisation for Economic Co-operation and Development (OECD) published *Health at a Glance 2011*⁶ which

includes data on alcohol consumption among adults across different countries.

Figure 2.2.1 on page 53 of the OECD report shows alcohol consumption for the population aged 15 and over in 2009 (or the nearest year) and change between 1980 and 2009. Average alcohol consumption, as measured by annual sales stood at 9.1 litres per adult across OECD countries in 2009. Alcohol consumption in the United Kingdom was higher than the average at 10.2 litres. France, Austria, Portugal, the Czech Republic and Estonia reported the highest consumption of alcohol, with 12.0 litres or more per adult per year in 2009. Low alcohol consumption was recorded in Indonesia, India, Turkey and Israel where religious and cultural traditions restrict the use of alcohol among some population groups, as well as in China, Mexico and some of the Nordic countries (Norway, Iceland and Sweden).

Average alcohol consumption has gradually fallen in many OECD countries between 1980 and 2009 with an average overall decrease of 9%. The United Kingdom however, has seen an increase of 9% over these three decades.

2.7.2 National comparisons of alcohol consumption

The GLF survey can be used to compare drinking patterns between England, Scotland and Wales. Findings from the GLF show that in 2010 adults in England and Wales were more likely to have drunk alcohol on at least 5 days in the week prior to interview than adults living in Scotland (14% for England, 13% for Wales compared with 8% for Scotland).

Adults in Scotland were however more likely to consume at least 4/3 units on their heaviest drinking day (35%) compared to England (31%) or Wales (32%). They were also more likely to consume more than 8/6 units on at least one day (18% in Scotland compared to

16% in Wales and 15% in England) (Tables 2.14 and 2.15).

Further information on alcohol consumption at a national level is available. Scotland, Wales and Northern Ireland carry out their own health surveys. *A profile of alcohol and health in Wales*¹⁴ has been produced by the Public Health Wales Observatory in 2009. This document contains information taken from several data sources and includes statistics on subjects including underage drinking, alcohol-related deaths, drinking during pregnancy, binge drinking and hospital admissions related to alcohol. The Scottish Government produce the biennial publication *Alcohol Statistics: Scotland*¹⁵ which contains statistics on the Alcohol Market, Alcohol Consumption, Alcohol Health and Social Harm. Northern Ireland produces statistics on Alcohol-related deaths and alcohol-related illnesses. Details of the methodologies used by each country are contained within the publications. These will need to be considered when attempting comparisons.

2.7.3 Alcohol consumption by region

Looking at the English Government Office Regions (GORs), adults were most likely to exceed 4/3 units on their heaviest drinking day in the North West (38%), South East (35%) and the Yorkshire and Humber (34%). The lowest proportions exceeding 4/3 units were in the West Midlands, (24%), London (28%) and East Midlands (29%). GORs where adults drank more than 8/6 units in their heaviest drinking day where highest in the North West (20%) and Yorkshire and the Humber (18%). The lowest was seen in the West Midlands and East Midlands (12% for both) (Table 2.15).

When looking at drinking in the week prior to interview, adults in London had the lowest prevalence (53%) followed by the West Midlands (56%). All the other GORs were broadly similar to each other (Table 2.14).

2.7.4 Alcohol consumption and sub-regional comparisons

While survey estimates can provide information on regional variation, it is not possible to look at a smaller geographical level due to small sample sizes. To address this information gap, the National Centre for Social Research was commissioned by the HSCIC, to test and produce model-based estimates for a range of healthy lifestyle behaviours. Estimates based on 2003-05 data at Local Authority (LA), Medium Super Output Area and at a Primary Care Organisational level are available from the HSCIC¹¹, and includes estimates of drinking more than 8/6 units. These statistics have been classified as 'Experimental Statistics'. Results for the whole range of healthy lifestyle behaviours considered are published on the ONS Neighbourhood Statistics website¹⁶. Other models are available that predict the prevalence of drinking more than 8/6 units at a smaller geographical level.

Almost one in four LAs were estimated to have significantly higher proportions of adults drinking more than 8/6 units on at least one day in the previous week than England as a whole. These were highly concentrated in the North with 98% of these LAs located in three GORs; North East, North West and Yorkshire and the Humber. LAs who were estimated to have a significantly lower rate than the national estimate, (approximately 3 in 10 in England) were only found within four GORs; East of England, London, South East and South West.

2.8 Drinking among children

The Smoking, drinking and drug use among young people in England in 2010⁷ (SDD10) report contains information on drinking in children aged 11 to 15 in secondary schools in England. The key findings are:

- In 2010, 45% of pupils said that they had drunk alcohol at least once. This continues the downward trend since 2003 when 61% of pupils had drunk alcohol and is markedly lower than the equivalent proportion in 2009, which was 51%.
- Boys and girls were equally likely to have drunk alcohol. The proportion who had done so increased with age from 10% of 11 years olds to 77% of 15 year olds.
- In 2010 13% of pupils had drunk alcohol in the last week, similar proportions for boys and girls. As with all drinking, this continues a decline from 26% in 2001, and is significantly lower than in 2009, when 18% of pupils reported drinking in the last week.
- Pupils aged 11 to 15 who drank in the last week drank a mean amount of 12.9 units and a median amount of 8.5 units.
- Thirty six per cent of pupils said they had obtained alcohol in the last four weeks, most commonly being given it by friends (23%) or parents (20%) or by asking someone else to buy it (15%)
- About half (48%) of pupils who drank alcohol said they bought it. This was usually from friends or relatives (26% of pupils who drank alcohol), someone else (16%), off licences (16%) or shops and supermarkets (12%). The proportion of pupils who bought alcohol from other people has increased since 1996, at the same time as the proportion who bought it from retail outlets has fallen.
- Pupils were most likely to drink alcohol in their own homes (49%), at parties with friends (44%), in someone else's home (43%) or on the street, in a park or somewhere else outside (25%). Younger pupils who drank alcohol were more likely to drink at home than anywhere else, but older pupils were increasingly likely to drink away from home.
- Pupils were most likely to drink with friends of both sexes (59% of current drinkers), their parents (50%) or

friends of the same sex (39%). Younger pupils were most likely to drink with family members, older pupils or with friends.

- About half (54%) of pupils who had drunk alcohol in the last four weeks said they had been drunk at least once during that time. Although 59% said they had deliberately tried to get drunk, 41% said that they had not.
- Pupils were more likely to drink if they live with other people who drink alcohol. 83% who lived with no one else who drank alcohol had themselves never drunk, compared with 26% of pupils who lived with three or more drinkers.
- Factors associated with having drunk alcohol in the last week included age, ethnicity, other risk-taking behaviours (smoking, drug taking, truancy), the number of drinkers at home, parental attitudes and the pupils own beliefs about why their age group drinks

2.8.1 Regional comparisons of drinking among children

In 2010 the sample design of the Smoking, drinking and drug use among young people in England survey was changed so samples were stratified by Strategic Health Authority (SHA). It is anticipated this additional region analysis will be included in next years report.

This year information on drinking prevalence among young people, by Government Office Region (GOR) is taken

from *Smoking, drinking and drug use among young people in England: Findings by region 2006-2008*⁸ published by the Health and Social Care Information Centre. This report presents information on drinking among children aged 11 to 15 by Government Office Region (GOR).

The results are based on data from the 2006 to 2008 survey years, combined and weighted to be regionally representative. The key findings on drinking alcohol by GOR are:

- Young people in London were much less likely to have ever drunk alcohol than those living elsewhere. In London, 39% had ever drunk alcohol; elsewhere this proportion varied between regions from 51% in the East Midlands to 63% in the North East.
- Young people in London were also much less likely to have drunk alcohol in the last week than those living in other regions. In London 12% of 11 to 15 year olds had drunk alcohol in the last week; elsewhere the proportion varied from 19% in the East Midlands and the South East to 26% in the North East.
- The mean consumption of alcohol (units of alcohol) of those who drank in the last week also varied by region. The amount consumed was lowest in London (11.3 units) and highest in the North East (17.7 units).

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List of Tables

- 2.1 Number of drinking days in the week prior to interview, by gender and age, 2010
- 2.2 Drinking in the week prior to interview among adults, by age and gender, 1998 to 2010
- 2.3 Adults' heaviest drinking day in the week prior to interview, by age, 2010
- 2.4 Alcohol consumption (units per week) among adults, by gender and age, 2010
- 2.5 Alcohol consumption (units per week) among adults, by gender, 1992 to 2010
- 2.6 Maximum daily amount drunk last week among adults, by average weekly consumption, 2010
- 2.7 Household consumption of alcoholic drinks, 1992 to 2010
- 2.8 Indices of alcohol price, retail prices, alcohol price index relative to retail prices index (all items), real households' disposable income, and affordability of alcohol, 1980 to 2011
- 2.9 Average weekly consumption of different types of drink, by gender and age, 2009
- 2.10 Adults' drinking in the last week, by socio-economic classification and gender, 2010
- 2.11 Adults' drinking in the last week, by economic activity status and gender, 2010
- 2.12 Adults' drinking in the last week, by usual gross weekly household income and gender, 2010
- 2.13 Drinking in the last week, by marital status and gender, 2010
- 2.14 Drinking in the last week among adults by gender, country and Government Office Region, 2010
- 2.15 Maximum drunk on any one day in the last week by gender, country and Government Office Region, 2010

Table 2.1 Number of drinking days in the week prior to interview, by gender and age¹ 2010²

England	Percentages				
	All ages ¹	16-24	25-44	45-64	65 or over
Drinking days last week: All persons					
0	39	53	36	33	46
1	18	21	20	17	15
2	14	12	16	14	9
3	10	6	11	11	7
4	6	4	7	7	3
5	4	2	3	5	4
6	3	1	2	3	3
7	7	1	4	9	13
Drank on 5 or more days	14	4	10	17	20
Drank in the week prior to interview	61	47	64	67	54
Drinking days last week: Men					
0	32	52	30	26	34
1	18	20	20	17	15
2	15	12	17	16	12
3	11	6	12	13	9
4	7	4	9	8	4
5	5	2	4	7	4
6	3	2	3	3	4
7	9	2	6	11	17
Drank on 5 or more days	17	6	13	21	26
Drank in the week prior to interview	68	48	70	74	66
Drinking days last week: Women					
0	46	54	42	39	56
1	19	22	21	18	15
2	12	12	16	12	7
3	8	6	10	10	5
4	4	3	5	6	2
5	3	1	3	4	3
6	2	1	2	3	2
7	5	0	3	7	10
Drank on 5 or more days	10	3	7	14	15
Drank in the week prior to interview	54	46	58	61	44
<i>Weighted bases (000s)</i>					
<i>All persons</i>	36,860	4,324	12,551	12,017	7,968
<i>Men</i>	17,249	1,998	5,962	5,741	3,548
<i>Women</i>	19,610	2,326	6,589	6,276	4,419
<i>Unweighted bases³</i>					
<i>All persons</i>	11,260	1,000	3,170	3,950	3,140
<i>Men</i>	5,130	460	1,380	1,830	1,460
<i>Women</i>	6,130	530	1,790	2,130	1,690

1. Aged 16 and over.

2. Results for 2010 include longitudinal data (see Appendix A).

3. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

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Table 2.2 Drinking in the week prior to interview among adults¹, by age and gender, 1998 to 2010

England					Percentages
	All ages ¹	16-24	25-44	45-64	65 and over
Men					
Drank last week					
1998	75	71	79	78	65
2000	75	70	78	77	68
2001	74	71	78	76	68
2002	73	68	76	76	66
2003	75	70	77	77	69
2004	74	67	76	78	70
2005 ²	73	64	75	77	67
2006 ³	72	60	74	77	68
2007 ³	73	65	75	77	68
2008 ³	71	63	72	75	67
2009 ³	69	56	72	73	67
2010 ³	68	48	70	74	66
Drank on 5 or more days					
1998	24	14	22	30	26
2000	22	12	20	26	29
2001	22	14	20	26	27
2002	23	12	19	27	29
2003	23	15	20	27	29
2004	24	8	21	30	30
2005 ²	22	10	19	28	27
2006 ³	21	9	18	26	28
2007 ³	23	10	19	27	30
2008 ³	20	7	14	25	28
2009 ³	19	8	14	23	28
2010 ³	17	6	13	21	26
Drank more than 4 units on at least one day					
1998	39	52	47	37	16
2000	38	49	44	37	16
2001	38	49	46	35	18
2002	37	48	45	37	15
2003	40	49	47	40	19
2004	39	48	48	37	19
2005 ²	34	42	42	34	16
2006 (original method) ^{3,4}	33	38	42	33	14
2006 (improved method) ^{3,4}	40	41	48	42	21
2007 ^{3,4}	41	44	48	45	22
2008 ^{3,4}	37	43	42	41	21
2008 (updated method) ^{3,5}	38	43	42	41	21
2009 ^{3,5}	37	35	44	42	20
2010 ^{3,5}	35	32	41	39	21
Drank more than 8 units on at least one day					
1998	22	39	29	17	4
2000	21	36	26	16	5
2001	21	35	28	15	5
2002	21	35	27	17	4
2003	23	35	30	19	5
2004	23	33	31	18	6
2005 ²	18	30	25	15	4
2006 (original method) ^{3,4}	18	27	25	15	4
2006 (improved method) ^{3,4}	23	29	31	21	6
2007 ^{3,4}	25	32	31	25	8
2008 ^{3,4}	21	32	27	20	7
2008 (updated method) ^{3,5}	22	32	28	21	7
2009 ^{3,5}	20	24	27	21	5
2010 ^{3,5}	19	22	25	19	6
Weighted bases (000s)⁶					
1998	16,527	2,047	6,529	5,017	2,934
2000	17,604	2,263	6,955	5,378	3,007
2001	17,205	2,139	6,773	5,261	3,031
2002	16,783	2,103	6,185	5,346	3,149
2003	16,680	2,120	6,059	5,336	3,166
2004	16,818	2,210	6,090	5,385	3,133
2005	16,798	2,181	5,998	5,433	3,185
2006	17,182	2,242	6,191	5,503	3,246
2007	17,077	2,190	6,087	5,532	3,269
2008	16,828	2,091	5,815	5,572	3,351
2009	16,818	1,952	5,777	5,657	3,433
2010	17,280	2,013	5,954	5,742	3,542
Unweighted bases^{6,7}					
1998	5,620	600	2,070	1,810	1,140
2000	5,710	670	2,020	1,900	1,120
2001	6,130	670	2,260	1,970	1,230
2002	5,910	660	2,060	1,980	1,210
2003	7,040	810	2,490	2,240	1,490
2004	5,870	680	2,060	1,940	1,200
2005	8,650	950	2,970	2,890	1,830
2006	6,600	670	2,160	2,270	1,500
2007	6,170	640	1,890	2,150	1,480
2008	5,740	550	1,680	2,070	1,440
2009	5,240	480	1,440	1,870	1,450
2010	5,120	470	1,380	1,830	1,450

1. Aged 16 or over.

2. 2005 data includes last quarter of 2004/05 data due to survey change from financial year to calendar year.

3. Results for 2006 onwards include longitudinal data (see Appendix A).

4. The method used for calculating the number of units drunk was updated for the 2006 survey. The change is designed to take into account changes in the way drinks are served and the changing strength of drinks. Two sets of data are included in the table for 2006; one is calculated using the original method and one with the improved method of calculating units. The earlier method is presented to allow for comparisons with 2006 data to previous years, and the improved method is our best estimate of current alcohol consumption.

5. In 2008 a wine glass size question was added and used to calculate the number of units of wine consumed as an update to the improvements to unit estimation made in 2006.

6. The bases shown in this table are for the number of respondents who drank more than 4 or 8 units on at least one day. Bases for the number of respondents who drank last week and drank on five or more days can be found in table 2.1.

7. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

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Table 2.2 continued...

England	Percentages				
	All ages ¹	16-24	25-44	45-64	65 and over
Women					
Drank last week					
1998	59	62	65	62	46
2000	60	62	67	62	44
2001	60	59	67	61	46
2002	60	59	65	63	47
2003	60	61	65	64	46
2004	59	60	62	63	46
2005 ²	58	56	63	62	45
2006 ³	57	55	61	61	45
2007 ³	57	54	62	61	46
2008 ³	56	55	59	61	44
2009 ³	55	51	59	60	43
2010 ³	54	46	58	61	44
Drank on 5 or more days					
1998	13	9	12	15	14
2000	13	7	12	16	15
2001	14	8	12	18	16
2002	14	7	12	18	16
2003	14	4	11	18	18
2004	13	5	10	19	17
2005 ²	13	5	11	18	15
2006 ³	12	3	10	15	16
2007 ³	13	4	12	16	16
2008 ³	12	3	9	16	15
2009 ³	11	2	8	14	14
2010 ³	10	3	7	14	15
Drank more than 3 units on at least one day					
1998	21	42	27	16	4
2000	22	39	30	18	4
2001	22	39	30	18	5
2002	22	40	30	19	5
2003	22	38	30	19	4
2004	22	39	29	20	5
2005 ²	20	36	26	18	4
2006 (original method) ^{3,4}	20	35	26	17	4
2006 (improved method) ^{3,4}	33	39	39	35	15
2007 ^{3,4}	34	40	43	35	15
2008 ^{3,4}	32	38	38	35	13
2009 ^{3,4}					
2008 (updated method) ^{3,5}	29	37	37	32	10
2009 ^{3,5}	29	37	36	32	12
2010 ^{3,5}	28	31	35	31	11
Drank more than 6 units on at least one day					
1998	8	23	11	4	1
2000	9	26	12	5	1
2001	9	26	13	5	1
2002	9	26	13	5	1
2003	9	25	13	5	1
2004	9	24	12	6	1
2005 ²	8	21	11	4	1
2006 (original method) ^{3,4}	8	21	12	4	1
2006 (improved method) ^{3,4}	15	26	21	12	2
2007 ^{3,4}	16	25	22	13	3
2008 ^{3,4}	14	25	20	13	2
2008 (updated method) ^{3,5}	15	25	20	13	2
2009 ^{3,5}	13	24	18	11	2
2010 ^{3,5}	12	17	20	11	2
Weighted bases (000s)⁶					
1998	18,512	2,182	6,855	5,376	4,099
2000	18,955	2,248	7,020	5,655	4,032
2001	18,845	2,181	7,070	5,577	4,018
2002	19,154	2,323	6,955	5,732	4,144
2003	18,627	2,174	6,688	5,697	4,068
2004	19,097	2,432	6,815	5,897	3,952
2005	19,070	2,364	6,788	5,884	4,035
2006	19,468	2,454	6,901	5,957	4,157
2007	19,401	2,247	6,863	6,097	4,193
2008	19,301	2,270	6,686	6,091	4,255
2009	19,119	2,079	6,517	6,219	4,304
2010	19,602	2,322	6,586	6,274	4,419
Unweighted bases^{6,7}					
1998	6,660	680	2,480	2,010	1,500
2000	6,460	700	2,370	2,030	1,360
2001	7,160	780	2,660	2,170	1,540
2002	6,890	780	2,430	2,220	1,460
2003	7,960	840	2,870	2,480	1,770
2004	6,820	800	2,450	2,210	1,360
2005	9,930	1,100	3,500	3,190	2,140
2006	7,700	810	2,620	2,530	1,740
2007	7,160	670	2,380	2,410	1,690
2008	6,780	590	2,170	2,360	1,660
2009	6,190	510	1,870	2,150	1,650
2010	6,130	530	1,790	2,130	1,690

1. Aged 16 or over.

2. 2005 data includes last quarter of 2004/05 data due to survey change from financial year to calendar year.

3. Results for 2006 onwards include longitudinal data (see Appendix A).

4. The method used for calculating the number of units drunk was updated for the 2006 survey. The change is designed to take into account changes in the way drinks are served and the changing strength of drinks. Two sets of data are included in the table for 2006; one is calculated using the original method and one with the improved method of calculating units. The earlier method is presented to allow for comparisons with 2006 data to previous years, and the improved method is our best estimate of current alcohol consumption.

5. In 2008 a wine glass size question was added and used to calculate the number of units of wine consumed as an update to the improvements made in 2006.

6. The bases shown in this table are for the number of respondents who drank more than 3 or 6 units on at least one day. Bases for the number of respondents who drank last week and drank on five or more days can be found in table 2.1

7. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

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Table 2.3 Adults¹ heaviest drinking day in the week prior to interview², by age, 2010³

England	Percentages				
	All ages ¹	16-24	25-44	45-64	65 or over
Sunday	23	12	19	25	32
Monday	9	8	7	10	14
Tuesday	9	4	6	9	14
Wednesday	10	11	8	10	12
Thursday	6	6	5	8	6
Friday	14	26	17	11	6
Saturday	29	33	36	27	16
<i>Weighted bases (000s)</i>	<i>22,320</i>	<i>2,022</i>	<i>7,986</i>	<i>8,037</i>	<i>4,275</i>
<i>Unweighted bases⁴</i>	<i>6,970</i>	<i>490</i>	<i>2,020</i>	<i>2,710</i>	<i>1,750</i>

1. Aged 16 and over.

2. Data relate only to those who had an alcoholic drink in the week prior to interview.

3. Results for 2010 include longitudinal data (see Appendix A).

4. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

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Table 2.4 Alcohol consumption (units per week) among adults¹, by gender and age, 2010^{2,3}

England	Percentages / mean weekly units				
	All ages ¹	16-24	25-44	45-64	65 and over
Men					
Non-drinker	13	20	12	11	15
Under 1 unit	8	11	5	7	11
1 - 10 units	33	35	31	31	36
11 - 21 units	20	13	23	21	19
22 - 35 units	13	11	15	14	11
36 - 50 units	7	4	6	9	4
51 units and over	6	7	7	7	4
More than 21 units	26	21	28	30	19
Mean weekly units	15.9	14.1	16.7	17.9	12.2
Women					
Non-drinker	19	22	17	15	28
Under 1 unit	16	11	11	17	23
1 - 7 units	33	37	37	32	30
8 - 14 units	14	12	16	16	10
15 - 25 units	10	9	12	11	5
26 - 35 units	4	6	5	5	2
36 units and over	3	3	3	4	2
More than 14 units	17	18	19	20	9
Mean weekly units	7.6	8.2	8.1	8.9	4.7
<i>Weighted bases (000s)</i>					
<i>Men</i>	17,211	1,998	5,930	5,739	3,544
<i>Women</i>	19,563	2,303	6,586	6,255	4,419
<i>Unweighted bases⁴</i>					
<i>Men</i>	5,110	460	1,370	1,830	1,450
<i>Women</i>	6,120	530	1,790	2,120	1,690

1. Aged 16 and over.

2. Results for 2010 include longitudinal data (see Appendix A).

3. The method used for calculating the number of units drunk was updated in the 2006 survey. The change is designed to take into account changes in the way drinks are served and the changing strength of drinks. A further improvement was made in the 2008 survey by adding a wine glass size question to more accurately estimate the number of units consumed by those drinking wine.

4. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

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Table 2.5 Alcohol consumption (units per week) among adults¹, by gender, 1992 to 2010²

England	Percentages / mean weekly units														
	Unweighted				Weighted										
	1992	1994	1996	1998 ³	1998 ³	2000	2001	2002	2005	2006 ^{4,5} original method	2006 ^{4,5} improved method	2008 ^{4,6} improved method	2008 ^{4,6} updated method	2009 ^{4,6} updated method	2010 ^{4,6} updated method
Men															
Non-drinker	7	7	7	7	7	9	9	9	11	11	11	11	11	12	13
Under 1 unit	10	9	8	8	7	8	11	8	8	8	7	7	8	7	8
1 - 10 units	36	35	35	37	36	34	31	33	36	36	30	33	33	34	33
11 - 21 units	21	22	23	22	22	22	22	22	21	22	21	21	20	20	20
22 - 35 units	13	14	15	14	14	14	14	14	12	12	15	13	13	13	13
36 - 50 units	7	6	7	6	7	7	6	6	6	6	7	7	7	6	7
51 units and over	6	6	6	6	7	7	7	7	6	5	9	7	7	7	6
More than 21 units	26	27	27	27	28	28	27	27	24	23	31	28	28	26	26
Mean weekly units	15.7	15.4	16.1	16.4	17.2	17.1	16.9	17.0	15.8	14.9	18.9	16.9	16.8	16.4	15.9
Women															
Non-drinker	12	14	13	14	14	14	15	15	18	17	17	19	19	19	19
Under 1 unit	22	21	20	19	19	17	22	16	17	18	15	14	14	16	16
1 - 7 units	39	37	37	37	37	36	32	37	37	39	33	33	33	33	33
8 - 14 units	15	15	16	16	16	16	15	15	14	14	15	15	14	15	14
15 - 25 units	8	9	9	10	10	11	9	10	8	8	10	10	10	10	10
26 - 35 units	2	2	3	3	3	3	3	3	3	2	5	5	5	4	4
36 units and over	2	2	2	2	2	3	3	3	2	2	6	4	5	4	3
More than 14 units	12	13	14	15	15	17	15	17	13	13	20	19	19	18	17
Mean weekly units	5.5	5.6	6.3	6.4	6.5	7.1	7.5	7.6	6.5	6.3	9.2	8.6	8.6	8.0	7.6
<i>Weighted bases (000s)</i>															
<i>Men</i>	..	..	..	..	16,541	17,594	17,192	16,781	16,704	17,189	17,189	16,751	16,751	16,722	17,211
<i>Women</i>	..	..	..	..	18,518	18,912	18,847	19,160	19,131	19,468	19,468	19,260	19,260	19,098	19,563
<i>Unweighted bases⁷</i>															
<i>Men</i>	7,270	6,600	6,150	5,620	5,620	5,700	6,120	5,910	7,160	6,610	6,610	5,710	5,710	5,210	5,110
<i>Women</i>	8,360	7,830	7,230	6,660	6,660	6,440	7,160	6,890	8,260	7,700	7,700	6,770	6,770	6,190	6,120

1. Aged 16 and over.

2. Data not available for 2003 and 2004.

3. In 2000 the decision was made to weight the data to compensate for under-representation of people in some groups. This table shows weighted and unweighted data for 1998 to give an indication of the effect of weighting. Caution should be exercised when comparing weighted data with unweighted data.

4. Results for 2006 onwards include longitudinal data (see Appendix A).

5. The method used for calculating the number of units drunk was updated for the 2006 survey. The change is designed to take into account changes in the way drinks are served and the changing strength of drinks. Two sets of data are included in the table for 2006; one is calculated using the original method and one with the improved method of calculating units. The earlier method is presented to allow for comparisons with 2006 data to previous years, and the improved method is our best estimate of current alcohol consumption.

6. In 2008 a wine glass size question was added and used to calculate the number of units of wine consumed as an update to the improvements to unit estimation made in 2006.

7. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

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Table 2.6 Maximum daily amount drunk last week among adults¹, by average weekly consumption, 2010^{2,3}

England		Percentages				
		Average weekly consumption (Men)				
	Total ⁴	Less than 1 unit	1-10 units	11-21 units	22 or more units	
Men						
Drank nothing last week	32	86	31	7	3	
Up to 4 units	32	12	52	43	22	
More than 4, up to 8 units	16	2	11	25	29	
More than 8, up to 12 units	9	1	4	14	19	
More than 12 units	10	0	2	11	26	
More than 4 units	35	3	17	50	74	
More than 8 units	19	1	6	25	45	
		Average weekly consumption (Women)				
	Total ⁴	Less than 1 unit	1-7 units	8-14 units	15 or more units	
Women						
Drank nothing last week	46	80	35	9	4	
Up to 3 units	26	17	43	38	19	
More than 3, up to 6 units	15	2	15	30	34	
More than 6, up to 9 units	6	0	3	12	18	
More than 9 units	7	0	3	11	24	
More than 3 units	28	2	21	52	77	
More than 6 units	12	0	6	23	42	
<i>Weighted bases (000s)</i>						
<i>Men</i>	17,250	1,319	5,610	3,514	4,497	
<i>Women</i>	19,602	3,095	6,536	2,800	3,327	
<i>Unweighted bases⁵</i>						
<i>Men</i>	5,120	390	1,730	1,070	1,320	
<i>Women</i>	6,130	990	2,070	870	1,050	

1. Aged 16 and over.

2. Results for 2010 include longitudinal data (see Appendix A).

3. The method used for calculating the number of units drunk was updated in the 2006 survey. The change is designed to take into account changes in the way drinks are served and the changing strength of drinks. A further improvement was made in the 2008 survey by adding a wine glass question to more accurately estimate the number of units consumed by those drinking wine.

4. Total includes those who said they did not drink in the last 12 months and those who did not answer questions on their average weekly drinking.

5. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

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Table 2.7 Household consumption of alcoholic drinks, 1992 to 2010¹

United Kingdom	ml per person per week						
	All alcoholic drinks	Beer ²	Cider and perry	Wine ³	Spirits ⁴	Alcopops ⁵	Other ^{5,6}
Consumption within the home							
1992	527	298	47	152	30	.	.
1993	536	297	44	164	32	.	.
1994	552	311	52	162	28	.	.
1995	627	338	77	180	32	.	.
1996	656	351	82	188	34	.	.
1997	653	365	58	196	32	2	.
1998	645	340	61	212	30	1	.
1999	640	329	60	213	35	4	.
2000	725	388	58	232	37	10	.
2001/02	735	386	55	236	39	18	.
2002/03	726	380	50	239	39	18	.
2003/04	792	416	64	251	41	19	.
2004/05	763	395	55	261	38	14	.
2005/06	779	403	49	274	39	13	.
2006 ⁷	760	393	59	255	41	12	.
2007	772	384	75	263	42	8	.
2008	706	349	69	242	38	8	.
2009	744	371	82	245	40	7	.
2010	762	378	79	252	43	9	.
Consumption outside the home⁸							
2001/02	733	623	21	20	21	34	15
2002/03	704	592	20	20	21	36	15
2003/04	664	557	20	21	22	25	21
2004/05	616	515	18	22	20	20	22
2005/06	597	499	16	22	20	15	25
2006 ⁷	561	459	24	23	18	11	25
2007	503	400	28	19	17	8	31
2008	443	358	21	18	14	6	25
2009	446	342	28	26	16	6	27
2010	413	299	29	34	16	5	30

1. Data from 1992 to 2000 was collected from the National Food Survey and has been adjusted to allow comparisons to data collected from 2001/02 to 2007 from the Expenditure and Food Survey (EFS). In 2008 the EFS was renamed the Living Costs and Food Survey (LCFS) when it became part of the Integrated Household Survey. The data presented here comes from the Family Food Module of LCFS.

2. 'Beer' includes beers, lagers and continental beers.

3. 'Wine' includes table wine, champagne and fortified wines.

4. 'Spirits' includes spirits and mixer, liqueurs and cocktails.

5. A '.' indicates data are unavailable. Alcopops did not really exist pre 1997.

6. 'Other' includes rounds of alcohol drinks bought and alcohol not otherwise specified.

7. From 2006 the survey moved onto a calendar year basis (from the previous financial year basis). As a consequence, the January 2006 to March 2006 data are common between the 2005/06 financial year results and the 2006 calendar year results.

8. Data on volumes consumed outside of the home from 1992 to 2000 are not available.

Source:

Family Food Module of Living Costs and Food Survey (LCFS) 2010 (Defra/ONS).

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Table 2.8 Indices of alcohol price, retail prices, alcohol price index relative to retail prices index (all items), real households' disposable income, real disposable income per adult and affordability of alcohol United Kingdom, 1980 to 2011

	Indices (1980 = 100)				
	Alcohol price index	Retail prices index (all items)	Alcohol price index relative to Retail price index (all items)	Real households' disposable income (revised) ²	Affordability of alcohol index (revised) ²
1980	100.0	100.0	100.0	100.0	100.0
1981	116.9	111.9	104.5	99.0	94.7
1982	130.2	121.5	107.2	98.4	91.8
1983	140.0	127.1	110.1	99.8	90.6
1984	148.1	133.4	111.0	102.8	92.6
1985	157.4	141.5	111.2	105.6	94.9
1986	164.5	146.3	112.4	109.4	97.4
1987	171.2	152.4	112.3	110.6	98.5
1988	179.9	159.9	112.5	116.3	103.4
1989	190.1	172.3	110.3	121.2	109.9
1990	208.4	188.6	110.5	126.2	114.2
1991	234.3	199.7	117.3	128.2	109.3
1992	249.4	207.2	120.3	131.4	109.2
1993	260.4	210.5	123.7	135.1	109.2
1994	266.7	215.6	123.7	136.8	110.6
1995	276.8	223.1	124.1	140.1	112.9
1996	284.8	228.4	124.7	144.2	115.7
1997	292.7	235.6	124.2	149.6	120.4
1998	302.7	243.7	124.2	153.0	123.2
1999	310.6	247.4	125.5	156.8	125.0
2000	315.4	254.8	123.8	163.6	132.1
2001	322.0	259.3	124.2	171.4	138.0
2002	329.3	263.6	124.9	175.1	140.1
2003	336.3	271.2	124.0	179.2	144.5
2004	342.8	279.3	122.7	179.7	146.4
2005	349.6	287.2	121.7	181.3	148.9
2006	358.0	296.4	120.8	182.5	151.0
2007	368.6	309.1	119.3	183.2	153.6
2008	383.3	321.3	119.3	182.1	152.7
2009	397.3	319.7	124.3	183.5	147.7
2010	411.2	334.5	122.9	181.5	147.6
2011 ³	435.1	351.9	123.7	179.3	145.0

1. See Appendix A for affordability calculations

2. An important adjustment was introduced for the first time in 'Statistics on Alcohol: England, 2011' so that the revised Real Households' Disposable Income (RHDI) index tracks, exclusively, changes in real disposable income per capita. The adjusted RHDI index was then carried forward to produce an adjusted affordability of alcohol index. Both the unadjusted RHDI index and the unadjusted affordability of alcohol index (as used in 'Statistics on Alcohol: England 2010' and prior publications) are presented alongside the revised indices for comparability purposes in the 'Statistics on Alcohol: England 2011' report.

3. The RHDI index was adjusted using mid-year ONS population estimates of the adult population aged 18 and over for each year. The adjustment to the 2011 RHDI index was carried out using mid 2010 estimates which are the most up to date currently available. A slightly revised 2011 RHDI and affordability of alcohol index based on mid-2011 estimates will be available in next year's report, although the difference is expected to be negligible.

Sources:

Alcohol Price and Retail Prices (all items) Indices: derived from Focus on Consumer Price Indices: (Codes CBAA, CBAB, CHBD, CHAW). The Office for National Statistics.

Real Households Disposable Income: Economic Trends: (Code NRJR). The Office for National Statistics.
Final Mid-Year Population Estimates (2001 census based). The Office for National Statistics.

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Table 2.9 Average weekly consumption of different types of drink, by gender and age¹, 2009

Great Britain	Numbers / Percentages									
	Men					Women				
	All ages ¹	16-24	25-44	45-64	65 and over	All ages ¹	16-24	25-44	45-64	65 and over
Total units²	15.6	17.5	15.0	16.8	12.5	9.5	11.0	10.2	10.5	5.8
Strong beer, lager, cider	2.0	4.1	1.6	2.0	1.0	0.4	1.2	0.4	0.3	0.2
Normal strength beer, lager, cider	7.3	7.9	8.2	7.7	4.4	1.5	1.3	1.9	1.7	0.5
Spirits	1.8	3.3	1.3	1.4	2.3	1.6	4.0	1.6	0.8	0.9
Fortified Wine	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.1	0.1	0.5
Wine	4.0	0.7	3.8	5.5	4.0	5.4	2.5	5.9	7.4	3.7
Alcopops	0.3	1.4	0.1	0.2	0.2	0.4	1.7	0.3	0.1	0.0
Percentages										
Strong beer, lager, cider	13	23	10	12	8	4	11	4	3	3
Normal strength beer, lager, cider	47	45	54	46	35	15	12	18	17	9
Spirits	12	19	9	8	18	16	37	16	8	15
Fortified Wine	1	0	0	1	1	2	2	1	1	9
Wine	25	4	25	32	35	57	22	58	70	63
Alcopops	2	8	1	2	2	4	16	3	1	0
<i>Weighted Bases (000s)³</i>	<i>23,414</i>	<i>3,633</i>	<i>8,182</i>	<i>7,419</i>	<i>4,181</i>	<i>24,641</i>	<i>3,484</i>	<i>8,290</i>	<i>7,681</i>	<i>5,186</i>
<i>Unweighted Bases⁴</i>	<i>960</i>	<i>80</i>	<i>300</i>	<i>340</i>	<i>240</i>	<i>1,150</i>	<i>80</i>	<i>380</i>	<i>390</i>	<i>300</i>

1. Aged 16 and over.

2. Includes 'other' drinks such as cocktails.

3. Weighted to population totals.

4. Figures for unweighted sample have been rounded independently. The sum of component items does not therefore necessarily add to the totals shown.

Shaded figures indicate the estimates are unreliable and any analysis using these figures may be invalid. Any use of shaded figures must be accompanied by this disclaimer.

Source:

Drinking: Adults' behaviour and knowledge in 2009. The Office for National Statistics (ONS).

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Table 2.10 Adults¹ drinking in the last week, by socio-economic classification² and gender, 2010^{3,4}

England	Percentages						
	All adults	Men	Women	All adults	Men	Women	
		Drank last week			Drank more than 4/3 units on at least one day		
All adults⁵	61	68	54	31	35	28	
Managerial and professional	70	76	65	37	40	35	
Large employers and higher managerial	77	81	73	45	47	43	
Higher professional	74	78	69	40	40	39	
Lower managerial and professional	67	73	61	35	37	32	
Intermediate	60	68	53	31	36	27	
Intermediate	57	65	52	28	35	23	
Small employers/own account	63	69	55	34	37	32	
Routine and manual	52	61	45	26	30	21	
Lower supervisory and technical	57	64	50	30	33	27	
Semi-routine	52	62	45	24	29	20	
Routine	48	57	39	23	29	17	
		Drank on five or more days in the last week			Drank more than 8/6 units on at least one day		
All adults⁵	14	17	10	15	19	12	
Managerial and professional	17	21	14	18	21	16	
Large employers and higher managerial	21	26	16	23	26	20	
Higher professional	20	24	15	19	19	18	
Lower managerial and professional	16	19	13	17	20	14	
Intermediate	13	16	11	16	20	12	
Intermediate	12	14	11	14	19	11	
Small employers/own account	14	17	10	17	21	13	
Routine and manual	11	14	8	13	16	9	
Lower supervisory and technical	12	15	10	15	17	13	
Semi-routine	11	16	8	12	17	9	
Routine	8	11	5	11	14	7	
<i>Weighted bases (000's)</i>							
<i>Managerial and professional</i>	15,749	7,648	8,102	15,754	7,653	8,101	
<i>Intermediate</i>	6,699	3,038	3,662	6,713	3,044	3,669	
<i>Routine and manual</i>	12,362	5,729	6,633	12,341	5,717	6,624	
<i>All adults⁵</i>	36,860	17,249	19,610	36,852	17,250	19,602	
<i>Unweighted bases⁶</i>							
<i>Managerial and professional</i>	4,850	2,300	2,550	4,850	2,310	2,550	
<i>Intermediate</i>	2,040	890	1,150	2,050	890	1,160	
<i>Routine and manual</i>	3,870	1,740	2,130	3,860	1,740	2,120	
<i>All adults⁵</i>	11,260	5,130	6,130	11,260	5,120	6,130	

1. Aged 16 and over.

2. From April 2001 the National Statistics Socio-economic Classification (NS-SEC) was introduced for all official statistics and surveys. It has replaced Social Class based on Occupation and Socio-economic Groups (SEG). Full-time students, persons in inadequately described occupations, persons who have never worked and the long term unemployed are not shown as separate categories, but are included in the figure for 'All adults'. Based on the current or last job of the household reference person.

3. Results for 2009 include longitudinal data (see Appendix A).

4. The method used for calculating the number of units drunk was updated in the 2006 survey. The change is designed to take into account changes in the way drinks are served and the changing strength of drinks. A further improvement was made in the 2008 survey by adding a wine glass size question to more accurately estimate the number of units consumed by those drinking wine.

5. All adults includes those for whom socio-economic classification was not available.

6. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

Source:

General Household Survey, 2010. The Office for National Statistics (ONS).

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Table 2.11 Adults¹ drinking in the last week, by economic activity status and gender, 2010^{2,3}

England	Percentages						
	All adults	Men	Women	All adults	Men	Women	
		Drank last week			Drank more than 4/3 Units on at least one day		
All adults of working age⁴	63	68	57	37	39	34	
Total working⁵	69	73	64	40	42	38	
Full time	72	76	65	43	44	41	
Part time	61	59	62	34	31	35	
Unemployed	47	49	45	29	31	27	
Economically inactive ⁶	46	53	41	26	28	24	
		Drank on five or more days in the last week			Drank more than 8/6 Units on at least one day		
All adults of working age⁴	12	15	8	19	22	17	
Total working⁵	13	16	9	22	25	19	
Full time	14	16	10	25	26	21	
Part time	10	13	9	15	14	16	
Unemployed	8	11	6	14	14	14	
Economically inactive ⁶	9	15	5	12	14	10	
<i>Weighted bases (000s)</i>							
<i>All adults of working age⁴</i>	27,294	13,701	13,592	27,293	13,708	13,584	
<i>Total working⁵</i>	20,211	10,461	9,750	20,210	10,461	9,749	
<i>Full time</i>	14,032	8,920	5,112	14,032	8,920	5,112	
<i>Part time</i>	5,957	1,427	4,530	5,953	1,425	4,529	
<i>Unemployed</i>	1,780	965	814	1,777	970	807	
<i>Economically inactive⁶</i>	5,303	2,275	3,028	5,306	2,278	3,029	
<i>Unweighted bases⁷</i>							
<i>All adults of working age⁴</i>	7,510	3,670	3,840	7,510	3,670	3,840	
<i>Total working⁵</i>	5,510	2,780	2,730	5,510	2,780	2,730	
<i>Full time</i>	3,770	2,360	1,410	3,770	2,360	1,410	
<i>Part time</i>	1,690	390	1,300	1,680	390	1,290	
<i>Unemployed</i>	470	250	220	470	260	210	
<i>Economically inactive⁶</i>	1,530	630	890	1,530	630	890	

1. Adults of working age. See footnote 4.

2. Results for 2010 include longitudinal data (see Appendix A).

3. The method used for calculating the number of units drunk was updated in the 2006 survey. The change is designed to take into account changes in the way drinks are served and the changing strength of drinks. A further improvement was made in the 2008 survey by adding a wine glass size question to more accurately estimate the number of units consumed by those drinking wine.

4. Working age is defined as 16 to 64 for men and 16 to 59 for women.

5. People who do unpaid family work, have inadequately described working hours or are on a government scheme are not included as separate categories but are included in the figures for 'total working'.

6. Economically inactive people are people who are neither working nor unemployed by the International Labour Organisation (ILO) measure. For example, this would include those who were looking after a home or retired.

7. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

Source:

General Household Survey, 2010. The Office for National Statistics (ONS).

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Table 2.12 Adults¹ drinking in the last week, by usual gross weekly household income and gender, 2010^{2,3}

England				Percentages			
	All adults	Men	Women	All adults	Men	Women	
		Drank last week			Drank more than 4/3 units on at least one day		
All adults⁴	61	68	54	31	35	28	
Up to £200.00	46	57	39	20	28	16	
£200.01 - £400.00	50	58	44	21	24	19	
£400.01 - £600.00	58	66	50	27	30	25	
£600.01 - £800.00	62	67	58	35	37	33	
£800.01 - £1000.00	70	75	66	38	39	37	
£1000.01 or more	75	79	70	45	48	42	
		Drank on five or more days in the last week			Drank more than 8/6 units on at least one day		
All adults⁴	14	17	10	15	19	12	
Up to £200.00	13	17	10	9	14	6	
£200.01 - £400.00	11	14	9	9	11	8	
£400.01 - £600.00	13	18	9	13	15	11	
£600.01 - £800.00	13	16	10	16	18	15	
£800.01 - £1000.00	15	17	12	19	21	17	
£1000.01 or more	16	19	13	25	29	20	
<i>Weighted bases (000s)</i>							
All adults⁴	36,860	17,249	19,610	36,852	17,250	19,602	
Up to £200.00	5,407	2,058	3,348	5,397	2,056	3,341	
£200.01 - £400.00	6,716	2,923	3,793	6,716	2,924	3,792	
£400.01 - £600.00	5,493	2,613	2,880	5,489	2,613	2,876	
£600.01 - £800.00	4,552	2,261	2,291	4,546	2,256	2,291	
£800.01 - £1000.00	3,706	1,810	1,896	3,720	1,825	1,896	
£1000.01 or more	8,052	4,192	3,860	8,052	4,192	3,860	
<i>Unweighted bases⁵</i>							
All adults⁴	11,260	5,130	6,130	11,260	5,120	6,130	
Up to £200.00	1,720	610	1,110	1,720	610	1,110	
£200.01 - £400.00	2,280	980	1,300	2,280	980	1,300	
£400.01 - £600.00	1,720	810	910	1,720	810	910	
£600.01 - £800.00	1,340	660	680	1,340	660	680	
£800.01 - £1000.00	1,080	520	560	1,090	530	560	
£1000.01 or more	2,220	1,130	1,090	2,220	1,130	1,090	

1. Aged 16 and over.

2. Results for 2010 include longitudinal data (see Appendix A).

3. The method used for calculating the number of units drunk was updated in the 2006 survey. The change is designed to take into account changes in the way drinks are served and the changing strength of drinks. A further improvement was made in the 2008 survey by adding a wine glass size question to more accurately estimate the number of units consumed by those drinking wine.

4. All adults includes those for whom household income was not available.

5. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

Source:

General Household Survey, 2010. The Office for National Statistics (ONS).

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Table 2.13 Drinking in the last week, by marital status¹ and gender, 2010^{2,3}

England				Percentages		
	All adults	Men	Women	All adults	Men	Women
	Drank last week			Drank more than 4/3 units on at least one day		
All adults	61	68	54	31	35	28
Single	52	55	48	33	34	31
Married/cohabiting	66	73	60	33	36	31
Divorced/separated	57	71	49	31	40	25
Widowed	43	62	37	12	21	9
	Drank on five or more days last week			Drank more than 8/6 units on at least one day		
All adults	14	17	10	15	19	12
Single	7	8	5	19	21	17
Married/cohabiting	16	20	12	16	18	13
Divorced/separated	15	20	11	15	23	10
Widowed	13	21	10	4	7	2
<i>Weighted bases (000s)</i>						
<i>All adults</i>	<i>36,860</i>	<i>17,249</i>	<i>19,610</i>	<i>36,852</i>	<i>17,250</i>	<i>19,602</i>
<i>Single</i>	<i>7,953</i>	<i>4,135</i>	<i>3,818</i>	<i>7,960</i>	<i>4,150</i>	<i>3,810</i>
<i>Married/cohabiting</i>	<i>23,259</i>	<i>11,330</i>	<i>11,929</i>	<i>23,250</i>	<i>11,317</i>	<i>11,933</i>
<i>Divorced/separated</i>	<i>2,968</i>	<i>1,129</i>	<i>1,839</i>	<i>2,963</i>	<i>1,129</i>	<i>1,834</i>
<i>Widowed</i>	<i>2,680</i>	<i>655</i>	<i>2,025</i>	<i>2,680</i>	<i>655</i>	<i>2,025</i>
<i>Unweighted bases⁴</i>						
<i>All adults</i>	<i>11,260</i>	<i>5,130</i>	<i>6,130</i>	<i>11,260</i>	<i>5,120</i>	<i>6,130</i>
<i>Single</i>	<i>1,940</i>	<i>940</i>	<i>1,000</i>	<i>1,940</i>	<i>950</i>	<i>990</i>
<i>Married/cohabiting</i>	<i>7,520</i>	<i>3,670</i>	<i>3,850</i>	<i>7,510</i>	<i>3,660</i>	<i>3,850</i>
<i>Divorced/separated</i>	<i>900</i>	<i>300</i>	<i>610</i>	<i>900</i>	<i>300</i>	<i>600</i>
<i>Widowed</i>	<i>900</i>	<i>220</i>	<i>680</i>	<i>900</i>	<i>220</i>	<i>680</i>

1. Marital status categories are classed as 'Single', 'Married/Cohabiting' (which includes same sex couples and civil partners), 'Divorced/separated' (which includes former separated/ dissolved civil partners) and 'Widowed' (which includes surviving partners of a former civil partnership).

2. Results for 2010 include longitudinal data (see Appendix A).

3. The method used for calculating the number of units drunk was updated in the 2006 survey. The change is designed to take into account changes in the way drinks are served and the changing strength of drinks. A further improvement was made in the 2008 survey by adding a wine glass size question to more accurately estimate the number of units consumed by those drinking wine.

4. The individual figures for unweighted sample sizes are rounded to the nearest 10 cases and may not add up to the figures shown as the totals.

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General Household Survey, 2010. The Office for National Statistics (ONS).

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Table 2.14 Drinking in the last week among adults¹ by gender, country and Government Office Region, 2010²

Great Britain	Drank last week	Drank on 5 or more days last week	Weighted bases (000s)	Percentages	
				Unweighted bases ³	
All adults					
England	61	14	36,860	11,260	
North East	61	12	1,732	590	
North West	63	14	5,234	1,620	
Yorkshire and the Humber	61	13	3,903	1,350	
East Midlands	61	12	3,087	1,040	
West Midlands	56	11	4,272	1,250	
East of England	63	16	4,213	1,380	
London	53	13	5,160	1,110	
South East	64	15	5,994	1,760	
South West	65	16	3,265	1,170	
Wales	57	13	2,168	740	
Scotland	55	8	3,953	1,270	
Great Britain	60	13	42,981	13,270	
Men					
England	68	17	17,249	5,130	
North East	68	16	738	250	
North West	69	16	2,520	750	
Yorkshire and the Humber	68	15	1,845	610	
East Midlands	70	16	1,430	470	
West Midlands	63	14	1,999	570	
East of England	69	18	1,999	650	
London	61	16	2,456	510	
South East	72	20	2,784	800	
South West	74	21	1,478	510	
Wales	64	17	1,069	350	
Scotland	62	11	1,924	590	
Great Britain	67	17	20,242	6,070	
Women					
England	54	10	19,610	6,130	
North East	55	10	994	340	
North West	58	11	2,714	870	
Yorkshire and the Humber	54	10	2,058	740	
East Midlands	54	9	1,657	570	
West Midlands	50	9	2,273	680	
East of England	57	13	2,213	740	
London	45	10	2,705	600	
South East	57	11	3,210	950	
South West	57	11	1,787	650	
Wales	50	8	1,099	380	
Scotland	49	5	2,029	680	
Great Britain	53	10	22,739	7,200	

1. Aged 16 and over.

2. Results for 2010 include longitudinal data (see Appendix A).

3. Figures for unweighted bases have been rounded independently. The sum of component items does not therefore necessarily add to the totals shown.

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General Lifestyle Survey 2010. The Office For National Statistics (ONS).

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Table 2.15 Maximum drunk on any one day in the last week¹, by gender, country and Government Office Region, 2010^{2,3}

Great Britain	Percentages			
	Drank more than 4/3 units on at least one day	Drank more than 8/6 units on at least one day	Weighted bases (000s)	Unweighted bases ⁴
All adults				
England	31	15	36,852	11,260
North East	33	16	1,732	590
North West	38	20	5,232	1,620
Yorkshire and the Humber	34	18	3,894	1,350
East Midlands	29	12	3,094	1,040
West Midlands	24	12	4,274	1,250
East of England	30	14	4,212	1,380
London	28	15	5,157	1,110
South East	35	16	5,995	1,760
South West	30	14	3,262	1,160
Wales	32	16	2,170	740
Scotland	35	18	3,953	1,270
Great Britain	32	16	42,976	13,260
Men				
England	35	19	17,250	5,120
North East	38	21	738	250
North West	41	24	2,520	750
Yorkshire and the Humber	38	22	1,844	610
East Midlands	33	15	1,435	470
West Midlands	27	15	2,000	570
East of England	33	16	2,002	650
London	33	19	2,456	510
South East	39	19	2,778	800
South West	34	18	1,478	510
Wales	36	19	1,069	350
Scotland	40	23	1,924	590
Great Britain	36	19	20,243	6,070
Women				
England	28	12	19,602	6,130
North East	30	12	994	340
North West	35	18	2,712	870
Yorkshire and the Humber	30	14	2,050	740
East Midlands	25	10	1,659	570
West Midlands	21	8	2,274	680
East of England	28	13	2,210	730
London	23	11	2,701	600
South East	31	13	3,217	950
South West	28	11	1,785	650
Wales	28	12	1,102	390
Scotland	31	14	2,029	680
Great Britain	28	13	22,733	7,200

1. Aged 16 and over.

2. Results for 2010 include longitudinal data (see Appendix A).

3. The method used for calculating the number of units drunk was updated in the 2006 survey. The change is designed to take into account changes in the way drinks are served and the changing strength of drinks. A further improvement was made in the 2008 survey by adding a wine glass size question to more accurately estimate the number of units consumed by those drinking wine.

4. Figures for unweighted bases have been rounded independently. The sum of component items does not therefore necessarily add to the totals shown.

Source:

General Lifestyle Survey 2010. The Office for National Statistics (ONS).

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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.

Three sources of information are used: The Office for National Statistics (ONS) Omnibus Survey Report *Drinking: adults' behaviour and knowledge in 2009*¹; the *Heath Survey for England 2007*²; and *Smoking, drinking and drug use among young people in England in 2008*³ (SDD).

The drinking topic in the ONS Omnibus Survey ran biannually but is currently 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 (HSE07) also 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 are not referenced in this chapter.

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 not unexpected that estimates are slightly different.

In this chapter the Omnibus survey report on drinking and HSE07 are used to explore the knowledge and attitudes people have towards alcohol. The Omnibus survey report on drinking also provides changes over time.

The *Smoking, drinking and drug use among young people in England (SDD)* survey began in 1982 and since 1998 each survey has included a core section of questions on smoking, drinking and drug use. From 2000 the questionnaire has focused on either, smoking and drinking, or drug use. The emphasis of the 2010 survey was on smoking and drinking.

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 contents. 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.

Government recommendations are that adult men should not regularly drink more than 3 to 4 units of alcohol a day and adult women should not regularly drink more than 2 to 3 units a day⁴. After an episode of heavy drinking, it is also advisable to refrain from drinking for 48 hours to allow tissues to recover.

The 2009 Omnibus survey report on drinking asked respondents whether they had heard of measuring alcohol consumption in units; 90% of respondents said that they had. This has steadily increased from 79% 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% 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% of those who did not drink at all (Table 3.1).

Those aged 65 and over were less likely to have heard of alcohol units: 80% had done so, compared with 96% of those aged 45 to 64 and 88% of the youngest age group (16 to 24). Although average weekly alcohol consumption is not strongly related to socio-economic classification, there were marked differences in awareness of units between those in different occupations. Those in managerial and professional occupational groupings were the most likely to have heard of measuring alcohol in units (96%), and those in routine and manual occupations the least likely to have done so (87%) (Table 3.2 and 3.3).

In the HSE07 most adults (92% of men and 89% 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

It is especially important that people are aware of the alcohol content of drinks they themselves drink. Therefore, for each of the most common types of drink, the 2009 Omnibus survey asked respondents who had drunk that particular drink in the last year if they knew what a unit of that drink was.

Results found 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, but even so, about a third (31%) of frequent beer drinkers and a sixth (17%) 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 (Table 3.4).

Further information on respondents' awareness of units for different types of alcohol can be found in [Chapter 4 on pages 56 to 57 of the ONS Omnibus Survey Report Drinking: adults' behaviour and knowledge in 2009](#)¹.

In the 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% 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% of men and 60% of 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 [Chapter 7 on pages 177 to 218 of HSE07](#).

3.3 Knowledge of drinking limits

3.3.1 Alcohol consumption

The 2009 Omnibus survey report on drinking asked respondents whether or not they kept a check on the number of units they drank: 13% said that they did. It should be noted however, given that not all respondents who drank each type of drink knew how many units were contained therein, the likelihood of them keeping an accurate check was, in some cases, low.

Although men were more likely than women to drink heavily (see [Chapter 2](#) of this report for details), they were not more likely to keep a check in terms of units on how much they drank – overall, 12% of men and 14% of women who had heard of units did so. Women who did keep a check on units were slightly more likely to do so on a weekly basis (6%) than on the daily basis (2%) 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% and 16% 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 (Table 3.5 and 3.6).

In the HSE07 results showed that the majority of adults who drank in the last week exceeded recommendations on at least one day; 59% of men and 55% of women had done so. This was more likely in adults of working age than those aged 65 or over.

Among adults who drank in the last week, 35% of men and 27% of women had drunk more than twice the recommended levels on at least one day in the last week. This was most common among the youngest age group (56% of men and 52% of women aged between 16 and 24), and decreased with age to 6% of men and 3% of women aged 75 and over.

3.3.2 Daily drinking limits

The current government advice on drinking is that daily intake should not regularly exceed 3 to 4 units a day for men and 2 to 3 units for women⁴. After an episode of heavy drinking, it is also advisable to refrain from drinking for 48 hours to allow tissues to recover.

The 2009 Omnibus survey report on drinking asked respondents if they had ever heard of the recommended maximum number of alcohol units that people should drink in a day.

There has been an increase from 54% in 1997 to 75% in 2009 in the percentage of people who had heard of daily drinking limits. Throughout the period, differences between men and women have been slight. Male non-drinkers and those who drank very little were less likely to have heard of daily drinking limits than heavier drinkers. The percentage of men who drank less than 1 unit a week who had

heard of daily drinking limits increased significantly from 49% in 2007 to 65% in 2009. Among women, non-drinkers were the least likely to have heard of daily drinking limits and heavier drinkers the most likely. For example, 70% of women who drank less than 1 unit a week had heard of daily consumption levels compared with 86% of those who drank 15 units or more a week (Table 3.7 and 3.8).

The HSE07 results showed 35% of men and 47% of women had heard of units but said they didn't know what the recommendations were for men, and 39% of men and 43% of women similarly knew about units but said they did not know the recommendations for women. Those who attempted to define the recommendations were more likely to be wrong than right. General awareness of units was higher among men and women who had drunk alcohol in the last week but most adults who drank more than the recommended amounts either did not know what these limits were or could not identify them correctly.

3.4 Children's attitudes to drinking alcohol

In *Smoking, drinking and drug use among young people in England in 2010*³ (SDD10) pupils were asked about their attitudes to drinking alcohol, including their perceptions of parents views on drinking alcohol and being drunk.

The key findings from the SDD10 showed that;

- There has been a fall in recent years in the proportion of pupils who think that drinking is acceptable for someone of their age. In 2010, 32% thought it was OK for someone of their age to drink once a week compared with 46% in 2003. Similarly 11% of pupils thought that it was OK for someone of their age to get drunk once a week, compared with 20% who thought that in 2003.
- Half (51%) of pupils thought their parents didn't like them to drink, slightly more than the proportion who said their parents didn't mind as long as they didn't drink too much

(48%). A few pupils (1%) said their parents let them drink as much as they liked. There was a strong relationship between pupils' drinking behaviour and their parents' attitudes to their drinking. 85% of pupils whose parents did not like them to drink had never drunk alcohol, compared with 27% who thought their parents wouldn't mind as long as they didn't drink too much.

- Pupils were most likely to think that people of their age drink to look cool in front of their friends (76%), to be more sociable with friends (65%), because their friends pressured them into it (62%) or because it gives them a rush or buzz (60%). There were differences between the opinions of pupils who drank alcohol and those who did not. Those who did drink were more likely to agree that people of their age drank to be sociable or for the rush or buzz; pupils who had never drunk alcohol were more likely to believe that people of their age drank to look cool or because of pressure from their friends

In the HSE07 children aged 13 to 15 were asked about their perceptions of their parents' views on drinking alcohol. Those who stated that they ever drank alcohol were asked whether their parents knew about it, and if so what their parents thought about them drinking alcohol. Very few who drank thought that their parents were unaware of this (5% of boys and 3% of girls). Among the rest, a minority said that their parents did not like them drinking (21% of boys and 17% of girls), while a slightly greater percentage said that their parents did not mind (38% and 35% respectively), or that their parents' views on their drinking varied (26% and 33% respectively).

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List of Tables

- 3.1 Percentage of respondents who said they had heard of measuring alcohol consumption in units: by gender and average weekly consumption, 1997 to 2009
- 3.2 Percentage of respondents who said they had heard of measuring alcohol consumption in units: by gender and age, 1997 to 2009
- 3.3 Percentage of respondents who said they had heard of measuring alcohol consumption in units: by gender and socio-economic classification, 2009
- 3.4 Percentage of drinkers of each drink who knew what a unit of each type of drink was: by how often they drank that type of drink, 1997 to 2009
- 3.5 Whether drinkers keep a check on units drunk: by gender, 1997 to 2009
- 3.6 Whether drinkers keep a check on units drunk: by gender and average weekly alcohol consumption, 2009
- 3.7 Percentage who had heard of daily drinking limits: by gender, 1997 to 2009
- 3.8 Percentage who had heard of daily drinking limits: by gender and average weekly alcohol consumption, 1997 to 2009

Table 3.1 Percentage of respondents who said they had heard of measuring alcohol consumption in units: by gender and average weekly consumption, 1997 to 2009

Great Britain												Percentages	
	1997	1998	2000	2002	2004	2006	2007 original method ¹	2007 updated method ¹	2008 ²	2008 ³	2009	2009 Weighted base (000s) ³	2009 Unweighted base ⁴
All													
Non-drinker	53	46	54	50	55	58	55	55	64	63	71	6,720	310
Less than 1 unit	71	61	74	70	74	81	80	78	81	81	85	8,495	380
1–10/1–7 units ⁵	82	78	83	87	88	90	90	89	91	90	94	14,253	610
11–21/8–14 units ⁵	89	85	88	89	93	94	95	95	94	94	96	8,014	340
22/15 units and over ⁵	90	88	90	90	92	93	94	95	95	95	95	10,551	470
Total	79	75	80	81	83	86	85	85	86	86	90	48,033	2,110
Men													
Non-drinker	55	53	56	51	55	56	56	56	66	67	79	2,291	110
Less than 1 unit	71	56	72	65	72	79	71	70	86	87	81	3,295	120
1–10 units	83	76	80	86	85	89	89	87	91	91	93	7,544	300
11–21 units	88	83	86	88	94	93	94	94	93	94	96	5,166	210
22 units and over	91	86	88	91	93	91	93	94	96	96	94	5,117	220
Total	82	76	80	82	84	86	85	85	89	89	91	23,414	960
Women													
Non-drinker	52	42	52	49	55	60	54	54	63	60	68	4,429	200
Less than 1 unit	71	64	75	72	75	81	84	82	79	79	87	5,200	260
1–7 units	81	80	86	88	91	91	92	90	90	90	95	6,709	300
8–14 units	90	86	91	91	93	94	97	97	94	94	96	2,847	140
15 units and over	89	90	92	90	91	95	95	96	94	94	96	5,433	250
Total	77	73	81	80	83	85	85	85	84	84	89	24,618	1,150

Bases for earlier years can be found in Opinions (Omnibus) reports for each year.

1997 to 2007 percentages weighted for unequal chance of selection.

1. In 2007 a methodology change was introduced to give a more accurate estimation of alcohol consumption taking into account the changing alcoholic content of some drinks and the increased glass sized in which wine is served (see appendix A).

2. Weighted for unequal chance of selection.

3. Weighted to population totals.

4. Figures for unweighted sample have been rounded independently. The sum of component items does not therefore necessarily add to the totals shown.

5. Number of units drunk by men/women.

Source:

Opinions Survey, Office for National Statistics

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Table 3.2 Percentage of respondents who said they had heard of measuring alcohol consumption in units: by gender and age, 1997 to 2009

Great Britain											Percentages	
	1997	1998	2000	2002	2004	2006	2007	2008 ¹	2008 ²	2009 ²	2009 Weighted base (000s) ²	2009 Unweighted base ³
All												
16–24	89	82	82	80	83	84	86	85	84	88	7,117	160
25–44	86	84	87	89	88	90	88	89	88	91	16,472	680
45–64	81	76	82	85	87	89	88	91	91	96	15,078	730
65 and over	56	50	62	60	68	73	75	76	76	80	9,366	540
Total	79	75	80	81	83	86	85	86	86	90	48,033	2,110
Men												
16–24	92	81	81	81	85	85	84	88	87	86	3,633	80
25–44	86	86	88	89	89	88	87	89	90	94	8,182	300
45–64	83	76	80	85	87	90	89	93	93	95	7,419	340
65 and over	63	55	66	65	70	76	76	81	82	81	4,181	240
Total	82	76	80	82	84	86	85	89	89	91	23,414	960
Women												
16–24	86	83	84	79	81	82	88	84	81	90	3,484	80
25–44	86	83	87	90	87	91	89	89	88	88	8,290	380
45–64	79	76	85	84	87	89	86	90	89	96	7,659	390
65 and over	50	47	59	55	66	71	74	71	71	78	5,186	300
Total	77	73	81	80	83	85	85	84	84	89	24,618	1,150

Bases for earlier years can be found in Opinions (Omnibus) reports for each year.

1997 to 2007 percentages weighted for unequal chance of selection.

1. Weighted for unequal chance of selection.

2. Weighted to population totals.

3. Figures for unweighted sample have been rounded independently. The sum of component items does not therefore necessarily add to the totals shown.

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Table 3.3 Percentage of respondents who said they had heard of measuring alcohol consumption in units: by gender and socio-economic classification, 2009

Great Britain	Percentages			
	Total ¹	Managerial and professional	Intermediate	Routine and manual
All	90	96	94	87
Men	91	96	95	86
Women	89	96	93	88
<i>Weighted base (000s)²</i>				
All	48,033	15,960	8,423	17,659
Men	23,414	8,447	3,446	9,131
Women	24,618	7,513	4,977	8,528
<i>Unweighted base³</i>				
All	2,110	720	390	810
Men	960	360	150	380
Women	1,150	360	240	430

1. Those who could not be classified (full-time students, those who had never worked or were long-term unemployed, and those whose occupation was not stated or inadequately described) are not shown as separate categories, but are included in the total.

2. Weighted to population totals.

3. Figures for unweighted sample have been rounded independently. The sum of component items does not therefore necessarily add to the totals shown.

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Table 3.4 Percentage of drinkers of each drink who knew what a unit of each type of drink was: by how often they drank that type of drink, 1997 to 2009

Those who drank each type of drink in the last year, Great Britain											Percentages	
	1997	1998	2000	2002	2004	2006	2007	2008 ¹	2008 ²	2009 ³	2009 Weighted base (000s) ²	2009 Unweighted base ³
Beer												
At least once a week	54	51	54	54	61	64	63	66	66	69	14,407	600
Less than once a week	41	40	46	48	54	53	59	59	59	59	9,271	380
Only once or twice a year	34	34	44	42	45	49	46	45	44	53	5,363	230
Total	47	45	50	50	56	58	59	60	60	63	29,040	1,210
Wine^{4,5}												
At least once a week	67	63	69	70	75	77	77	77	77	83	14,713	670
Less than once a week	48	48	56	57	62	64	67	67	67	76	10,878	470
Only once or twice a year	31	36	35	42	48	48	57	50	49	65	4,639	200
Total	54	53	58	61	67	68	71	69	68	78	30,230	1,340
Spirits												
At least once a week	57	57	63	59	66	72	72	65	66	67	7,920	340
Less than once a week	60	57	62	66	65	70	69	70	70	70	12,338	520
Only once or twice a year	50	46	51	54	58	62	61	58	58	68	6,922	310
Total	57	55	60	61	64	69	68	65	66	69	27,180	1,160
Fortified wine												
At least once a week	50	44	51	51	59	56	68	57	55	65	1,204	60
Less than once a week	50	50	54	52	48	57	59	64	66	62	2,683	130
Only once or twice a year	44	44	50	52	51	60	59	54	54	61	4,542	210
Total	48	47	52	52	52	59	61	58	58	62	8,429	400
Alcopsops⁶												
At least once a week	.	.	.	.	.	.	55	58	[25] ⁷	77	1,209	40
Less than once a week	.	.	.	.	.	.	62	50	50	63	2,720	80
Only once or twice a year	.	.	.	.	.	.	65	68	70	62	2,511	80
Total	.	.	.	.	.	.	61	58	58	65	6,441	210

Bases for earlier years can be found in Opinions (Omnibus) reports for each year. 1997 to 2007 percentages and bases weighted for unequal chance of selection.

1. Weighted for unequal chance of selection.
2. Weighted to population totals.
3. Figures for unweighted sample have been rounded independently. The sum of component items does not therefore necessarily add to the totals shown.
4. From 2007, includes those who said it was a small glass, as well as those who said, correctly, that it was less than a small glass.
5. From 2007, includes those who said it was a small bottle, as well as those who said, correctly, that it was less than a small bottle.
6. Question introduced in 2007.
7. Percentages are provided for all cells in this table except where a '.' is shown, or a number in square brackets appears. '.' corresponds to a cell where the unweighted base was less than 50 and therefore the associated percentage regarded as unreliable. The number within the square brackets (in this case 25) indicates that in 2008, 25 out of 40 people in the sample who drunk alcopsops at least once a week knew what a unit of alcopsops was.

Shaded figures indicate the estimates may be unreliable due to small sample sizes and any analysis using these figures should be treated with caution. Any use of these shaded figures must be accompanied by this disclaimer.

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Table 3.5 Whether drinkers keep a check on units drunk: by gender, 1997 to 2009

Drinkers who had heard of units, Great Britain	Percentages									
	1997	1998	2000	2002	2004	2006	2007	2008 ¹	2008 ²	2009 ²
All										
Daily	4	3	4	2	4	3	4	4	4	3
Weekly	5	5	5	4	4	5	6	6	6	4
Both daily and weekly	2	2	2	1	2	2	2	1	1	2
Other	2	3	3	4	3	3	3	4	4	4
All who kept a check	13	12	13	11	13	13	15	15	16	13
Men										
Daily	5	3	5	2	4	4	5	5	5	4
Weekly	4	5	5	3	5	4	6	6	6	3
Both daily and weekly	2	2	1	2	1	1	2	1	1	1
Other	3	3	3	3	3	4	3	4	4	3
All who kept a check	14	13	14	10	13	12	16	15	15	12
Women										
Daily	3	3	2	2	4	3	3	3	4	2
Weekly	5	5	6	6	4	5	6	7	7	6
Both daily and weekly	2	2	2	1	2	2	2	2	2	2
Other	2	2	3	4	3	3	3	4	4	4
All who kept a check	12	12	13	13	13	13	14	16	16	14
<i>Weighted base¹</i>										
All	2,625	3,847	2,560	2,716	2,650	1,949	1,718	1,717		
Men	1,284	1,832	1,211	1,342	1,212	912	809	847		
Women	1,341	2,016	1,352	1,374	1,438	1,036	908	875		
<i>Weighted base (000s)²</i>										
All									35,645	38,342
Men									17,923	19,475
Women									17,721	18,867
<i>Unweighted base³</i>										
All									1,690	1,670
Men									790	790
Women									900	880

1997 to 2007 percentages and bases weighted for unequal chance of selection.

1. Weighted for unequal chance of selection.

2. Weighted to population totals.

3. Figures for unweighted sample have been rounded independently. The sum of component items does not therefore necessarily add to the totals.

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Table 3.6 Whether drinkers keep a check on units drunk: by gender and average weekly alcohol consumption, 2009

Drinkers who had heard of units, Great Britain	Percentages				
	Average weekly alcohol consumption				
	Total	Less than 1 unit	1–10/1–7 units ¹	11–21/8–14 units ¹	22/15 units and over ¹
All					
Daily	3	2	2	4	5
Weekly	4	0	4	6	7
Both daily and weekly	2	1	2	3	1
Other	4	6	4	3	4
All who kept a check	13	9	12	14	16
Men					
Daily	4	2	2	4	7
Weekly	3	1	3	4	3
Both daily and weekly	1	2	1	3	0
Other	3	5	3	2	4
All who kept a check	12	10	9	13	15
Women					
Daily	2	2	2	3	3
Weekly	6	-	6	8	10
Both daily and weekly	2	0	3	2	2
Other	4	6	4	3	3
All who kept a check	14	9	15	17	18
<i>Weighted base (000s)²</i>					
All	38,342	7,220	13,404	7,664	10,054
Men	19,475	2,685	6,414	4,934	4,826
Women	18,867	4,535	6,374	2,730	5,228
<i>Unweighted base³</i>					
All	1,670	332	570	330	440
Men	790	100	280	200	210
Women	880	230	290	130	230

1. Number of units drunk by men/women.

2. Weighted to population totals.

3. Figures for unweighted sample have been rounded independently. The sum of component items does not therefore necessarily add to the totals shown.

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Table 3.7 Percentage who had heard of daily drinking limits: by gender, 1997 to 2009

Great Britain	Percentages									
	1997	1998	2000	2002	2004	2006	2007	2008 ¹	2008 ²	2009 ²
All										
Yes	54	58	64	60	61	69	69	70	70	75
No	37	34	29	30	29	22	23	20	21	17
Not sure	8	8	7	10	9	9	8	10	10	9
Men										
Yes	54	59	62	59	62	68	68	72	72	74
No	38	32	32	30	29	22	24	18	18	17
Not sure	8	9	6	10	9	9	8	10	9	8
Women										
Yes	54	57	66	61	61	69	70	68	67	75
No	37	35	27	30	29	22	22	22	23	16
Not sure	9	8	8	9	9	10	8	10	10	9
<i>Weighted base¹</i>										
All	3,637	5,510	3,442	3,613	3,511	2,472	2,225	2,242		
Men	1,707	2,550	1,613	1,729	1,572	1,125	1,029	1,062		
Women	1,930	2,960	1,829	1,884	1,939	1,347	1,196	1,180		
<i>Weighted base (000s)²</i>										
All									46,596	48,055
Men									22,478	23,414
Women									24,119	24,641
<i>Unweighted base³</i>										
All									2,240	2,110
Men									1,000	960
Women									1,240	1,150

1997 to 2007 percentages and bases weighted for unequal chance of selection.

1. Weighted for unequal chance of selection.

2. Weighted to population totals.

3. Figures for unweighted sample have been rounded independently. The sum of component items does not therefore necessarily add to the totals shown.

Source:

Opinions Survey, Office for National Statistics.

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Table 3.8 Percentage who had heard of daily drinking limits: by gender and average weekly alcohol consumption, 1997 to 2009

Great Britain												Percentages	
	1997	1998	2000	2002	2004	2006	2007 original method ¹	2007 updated method ¹	2008 ²	2008 ²	2009 ²	2009 Weighted base (000s) ³	2009 Unweighted base ⁴
Men													
Non-drinker	33	45	42	39	40	45	44	44	48	49	66	2,291	100
Less than 1 unit	41	39	56	43	51	61	49	49	70	71	65	3,295	120
1-10 units	54	58	62	60	62	70	70	69	71	72	72	7,544	300
11-21 units	62	66	65	67	70	73	79	77	78	78	80	5,166	210
22 units and over	64	67	70	66	71	75	74	75	81	81	83	5,117	220
Total	54	59	62	59	62	68	68	68	72	72	74	23,414	960
Women													
Non-drinker	43	36	43	39	37	46	45	45	46	44	58	4,429	200
Less than 1 unit	47	49	64	54	57	64	63	62	64	63	70	5,222	260
1-7 units	55	62	70	69	66	74	78	76	73	72	76	6,709	300
8-14 units	63	65	74	67	68	77	82	81	76	76	84	2,847	140
15 units and over	68	72	71	70	74	80	82	83	80	80	86	5,433	250
Total	54	57	66	61	61	69	70	70	68	67	75	24,641	1,150

Bases for earlier years can be found in Opinions (Omnibus) reports for each year.

1997 to 2007 percentages and bases weighted for unequal chance of selection.

1. In 2007 a methodology change was introduced to give a more accurate estimation of the number of units in strong beer and in a glass of wine. (See Appendix A).

2. Weighted for unequal chance of selection.

3. Weighted to population totals.

4. Figures for unweighted sample have been rounded independently. The sum of component items does not therefore necessarily add to the totals shown.

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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 number of deaths that are linked to alcohol and information on prescription drugs used for the treatment of alcohol dependence. Information on the cost of alcohol misuse to the NHS is considered.

Data on hazardous or harmful drinking and alcohol dependence are presented from the findings of the report, *Adult psychiatric morbidity in England: results of a household survey, 2007*¹ (APMS 2007). This is a national survey based on adults aged 16 and over living in private households in England and is the third survey of its kind. The APMS is published every seven years with the next survey due to take place in 2014 and the results due for publication in 2015/16.

This chapter also presents an estimate of NHS hospital admissions related to the consumption of alcohol.

Estimates of the number of alcohol-related admissions to hospital are calculated using information on patients' characteristics and diagnoses from the Hospital Episode Statistics (HES) databank², together with estimates for the proportion of cases of a particular disease or injury that are caused by alcohol consumption, known as alcohol-attributable fractions (AAFs). AAFs were calculated for 47 conditions where a causal relationship with alcohol consumption has been established using a method devised by North West Public Health Observatory

(NWPHO³). For some conditions, alcohol consumption causes all cases and so all admissions for these conditions are included (e.g. alcoholic liver diseases), whereas other conditions are partially attributable to alcohol, meaning that only a fraction of these cases can be attributable to alcohol consumption (e.g. cancer of the oesophagus). Thirteen conditions were by definition wholly attributable to alcohol consumption and 34 conditions were partially attributable to alcohol consumption.

NWPHO also publish local level information on alcohol related admissions in the Local Alcohol Profiles for England (LAPE) available at www.lape.org.uk which can be used to supplement the information on alcohol related admissions available in this report.

A review of the methodology used to estimate alcohol related admissions is taking place in the form of a public consultation led by the NWPHO working with the Department of Health and the Health and Social Care Information Centre (HSCIC). The consultation was launched on 31 May 2012, and will run for 12 weeks. Full details, including how to submit comments, can be found on the NWPHO website at: www.lape.org.uk

Information on prescription items for the treatment of alcohol dependence are presented from Prescription Services⁴, a division of the NHS Business Services Authority (NHS BSA) by the HSCIC.

The latest data on deaths from causes directly linked to alcohol consumption in England and Wales are produced by the Office for National Statistics (ONS) in

*Mortality statistics – Deaths registered in 2010*⁵. These are classified by the ICD-10 code and only causes of deaths that are defined by ONS as being wholly or predominantly caused by alcohol consumption are included. This chapter reports on deaths in England only.

Information on estimated costs to the NHS of alcohol misuse are also presented from the government paper, *The cost of alcohol harm to the NHS in England*⁶. This was published in 2008 and is an update to the Cabinet Office study *Alcohol misuse: how much does it cost?*⁷.

4.2 Hazardous, harmful and dependent drinking

The 2007 *Adult Psychiatric Morbidity Survey* (APMS) estimated the prevalence of hazardous or harmful drinking and dependent drinking. Hazardous drinking is a pattern of drinking which brings about the risk of physical or psychological harm. Harmful drinking is defined as a pattern of drinking which is likely to cause physical or psychological harm (a subset of hazardous drinking). Hazardous and harmful drinking were assessed in the survey using the Alcohol Use Disorders Identification Test (AUDIT). This test, developed by the World Health Organisation (WHO), consists of ten questions with five predefined answers, each scoring zero to four points. In the APMS an audit score of eight or more indicated hazardous drinking and score of 16 or more indicated harmful drinking.

In 2007, a quarter of adults, aged 16 and over, in England (24%) were classified as hazardous drinkers. Men were twice as likely as women to be hazardous drinkers (33% of men compared to 16% of women). Younger men and women were more likely to be hazardous drinkers than older adults. A similar pattern was seen for harmful drinking. Six per cent of men and 2% of women were classified as harmful drinkers

and the proportions were lower in older age groups.

Substance dependence is defined by the ICD-10 as a cluster of behavioural, cognitive and physiological phenomena that can develop after repeated substance use and that typically include a strong desire to take the substance, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

The prevalence of alcohol dependence was measured in the APMS by the community version of the Severity of Alcohol Dependence Questionnaire (SADQ-C) and the resulting scores defined in terms of no dependence, mild, moderate and severe dependence. For comparability with data collected in 2000, the prevalence of alcohol dependence has been determined for those aged 16 to 74. Alcohol dependence showed similar patterns to hazardous and harmful drinking. Overall, dependence was higher in men aged 16 to 74 than women in 2007 (9.3% of men compared to 3.6% of women) and was also higher among younger adults.

The prevalence of alcohol dependence in men decreased slightly between 2000 and 2007, with 11.5% of men aged 16 to 74 in 2000 dependent on alcohol, mostly at the mild level. This decreased to 9.3% in 2007, again mostly at the mild level. The same pattern was not seen among women where the levels remained similar.

The 2007 APMS also shows hazardous, harmful and dependent drinking by a number of other characteristics such as ethnicity, region, marital status and income. These can be found in [Chapter 9, pages 151 to 174, of the APMS report](#)¹.

4.3 Discussion of drinking with health professional and specialist treatment

4.3.1 Discussion of drinking with health professionals

Respondents to the Omnibus Survey 2009⁸, carried out by the ONS, 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.

In 2009, one in ten male drinkers and a slightly lower proportion of female drinkers (7%) had such discussions in the last year, the majority of these with their GP. There has been little change since 2000, when this question was first asked, in the proportions having such discussions (Tables 4.17 to 4.19 and pages 77 to 79 of the report).

4.3.2 Specialist alcohol treatment

From April 2008, the Department of Health started collecting and monitoring data on specialist alcohol treatment, requiring providers of specialist treatment for alcohol misuse to submit data to the National Alcohol Treatment Monitoring System (NATMS). The aim is to provide an ongoing published dataset on specialist alcohol treatment in England similar to that already available for drug misuse treatment. A copy of the 2010/11 National Alcohol Treatment Monitoring System report, which covers the data period 1 April 2010 to 31 March 2011 can be found on the National Treatment Agency website⁹.

4.4 Alcohol-related hospital admissions

This section describes trends in finished admission episodes with diseases, injuries and conditions that can be attributed to alcohol consumption. Work in this area was carried out by the North West Public Health Observatory (NWPHO) on commission by the Department of Health using Hospital Episode Statistics² (HES) data from the HSCIC. This is used to determine the proportions of a wide range of diseases and injuries that can be partially attributed to alcohol as well as those that are, by definition, wholly attributable to alcohol.

This data was used in three national indicators created by the previous government; National Indicator 39, Vital Signs Indicator 26 and Public Service Agreement Indicator 25.2. These indicators have not been retained by the current government.

The Department of Health are currently developing an alcohol-related admissions indicator for inclusion in the Public Health Outcomes Framework¹⁰. Although the indicator definition requires further development, currently the preferred option is for an indicator which estimates alcohol related admissions using the narrow measure (primary diagnoses only). The Public Health Outcomes Framework states that this is in order to “minimise the risk of perverse consequences from any changes in coding practice so the indicator rewards local areas for good performance”.

NWPHO also publish local level information on alcohol related admissions in the Local Alcohol Profiles for England (LAPE) available at www.lape.org.uk

Finished Admission Episodes (FAEs) represent the first period of inpatient care under one healthcare provider and are referred to here as 'hospital admissions'.

Hospital admissions data on diagnoses are based on the tenth revision of the International Classification of Diseases (ICD-10). The list of the ICD-10 codes for diseases, injuries and conditions found to be wholly or partly attributable to alcohol can be found in the tables to this chapter. For the purpose of this report, the diseases, injuries and conditions have been split into those which are wholly attributable to alcohol ('alcohol-specific') such as alcoholic liver disease or mental and behavioural disorders due to the use of alcohol, and those which are partly attributable to alcohol such as some cancers, accidents and injuries.

Estimates of the number of alcohol-related admissions to hospital are calculated using information on patients' characteristics and diagnoses from the HES databank, together with estimates for the proportion of cases of a particular disease or injury that are caused by alcohol consumption, known as alcohol-attributable fractions (AAFs). AAFs were calculated for 47 conditions where a causal relationship with alcohol consumption has been established using a method devised by North West Public Health Observatory (NWPHO)³ For some conditions, alcohol consumption causes all cases and so all admissions for these conditions are included (e.g. alcoholic liver diseases), whereas other conditions are partially attributable to alcohol, meaning that only a fraction of these cases can be attributable to alcohol consumption (e.g. cancer of the oesophagus). Thirteen conditions were by definition wholly attributable to alcohol consumption and 34 conditions were partially attributable to alcohol consumption.

To construct alcohol related admission estimates, the AAFs are applied to the data on admitted patients (inpatients) collected in HSCIC HES databank. HES is the

national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. The full list of diseases, injuries and conditions and the age and gender specific attributable fractions that are applied to the HES data can be found in [Table A.3](#) within [Appendix A](#).

For each episode of care in hospital, clinicians record the primary diagnosis and up to 19 secondary diagnoses. The primary diagnosis is defined in the NHS Data Dictionary as "the main condition treated or investigated during the relevant episode of healthcare".

In order to estimate the number of admissions attributable to alcohol, a methodology is used which involves assigning an AAF to each hospital episode that contains at least one of the 47 conditions known to be associated with alcohol consumption in either the primary or one of the 19 secondary diagnosis positions. Where an episode involves more than one alcohol related diagnosis, the AAF associated with the diagnosis most strongly related to alcohol (the one with the highest AAF) is assigned. Where there are two or more codes with equally high AAFs the one which appears earliest in the diagnostic fields is selected. The estimate of the overall number of alcohol related admissions is then derived by summing the AAFs across all episodes.

Within this publication, two main measures of alcohol related admissions are presented: a broad measure and a narrow measure. The 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). The narrow measure is constructed in a similar way but counts only the fraction associated with the diagnosis in the primary position. 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.

In a number of cases, the epidemiological studies on which the AAFs were based estimated the increased risks of morbidity in the general population, rather than among those admitted to hospital. Where this is the case, applying these AAFs to admissions involves making the assumption that the AAFs for admitted patients are the same as those for the general population.

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. 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.

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.

These matters, together with a wider review of the methodology used to estimate alcohol related admissions is taking place in the form of a public consultation led by the NWPHO working with the Department of Health and the HSCIC. The consultation was launched on 31 May 2012, and will run for 12 weeks. Full details, including how to

submit comments, can be found on the NWPHO website: www.lape.org.uk

Estimates based on the broad measure are referred to throughout this chapter as alcohol related admissions, although the issues around the interpretation of these estimates should be borne in mind when interpreting this term. The presentation of estimates in future editions of this report will be reviewed in light of the outcome of this consultation.

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 2010/11, there were an estimated 1,168,300 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 an increase of 11% on the 2009/10 figure (1,056,900) and more than twice as many as in 2002/03 (510,700) ([Table 4.1](#)).

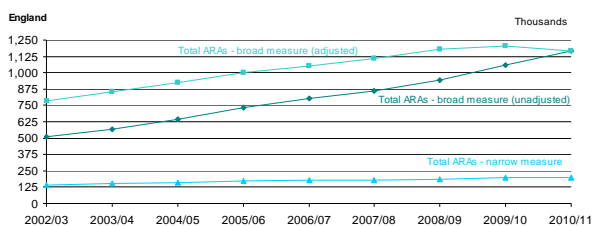
It is important to note that these comparisons over time in the broad measure are complicated by changes in recording practices over the period. All hospital episodes have a primary diagnosis, but the number of secondary diagnoses used depends on the circumstance. At a national level there has been an increase in the coding of secondary conditions. It is likely that this increase in secondary diagnoses is at least partly due to improvements in diagnosis and improvements in recording. This increase in secondary diagnoses affects the estimates based on the broad measure but not the estimates based on the narrow measure.

In order to estimate the trend once changes in recording practices are accounted for, a method has been developed to adjust the national figures so that the adjusted series is free from the effects of changes in recording practice over time. This method and the assumptions that underpin it are explained in [Appendix G](#).

The method produces adjusted figures for earlier years based on what they would be if coding practice for secondary diagnoses in each of those years had matched practice in 2010/11. Because the use of secondary coding positions was less in earlier years, this has the effect of increasing the estimated alcohol related admissions for those years.

Adjusted figures show a 49% increase from an estimated 783,300 alcohol related admissions in 2002/03 but a 3% decrease from 1,208,100 in 2009/10 ([Figure 4.1](#) and [Table 4.11](#)).

Figure 4.11 Alcohol-related NHS hospital admissions (ARAs) 2002/03 to 2010/11



Source: Hospital Episode Statistics, The Health and Social Care Information Centre and North West Public Health Observatory attributable fractions

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Of the estimated 1,168,300 alcohol related admissions (broad measure) in 2010/11, 75% (880,200) were due to conditions which were categorised as chronic, 8% (96,100) were for conditions categorised as acute and 16% (192,000) were for mental and behavioural disorders due to alcohol ([Table 4.2](#)).

In 2010/11, males were more likely to be admitted to hospital with alcohol related diseases, injuries and conditions than females, with 63% of the overall admissions being male patients ([Table 4.3](#)).

In 2010/11 there were 1,895 alcohol-related hospital admissions per 100,000 population in England. Among Strategic Health Authorities (SHAs) the rate of alcohol-related admissions varied from 2,597 and 2,425 per 100,000 population in North East SHA and North West SHA respectively, to 1,335 admissions per 100,000 population in South Central SHA. All rates are age and sex standardised to allow meaningful comparisons ([Table 4.5](#)).

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

Out of the 1,168,300 alcohol-related admissions in 2010/11, approximately 287,200 were for diseases or injuries that were wholly attributable to alcohol consumption or 'alcohol-specific' (i.e. had an attributable fraction of 1). Of this group, mental and behaviour disorders due to the use of alcohol (ICD-10 code F10) was the most common alcohol-related diagnosis, accounting for two-thirds of these admissions (192,000). Additionally, there were around 47,400 admissions with alcoholic liver disease (ICD-10 code K70) and 35,900 admissions with the toxic effects of alcohol types which are common in alcoholic drinks (ICD-10 codes T51.0, T51.1 and T51.9) ([Tables 4.1](#) and [4.3](#)).

4.4.3 Alcohol-related admissions based on the broad measure - admissions relating to partially attributable conditions only

Out of the 1,168,300 admissions in 2010/11, around 881,100 admissions 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). Nearly half of these partly attributable admissions were with hypertensive diseases (ICD-10 codes I10 –

I15), accounting for approximately 436,700 admissions. The second highest condition in this category was cardiac arrhythmias (abnormal electrical activity in the heart, ICD-10 codes I47 – I48) with 204,500 admissions. Admissions with other partly attributable diseases, injuries or conditions were much lower in comparison (Tables 4.1 and 4.3).

4.4.4 Alcohol-related admissions based on the narrow measure (primary diagnosis only) - admissions relating to wholly and partially attributable conditions combined

In 2010/11, there were 198,900 admissions where the primary diagnosis was attributable to the consumption of alcohol (the narrow measure). This is a 2.1% increase since 2009/10 when there were 194,800 admissions of this type and a 40% increase since 2002/03 when there were around 142,000 such admissions (Table 4.6).

Of these, 76% (150,900) were due to conditions which were categorised as chronic, 1% (1,200) were for conditions categorised as acute and 24% (46,800) were for mental and behavioural disorders due to alcohol. As external causes such as accidents and violence are never recorded as primary diagnoses, the number (and percentage) of acute events will be understated (Table 4.7).

Overall in 2010/11 more males than females were admitted to hospital with a primary diagnosis of a condition attributable to alcohol (120,000 and 78,800 admissions respectively) (Table 4.8).

These figures are not affected by changes in secondary diagnosis coding practice.

4.4.5 Alcohol-related admissions based on the narrow measure as a proportion of wider admission numbers

Table 4.9 shows the proportion of all hospital admissions that are estimated to be alcohol related. It also shows the proportion of all cancers, all circulatory diseases and all diseases of the digestive system estimated to be alcohol related. This information is broken down by gender, and there are also data which shows estimates of the number of admissions that are caused by alcohol consumption as a proportion of admissions that can be caused by alcohol consumption (attributable percentage).

It is appropriate that the information found in Table 4.9 is based on the narrow measure only. In order to calculate the attributable percentage for conditions that can be caused by alcohol consumption, the numerator and denominator must be on a compatible basis, and this can only be achieved by working with the narrow measure.

In 2010/11, there were 813,600 hospital admissions with a primary diagnosis of a disease that can be caused by alcohol consumption. Overall, 198,900 (24%) of these were estimated to be attributable to alcohol consumption. This accounts for 1.3% of all hospital admissions.

Overall, 78,800 (0.9%) of all hospital admissions among women were estimated to be alcohol related based on the narrow measure, compared with 120,000 (1.9%) among men.

5.8% (54,400) of all admissions with a primary diagnosis of circulatory disease and 2.3% (36,500) of all admissions with a primary diagnosis of cancer were attributable to alcohol consumption. In addition, 1.7% (29,800) of admissions with a primary diagnosis of diseases of the digestive system were estimated to be alcohol related (Table 4.9).

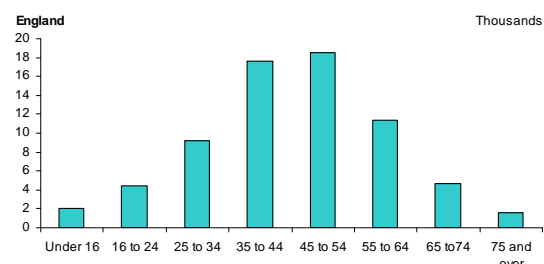
4.4.6 Alcohol-related admissions based on the narrow measure - admissions relating to wholly attributable conditions only

In 2010/11, there were around 69,300 admissions where the primary diagnosis was wholly attributable to alcohol. This is a 1.3% increase since 2009/10 when there were 68,400 admissions of this type and a 54% increase since 2002/03 when there were around 45,000 such admissions.

Mental and behavioural disorders due to alcohol and alcoholic liver disease were the two most common primary reasons for hospitalisation (around 46,800 and 15,700 admissions respectively) (Table 4.6).

Among different age groups, those aged 75 and over had the lowest number of admissions where the primary diagnosis was wholly attributable to alcohol. There was a peak in admissions among those aged 35 to 54 (Figure 4.2).

Figure 4.2 Number of hospital admissions where there was a primary diagnosis of a disease or condition wholly attributable to alcohol, by age, 2010/11



Source: Figures provided by The Department of Health based on Hospital Episode Statistics admissions data and North West Public Health Observatory attributable fractions
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In 2010/11, there were 132 admissions per 100,000 population in England, where the primary diagnosis was wholly attributable to alcohol. Among SHAs the rate varied from 203 per 100,000 in North West SHA to 79 admissions per 100,000 population in South Central SHA. All rates are age and sex standardised to allow meaningful comparisons (Table 4.10).

4.4.7 Alcohol-related admissions based on the narrow measure - admissions relating to partially attributable conditions only

Out of the 198,900 admissions in 2010/11 around 129,600 admissions were for reasons that are partly attributable to alcohol consumption. 28% of these partly attributable admissions were with cancer, accounting for approximately 36,500 admissions. The second highest condition in this category was cardiac arrhythmias (abnormal electrical activity in the heart, ICD-10 codes I47 – I48) with 34,400 (27%) admissions (Table 4.6).

4.5 Prescribing

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).

Acamprosate Calcium 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. Disulfiram produces an acute sensitivity to alcohol resulting in a highly unpleasant reaction when the patient under treatment ingests even small amounts of alcohol.

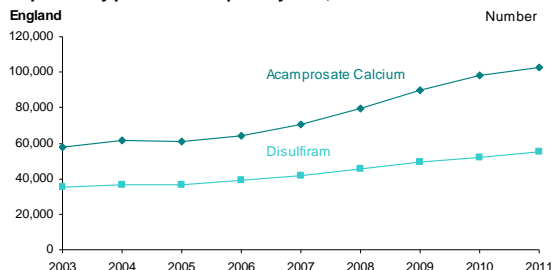
Presented here are data on prescription items and Net Ingredient Cost (NIC) for drugs used to treat alcohol dependence. Prescription items give a measure of how often a prescriber has decided to write a prescription for the treatment of alcohol dependence. The number of items is not a good measure of 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.

In 2011, there were 167,764 prescription items prescribed for the treatment of alcohol dependence in primary care settings or NHS hospitals and dispensed in the community. The majority of these prescription items (94%) were prescribed in a primary care setting (such as a GP surgery, pharmacist or clinic) with only 6% prescribed in NHS hospitals. Overall, this number has increased by 4.7% since 2010 when it was 160,181 and by 63% since 2003 when 102,741 items were prescribed in primary care and NHS hospitals. The Net Ingredient Cost (NIC) of these prescription items in 2011 was £2.49 million, an increase of 3.3% since 2010 when it was £2.41 million and a 45% since 2003 when it was £1.72 million.

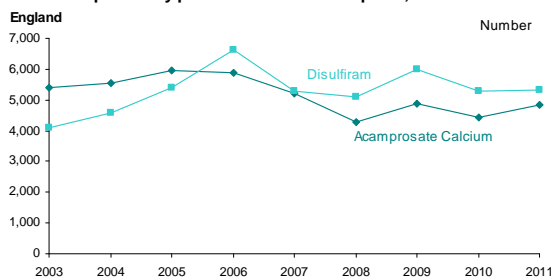
Out of the two main drugs prescribed for the treatment of alcohol dependence, Acamprosate Calcium continues to account for the majority of the prescription items, with 64% of the prescription items prescribed in primary care for alcohol dependence and NHS hospitals in 2011 being for this drug. However, in recent years there have been slightly more prescription items for Disulfiram than Acamprosate Calcium prescribed in NHS hospitals (52% of the items prescribed in hospitals in 2011 were for Disulfiram) (Table 4.12, Figures 4.3 and 4.4).

Figure 4.3 Number of prescription items for the treatment of alcohol dependency prescribed in primary care, 2003 to 2011



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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Figure 4.4 Number of prescription items for the treatment of alcohol dependency prescribed in NHS hospitals, 2003 to 2011



Source: Prescription Cost Analysis (PCA) from NHS Prescription Services of the NHS Business Services Authority, Health and Social Care Information Centre
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In 2011 302 prescription items per 100,000 population were dispensed for alcohol dependency. Among Strategic Health Authorities (SHA) the North West SHA had the highest number of prescription items per 100,000 population (517) and London SHA had the lowest (138).

The North West SHA had the highest number of prescription items per 100,000 population for Acamprosate Calcium (378), while Yorkshire & the Humber SHA had the highest number of prescription items for Disulfiram (198). London SHA had the lowest number of prescription items per 100,000 population for Acamprosate Calcium and Disulfiram (106 and 32 items respectively) (Table 4.13).

4.6 Deaths related to alcohol consumption

Alcohol misuse can be directly related to deaths from certain types of diseases, such as cirrhosis of the liver, and in some cases, may be associated with other causes of death, such as a stroke. Table 4.14 shows deaths from causes directly related to alcohol consumption as defined in *Alcohol-related deaths in the UK 2010*¹¹ by the Office for National Statistics (ONS). The ONS definition of alcohol-related deaths was updated in 2006 to ensure consistency across the UK^{12,13} and currently only includes deaths where the cause is specifically or predominantly related to

alcohol consumption and is also the underlying or main cause of death.

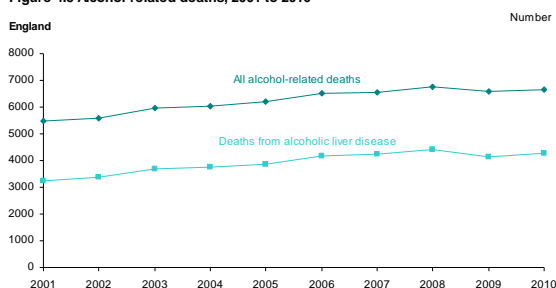
Using the current ONS definition, in England, in 2010 there were 6,669 deaths directly related to alcohol. This is a 22% increase since 2001 when there were 5,476 alcohol related deaths and a 1.3% increase from 2009 when there were 6,584 such deaths

The most common cause of death linked to alcohol consumption was alcoholic liver disease which accounted for 64% (4,275) of all alcohol-related deaths in 2010. This proportion has remained stable throughout the time series (Figure 4.5).

The number of deaths from alcohol-related fibrosis and cirrhosis of the liver were also high among the causes directly related to alcohol consumption accounting for 21% (1,399) of deaths in 2010.

The number of male deaths increased from 4,316 in 2009 to 4,439 in 2010 whereas the number of female deaths decreased from 2,268 in 2009 to 2,230 in 2010. More men than women died from each of the causes directly related to alcohol, except for chronic hepatitis, where the reverse was true.

Figure 4.5 Alcohol-related deaths, 2001 to 2010



Source: DH2 Mortality Statistics - Cause, No.s 28, 29, 30, 31 and 32, 2001, 2002, 2003, 2004, 2005 and Mortality Statistics: Deaths registered in 2006 to 2010, ONS
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In 2008, the North West Public Health Observatory (NWPHO) estimated the number of deaths that can be attributed in some way to alcohol using similar attributable fractions methodology to that

for alcohol-related hospital admissions. For further details on the methodology used to develop the attributable fractions see the NWPHO report *Alcohol-attributable fractions for England – alcohol-attributable deaths and hospital admissions*³. Applying this methodology to 2009 deaths data they estimated that in 2009 there were 15,401 deaths that were attributable to alcohol consumption (10,289 for men and 5,111 for women).

4.7 Costs to the NHS

In 2004, *The Alcohol Harm Reduction Strategy for England*¹⁴ 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*¹⁵. In 2003, the Cabinet Office report *Alcohol misuse: how much does it cost?*⁷ estimated that alcohol misuse costs the health service £1.7 billion per year (in 2001 prices), while the costs associated with alcohol-related crime and anti-social behaviour was estimated to be £7.3 billion each year. It also estimated that workplace costs of alcohol misuse are £6.4 billion per year through loss in productivity.

In 2008, the then government produced an update to the 2003 report. The report, *The cost of alcohol harm to the NHS in England*⁶, takes into account increases in unit costs as well as more recent and accurate data on alcohol consumption and harm. Using similar methods to the 2003 report, it is estimated that the cost of alcohol harm to the NHS in England is £2.7 billion in 2006/07 prices (Figure 4.6).

Figure 4.6 Estimates of the annual cost of alcohol misuse to the NHS in England (2006/07 prices)

	Cost estimate (£m)
Hospital inpatient and day visit	
Directly attributable to alcohol misuse	167.6
Partly attributable to alcohol misuse	1,022.7
Hospital outpatient visits	272.4
Accident and emergency visits	645.7
Ambulance services	372.4
NHS GP consultants	102.1
Practice nurse consultants	9.5
Laboratory tests	N/A
Dependency prescribed drugs	2.1
Specialist treatment services	55.3
Other health care costs	54.4
Total	2,704.1

Source: The cost of alcohol harm to the NHS, The Department of Health

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List of Tables

- 4.1 Alcohol-related NHS hospital admissions based on primary and secondary diagnoses, 2002/03 to 2010/11
- 4.2 Alcohol-related NHS hospital admissions based on primary and secondary diagnoses, by whether condition is categorised as acute, chronic or due to mental and behavioural disorders due to use of alcohol 2002/03 to 2010/11
- 4.3 Alcohol-related NHS hospital admissions based on primary and secondary diagnoses, by gender, 2010/11
- 4.4 Alcohol-related NHS hospital admissions based on primary and secondary diagnoses, by age, 2010/11
- 4.5 Alcohol-related NHS hospital admissions based on primary and secondary diagnoses, by Strategic Health Authority, 2010/11
- 4.6 NHS hospital admissions with a primary diagnosis wholly or partly attributable to alcohol, 2002/03 to 2010/11
- 4.7 NHS hospital admissions with a primary diagnosis attributable to alcohol, by whether condition is categorised as acute, chronic or due to mental and behavioural disorders due to use of alcohol 2002/03 to 2010/11
- 4.8 NHS hospital admissions with a primary diagnosis wholly or partly attributable to alcohol, by gender, 2010/11
- 4.9 NHS hospital admissions, by gender, with a diagnosis of a disease or condition which can be alcohol related, and of those, estimates of the number and percentage where the primary diagnosis was alcohol related (i.e. attributable to alcohol), 2010/11
- 4.10 NHS hospital admissions with a primary diagnosis wholly or partly attributable to alcohol, by Strategic Health Authority, 2010/11
- 4.11 Alcohol-related NHS hospital admission estimates derived using the unadjusted broad measure, adjusted broad measure and narrow measure, 2002/03 to 2010/11
- 4.12 Number of prescription items, net ingredient cost and average net ingredient cost per item of drugs prescribed for the treatment of alcohol dependence dispensed in the community, 2003 to 2011
- 4.13 Number of prescription items and prescription items per 100,000 of the population for the treatment of alcohol dependence prescribed in primary care and dispensed in the community, by Strategic Health Authority, 2011
- 4.14 Alcohol-related deaths by gender, 2001 to 2010

Table 4.1 Alcohol-related¹ NHS² hospital admissions³ based on primary and secondary diagnoses, 2002/03 to 2010/11^{4,5}

England		Number of admissions (rounded to nearest hundred)									
ICD-10 Code ⁶		2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	
Total		510,700	570,100	644,700	736,000	802,000	863,500	945,400	1,056,900	1,168,300	
Total - Wholly attributable⁷		131,100	150,600	173,600	196,700	210,300	222,600	237,800	265,200	287,200	
F10	Mental and behavioural disorders due to use of alcohol	83,400	97,000	113,000	128,100	136,900	144,700	156,500	177,400	192,000	
F10.0	Acute intoxication	22,400	28,100	34,500	41,200	43,300	45,300	47,800	55,200	57,400	
F10.1	Harmful use	18,300	20,700	24,500	27,600	30,500	31,900	35,900	41,100	48,700	
F10.2	Dependence syndrome	29,500	33,200	37,200	40,300	42,400	45,100	48,500	54,700	59,100	
F10.3	Withdrawal state	9,200	10,700	12,600	14,400	16,400	18,000	20,100	21,900	22,300	
F10.4	Withdrawal state with delirium	1,200	1,300	1,300	1,400	1,400	1,200	1,200	1,200	1,100	
F10.5	Psychotic disorder	600	500	600	600	500	500	400	500	400	
F10.6	Amnesic syndrome	600	600	600	700	800	800	900	1,100	1,300	
F10.7	Residual and late-onset psychotic disorder	500	500	500	500	500	500	500	600	700	
F10.8	Other mental and behavioural disorders due to use of alcohol	100	100	100	100	100	100	100	100	100	
F10.9	Unspecified mental and behavioural disorders due to use of alcohol	1,100	1,200	1,100	1,300	1,200	1,400	1,100	1,000	1,000	
K70	Alcoholic liver disease	25,700	28,600	31,500	34,400	37,700	38,300	39,600	43,100	47,400	
K70.0	Alcoholic fatty liver	400	400	600	600	600	700	800	1,000	1,100	
K70.1	Alcoholic hepatitis	1,600	1,800	1,900	2,100	2,200	2,200	2,400	2,700	3,000	
K70.2	Alcoholic fibrosis and sclerosis of liver	200	200	200	200	200	100	100	200	200	
K70.3	Alcoholic cirrhosis of liver	7,200	8,000	9,100	10,200	11,600	12,500	13,900	16,400	19,500	
K70.4	Alcoholic hepatic failure	1,100	1,200	1,300	1,500	1,700	1,800	2,100	2,600	3,000	
K70.9	Alcoholic liver disease, unspecified	15,300	17,000	18,400	19,900	21,200	20,900	20,100	20,200	20,600	
T51⁸	Toxic effect of alcohol	16,000	18,400	21,400	25,800	26,600	30,100	31,700	33,600	35,900	
T51.0	Toxic effect of ethanol	12,300	14,200	16,800	21,200	22,200	25,600	27,400	30,300	32,700	
T51.1	Toxic effect of methanol	100	0	100	100	0	100	0	0	0	
T51.9	Toxic effect of alcohol, unspecified	3,600	4,200	4,400	4,600	4,300	4,500	4,200	3,300	3,200	
Other wholly - attributable conditions		6,000	6,700	7,700	8,500	9,200	9,500	10,100	11,200	11,800	
E24.4	Alcohol-induced pseudo-Cushing's syndrome	0	0	0	0	0	0	0	0	0	
G31.2	Degeneration of nervous system due to alcohol	400	400	400	500	500	600	500	700	700	
G62.1	Alcoholic polyneuropathy	200	200	300	300	300	300	300	300	400	
G72.1	Alcoholic myopathy	100	100	0	100	100	100	100	100	100	
I42.6	Alcoholic cardiomyopathy	800	800	900	900	900	1,000	1,000	1,100	1,100	
K29.2	Alcoholic gastritis	1,200	1,200	1,500	1,600	1,600	1,500	1,800	1,900	2,000	
K86.0	Chronic pancreatitis (alcohol induced)	3,100	3,800	4,400	5,000	5,700	5,900	6,300	7,000	7,400	
X45	Accidental poisoning by and exposure to alcohol	200	100	200	200	100	100	200	200	100	
Total - partly attributable⁹		379,700	419,400	471,100	539,300	591,700	641,000	707,600	791,700	881,100	
Accidents and injuries		20,000	21,000	21,900	23,300	23,600	23,800	25,100	27,000	26,200	
W78-W79	Inhalation of gastric contents/Inhalation and ingestion of food causing obstruction of the respiratory tract	200	200	200	300	300	400	500	700	700	
W00-W19	Fall injuries	17,400	18,300	19,200	20,400	20,700	20,900	22,000	23,800	23,000	
W24-W31	Work/machine injuries	1,400	1,500	1,500	1,600	1,600	1,500	1,500	1,500	1,400	
W32-W34	Firearm injuries	200	200	200	200	200	200	200	100	100	
W65-W74	Drowning	0	0	0	0	0	100	0	0	100	
X00-X09	Fire injuries	600	600	700	700	700	700	700	700	700	
X31	Accidental excessive cold	100	100	100	100	100	100	100	200	200	
Violence		21,700	24,000	26,100	28,500	29,000	28,000	28,200	28,100	28,800	
X60-X84, Y10-Y33	Intentional self-harm/Event of undetermined intent	14,200	16,000	17,500	19,400	19,200	19,100	19,500	19,600	20,700	
X85-Y09	Assault	7,500	8,100	8,700	9,200	9,800	8,900	8,700	8,500	8,100	
Transport accidents		5,700	5,800	5,800	6,200	6,000	6,000	5,400	5,300	5,000	
V02-V04 (1, 9), V06.1, V09.2, V09.3	Pedestrian traffic accidents	1,100	1,100	1,100	1,200	1,200	1,200	1,100	1,100	1,000	
for codes see footnote 10	Road traffic accidents - non-pedestrian	4,500	4,600	4,600	4,900	4,700	4,600	4,200	4,200	3,800	
V90-V94	Water transport accidents	100	100	100	100	100	100	100	100	100	
V95-V97	Air/space transport accidents	0	0	0	0	0	0	0	0	0	
Spontaneous abortion		8,700	8,700	9,000	9,600	9,000	9,000	8,900	9,300	8,800	
O03	Spontaneous abortion	8,700	8,700	9,000	9,600	9,000	9,000	8,900	9,300	8,800	
Digestive		14,000	14,800	15,400	17,100	18,100	19,200	20,600	22,200	25,000	
K22.6	Gastro-oesophageal laceration-haemorrhage syndrome	1,100	1,100	1,100	1,200	1,200	1,200	1,200	1,200	1,100	
K73, K74	Unspecified liver disease	5,800	6,400	6,900	8,100	8,700	9,500	10,400	11,800	14,200	
K85, K86.1	Acute and chronic pancreatitis	3,300	3,400	3,400	3,500	3,600	3,600	3,700	3,900	4,100	
I85	Oesophageal varices	3,700	3,900	3,900	4,200	4,600	4,900	5,300	5,400	5,600	
Cancer		29,400	30,300	31,100	33,100	35,200	35,800	36,900	36,900	37,600	
C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	5,200	5,500	6,000	6,600	7,600	8,000	9,100	9,700	10,300	
C15	Malignant neoplasm of oesophagus	7,800	7,900	7,900	8,500	8,400	8,000	8,000	7,400	7,100	
C32	Malignant neoplasm of larynx	1,200	1,300	1,300	1,400	1,400	1,500	1,500	1,500	1,500	
C18	Malignant neoplasm of colon	2,800	2,700	2,600	2,700	2,500	2,400	2,400	2,200	2,200	
C20	Malignant neoplasm of rectum	2,800	2,700	2,500	2,700	2,400	2,200	2,200	2,100	2,100	
C22	Malignant neoplasm of liver and intrahepatic bile ducts	500	500	500	600	600	600	700	700	700	
C50	Malignant neoplasm of breast	9,100	9,700	10,300	10,800	12,200	13,000	13,100	13,300	13,600	
Hypertensive diseases		136,000	159,400	191,200	228,700	262,200	292,700	333,500	383,900	436,700	
I10-I15	Hypertensive diseases	136,000	159,400	191,200	228,700	262,200	292,700	333,500	383,900	436,700	
Cardiac arrhythmias		87,000	95,700	106,200	121,600	132,700	146,300	163,000	182,300	204,500	
I47-I48	Cardiac arrhythmias	87,000	95,700	106,200	121,600	132,700	146,300	163,000	182,300	204,500	
Other partly-attributable conditions		57,200	59,700	64,300	71,300	75,900	80,100	86,100	96,600	108,600	
G40-G41	Epilepsy and Status epilepticus	48,800	51,300	56,700	63,100	67,800	71,800	77,300	86,500	97,200	
I60-I62, I69.0-I69.2	Haemorrhagic stroke	2,900	2,800	2,700	2,700	2,600	2,400	2,400	2,400	2,300	
I63-I66, I69.3, I69.4	Ischaemic stroke	1,600	1,500	1,400	1,400	1,200	1,100	1,200	1,200	1,300	
L40 excluding cirrhosis L40.5	Psoriasis	4,000	4,100	3,400	4,200	4,500	4,800	5,100	6,500	7,800	

1. The number of alcohol-related admissions is based on methodology developed by the North West Public Health Observatory (NWPHO). This methodology includes a wide range of diseases, injuries and conditions in which alcohol plays a part and estimates the proportion of cases that are attributable to the consumption of alcohol. Finished admission episodes are identified where an alcohol-related diagnosis is recorded in any of the 20 (14 from 2002/03 to 2006/07 and 7 prior to 2002/03) primary and secondary diagnosis fields in a Hospital Admission Statistics record. For each of these episodes, an attributable fraction is applied, based on the diagnostic codes, age group and gender of the patient. Where there is more than one alcohol-related condition among the diagnostic codes, the condition with the largest attributable fraction is used. Where there are two or more codes with the maximum attributable fraction, the code from the earliest diagnostic 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.

2. The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.
 3. A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.
 4. Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed).
 5. Data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions or no fixed abode or unknown.
 6. See Appendix A for further information about International Classification of Diseases.
 7. Wholly attributable conditions are alcohol-specific by definition and so have an attributable fraction of one.
 8. The totals shown for T51 - Toxic effect of alcohol, do not include the full breakdown for ICD-10 code T51, only T51.0, T51.1 and T51.9 as these cover types of alcohol most commonly found in alcoholic drinks.
 9. Partially attributable conditions are those where some but not all cases are a result of alcohol consumption and so have an attributable fraction of less than one.
 10. ICD-10 codes for road traffic accidents: V12-V14 (3 - 9), V19.4-V19.6, V19.9, V20-V28 (3 - 9), V29-V79 (4 - 9), V80.3-V80.5, V81.1, V82.1, V82.9, V83.0-V86 (0 - 3), V87.0-V87.9, V89.2, V89.3, V89.9.
 11. Admission numbers for 2002/03 to 2006/07 have been updated to include records relating to disease codes K73 (chronic hepatitis) and L40 (psoriasis), that were excluded unintentionally from the previous figures. As a result the latest figures are slightly higher than those published in the 2009 report. The minimum effect at a national level is to increase the total number of admissions by 543 admissions (0.07%) in 2005/06, whilst the maximum effect is an increase of 2,946 (0.37%) in 2006/07.
 12. Due to very minor revisions to historic data, the overall totals presented in row 6 of this table are 100 less than the totals presented in Table 4.1 of *Statistics on Alcohol, England 2011* for 2002/03 and each year from 2005/06 to 2009/10.
 13. All figures are rounded to the nearest hundred. Therefore a figure of '0' corresponds to an unrounded number of less than 50.

Sources:
 Figures provided by The Department of Health based on:
 Hospital Episode Statistics, Health and Social Care Information Centre - Data for total number of admissions for each ICD-10 code.
 North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.2 Alcohol-related¹ NHS² hospital admissions³ based on primary and secondary diagnoses, by whether condition is categorised as acute, chronic or due to mental and behavioural disorders due to use of alcohol⁴ 2002/03 to 2010/11^{5,6}

England	Number of admissions (rounded to nearest hundred)								
	2002/03 ⁷	2003/04 ⁷	2004/05 ⁷	2005/06 ⁷	2006/07 ⁷	2007/08 ⁷	2008/09 ⁷	2009/10 ⁷	2010/11 ⁷
Total	510,700	570,100	644,700	736,000	802,000	863,500	945,400	1,056,900	1,168,300
Acute	63,500	69,400	75,400	83,900	85,300	88,100	90,500	94,200	96,100
Chronic	363,800	403,700	456,200	524,000	579,900	630,800	698,400	785,400	880,200
Mental and behavioural disorders due to use of alcohol	83,400	97,000	113,000	128,100	136,900	144,700	156,500	177,400	192,000

1. The number of alcohol-related admissions is based on methodology developed by the North West Public Health Observatory (NWPHO). This methodology includes a wide range of diseases, injuries and conditions in which alcohol plays a part and estimates the proportion of cases that are attributable to the consumption of alcohol. Finished admission episodes are identified where an alcohol-related diagnosis is recorded in any of the 20 (14 from 2002/03 to 2006/07 and 7 prior to 2002/03) primary and secondary diagnosis fields in a Hospital Admission Statistics record. For each of these episodes, an attributable fraction is applied, based on the diagnostic codes, age group and gender of the patient. Where there is more than one alcohol-related condition among the diagnostic codes, the condition with the largest attributable fraction is used. Where there are two or more codes with the maximum attributable fraction, the code from the earliest diagnostic 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.

2. The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.

3. A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

4. For the purpose of the analyses which appears in this table, each of the 47 alcohol related conditions which appear in table 4.1 have been classified as either acute, chronic or as a mental and behavioural disorder due to use of alcohol. This has been done using the classification defined and used by North West Public Health Observatory (NWPHO) and published in the 'NI39 Subanalysis by 10 conditions' available at www.lape.org.uk/natind.html

5. Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed).

6. Data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions or no fixed abode or unknown.

7. Admission numbers for 2002/03 to 2006/07 have been updated to include records relating to disease codes K73 (chronic hepatitis) and L40 (psoriasis), that were excluded unintentionally from the previous figures. As a result the latest figures are slightly higher than those published in the 2009 report. The minimum effect at a national level is to increase the total number of admissions by 543 admissions (0.07%) in 2005/06, whilst the maximum effect is an increase of 2,946 (0.37%) in 2006/07.

Sources:

Figures provided by The Department of Health based on:

Hospital Episode Statistics, Health and Social Care Information Centre - Data for total number of admissions for each ICD-10 code.

North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.3 Alcohol-related¹ NHS² hospital admissions³ based on primary and secondary diagnoses, by gender, 2010/11^{4,5}

England		Number of admissions (rounded to nearest hundred)		
ICD-10 Code ⁶		All persons	Males	Females
Total		1,168,300	731,000	437,200
Total - Wholly attributable⁷		287,200	197,000	90,200
F10	Mental and behavioural disorders due to use of alcohol	192,000	138,600	53,400
F10.0	Acute intoxication	57,400	41,200	16,200
F10.1	Harmful use	48,700	35,000	13,700
F10.2	Dependence syndrome	59,100	42,300	16,900
F10.3	Withdrawal state	22,300	16,800	5,500
F10.4	Withdrawal state with delirium	1,100	800	300
F10.5	Psychotic disorder	400	300	100
F10.6	Amnesic syndrome	1,300	1,000	300
F10.7	Residual and late-onset psychotic disorder	700	500	200
F10.8	Other mental and behavioural disorders due to use of alcohol	100	0	0
F10.9	Unspecified mental and behavioural disorders due to use of alcohol	1,000	600	400
K70	Alcoholic liver disease	47,400	32,900	14,500
K70.0	Alcoholic fatty liver	1,100	800	400
K70.1	Alcoholic hepatitis	3,000	1,900	1,100
K70.2	Alcoholic fibrosis and sclerosis of liver	200	200	100
K70.3	Alcoholic cirrhosis of liver	19,500	13,900	5,600
K70.4	Alcoholic hepatic failure	3,000	2,000	1,000
K70.9	Alcoholic liver disease, unspecified	20,600	14,200	6,400
T51⁸	Toxic effect of alcohol	35,900	16,200	19,800
T51.0	Toxic effect of ethanol	32,700	14,700	18,000
T51.1	Toxic effect of methanol	0	0	0
T51.9	Toxic effect of alcohol, unspecified	3,200	1,400	1,700
Other wholly - attributable conditions		11,800	9,400	2,500
E24.4	Alcohol-induced pseudo-Cushing's syndrome	0	0	0
G31.2	Degeneration of nervous system due to alcohol	700	500	200
G62.1	Alcoholic polyneuropathy	400	300	100
G72.1	Alcoholic myopathy	100	100	0
I42.6	Alcoholic cardiomyopathy	1,100	1,000	100
K29.2	Alcoholic gastritis	2,000	1,500	500
K86.0	Chronic pancreatitis (alcohol induced)	7,400	5,900	1,600
X45	Accidental poisoning by and exposure to alcohol	100	100	100
Total - partly attributable⁸		881,100	534,000	347,000
Accidents and injuries		26,200	16,100	10,100
W78-W79	Inhalation of gastric contents/Inhalation and ingestion of food causing obstruction of the respiratory tract	700	300	400
W00-W19	Fall injuries	23,000	14,000	9,000
W24-W31	Work/machine injuries	1,400	1,100	300
W32-W34	Firearm injuries	100	100	0
W65-W74	Drowning	100	0	0
X00-X09	Fire injuries	700	400	200
X31	Accidental excessive cold	200	100	100
Violence		28,800	14,800	14,000
X60-X84, Y10-Y33	Intentional self-harm/Event of undetermined intent	20,700	8,200	12,600
X85-Y09	Assault	8,100	6,600	1,400
Transport accidents		5,000	4,100	900
V02-V04 (1, 9), V06.1, V09.2, V09.3 for codes see footnote 10	Pedestrian traffic accidents	1,000	800	200
V90-V94	Road traffic accidents - non-pedestrian	3,800	3,200	600
V95-V97	Water transport accidents	100	100	0
	Air/space transport accidents	0	0	0
Spontaneous abortion		8,800	-	8,800
O03	Spontaneous abortion	8,800	-	8,800
Digestive		25,000	15,600	9,400
K22.6	Gastro-oesophageal laceration-haemorrhage syndrome	1,100	600	500
K73, K74	Unspecified liver disease	14,200	8,400	5,800
K85, K86.1	Acute and chronic pancreatitis	4,100	2,700	1,400
I85	Oesophageal varices	5,600	3,800	1,700
Cancer		37,600	18,900	18,700
C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	10,300	8,200	2,100
C15	Malignant neoplasm of oesophagus	7,100	5,700	1,400
C32	Malignant neoplasm of larynx	1,500	1,300	200
C18	Malignant neoplasm of colon	2,200	1,500	700
C20	Malignant neoplasm of rectum	2,100	1,600	500
C22	Malignant neoplasm of liver and intrahepatic bile ducts	700	500	200
C50	Malignant neoplasm of breast	13,600	-	13,600
Hypertensive diseases		436,700	288,200	148,400
I10-I15	Hypertensive diseases	436,700	288,200	148,400
Cardiac arrhythmias		204,500	123,100	81,300
I47-I48	Cardiac arrhythmias	204,500	123,100	81,300
Other partly-attributable conditions		108,600	53,200	55,400
G40-G41	Epilepsy and Status epilepticus	97,200	46,200	50,900
I60-I62, I69.0-I69.2	Haemorrhagic stroke	2,300	1,600	700
I63-I66, I69.3, I69.4	Ischaemic stroke	1,300	1,300	0
L40 excluding cirrhosis L40.5	Psoriasis	7,800	4,100	3,700

1. The number of alcohol-related admissions is based on methodology developed by the North West Public Health Observatory (NWPHO). This methodology includes a wide range of diseases, injuries and conditions in which alcohol plays a part and estimates the proportion of cases that are attributable to the consumption of alcohol. Finished admission episodes are identified where an alcohol-related diagnosis is recorded in any of the 20 (14 from 2002/03 to 2006/07 and 7 prior to 2002/03) primary and secondary diagnosis fields in a Hospital Episode Statistics record. For each of these episodes, an attributable fraction is applied, based on the diagnostic codes, age group and gender of the patient. Where there is more than one alcohol-related condition among the diagnostic codes, the condition with the largest attributable fraction is used. Where there are two or more codes with the maximum attributable fraction, the code from the earliest diagnostic 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 alcohol-related condition.

- The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.
- A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.
- Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed).
- Data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions or no fixed abode or unknown.
- See Appendix A for further information about International Classification of Diseases.
- Wholly attributable conditions are alcohol-specific by definition and so have an attributable fraction of one.
- The totals shown for T51 - Toxic effect of alcohol, do not include the full breakdown for ICD-10 code T51, only T51.0, T51.1 and T51.9 as these cover types of alcohol most commonly found in alcoholic drinks.
- Partially attributable conditions are those where some but not all cases are a result of alcohol consumption and so have an attributable fraction of less than one.
- ICD-10 codes for road traffic accidents: V12-V14 (3 - 9), V19.4-V19.6, V19.9, V20-V28 (3 - 9), V29-V79 (4 - 9), V80.3-V80.5, V81.1, V82.1, V82.9, V83.0-V86 (0 - 3), V87.0-V87.9, V89.2, V89.3, V89.9.
- A '-' indicates there were no observations.
- All figures are rounded to the nearest hundred. Therefore a figure of '0' corresponds to an unrounded number of less than 50.

Sources:

Figures provided by The Department of Health based on:
 Hospital Episode Statistics, Health and Social Care Information Centre - Data for total number of admissions for each ICD-10 code.
 North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.4 Alcohol-related¹ NHS² hospital admissions³ based on primary and secondary diagnoses, by age, 2010/11^{4,5}

England	Number of admissions (rounded to nearest hundred)								
	Total	Under 16 ⁶	16 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75 and over
Total	1,168,300	3,100	54,300	71,600	117,700	174,700	225,900	232,300	288,600
Wholly-attributable ⁷	287,200	3,100	23,300	36,600	63,400	69,400	50,900	27,900	12,600
Partly-attributable ⁸	881,100	-	31,100	35,000	54,300	105,300	175,000	204,400	276,000

1. The number of alcohol-related admissions is based on methodology developed by the North West Public Health Observatory (NWPHO). This methodology includes a wide range of diseases, injuries and conditions in which alcohol plays a part and estimates the proportion of cases that are attributable to the consumption of alcohol. Finished admission episodes are identified where an alcohol-related diagnosis is recorded in any of the 20 (14 from 2002/03 to 2006/07 and 7 prior to 2002/03) primary and secondary diagnosis fields in a Hospital Episode Statistics record. For each of these episodes, an attributable fraction is applied, based on the diagnostic codes, age group and gender of the patient. Where there is more than one alcohol-related condition among the diagnostic codes, the condition with the largest attributable fraction is used. Where there are two or more codes with the maximum attributable fraction, the code from the earliest diagnostic 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.

2. The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.

3. A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

4. Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed).

5. Data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions or no fixed abode or unknown.

6. The attributable fractions are not applicable to children under 16, therefore data is only shown for wholly-attributable admissions for this age group, where the attributable fraction is one.

7. Wholly-attributable conditions are alcohol-specific by definition and so have an attributable fraction of one.

8. Partially-attributable conditions are those where some but not all cases are a result of alcohol consumption and so have an attributable fraction of less than one.

9. A '-' indicates there were no observations.

Sources:

Figures provided by The Department of Health based on:

Hospital Episode Statistics, Health and Social Care Information Centre - Data for total number of admissions for each ICD-10 code.

North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.5 Alcohol-related¹ NHS² hospital admissions³ based on primary and secondary diagnoses, by Strategic Health Authority,

England			Number of admissions (rounded to nearest hundred)					
			Total		Wholly-attributable ⁶		Partly-attributable ⁷	
			Number of admissions per 100,000 population ⁸		Number of admissions per 100,000 population ⁸		Number of admissions per 100,000 population ⁸	
			Admissions	population ⁸	Admissions	population ⁸	Admissions	population ⁸
England			1,168,300	1,895	287,200	536	881,100	1,359
Q30	E18000001	North East SHA	80,700	2,597	21,900	823	58,800	1,773
Q31	E18000002	North West SHA	196,000	2,425	60,300	851	135,700	1,575
Q32	E18000003	Yorkshire & Humber SHA	119,700	1,941	30,800	574	88,900	1,367
Q33	E18000004	East Midlands SHA	97,600	1,813	21,600	475	75,900	1,338
Q34	E18000005	West Midlands SHA	123,700	1,910	28,700	521	95,000	1,390
Q35	E18000006	East England SHA	119,400	1,631	20,800	343	98,600	1,288
Q36	E18000007	London SHA	146,400	1,912	35,900	477	110,500	1,435
Q37	E18000008	South East Coast SHA	87,200	1,564	17,200	384	70,000	1,180
Q38	E18000009	South Central SHA	65,600	1,335	14,800	344	50,800	991
Q39	E18000010	South West SHA	119,600	1,754	26,400	484	93,200	1,270

1. The number of alcohol-related admissions is based on methodology developed by the North West Public Health Observatory (NWPHO). This methodology includes a wide range of diseases, injuries and conditions in which alcohol plays a part and estimates the proportion of cases that are attributable to the consumption of alcohol. Finished admission episodes are identified where an alcohol-related diagnosis is recorded in any of the 20 (14 from 2002/03 to 2006/07 and 7 prior to 2002/03) primary and secondary diagnosis fields in a Hospital Episode Statistics record. For each of these episodes, an attributable fraction is applied, based on the diagnostic codes, age group and gender of the patient.

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

2. The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.

3. A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

4. Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed).

5. Data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions. The England admissions total differs from the sum of the 10 individual SHAs as cases of no fixed or unknown abode are included in the England figure but excluded from the individual SHA figures.

6. Wholly attributable conditions are alcohol-specific by definition and so have an attributable fraction of one.

7. Partially attributable conditions are those where some but not all cases are a result of alcohol consumption and so have an attributable fraction of less than one.

8. Admissions per 100,000 population are age and gender standardised. Mid-2010 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 European Standard population in each age and gender group.

Sources:

Figures provided by The Department of Health based on:

Hospital Episode Statistics, Health and Social Care Information Centre - Data for total number of admissions for each ICD-10 code.

North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.6 NHS¹ hospital admissions² with a primary diagnosis³ wholly⁴ or partly⁵ attributable to alcohol, 2002/03 to 2010/11^{6,7,8}

England		Number of admissions (rounded to nearest hundred)								
ICD-10 Code ⁹		2002/03 ¹⁴	2003/04 ¹⁴	2004/05 ¹⁴	2005/06 ¹⁴	2006/07 ¹⁴	2007/08	2008/09	2009/10	2010/11
Total		142,000	151,000	160,500	173,900	179,900	181,300	185,800	194,800	198,900
Total - Wholly attributable⁴		45,000	49,500	55,200	59,600	61,400	62,400	63,300	68,400	69,300
F10	Mental and behavioural disorders due to use of alcohol	28,500	31,800	36,000	39,500	40,300	41,200	42,500	46,900	46,800
F10.0	Acute intoxication	7,500	9,800	12,200	15,400	15,900	15,800	16,000	18,300	18,500
F10.1	Harmful use	2,400	2,500	2,900	2,900	2,500	2,700	2,900	2,900	2,900
F10.2	Dependence syndrome	10,100	10,200	10,300	9,300	8,800	8,500	8,300	9,200	9,000
F10.3	Withdrawal state	5,900	6,800	8,000	9,300	10,700	11,800	13,300	14,600	14,500
F10.4	Withdrawal state with delirium	900	1,000	1,000	1,100	1,100	900	1,000	900	900
F10.5	Psychotic disorder	500	400	500	500	400	400	300	400	300
F10.6	Amnesic syndrome	300	300	200	200	300	200	300	300	300
F10.7	Residual and late-onset psychotic disorder	200	200	200	200	100	200	100	100	200
F10.8	Other mental and behavioural disorders due to use of alcohol	100	100	100	100	100	0	0	0	0
F10.9	Unspecified mental and behavioural disorders due to use of alcohol	600	600	600	600	500	600	400	300	300
K70	Alcoholic liver disease	11,500	12,200	13,100	13,800	14,500	14,300	14,200	14,700	15,700
K70.0	Alcoholic fatty liver	100	200	200	200	200	200	200	200	200
K70.1	Alcoholic hepatitis	1,100	1,200	1,200	1,300	1,400	1,400	1,500	1,600	1,700
K70.2	Alcoholic fibrosis and sclerosis of liver	100	100	100	100	100	100	100	100	100
K70.3	Alcoholic cirrhosis of liver	3,100	3,400	3,800	4,200	4,800	4,800	4,900	5,700	6,300
K70.4	Alcoholic hepatic failure	800	800	900	1,000	1,100	1,100	1,400	1,600	1,900
K70.9	Alcoholic liver disease, unspecified	6,300	6,500	6,800	7,000	7,000	6,700	6,100	5,600	5,500
T51¹⁰	Toxic effect of alcohol	1,300	1,400	1,600	1,400	1,400	1,700	1,400	1,200	1,200
T51.0	Toxic effect of ethanol	800	900	1,000	1,000	900	1,100	1,000	900	900
T51.1	Toxic effect of methanol	0	0	0	0	0	0	0	0	0
T51.9	Toxic effect of alcohol, unspecified	500	500	600	400	500	500	400	200	200
Other wholly - attributable conditions		3,800	4,100	4,500	4,900	5,200	5,200	5,200	5,600	5,600
E24.4	Alcohol-induced pseudo-Cushing's syndrome	0	0	0	0	0	0	0	0	0
G31.2	Degeneration of nervous system due to alcohol	200	300	300	300	300	300	200	300	300
G62.1	Alcoholic polyneuropathy	100	100	100	100	100	100	100	100	100
G72.1	Alcoholic myopathy	0	100	0	100	0	0	0	0	0
I42.6	Alcoholic cardiomyopathy	200	200	200	200	200	200	200	200	200
K29.2	Alcoholic gastritis	900	1,000	1,200	1,300	1,300	1,300	1,500	1,600	1,700
K86.0	Chronic pancreatitis (alcohol induced)	2,200	2,500	2,700	3,000	3,200	3,300	3,100	3,300	3,300
X45	Accidental poisoning by and exposure to alcohol	0	0	0	0	0	0	0	0	0
Total - partly attributable⁵		97,100	101,500	105,300	114,300	118,500	119,000	122,500	126,500	129,600
Accidents and injuries										
W78-W79	Inhalation of gastric contents/inhalation and ingestion of food causing obstruction of the respiratory tract	-	-	-	-	-	-	-	-	-
W00-W19	Fall injuries	-	-	-	-	-	-	-	-	-
W24-W31	Work/machine injuries	-	-	-	-	-	-	-	-	-
W32-W34	Firearm injuries	-	-	-	-	-	-	-	-	-
W65-W74	Drowning	-	-	-	-	-	-	-	-	-
X00-X09	Fire injuries	-	-	-	-	-	-	-	-	-
X31	Accidental excessive cold	-	-	-	-	-	-	-	-	-
Violence										
X60-X84, Y10-Y33	Intentional self-harm/Event of undetermined intent	-	-	-	-	-	-	-	-	-
X85-Y09	Assault	-	-	-	-	-	-	-	-	-
Transport accidents										
V02-V04 (.1, .9), V06.1, V09.2, V09.3	Pedestrian traffic accidents	-	-	-	-	-	-	-	-	-
for codes see footnote 15	Road traffic accidents - non-pedestrian	-	-	-	-	-	-	-	-	-
V90-V94	Water transport accidents	-	-	-	-	-	-	-	-	-
V95-V97	Air/space transport accidents	-	-	-	-	-	-	-	-	-
Spontaneous abortion		8,700	8,700	9,000	9,500	9,000	9,000	8,900	9,300	8,800
O03	Spontaneous abortion	8,700	8,700	9,000	9,500	9,000	9,000	8,900	9,300	8,800
Digestive		10,000	10,300	10,500	11,300	11,800	12,200	12,500	13,000	13,700
K22.6	Gastro-oesophageal laceration-haemorrhage syndrome	900	900	900	1,000	1,000	1,000	900	900	900
K73, K74 ¹³	Unspecified liver disease	2,200	2,400	2,300	2,700	2,700	2,800	2,900	2,900	3,500
K85, K86.1	Acute and chronic pancreatitis	3,200	3,400	3,600	3,700	3,900	4,000	4,200	4,500	4,600
I85	Oesophageal varices	3,600	3,600	3,700	3,900	4,200	4,400	4,600	4,600	4,600
Cancer		27,800	28,800	29,700	32,000	34,200	34,600	35,600	35,900	36,500
C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	4,600	4,800	5,200	5,800	6,600	6,900	7,700	8,200	8,700
C15	Malignant neoplasm of oesophagus	7,400	7,600	7,600	8,300	8,300	7,900	7,800	7,300	7,000
C32	Malignant neoplasm of larynx	1,100	1,100	1,200	1,300	1,300	1,300	1,300	1,300	1,300
C18	Malignant neoplasm of colon	2,900	2,700	2,700	2,800	2,700	2,700	2,700	2,600	2,600
C20	Malignant neoplasm of rectum	2,800	2,800	2,600	2,800	2,600	2,400	2,400	2,300	2,300
C22	Malignant neoplasm of liver and intrahepatic bile ducts	500	500	500	600	700	700	800	800	1,000
C50	Malignant neoplasm of breast	8,600	9,300	9,900	10,400	12,000	12,700	12,900	13,300	13,600
Hypertensive diseases		3,600	5,000	6,200	7,700	9,100	6,600	7,700	8,500	9,300
I10-I15	Hypertensive diseases	3,600	5,000	6,200	7,700	9,100	6,600	7,700	8,500	9,300
Cardiac arrhythmias		25,000	26,100	27,000	29,400	30,200	31,700	32,400	33,600	34,400
I47-I48	Cardiac arrhythmias	25,000	26,100	27,000	29,400	30,200	31,700	32,400	33,600	34,400
Other partly-attributable conditions		22,000	22,600	22,900	24,300	24,300	24,800	25,200	26,200	26,800
G40-G41	Epilepsy and Status epilepticus	14,500	15,100	16,200	17,300	17,500	17,800	18,200	18,500	18,900
I60-I62, I69.0-I69.2	Haemorrhagic stroke	3,500	3,500	3,500	3,700	3,600	3,700	3,800	3,900	4,000
I63-I66, I69.3, I69.4	Ischaemic stroke	1,600	1,600	1,700	1,600	1,600	1,600	1,600	1,800	1,900
L40 excluding cirrhosis L40.5	Psoriasis									
		2,400	2,300	1,500	1,700	1,500	1,600	1,600	2,100	2,000

1. The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.
 2. A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.
 3. 'Primary diagnosis only' alcohol related admission estimates are derived by summing the alcohol attributable fraction (AAF) associated with the alcohol related condition which appears in the primary diagnosis field (where there is one, out of the 47 such conditions identified in Table A.3 within Appendix A) regardless of whether or not there is an alcohol related condition with a higher AAF in one of the secondary diagnosis positions.
 4. Wholly attributable conditions are alcohol-specific by definition and so have an attributable fraction of one.
 5. Partially attributable conditions are those where some but not all cases are a result of alcohol consumption and so have an attributable fraction of less than one.
 6. Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed).
 7. Data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions or no fixed abode or unknown.
 8. Figures for 2002/03 to 2006/07 are slightly different to those published in previous *Statistics on Alcohol: England* reports as more ICD-10 codes have been included in the group of wholly-attributable diseases, conditions and injuries and these data only include those records where age and sex were known, whereas previous data included records where age and/or sex was not specified.
 9. See Appendix A for further information about International Classification of Diseases.
 10. The totals shown for T51 - Toxic effect of alcohol, do not include the full breakdown for ICD-10 code T51, only T51.0, T51.1 and T51.9 as these cover types of alcohol most commonly found in alcoholic drinks.
 11. A '-' indicates there were no observations. This is due the ICD-10 codes against which a '-' is recorded belonging to a group known as 'cause codes'. Such conditions are always recorded as a secondary diagnosis, and are never recorded in the primary position. They include acute conditions/injuries such as accidents, violence, etc (see rows 42 to 56 for the full list).
 12. All figures are rounded to the nearest hundred. Therefore a figure of '0' corresponds to an unrounded number of less than 50.
 13. There was an error in the 2009/10 admissions figures published in Table 4.5 of 'Statistics on Alcohol: England, 2011' for 'Unspecified liver disease' (K73, K74) and 'Acute and chronic pancreatitis' (K85, K86.1), which both appear under the 'Digestive' heading. This was a transcription error. In 2009/10, there were in fact 2,900 (rather than 4,500) admissions for 'Unspecified liver disease' and 4,500 (rather than 2,900) admissions for 'Acute and chronic pancreatitis'. This error has been corrected in the table presented above. No other figures, including overall England admissions figures, were affected by this error.
 14. There was an error in the admissions figures published for each year from 2002/03 to 2006/07 in Table 4.5 of previous editions of this report for 'Unspecified liver disease' (K73, K74) which appears under the 'Digestive' heading. This error also affects the 'Digestive', 'Total - partly attributable' and 'Total' rows for each of these years. These figures have been updated to include records relating to disease codes K73 (chronic hepatitis) that were excluded unintentionally from the previous figures. As a result the latest figures are slightly higher than those published previously. The minimum effect at a national level is to increase the total number of these admissions by 258 (0.14%) in 2006/07, whilst the maximum effect is an increase of 376 (0.25%) in 2003/04.
 15. ICD-10 codes for road traffic accidents: V12-V14 (-3 -.9), V19.4-V19.6, V19.9, V20-V28 (-3 -.9), V29-V79 (-4 -.9), V80.3-V80.5, V81.1, V82.1, V82.9, V83.0-V86 (-0 -.3), V87.0-V87.9, V89.2, V89.3, V89.9.

Sources:
 Figures provided by The Department of Health based on:
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 North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.7 NHS¹ hospital admissions² with a primary diagnosis attributable to alcohol³, by whether condition is categorised as acute, chronic or due to mental and behavioural disorders due to use of alcohol⁴ 2002/03 to 2010/11^{5,6}

England	Number of admissions (rounded to nearest hundred)									
	2002/03 ⁷	2003/04 ⁷	2004/05 ⁷	2005/06 ⁷	2006/07 ⁷	2007/08	2008/09	2009/10	2010/11	
Total	142,000	151,000	160,500	173,900	179,900	181,300	185,800	194,800	198,900	
Acute ⁸	1,300	1,400	1,600	1,400	1,400	1,700	1,400	1,200	1,200	
Chronic	112,300	117,800	122,900	133,000	138,200	138,500	141,900	146,800	150,900	
Mental and behavioural disorders due to use of alcohol	28,500	31,800	36,000	39,500	40,300	41,200	42,500	46,900	46,800	

1. The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.

2. A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

3. 'Primary diagnosis only' alcohol related admission estimates are derived by summing the alcohol attributable fraction (AAF) associated with the alcohol related condition which appears in the primary diagnosis field (where there is one, out of the 47 such conditions identified in Table A.3 within Appendix A) regardless of whether or not there is an alcohol related condition with a higher AAF in one of the secondary diagnosis positions.

4. For the purpose of the analyses which appears in this table, each of the 47 alcohol related conditions which appear in table 4.1 have been classified as either acute, chronic or as a mental and behavioural disorder due to use of alcohol. This has been done using the classification defined and used by North West Public Health Observatory (NWPHO) and published in the 'NI39 Subanalysis by 10 conditions' available at www.lape.org.uk/natind.html

5. Figures have not been adjusted for shortfalls in data (i.e. the data are ungressed).

6. Data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions or no fixed abode or unknown.

7. Alcohol related admission estimates published for each year from 2002/03 to 2006/07 based on primary diagnosis only have been updated to include records relating to disease codes K73 (chronic hepatitis) that were excluded unintentionally from the previous figures. As a result the latest figures are slightly higher than those published previously. The minimum effect at a national level is to increase the total number of these admissions by 258 (0.14%) in 2006/07, whilst the maximum effect is an increase of 376 (0.25%) in 2003/04.

8. There are a group of ICD-10 codes known as 'cause codes'. Such conditions are always recorded as a secondary diagnosis, and are never recorded in the primary position. They include acute conditions/injuries such as accidents, violence, etc (see rows 42 to 56 of Table 4.6 for the full list) and so therefore the 'acute' estimates presented in this table are underestimates.

Sources:

Figures provided by The Department of Health based on:

Hospital Episode Statistics, Health and Social Care Information Centre - Data for total number of admissions for each ICD-10 code.

North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.8 NHS¹ hospital admissions² with a primary diagnosis³ wholly⁴ or partly⁵ attributable to alcohol, by gender, 2010/11^{6,7}

England		Number of admissions (rounded to nearest hundred)		
ICD10-Code ⁸		All persons	Males	Females
Total		198,900	120,000	78,800
Total - Wholly attributable⁴		69,300	48,500	20,800
F10	Mental and behavioural disorders due to use of alcohol	46,800	32,700	14,100
F10.0	Acute intoxication	18,500	12,300	6,200
F10.1	Harmful use	2,900	1,900	900
F10.2	Dependence syndrome	9,000	6,100	2,800
F10.3	Withdrawal state	14,500	10,900	3,600
F10.4	Withdrawal state with delirium	900	600	200
F10.5	Psychotic disorder	300	200	100
F10.6	Amnesic syndrome	300	200	100
F10.7	Residual and late-onset psychotic disorder	200	100	0
F10.8	Other mental and behavioural disorders due to use of alcohol	0	0	0
F10.9	Unspecified mental and behavioural disorders due to use of alcohol	300	200	100
K70	Alcoholic liver disease	15,700	10,800	4,900
K70.0	Alcoholic fatty liver	200	100	100
K70.1	Alcoholic hepatitis	1,700	1,100	700
K70.2	Alcoholic fibrosis and sclerosis of liver	100	0	0
K70.3	Alcoholic cirrhosis of liver	6,300	4,600	1,800
K70.4	Alcoholic hepatic failure	1,900	1,300	600
K70.9	Alcoholic liver disease, unspecified	5,500	3,700	1,700
T51⁹	Toxic effect of alcohol	1,200	600	600
T51.0	Toxic effect of ethanol	900	500	500
T51.1	Toxic effect of methanol	0	0	0
T51.9	Toxic effect of alcohol, unspecified	200	100	100
	Other wholly - attributable conditions	5,600	4,400	1,200
E24.4	Alcohol-induced pseudo-Cushing's syndrome	0	0	0
G31.2	Degeneration of nervous system due to alcohol	300	200	100
G62.1	Alcoholic polyneuropathy	100	100	0
G72.1	Alcoholic myopathy	0	0	0
I42.6	Alcoholic cardiomyopathy	200	200	0
K29.2	Alcoholic gastritis	1,700	1,300	400
K86.0	Chronic pancreatitis (alcohol induced)	3,300	2,600	700
X45	Accidental poisoning by and exposure to alcohol	-	-	-
Total - partly attributable⁵		129,600	71,500	58,000
	Accidents and injuries			
W78-W79	Inhalation of gastric contents/Inhalation and ingestion of food causing obstruction of the respiratory tract	-	-	-
W00-W19	Fall injuries	-	-	-
W24-W31	Work/machine injuries	-	-	-
W32-W34	Firearm injuries	-	-	-
W65-W74	Drowning	-	-	-
X00-X09	Fire injuries	-	-	-
X31	Accidental excessive cold	-	-	-
	Violence			
X60-X84, Y10-Y33	Intentional self-harm/Event of undetermined intent	-	-	-
X85-Y09	Assault	-	-	-
	Transport accidents			
V02-V04 (.1, .9), V06.1, V09.2, V09.3	Pedestrian traffic accidents	-	-	-
for codes see footnote 13	Road traffic accidents – non-pedestrian	-	-	-
V90-V94	Water transport accidents	-	-	-
V95-V97	Air/space transport accidents	-	-	-
	Spontaneous abortion	8,800		8,800
O03	Spontaneous abortion	8,800	-	8,800
	Digestive	13,700	9,400	4,300
K22.6	Gastro-oesophageal laceration-haemorrhage syndrome	900	600	400
K73, K74	Unspecified liver disease	3,500	2,200	1,300
K85, K86.1	Acute and chronic pancreatitis	4,600	3,300	1,300
I85	Oesophageal varices	4,600	3,300	1,400
	Cancer	36,500	18,200	18,300
C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	8,700	6,900	1,800
C15	Malignant neoplasm of oesophagus	7,000	5,800	1,200
C32	Malignant neoplasm of larynx	1,300	1,200	100
C18	Malignant neoplasm of colon	2,600	1,800	800
C20	Malignant neoplasm of rectum	2,300	1,800	500
C22	Malignant neoplasm of liver and intrahepatic bile ducts	1,000	700	200
C50	Malignant neoplasm of breast	13,600	-	13,600
	Hypertensive diseases	9,300	6,600	2,800
I10-I15	Hypertensive diseases	9,300	6,600	2,800
	Cardiac arrhythmias	34,400	21,200	13,200
I47-I48	Cardiac arrhythmias	34,400	21,200	13,200
	Other partly-attributable conditions	26,800	16,100	10,700
G40-G41	Epilepsy and Status epilepticus	18,900	10,300	8,600
I60-I62, I69.0-I69.2	Haemorrhagic stroke	4,000	2,900	1,100
I63-I66, I69.3, I69.4	Ischaemic stroke	1,900	1,900	0
L40 excluding cirrhosis	Psoriasis	-	-	-
L40.5		-	-	-
		2,000	1,100	900

1. The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.

2. A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

3. 'Primary diagnosis only' alcohol related admission estimates are derived by summing the alcohol attributable fraction (AAF) associated with the alcohol related condition which appears in the primary diagnosis field (where there is one, out of the 47 such conditions identified in Table A.3 within Appendix A) regardless of whether or not there is an alcohol related condition with a higher AAF in one of the secondary diagnosis positions.

4. Wholly attributable conditions are alcohol-specific by definition and so have an attributable fraction of one.

5. Partially attributable conditions are those where some but not all cases are a result of alcohol consumption and so have an attributable fraction of less than one.

6. Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed).

7. Admissions data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions or no fixed abode or unknown.

8. See Appendix A for further information about International Classification of Diseases.

9. The totals shown for T51 - Toxic effect of alcohol, do not include the full breakdown for ICD-10 code T51, only T51.0, T51.1 and T51.9 as these cover types of alcohol most commonly found in alcoholic drinks.

10. A '-' indicates there were no observations.

11. All figures are rounded to the nearest hundred. Therefore a figure of '0' corresponds to an unrounded number of less than 50.

12. There are a group of ICD-10 codes known as 'cause codes'. Such conditions are always recorded as a secondary diagnosis, and are never recorded in the primary position. They include acute conditions/injuries such as accidents, violence, etc (see rows 42 to 56 for the full list).

13. ICD-10 codes for road traffic accidents: V12-V14 (.3 - .9), V19.4-V19.6, V19.9, V20-V28 (.3 - .9), V29-V79 (.4 - .9), V80.3-V80.5, V81.1, V82.1, V82.9, V83.0-V86 (.0 - .3), V87.0-V87.9, V89.2, V89.3, V89.9.

Sources:

Figures provided by The Department of Health based on:

Hospital Episode Statistics, Health and Social Care Information Centre - Data for total number of admissions for each ICD-10 code.

North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.9 NHS¹ hospital admissions², by gender, with a primary diagnosis of a disease or condition which can be alcohol related, and of those, estimates of the number and percentage where the primary diagnosis³ was alcohol related (i.e. attributable to alcohol), 2010/11^{4,5}

England		Number of admissions (rounded to nearest hundred)								
ICD-10 Code ⁶		All persons			Men			Women		
		Admissions ⁵	Attributable number	Attributable percentage	Admissions ⁵	Attributable number	Attributable percentage	Admissions ⁵	Attributable number	Attributable percentage
	All admissions	14,747,200	198,900	1.3	6,421,500	120,000	1.9	8,325,700	78,800	0.9
C00-D48	All cancers	1,590,500	36,500	2.3	770,500	18,200	2.4	820,000	18,300	2.2
I00-I99	All circulatory diseases	934,600	54,400	5.8	532,400	36,000	6.8	402,100	18,500	4.6
K00-K93	All diseases of the digestive system	1,719,600	29,800	1.7	837,700	20,800	2.5	881,800	9,000	1.0
All diseases which can be caused by alcohol consumption		813,600	198,900	24	349,200	120,000	34	464,400	78,800	17
Alcohol related admissions - Wholly attributable⁷		69,300	69,300	100	48,500	48,500	100	20,800	20,800	100
F10	Mental and behavioural disorders due to use of alcohol	46,800	46,800	100	32,700	32,700	100	14,100	14,100	100
F10.0	Acute intoxication	18,500	18,500	100	12,300	12,300	100	6,200	6,200	100
F10.1	Harmful use	2,900	2,900	100	1,900	1,900	100	900	900	100
F10.2	Dependence syndrome	9,000	9,000	100	6,100	6,100	100	2,800	2,800	100
F10.3	Withdrawal state	14,500	14,500	100	10,900	10,900	100	3,600	3,600	100
F10.4	Withdrawal state with delirium	900	900	100	600	600	100	200	200	100
F10.5	Psychotic disorder	300	300	100	200	200	100	100	100	100
F10.6	Amnesic syndrome	300	300	100	200	200	100	100	100	100
F10.7	Residual and late-onset psychotic disorder	200	200	100	100	100	100	0	0	100
F10.8	Other mental and behavioural disorders due to use of alcohol	0	0	100	0	0	100	0	0	100
F10.9	Unspecified mental and behavioural disorders due to use of alcohol	300	300	100	200	200	100	100	100	100
K70	Alcoholic liver disease	15,700	15,700	100	10,800	10,800	100	4,900	4,900	100
K70.0	Alcoholic fatty liver	200	200	100	100	100	100	100	100	100
K70.1	Alcoholic hepatitis	1,700	1,700	100	1,100	1,100	100	700	700	100
K70.2	Alcoholic fibrosis and sclerosis of liver	100	100	100	0	0	100	0	0	100
K70.3	Alcoholic cirrhosis of liver	6,300	6,300	100	4,600	4,600	100	1,800	1,800	100
K70.4	Alcoholic hepatic failure	1,900	1,900	100	1,300	1,300	100	600	600	100
K70.9	Alcoholic liver disease, unspecified	5,500	5,500	100	3,700	3,700	100	1,700	1,700	100
T51 ⁸	Toxic effect of alcohol	1,200	1,200	100	600	600	100	600	600	100
T51.0	Toxic effect of ethanol	900	900	100	500	500	100	500	500	100
T51.1	Toxic effect of methanol	0	0	100	0	0	100	0	0	100
T51.9	Toxic effect of alcohol, unspecified	200	200	100	100	100	100	100	100	100
Other wholly - attributable conditions		5,600	5,600	100	4,400	4,400	100	1,200	1,200	100
E24.4	Alcohol-induced pseudo-Cushing's syndrome	0	0	100	0	0	100	0	0	100
G31.2	Degeneration of nervous system due to alcohol	300	300	100	200	200	100	100	100	100
G62.1	Alcoholic polyneuropathy	100	100	100	100	100	100	0	0	100
G72.1	Alcoholic myopathy	0	0	100	0	0	100	0	0	100
I42.6	Alcoholic cardiomyopathy	200	200	100	200	200	100	0	0	100
K29.2	Alcoholic gastritis	1,700	1,700	100	1,300	1,300	100	400	400	100
K86.0	Chronic pancreatitis (alcohol induced)	3,300	3,300	100	2,600	2,600	100	700	700	100
X45	Accidental poisoning by and exposure to alcohol	-	-	-	-	-	-	-	-	-
Alcohol related admissions - partly attributable⁹		744,300	129,600	17	300,700	71,500	24	443,600	58,000	13
Accidents and injuries		-	-	-	-	-	-	-	-	-
W78-W79	Inhalation of gastric contents/Inhalation and ingestion of food causing obstruction of the respiratory tract	-	-	-	-	-	-	-	-	-
W00-W19	Fall injuries	-	-	-	-	-	-	-	-	-
W24-W31	Work/machine injuries	-	-	-	-	-	-	-	-	-
W32-W34	Firesarm injuries	-	-	-	-	-	-	-	-	-
W65-W74	Drowning	-	-	-	-	-	-	-	-	-
X00-X09	Fire injuries	-	-	-	-	-	-	-	-	-
X31	Accidental excessive cold	-	-	-	-	-	-	-	-	-
Violence		-	-	-	-	-	-	-	-	-
X60-X84, Y10-Y33	Intentional self-harm/Event of undetermined intent	-	-	-	-	-	-	-	-	-
X85-Y09	Assault	-	-	-	-	-	-	-	-	-
Transport accidents		-	-	-	-	-	-	-	-	-
V02-V04 (1, 9), V06.1, V09.2, V09.3	Pedestrian traffic accidents	-	-	-	-	-	-	-	-	-
For codes see footnote 10	Road traffic accidents - non-pedestrian	-	-	-	-	-	-	-	-	-
V90-V94	Water transport accidents	-	-	-	-	-	-	-	-	-
V95-V97	Air/space transport accidents	-	-	-	-	-	-	-	-	-
Spontaneous abortion		40,800	8,800	22	-	-	-	40,800	8,800	22
O03	Spontaneous abortion	40,800	8,800	22	-	-	-	40,800	8,800	22
Digestive		37,900	13,700	36	22,000	9,400	43	15,900	4,300	27
K22.6	Gastro-oesophageal laceration-haemorrhage syndrome	2,200	900	44	1,300	600	44	800	400	43
K73, K74	Unspecified liver disease	5,600	3,500	63	3,100	2,200	73	2,600	1,300	52
K85, K86.1	Acute and chronic pancreatitis	23,000	4,600	20	13,200	3,300	25	9,900	1,300	13
I85	Oesophageal varices	7,100	4,600	65	4,400	3,300	73	2,700	1,400	52
Cancer		359,100	36,500	10	115,200	18,200	16	243,900	18,300	7
C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	20,400	8,700	43	14,400	6,900	48	6,000	1,800	30
C15	Malignant neoplasm of oesophagus	29,600	7,000	24	21,300	5,800	27	8,300	1,200	14
C32	Malignant neoplasm of larynx	4,900	1,300	28	4,000	1,200	30	900	100	17
C18	Malignant neoplasm of colon	80,600	2,600	3	44,500	1,800	4	36,100	800	2
C20	Malignant neoplasm of rectum	38,800	2,300	6	25,600	1,800	7	13,200	500	4
C22	Malignant neoplasm of liver and intrahepatic bile ducts	8,700	1,000	11	5,400	700	13	3,300	200	7
C50	Malignant neoplasm of breast	176,000	13,600	8	-	-	-	176,000	13,600	8
Hypertensive diseases		42,700	9,300	22	23,400	6,600	28	19,200	2,800	14
I10-I15	Hypertensive diseases	42,700	9,300	22	23,400	6,600	28	19,200	2,800	14
Cardiac arrhythmias		112,400	34,400	31	62,400	21,200	34	50,000	13,200	26
I47-I48	Cardiac arrhythmias	112,400	34,400	31	62,400	21,200	34	50,000	13,200	26
Other partly-attributable conditions		151,400	26,800	18	77,700	16,100	21	73,800	10,700	14
G40-G41	Epilepsy and Status epilepticus	45,900	18,900	41	24,700	10,300	42	21,200	8,600	41
I60-I62, I69.0-I69.2	Haemorrhagic stroke	24,500	4,000	16	12,500	2,900	23	12,000	1,100	9
I63-I66, I69.3, I69.4	Ischaemic stroke	74,800	1,900	3	37,200	1,900	5	37,600	0	0
L40 excluding cirrhosis L40.5	Psoriasis	6,200	2,000	32	3,200	1,100	34	3,000	900	30

1. The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.

2. A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

3. 'Primary diagnosis only' alcohol related admission estimates are derived by summing the alcohol attributable fraction (AAF) associated with the alcohol related condition which appears in the primary diagnosis field (where there is one, out of the 47 such conditions identified in Table A.3 within Appendix A) regardless of whether or not there is an alcohol related condition with a higher AAF in one of the secondary diagnosis positions.

4. Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed).

5. Admission data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions or no fixed abode or unknown.

6. See Appendix A for further information about International Classification of Diseases.

7. Wholly attributable conditions are alcohol-specific by definition and so have an attributable fraction of one.

8. The totals shown for T51 - Toxic effect of alcohol, do not include the full breakdown for ICD-10 code T51, only T51.0, T51.1 and T51.9 as these cover types of alcohol most commonly found in alcoholic drinks.

9. Partially attributable conditions are those where some but not all cases are a result of alcohol consumption and so have an attributable fraction of less than one.

10. ICD-10 codes for road traffic accidents: V12-V14 (3-9), V19.4-V19.6, V19.9, V20-V28 (3-9), V29-V79 (4-9), V80.3-V80.5, V81.1, V82.1, V82.9, V83.0-V86 (0-3), V87.0-V87.9, V89.2, V89.3, V89.9.

11. A '-' indicates there were no observations.

12. All admissions have been rounded to the nearest hundred. Therefore a figure of 0 in either the 'Admissions' or 'Attributable number' columns corresponds to an unrounded figure of less than 50.

13. There are a group of ICD-10 codes known as 'cause codes'. Such conditions are always recorded as a secondary diagnosis, and are never recorded in the primary position. They include acute conditions/injuries such as accidents, violence, etc (see rows 42 to 56 for the full list).

Sources:

Figures provided by The Department of Health based on:

Hospital Episode Statistics, Health and Social Care Information Centre - Data for total number of admissions for each ICD-10 code.

North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.10 NHS¹ hospital admissions² with a primary diagnosis³ wholly⁴ or partly attributable⁵ to alcohol, by Strategic Health Authority, 2010/11^{6,7}

England			Number of admissions (rounded to nearest hundred)					
			Total	Wholly-attributable ⁴		Partly-attributable ⁵		
			Admissions	Number of admissions per 100,000 population ⁸	Admissions	Number of admissions per 100,000 population ⁸	Admissions	Number of admissions per 100,000 population ⁸
England			198,900	353	69,300	132	129,600	221
Q30	E18000001	North East SHA	12,200	432	4,400	170	7,800	263
Q31	E18000002	North West SHA	32,900	443	14,100	203	18,900	239
Q32	E18000003	Yorkshire and the Humber SHA	20,300	360	7,000	134	13,200	225
Q33	E18000004	East Midlands SHA	16,800	344	5,300	119	11,400	226
Q34	E18000005	West Midlands SHA	22,000	377	7,600	142	14,400	235
Q35	E18000006	East of England SHA	18,300	280	4,800	81	13,500	199
Q36	E18000007	London SHA	27,400	360	10,000	131	17,400	229
Q37	E18000008	South East Coast SHA	14,100	284	4,100	92	10,000	192
Q38	E18000009	South Central SHA	11,100	246	3,400	79	7,800	167
Q39	E18000010	South West SHA	19,700	327	5,300	101	14,400	226

1. The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.

2. A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

3. 'Primary diagnosis only' alcohol related admission estimates are derived by summing the alcohol attributable fraction (AAF) associated with the alcohol related condition which appears in the primary diagnosis field (where there is one, out of the 47 such conditions identified in Table A.3 within Appendix A) regardless of whether or not there is an alcohol related condition with a higher AAF in one of the secondary diagnosis positions.

4. Wholly attributable conditions are alcohol-specific by definition and so have an attributable fraction of one.

5. Partially attributable conditions are those where some but not all cases are a result of alcohol consumption and so have an attributable fraction of less than one.

6. Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed).

7. Admission data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions or no fixed abode or unknown. The England admissions total differs from the sum of the 10 individual SHAs as cases of no fixed or unknown abode are included in the England figure but excluded from the individual SHA figures.

8. Admissions per 100,000 population are aged standardised. Mid-2010 population estimates were used to derive age-group and gender specific rates for each area. The age standardised rates are obtained as a weighted sum of the age group and gender specific rates, where the weights are the proportion of the European Standard population in each age and gender group.

Sources:

Figures provided by The Department of Health based on:

Hospital Episode Statistics, Health and Social Care Information Centre - Data for total number of admissions for each ICD-10 code.

North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.11 Alcohol-related¹ NHS² hospital admission³ estimates derived using the unadjusted broad measure, adjusted broad measure and narrow measure, 2002/03 to 2010/11⁴

England	Number of admissions (rounded to nearest hundred)									
	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	% change 2002/03 to 2010/11
Total ARAs - broad measure¹ (unadjusted)	510,800	570,100	644,700	736,100	802,100	863,600	945,500	1,057,000	1,168,300	128.7
Total ARAs - broad measure¹ (adjusted⁵)	783,300	853,900	923,300	1,003,600	1,054,600	1,110,400	1,180,700	1,208,100	1,168,300	49.1
Total ARAs - narrow measure¹	141,700	150,600	160,200	173,600	179,700	181,300	185,800	194,800	198,900	40.3

1. Each of the 3 alcohol-related admissions (ARAs) totals are underpinned by a methodology developed by the North West Public Health Observatory (NWPHO). This methodology includes a wide range of diseases, injuries and conditions in which alcohol plays a part and estimates the proportion of cases that are attributable to the consumption of alcohol. For the broad measure, finished admission episodes are identified where an alcohol-related diagnosis is recorded in any of the 20 (14 from 2002/03 to 2006/07 and 7 prior to 2002/03) primary and secondary diagnosis fields in a Hospital Admission Statistics record. For each of these episodes, an attributable fraction is applied, based on the diagnostic codes, age group and gender of the patient. Where there is more than one alcohol-related condition among the diagnostic codes, the condition with the largest attributable fraction is used. Where there are two or more codes with the maximum attributable fraction, the code from the earliest diagnostic 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 ARAs is arrived at by summing up the number of episodes counted against each alcohol-related condition. Alcohol related admission estimates based on the narrow measure are derived by summing the alcohol attributable fraction (AAF) associated with the alcohol related condition which appears in the primary diagnosis field (where there is one, out of the 47 such conditions identified in Table A.3 within Appendix A) regardless of whether or not there is an alcohol related condition with a higher AAF in one of the secondary diagnosis positions.

2. The data include activity in English NHS hospitals and English NHS commissioned activity in the independent sector.

3. A finished admission episode is the first period of inpatient care under one healthcare provider. Finished admission episodes are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

4. Data includes only ordinary, day cases and maternity admissions, where the age and sex of the patient was known and where the region of residence was one of the English regions or no fixed abode or unknown.

5. Alcohol related admission estimates based on the 'adjusted broad measure' are derived by applying the methodology described in Appendix G to the unadjusted broad measure in an attempt to adjust for changes in recording practices in relation to secondary diagnoses in recent years. The methodology relies on several important assumptions which are listed in Appendix G.

Sources:

Hospital Episode Statistics, The Health and Social Care Information Centre

North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

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Table 4.12 Number of prescription items¹, net ingredient cost² and average net ingredient cost per item of drugs prescribed³ for the treatment of alcohol dependence dispensed in the community, 2003 to 2011

England ^{4,5}	Numbers / £								
	2003 ⁵	2004	2005	2006	2007 ⁶	2008 ⁶	2009	2010	2011
Prescription items									
Acamprosate Calcium	63,387	66,863	66,851	70,216	75,842	83,983	94,921	102,679	107,389
Disulfiram	39,354	41,218	42,261	45,652	46,936	50,440	55,524	57,502	60,375
Total	102,741	108,081	109,112	115,868	122,778	134,423	150,445	160,181	167,764
Prescribed in primary care									
Acamprosate Calcium	57,987	61,310	60,912	64,322	70,615	79,708	90,051	98,242	102,536
Disulfiram	35,254	36,651	36,851	39,015	41,652	45,343	49,533	52,214	55,052
Total	93,241	97,961	97,763	103,337	112,267	125,051	139,584	150,456	157,588
Prescribed in NHS hospitals									
Acamprosate Calcium	5,400	5,553	5,939	5,894	5,227	4,275	4,870	4,437	4,853
Disulfiram	4,100	4,567	5,410	6,637	5,284	5,097	5,991	5,288	5,323
Total	9,500	10,120	11,349	12,531	10,511	9,372	10,861	9,725	10,176
Net Ingredient Cost (£ 000s)									
Acamprosate Calcium	1,302	1,370	1,362	1,456	1,532	1,634	1,589	1,624	1,707
Disulfiram	420	456	599	686	715	767	791	790	786
Total	1,722	1,516	1,960	2,142	2,247	2,400	2,380	2,414	2,493
Average Net Ingredient Cost per item (£)									
Acamprosate Calcium	21	20	20	21	20	19	17	16	16
Disulfiram	11	11	14	15	15	15	14	14	13
Total	17	14	18	18	18	18	16	15	15

1. Prescriptions are written on a prescription form known as a FP10. Each single item written on the form is counted as a prescription item.

2. Net Ingredient Cost (NIC) is the basic cost of a drug. It does not take account of discounts, dispensing costs, fees or prescription charge income.

3. This information was obtained from the Prescribing Analysis and Cost Tool (PACT) system, which covers prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK and prescriptions written in hospitals /clinics that are dispensed in the community. Prescriptions dispensed in hospitals and private prescriptions are not included in PACT data.

4. Prescribing Analysis and Cost (PACT) from NHS Prescription Services of the Business Service Authority. Health and Social Care Information Centre

5. Prescription item numbers for items prescribed in NHS hospitals for this year are only available rounded to the nearest 100.

6. Figures for 2007 and 2008 have been updated by the NHS Prescription Services of the Business Services Authority.

Source:

Prescribing Analysis and Cost (PACT) from NHS Prescription Services of the Business Service Authority. Health and Social Care Information Centre

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Table 4.13 Number of prescription items¹ and prescription items per 100,000 population for the treatment of alcohol dependence prescribed in primary care² and dispensed in the community, by Strategic Health Authority³, 2011

England			Prescription items			Prescription items per 100,000 population ⁶			Numbers
			Total	Acamprosate Calcium	Disulfiram	Total	Acamprosate Calcium	Disulfiram	
England^{4,5}			157,588	102,536	55,052	302	196	105	
Q30	E18000001	North East	11,185	8,282	2,903	429	318	111	
Q31	E18000002	North West	35,840	26,214	9,626	517	378	139	
Q32	E18000003	Yorkshire and the Humber	22,982	12,461	10,521	434	235	198	
Q33	E18000004	East Midlands	9,642	4,853	4,789	215	108	107	
Q34	E18000005	West Midlands	17,895	12,010	5,885	328	220	108	
Q35	E18000006	East of England	19,475	11,318	8,157	334	194	140	
Q36	E18000007	London	10,808	8,302	2,506	138	106	32	
Q37	E18000008	South East Coast	7,058	5,186	1,872	161	118	43	
Q38	E18000009	South Central	9,138	5,484	3,654	221	133	88	
Q39	E18000010	South West	13,387	8,310	5,077	254	158	96	

1. Prescriptions are written on a prescription form known as a FP10. Each single item written on the form is counted as a prescription item.

2. This information was obtained from the Prescribing Analysis and Cost Tool (PACT) system, which covers prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Prescriptions written in hospitals /clinics that are dispensed in the community, prescriptions dispensed in hospitals and private prescriptions are not included in PACT data.

3. For data at SHA level, prescriptions written by a prescriber located in a particular SHA but dispensed outside that SHA will be included in the SHA in which the prescriber is based.

4. Prescriptions written in England but dispensed outside England are included.

5. Including unidentified Doctors (not possible for NHS Prescription Services of the Business Service Authority to allocate to a SHA).

6. Office for National Statistics (ONS) estimated resident population mid-2010 all age group figures have been used to calculate prescription items per 100,000 population. Information on ONS population data is available at:

<http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-231847>

Source:

Prescribing Analysis and Cost (PACT) from the NHS Prescription Services of the Business Service Authority. Health and Social Care Information Centre Population figures are 2010 Mid-Year Population Estimates, supplied by the Office for National Statistics, Population Estimates Unit.

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Table 4.14 Alcohol-related deaths^{1,2} by gender, 2001 to 2010

England		Numbers									
ICD 10 code ³		2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
All persons		5,476	5,582	5,981	6,036	6,191	6,517	6,541	6,768	6,584	6,669
F10	Mental and behavioural disorders due to alcohol	484	430	433	462	539	506	484	637	596	626
I42.6	Alcoholic cardiomyopathy	108	122	99	94	75	83	75	80	98	74
K70	Alcoholic liver disease	3,236	3,392	3,697	3,759	3,874	4,160	4,249	4,400	4,154	4,275
K73	Chronic hepatitis - not elsewhere specified	70	72	58	63	58	68	68	62	70	50
K74	Fibrosis and cirrhosis of the liver (excluding K74.3-K74.5)	1,406	1,407	1,511	1,466	1,427	1,490	1,432	1,367	1,435	1,399
K86.0	Alcoholic induced chronic pancreatitis	33	32	32	43	52	41	48	48	41	54
X45	Accidental poisoning by and exposure to alcohol	126	112	127	130	151	149	157	153	168	173
	Other causes ⁴	13	15	24	19	15	20	28	21	22	18
Men		3,576	3,631	3,970	3,922	4,096	4,272	4,236	4,473	4,316	4,439
F10	Mental and behavioural disorders due to alcohol	337	306	320	326	400	349	321	434	424	445
I42.6	Alcoholic cardiomyopathy	95	93	88	78	59	74	66	68	78	64
K70	Alcoholic liver disease	2,146	2,275	2,513	2,461	2,602	2,769	2,814	2,966	2,750	2,877
K73	Chronic hepatitis - not elsewhere specified	22	16	14	14	12	14	10	16	23	6
K74	Fibrosis and cirrhosis of the liver (excluding K74.3-K74.5)	858	835	909	904	869	918	865	829	880	874
K86.0	Alcoholic induced chronic pancreatitis	19	24	22	34	43	33	35	39	29	37
X45	Accidental poisoning by and exposure to alcohol	90	70	86	91	100	96	106	110	117	120
	Other causes ⁴	9	12	18	14	11	19	19	11	15	16
Women		1,900	1,951	2,011	2,114	2,095	2,245	2,305	2,295	2,268	2,230
F10	Mental and behavioural disorders due to alcohol	147	124	113	136	139	157	163	203	172	181
I42.6	Alcoholic cardiomyopathy	13	29	11	16	16	9	9	12	20	10
K70	Alcoholic liver disease	1,090	1,117	1,184	1,298	1,272	1,391	1,435	1,434	1,404	1,398
K73	Chronic hepatitis - not elsewhere specified	48	56	44	49	46	54	58	46	47	44
K74	Fibrosis and cirrhosis of the liver (excluding K74.3-K74.5)	548	572	602	562	558	572	567	538	555	525
K86.0	Alcoholic induced chronic pancreatitis	14	8	10	9	9	8	13	9	12	17
X45	Accidental poisoning by and exposure to alcohol	36	42	41	39	51	53	51	43	51	53
	Other causes ⁴	4	3	6	5	4	1	9	10	7	2

1. Deaths occurring in each calendar year.

2. Data may include non-residents.

3. See Appendix A for further information about International Classification of Disease.

4. Some causes linked to alcohol consumption as defined by ONS resulted in a small number of deaths per year (less than ten). These have been grouped together and listed as 'other causes'. This includes the following ICD 10 codes: G31.2, G62.1, K29.2, X65 and Y15.

Source:

DH2 Mortality Statistics - Cause, Nos 28, 29, 30, 31 and 32, 2001, 2002, 2003, 2004, 2005 and Mortality statistics: Deaths registered in 2006 to 2010, Office for National Statistics.

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Appendix A: Key sources

Alcohol attributable fractions

Affordability data

General Lifestyle Survey

Health Survey for England

Hospital Episode Statistics

Infant Feeding Survey

International Classification of Diseases and related health problems (ICD)

Living Costs and Food Survey (LCFS)

Mortality statistics

Organisation for Economic Co-operation and Development (OECD) Health Data

Omnibus Survey

Prescription data

Psychiatric Morbidity Surveys

Smoking, Drinking & Drug Use among Young People in England

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 Statistics. It is a statutory requirement that National Statistics should observe the Code of Practice for Official Statistics. The United Kingdom Statistics Authority (UKSA) assesses all National Statistics for compliance with the Code of Practice.

Some of the statistics included in this publication are not National Statistics and are included here to provide a fuller picture; some of these are Official Statistics, whilst others are neither National Statistics nor Official Statistics. Those which are Official Statistics should still conform to the Code of Practice for Official Statistics, although this is not a statutory requirement. Those that are neither National Statistics nor Official Statistics may not conform to the Code of Practice for Official Statistics. Unless otherwise stated, all sources contained within this publication are considered robust. A brief explanation and short review of the quality of each of the sets of statistics used in this publication are provided below.

Alcohol attributable fractions

The North West Public Health Observatory (NWPHO) have developed alcohol attributable fractions (AAFs) which take into account the level of risk all injuries and diseases attributable to alcohol consumption have on a patient being admitted to hospital. With commission from the Department of Health these AAF have been applied to data from Hospital Episode Statistics (HES) and Office for National Statistics (ONS) to give an estimation of the number of hospital admissions attributable to alcohol. Within this publication, two main measures of alcohol related admissions are presented: a broad measure and a narrow measure. The 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). The narrow measure is constructed in a similar way but counts only the fraction associated with the diagnosis in the

primary position. 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.

Tables 4.1 to 4.5 and Table 4.11 show the number of admissions into hospital based on primary and secondary diagnoses attributable to the consumption of alcohol; Tables 4.6 to 4.10 show the number of admissions based on the primary diagnosis only.

The number of alcohol-related admissions is based on the methodology developed by the NWPHO, which uses 47 indicators for alcohol-related illnesses, determining the proportion of a wide range of diseases and injuries that can be partly attributed to alcohol as well as those that are, by definition, wholly attributable to alcohol. Wholly attributable conditions are alcohol-specific by definition and so have an attributable fraction of one, whereas partially attributable conditions are those where some, but not all cases can be ascribed to alcohol consumption so have an attributable fraction of less than one. Where there is more than one alcohol-related condition among the diagnostic codes the condition with the largest condition 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 at;

<http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf>

A list of the ICD-10 codes used and the alcohol attributable fractions applied to each of these by age and sex can be found in [Tables A.2 and A.3](#)

The application of the NWPHO methodology was updated in summer 2010. As such, information about episodes estimated to be alcohol related may be slightly different from previously published data.

This methodology is currently subject to a public consultation, led by the NWPHO working with the Department of Health and the Health and Social Care Information Centre (HSCIC). The consultation was launched on 31 May 2012, and will run for 12 weeks. Full details can be found on the NWPHO website: www.lape.org.uk

We welcome any comments you may have on this subject.

Affordability data

An important adjustment was introduced for the first time in *Statistics on Alcohol: England, 2011* so that the revised Real Households' Disposable Income (RHDI) index tracks, exclusively, changes in real disposable income **per capita**.

Previously, the RHDI index tracked changes in the total disposable income of all households and was not on a per capita basis. This meant that changes in the RHDI index over time were, in part, due to changes in the size of the population and not exclusively due to changes in real disposable income per capita. The RHDI index feeds into the affordability of alcohol index, and so this was also affected.

The adjustment was carried out using ONS mid-year population estimates of the adult population aged 18 and over, and was applied to all years in the index (1980 onwards). The adjusted RHDI index was then carried forward to produce an adjusted affordability of alcohol index

The alcohol price index in [Table 2.8](#) shows how much the average price of alcohol has changed compared with the base price (1980 in this bulletin).

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

The relative alcohol price index is calculated in the following way:

$$(\text{alcohol price index} / \text{retail prices index}) * 100$$

This shows how the average price of alcohol has changed since the base (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, for example between January 1980 and 2011, the price of alcohol increased by 335.1%. After considering inflation at 251.9%, alcohol prices increased by 23.7% over the period, as shown by the relative index of 123.7.

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%.

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). It is calculated in the following way;

$$(\text{adjusted real households' disposable income index} / \text{relative alcohol price index}) * 100$$

If the affordability index is above 100, then alcohol is relatively more affordable than in the base year, 1980. For example, in 2011 alcohol prices were 335.1% higher than in 1980 but, after taking inflation and households' disposable income per capita into account, alcohol was 45.0% more affordable, as shown by the affordability index of 145.0.

Price Indices and Inflation, Office for National Statistics. Available at:

<http://www.statistics.gov.uk/hub/economy/prices-output-and-productivity/price-indices-and-inflation>

Economic and Labour Market Review, Office for National Statistics. Available at:

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

Final Mid-Year Population Estimates (2001 census based), Office for National Statistics. Available at:

<http://www.statistics.gov.uk/hub/population/population-change/population-estimates/index.html>

Affordability data can be found in Chapter 2 – Drinking behaviour among adults and children.

Both the unadjusted RHD index and the unadjusted affordability of alcohol index (as used in *Statistics on Alcohol: England 2010* and prior publications) are presented alongside the revised indices for comparability purposes in *Statistics on Alcohol: England 2011*.

The affordability of alcohol measure was subject to comments received via the public user consultation in 2011. [Appendix F](#) contains further details of the comments received and how these have been addressed for this publication.

General Lifestyle Survey

From 2008, the General Household Survey (GHS) became a module of the Integrated Household Survey (IHS). In recognition, the survey was renamed the General Lifestyle Survey (GLF). Please refer to the IHS web page for further information:

<http://www.esds.ac.uk/government/ghs/>

The GLF collects information on a range of topics from people living in private households in Great Britain. Questions about drinking alcohol were included in the GLF every two years from 1978 to 1998. Following the review of the GHS, the questions about drinking in the last seven days form part of the continuous survey, and have been included every year from 2000 onwards. Questions designed to measure average weekly alcohol consumption were included from 2000 to 2002 and again in 2005 and 2006 but were not included in the 2007 questionnaire. Before 1988 questions about drinking were asked only of those aged 18 and over, but since then respondents aged 16 and 17 have answered the questions using a self-completion questionnaire.

Questions on the maximum daily amount drunk in the week prior to interview have been included in the GHS since 1998, following an inter-departmental review of the effects of drinking. This review concluded that it was more appropriate to set benchmarks for daily consumption rather than for weekly consumption of alcohol. This is in line with the then Government's advice on sensible drinking which is based on the same daily benchmarks and GHS data are used to monitor the extent to which people are following the advice given.

Questions to establish average weekly alcohol consumption have been included in the GHS, in their current form, periodically since 1986. This measure was developed in response to earlier medical guidelines on drinking related to maximum recommended weekly amounts of alcohol. Respondents are asked how often over the last year they have drunk a range of alcoholic drinks and how much of these they have usually drunk on any one day. This information is combined to give an estimate of the respondent's weekly alcohol consumption. The questions were asked in the 2005 survey and prior to that, in the 2002 survey.

Updated method of converting volumes drunk to units

GHS 2007 presents an updated method of converting what respondents say they drink into standard alcohol units. In recent years, new types of alcoholic drink have been introduced, the alcohol content of some drinks has increased, and alcoholic drinks are now sold in more variable quantities than used to be the case. The GHS, in common with other surveys, has partially taken this into account: since 1998, alcopops and strong beer, lager and cider have been included as separate categories. However, it has recently also become necessary to reconsider the assumptions made in obtaining estimates of alcohol consumption, taking into account the following:

- increases in the size of glass in which wine is served on licensed premises;
- the increased alcoholic strength of wine;
- better estimates of the alcoholic strengths of beers, lagers and ciders.

For wine, it was decided to adopt a method which requires a question to be asked about glass size, which has the advantage that future changes in the average size of glass will be taken into account automatically.

It should be noted, that changing the way in which alcohol consumption estimates are derived does not in itself reflect a real change in drinking among the adult population.

The changes in conversion factors are summarised in [Table A.1](#).

Estimating alcohol consumption from survey data: updated method of converting volumes to units, 2007, Office for National Statistics. Available at:

<http://www.ons.gov.uk/ons/publications/all-releases.html?definition=tcm%3A77-29429>

In addition to the revised method, a new question about wine glass size was included in the GLF survey in 2008. Respondents are now asked whether they have consumed small (125 ml), standard (175 ml) or large (250 ml) glasses of wine. The data from this question are used when calculating the number of units of alcohol consumed by the respondent. It is now assumed that a small glass contains 1.5 units, a standard glass contains 2 units and a large glass contains 3 units. However, in 2006 and 2007 it was assumed that all respondents drank from a standard (175 ml) glass containing 2 units. The updated method has made little difference overall in the GLF, but has slightly reduced the proportion of women exceeding 3 units on their heaviest drinking day in the week before interview. There are two reasons for this. Firstly, when glass size was analysed by sex and age, for most groups the average size was close to the average assumed under the previous method but for women aged 45-64 average size was lower and for men and women aged 65 and over it was much lower. Secondly, approximately 60% of the units of alcohol consumed by women come from wine whereas only around 25% of men's units do so. This means that any change to the calculation of units of alcohol coming from wine has a much greater effect on the total units for women than on the total for men.

Move to calendar year

Previous GHS reports were based on data collected over a full financial year from April to the following March. In 2005, the timeframe for the survey was changed from a financial year basis to calendar year basis. Where questions were the same in 2005 as in 2004/05, the final quarter of the 2004/05 collection has been added to the nine months of the 2005 survey data in order to provide estimates based on a full calendar year, and to ensure any seasonal variation is accounted for. However, questions on weekly alcohol consumption were not asked in 2004/05. As the 2004 survey

ran from April 2004 to March 2005 any new questions introduced in the 2005 survey were only asked from April 2005. Thus data for these questions cannot be combined with estimates from the last quarter of the previous survey to give seasonally representative data. In order to assess the effect of this on the estimates of alcohol consumption, data for 2002, the last survey in which the questions covered the full year, were examined. The GHS 2005 report concluded that there was no statistically significant difference in average weekly consumption between April to December 2002 and January to March 2003. The GHS therefore assumes that the absence of data for January to March 2005 has not significantly affected the estimates of average weekly alcohol consumption. The bases shown in the GHS 2005 report for such questions (including weekly alcohol consumption) have been scaled to account for this. Future GHS surveys will run from January to December.

In 2010, 7,960 households in Great Britain took part in the GLF and around 15,000 interviews were conducted with adults aged 16 and older. The household response rate was 72 per cent.

Longitudinal data

Another change in 2005 was that, in line with European requirements, the GHS adopted a longitudinal sample design, in which households remain in the sample for four years (waves) with one quarter of the sample being replaced each year. Thus approximately three quarters of the 2005 sample were re-interviewed in 2006. A major advantage of the longitudinal component of the design is that it is more efficient at detecting statistically significant estimates of change over time than the previous cross-sectional design. This is because an individual's responses to the same question at different points in time tend to be positively correlated, and this reduces the standard errors of estimates of change. The majority of information published using GLF data on drinking relate to Great Britain, and therefore differ from those shown in this bulletin, which covers England only. Most of the England figures presented in Chapter 2 of this bulletin – Drinking among adults, have been obtained by re-analysing the GHS data set.

Future of the GLF

Following consultation with users, the ONS has decided that the GLF will not continue in its current format after January 2012. Full details are available from the ONS website in the 'Response to the future of the GLF survey consultation' document: <http://www.ons.gov.uk/ons/about-ons/consultations/closed-consultations/2011/the-future-of-the-glf-survey/index.html>

Questions on drinking (except average weekly alcohol consumption) will instead be included in the new ONS Opinions and Lifestyles Survey. Average weekly alcohol consumption will be included in the Health Survey for England for 2011 and 2012. Further information on the consultation and an assessment of the possible impact of the change in data source may have can also be found on the ONS consultation page.

General Lifestyle Survey 2010. Office for National Statistics 2012. Available at: <http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2010/index.html>

The General Lifestyle Survey is a National Statistic.

Health Survey for England

The Health Survey for England (HSE) is an annual survey, monitoring the health of the population which is currently commissioned by the Health and Social Care Information Centre (the 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 recent 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, as in 2006 and 2007, children.

This statistical report uses data from HSE 2007. The primary focus of the 2007 HSE report was knowledge, attitudes and behaviour in respect of healthy lifestyles. The report investigated associated lifestyle factors such as physical activity, diet, smoking and drinking, and also assessed the immediate impact of the smoking ban in public places introduced in England in July 2007 as a secondary focus.

Non-response weighting was introduced to the HSE in 2003, and has been used in all subsequent years. All 2007 data in the HSE 2007 are weighted. The unweighted bases show the number of participants involved, whereas, the weighted bases show the relative sizes of the various sample elements after weighting, reflecting their proportions in the English population, so that data from different columns can be combined in their correct proportions. The absolute size of the weighted bases has no particular significance, since they have been scaled to the achieved sample size. Further details are provided within the HSE 2007.

Since 1995, children's data have each year been weighted to adjust for the probability of selection, since a maximum of two children are selected in each household. This ensures that children from larger households are not under-represented. Since 2003, non-response weighting has also been applied in addition to selection weighting.

Data from the HSE are used in Chapter 3.

Health Survey for England 2007: Healthy lifestyles: Knowledge, Attitudes and behaviour. Available at:

Main report:

<http://www.ic.nhs.uk/pubs/hse07healthylifestyles>

Trend tables:

<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england-2007-latest-trends-%5Bns%5D>

The Health Survey for England is a 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. During this time there have been ongoing improvements in data quality and coverage, which particularly affect earlier data years. As well as this, there have been a number of changes to the classifications used within HES records. Changes have also been made to the organisation of the NHS. Figures have not been adjusted for shortfalls in data (i.e. the data are ungrossed)

HES data are classified using International Classification of Diseases (ICD). The ICD is the international standard diagnostic classification for all general epidemiological and many health management purposes. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and hospital records. The International Classification of Diseases, Tenth Revision (ICD-10), published by the World Health Organisation (WHO) is currently in use.

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.

Tables 4.1 to 4.5 and Table 4.11 in Chapter 4 of this report are based on finished admission episodes where an alcohol related diagnosis is recorded in any of the 20 primary and secondary diagnosis fields in a HES record. Tables 4.6 to 4.10 are based finished admission episodes with a primary diagnosis of a disease, injury or condition wholly or partially attributable to the consumption of alcohol. The ICD-10 codes used, as developed by the North West Public Health Observatory (NWPHO) are shown in Table A.2, Table A.3 and Table A.4. Further information on the work alcohol attributable fractions as developed by the NWPHO can be found at the beginning of this appendix.

The HES Service and website (see below) are run by Northgate Information Solutions on behalf of the Health and Social Care Information Centre.

www.hesonline.nhs.uk

Infant Feeding Survey

Statistics on drinking during pregnancy are taken from Infant Feeding Survey (IFS) 2005. The (IFS) covers the population of new mothers in the United Kingdom, and is carried out every 5 years, the

first in 1975. In 2005, the survey was conducted by the British Market Research Bureau (BMRB) with a sample size of around 12,290. The main aim of the survey is to provide figures on the incidence, prevalence and duration of breastfeeding and other feeding practises. The survey also collects information on the smoking and drinking behaviours of women before, during and after pregnancy.

Drinking during pregnancy is reported on in Chapter 2 – Drinking behaviour among adults and children.

Infant Feeding 2005, The Health and social care Information Centre. May 2007. Available at: www.ic.nhs.uk/pubs/ifs2005

The Infant Feeding Survey is a National Statistic.

Infant Feeding Survey 2010: Early Results were published by The HSCIC on 21 June 2011 (www.ic.nhs.uk/ifs2010) and the Infant Feeding Survey 2010 report is provisionally due for publication by the HSCIC in September 2012.

International Classification of Diseases and related health problems (ICD)

The Tenth Revision of the ICD codes (ICD-10) is the latest in a series of classifications started in 1993, and incorporates a major reorganisation of the structure and groupings used in the ninth revision (ICD-9). An alphanumeric coding scheme replaced the numeric one, e.g. alcohol dependence syndrome changed from 303 in ICD 9 to F10.2 in ICD 10. The regrouping of classifications means that classifications may not map precisely between the two revisions - the nearest equivalent to ICD 9 571.1 (acute alcoholic hepatitis), is the ICD 10 code K70.1 (alcoholic hepatitis) and ICD 10 code K70.9 (alcoholic liver disease, unspecified).

Deaths in England and Wales were classified using ICD 9 to 2000 and by ICD 10 for 1999, and 2001 onwards. Hospital Episode Statistics (HES) have been classified using ICD 10 for 1995/96 onwards.

ICD 10 codes are used in this bulletin in Chapter 4 – Alcohol-related costs, ill health and mortality and are shown in [Table A.2](#), [Table A.3](#) and [Table A.4](#).

Living Costs and Food Survey

In 2008 the Expenditure and Food Survey (EFS) was renamed as the Living Costs and Food Survey (LCFS) 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. In 2010 the LCFS collected the diaries of 12,196 people within 5263 households across the UK. Each household member over the age of seven years kept a diary of all their expenditure over a 2 week period. Note that the diaries record expenditure and quantities of purchases of food and drink rather than consumption of food and drink.

Historical estimates of household purchases between 1974 and 2000 have been adjusted to align with the level of estimates from the Family Expenditure Survey in 2000. These estimates of household purchases are broadly comparable with estimates of household purchases from the LCSF and EFS which commenced in April 2001.

The aligned estimates are generally higher than the original ones and indicate that the scaling has partially corrected for under-reporting in the NFS. Under-reporting is likely to be lower in the LCSF because it does not focus on diet but on expenditure across the board and is largely based on till receipts. However it is necessary to be aware that there is a change in methodology which makes the estimate of the year on year change unreliable between 2000 and 2001/02. The largest adjustments were for confectionery, alcoholic drinks, beverages and sugar and preserves. Details of the adjustments to the NFS estimates can be found in Family Food 2002/03.

The latest consumption and purchased quantities of alcoholic drinks from the 2010 LCFS can be found in the Family Food module of the LCFS 2010 published by the Department for Environment, Food and Rural Affairs (DEFRA) and the Office for National Statistics.

Data from the Living Costs and Food Survey can be found in Chapter 2 – Drinking behaviour among adults and children.

Expenditure and Family Food Datasets of the Living Costs and Food Survey (LCFS) 2010. DEFRA and ONS. Available at:

<http://www.defra.gov.uk/statistics/foodfarm/food/familyfood/datasets/>

The Living Cost and Food Survey is a National Statistic.

Mortality statistics

The Office for National Statistics (ONS) produces annual statistics on numbers of deaths by cause in England and Wales. Registered deaths in England and Wales are classified using ICD 9 to 2000 and by ICD 10 for both 1999, and from 2001 onwards. A list of the codes used are presented in **Table A.4**. The majority of information published using ONS mortality data on drinking relate to England and Wales, and therefore differ from those shown in this report, which covers England only. This information is presented in Chapter 4 of this report – Drinking-related costs, ill-health and mortality, and has been obtained from the ONS mortality statistics data set.

In 2006, ONS revised their definition of alcohol-related deaths to include a number of extra diseases that are wholly attributable to alcohol consumption. They do not currently consider deaths from causes that can be partly attributable to alcohol, however the North West Public Health Observatory (NWPHO) report, Alcohol-attributable fractions for England, does include analysis of deaths that can be attributed to alcohol consumption based on the same methodology as that for alcohol-related hospital admissions (see above).

Mortality statistics: Deaths registered in 2010, Office for National Statistics. Available at:

<http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2010/index.html>

<http://www.statistics.gov.uk/hub/health-social-care/health-of-the-population/causes-of-death/index.html>

Mortality Statistics produced by ONS are National Statistics

Organisation for Economic Co-operation and Development (OECD) Health Data 2011 – Frequently Requested Data

Released during November 2011, this report 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. Data from this report can be found in Chapter 2 (Drinking behaviour in Adults and Children)

Health at a Glance 2011. Organisation for Economic Co-operation and Development, 2011. Available at: <http://www.oecd.org/dataoecd/6/28/49105858.pdf>

Definitions. Sources and Methods can be found at:

http://www.oecd.org/document/30/0,3746,en_2649_33929_12968734_1_1_1_1,00.html

Omnibus Survey

The Opinions Survey is a multi-purpose survey carried out by the Office for National Statistics for use by government departments and other public or non-profit making bodies. Interviewing is carried out every month and each month's questionnaire covers a variety of topics, reflecting different users' requirements. In 2009, interviews were conducted with around 1,200 adults aged 16 or over, throughout Great Britain each month, during the period in which questions on alcohol were included.

Questions on drinking are included on an ad-hoc basis, usually for two months. In 2009, data on drinking was collected during April and May and included: Consumption of different types of drink; Drinking in the last week; Keeping a check on alcohol consumption; Knowledge of daily drinking limits; Frequency of Purchases and Awareness of unit labelling. In this bulletin information on Drinking-related knowledge and behaviour is reported in Chapter 3 – Knowledge and attitudes to alcohol.

The Omnibus Survey is currently discontinued so information from the last publication, *Drinking: Adults' behaviour and knowledge in 2009*² is used, in chapter 2.

Drinking: Adults' Behaviour and Knowledge in 2009, Office for National Statistics. Available at:

<http://www.ons.gov.uk/ons/release-calendar/index.html?pagetype=calendar-entry&pageSize=50&newquery=drinking+behaviour&sortBy=releaseDate&sortDirection=DESCENDING&releaseDateRangeType=allDates>

The Omnibus Surveys are National Statistics.

Prescription data

There are two main drugs prescribed for the treatment of alcohol dependence; Acamprosate Calcium (Campral) and Disulfiram (Antabuse).

Information on prescription items prescribed in primary care settings in England are obtained from the Prescribing Analysis and Cost Tool (PACT) system. The PACT 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 are also included but prescriptions dispensed in hospitals and private prescriptions are not included in PACT data.

Prescriptions are written on a prescription form known as a FP10. Each single item written 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.

NHS Prescription Services have stated that due to the complex and manual processes involved there may be inaccuracies in capturing prescription information which are then reflected in the data. Internal quality assurance processes exist and currently the prescription processing activity is internally audited to 97.5 per cent accuracy (i.e. at least 97.5 per cent of prescriptions are recorded accurately).

Preparations where the number of items dispensed is small are more likely to be significantly affected by any processing errors.

Psychiatric Morbidity Surveys

A series of national surveys of psychiatric morbidity have been commissioned by the Department of Health, the Scottish Executive and the National Assembly for Wales and carried out by the Office for National Statistics (ONS). Each survey has covered a different population group for example, adults aged 16 to 64 living in private households, prisoners, adults living in institutions, homeless people, people with psychotic disorders, children and adolescents, and young people looked after by local authorities.

The survey of psychiatric morbidity among adults in private households in Great Britain was first carried out in 1993 with a second survey conducted in 2000. In 2007 The Health and Social Care Information Centre commissioned the National Centre for Social Research (NatCen) to carry out a third Adult psychiatric morbidity survey (APMS) covering adults living in private households in England.

The survey assessed the prevalence of hazardous and harmful drinking using the Alcohol Use Disorders Identification Test (AUDIT). This is a questionnaire consisting of ten questions, which can each score a maximum of four points. For the purpose of the survey anyone who scored a total of over eight on the AUDIT test was considered to be a hazardous drinker, while those scoring over 16 were considered to be harmful drinkers. The questions included in the AUDIT questionnaire can be found in [Table A.5](#).

The AUDIT test was designed by the World Health Organisation as a tool to identify hazardous, harmful and dependent drinkers. [Table A.6](#) shows which questions are designed to identify

hazardous, harmful and dependent drinking. The AUDIT manual for primary care workers suggests that a cut-off score of eight will capture most of the drinkers who can be classed as hazardous or harmful. The identification of these types of drinking behaviours is based on which of the ten questions in the test the respondent scored points on. Therefore it would be possible to score less than 16 points on the test, yet score most of the points on the harmful drinking questions.

The survey assessed alcohol dependence from answers to a different self-completion questionnaire (Severity of Alcohol Dependence Questionnaire) which consists of 20 questions focusing on the three components of dependence: loss of control, symptomatic behaviour and binge drinking. The 2007 APMS used the community version of the Severity of Alcohol Dependence Questionnaire (SADQ-C). The questions included in the SADQ-C questionnaire can be found in questionnaire documentation in [Appendix E](#) of the Adult psychiatric morbidity survey report.

Adult psychiatric morbidity in England, 2007: results of a household survey. The Health and Social Care Information Centre. Available at:

www.ic.nhs.uk/pubs/psychiatricmorbidity07

This report is a National Statistic.

Smoking, Drinking & Drug Use among Young People in England

Between 1982 and 2003, surveys of secondary school children in England were carried out for the Department of Health. This was done by the Office of Population Census and Surveys (OPCS) between 1982 and 1994, by the Office for National Statistics (ONS) between 1994 and 1999 and by the National Centre for Social Research (NatCen) and the National Foundation for Educational Research (NFER) between 2000 and 2003. Since 2004, the survey has been run by NatCen and NFER on behalf of the Health and Social Care Information Centre.

From 1982 to 1988, the survey was solely concerned with monitoring trends of young people and smoking. In 1988, questions on alcohol consumption were added and have been included in the survey ever since. The 1998 survey was also expanded to include questions on drug use. The core of the questionnaire comprises of questions about the prevalence of drug use, smoking and drinking and, since 2000, the remainder of the questionnaire focuses, in alternate years, on either smoking and drinking or drug taking. The most recent survey in the series, Smoking, Drinking and Drug Use among Young People in England in 2010 (SDD10) focused on smoking and drinking.

The target population for the survey is secondary school children in England, in years 7 to 11, from almost all types of school (comprehensive, secondary modern, grammar and other secondary schools), both state and public. Only special schools and hospital schools are excluded from the survey.

The survey uses a stratified design in which every eligible child has an equal chance of inclusion in the study. The survey is conducted using a confidential questionnaire, which the pupils fill in individually. Fieldwork for the SDD 2010 report was carried out during the autumn term of 2010 and 246 schools agreed to take part in the survey, resulting in 7,296 completed questionnaires.

Changes to questions on alcohol

The questionnaire development for the 2002 survey included cognitive testing of questions about alcohol consumption in the last week. This cognitive development work focused on children's comprehension of the categories of drink asked about in the survey and the language used in the questionnaire.

The cognitive work on alcohol consumption found that:

- 'Alcopops' was a widely used and commonly understood term among young people, but 'pre-mixed alcoholic drinks' was not;
- There was some confusion about how strong shandy should be before it counted as a proper alcoholic drink; and
- There were some brands and types of drink, such as champagne, that young people have difficulty classifying.

As a result of these findings a number of changes were made in 2002 to the questions asking about alcohol consumption in the last week.

First, references to 'alcopops and pre-mixed alcoholic drinks' were replaced with just 'alcopops'. Second, a question asking about the composition of shandy usually drunk was added to the end of the set of questions asking about drinking shandy in the last week. Finally, an additional set of questions was added, asking whether any types of alcohol had been drunk, other than the categories already asked about (i.e. alcopops; beer, lager and cider; Martini and sherry; shandy; spirits and liqueurs; and wine). The examples of spirits and liqueurs and alcopops given were updated to reflect those young people were most likely to have drunk or least likely to be able to classify.

These changes are likely to have only a very minor effect on comparability and estimates of alcohol consumption in the last week for the following reasons.

- Where new questions were introduced, these were placed at the end of a section to minimise any effect on how preceding questions were answered.
- Analysis of the quantities of other alcoholic drinks that were reported suggested that the 'other types of alcohol' questions were not completed very reliably. Therefore answers from this additional set of questions have not been included in survey estimates of amount of alcohol drunk, and comparability with how these estimates were derived in surveys before 2002 has been retained.
- The questions measuring drinking in the last week are regularly updated to reflect changes in the drinks market: 'alcopops' was introduced as a new category of drink in 1996 and the list of example brands is updated annually. Therefore estimates have not been strictly comparable year-on-year.

Converting consumption of alcohol into units

Since 1990, the multipliers used to convert drinks into units of alcohol have been based on those first used in the 1990 General Household Survey (GHS). In the intervening years, there have been significant changes to the way English people drink. The average alcohol content of beer and wine has increased, and standard glass sizes in pubs, bars and restaurants are now more diverse. In response, the 2006 GHS and the Health Survey for England (HSE) both published in January 2008, introduced changes in the method by which reported alcohol consumption by adults is converted into units of alcohol. To conform with changes to these surveys, the way in which estimates of alcohol consumption are calculated in this survey has also been revised. The original and revised equivalents used in Smoking, Drinking and Drug Use among Young People in England to estimate the number of units drunk are shown in Table A.7.

Changes to the survey design and the impact on estimates

In 2010 the design of the SDD sample changed from that used in previous years. In 2010, the sample was stratified by Strategic Health Authority (SHA); within each SHA an equal number of schools were sampled. This new methodology is intended to enable more up-to-date analyses by region than was possible with the previous sample design.

The change in sampling methodology was designed to produce results comparable with previous years' surveys. In 2010, some key survey estimates, while continuing established trends, showed greater than expected change from 2009 (for example, estimates of the prevalence of drinking alcohol). Detailed analysis was undertaken to assess whether these were due in part or whole to the change in sampling methodology, the application of weights or the school response rate, which was 6 percentage points lower in 2010, than in 2009. The analysis did not find any evidence to suggest that they were (see [Appendix B](#) of the report).

Future data will be needed to establish how the results from 2010 fit into longer term trends. For further details of the sample design, see [Appendix A](#) of the report.

See the accompanying Data Quality Statement for further info:

http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Smoking%20drinking%20drug%20use%202010/SDD_Data_Quality_Statement.pdf

Information from SDD can be found in Chapters 2 and 3

Smoking, Drinking and Drug Use among Young People in England in 2010. Health and Social Care Information Centre. Available at:

<http://www.ic.nhs.uk/pubs/sdd10fullreport>

This is a National Statistic.

List of Tables

- A.1 Original and improved factors for converting alcohol volume to units
- A.2 ICD-10 codes for alcohol related hospital admissions
- A.3 Indicator Conditions and Fractions
- A.4 National Statistics definition of alcohol-related deaths
- A.5 Alcohol use disorders identification test (AUDIT)
- A.6 Domains and item content of Alcohol Use Disorders Identification Test (AUDIT)
- A.7 Approximations used in Smoking, Drinking and Drug use among Young People, to calculate Alcohol consumption

Table A.1 Original and improved factors for converting alcohol volume to units

Type of drink	Usual volume (ml)	Original conversion factor (units)	Improved conversion factor (units)
Normal strength beer, lager, cider			
half pint	284	1.0	1.0
small can/bottle	330	1.0	1.5
large can/bottle	440	1.5	2.0
Strong beer, lager, cider (ABV = 6%)			
half pint	284	1.5	2.0
small can/bottle	330	1.5	2.0
large can/bottle	440	2.3	3.0
Table wine			
glass – 125 ml	125	.	1.5
glass – 175 ml	175	.	2.0
glass – 250 ml/small can	250	.	3.0
glass - size unspecified	170	1.0	2.0
Fortified wine			
small glass	50	1.0	1.0
Spirits			
single	25	1.0	1.0
Alcopops			
bottle	275	1.5	1.5

Table A.2 ICD-10 codes for alcohol related hospital admissions

ICD-10 code and definition	
Wholly attributable	
F10	Mental and behavioural disorders due to use of alcohol
F10.0	Acute intoxication
F10.1	Harmful use
F10.2	Dependence syndrome
F10.3	Withdrawal state
F10.4	Withdrawal state with delirium
F10.5	Psychotic disorder
F10.6	Amnesic syndrome
F10.7	Residual and late-onset psychotic disorder
F10.8	Other mental and behavioural disorders due to use of alcohol
F10.9	Unspecified mental and behavioural disorders due to use of alcohol
K70	Alcoholic liver disease
K70.0	Alcoholic fatty liver
K70.1	Alcoholic hepatitis
K70.2	Alcoholic fibrosis and sclerosis of liver
K70.3	Alcoholic cirrhosis of liver
K70.4	Alcoholic hepatic failure
K70.9	Alcoholic liver disease, unspecified
T51	Toxic effect of alcohol
T51.0	Toxic effect of ethanol
T51.1	Toxic effect of methanol
T51.9	Toxic effect of alcohol, unspecified
Other wholly - attributable conditions	
E24.4	Alcohol-induced pseudo-Cushing's syndrome
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
G72.1	Alcoholic myopathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K86.0	Chronic pancreatitis (alcohol induced)
X45	Accidental poisoning by and exposure to alcohol
Partly attributable	
Accidents and injuries	
W78-W79	Inhalation of gastric contents/Inhalation and ingestion of food causing obstruction of the respiratory tract
W00-W19	Fall injuries
W24-W31	Work/machine injuries
W32-W34	Firearm injuries
W65-W74	Drowning
X00-X09	Fire injuries
X31	Accidental excessive cold
Violence	
X60-X84, Y10-Y33	Intentional self-harm/Event of undetermined intent
X85-Y09	Assault
Transport accidents	
V02-V04 (.1, .9), V06.1, V09.2, V09.3	Pedestrian traffic accidents
for codes see footnote	Road traffic accidents – non-pedestrian
V90-V94	Water transport accidents
V95-V97	Air/space transport accidents
Spontaneous abortion	
O03	Spontaneous abortion
Digestive	
K22.6	Gastro-oesophageal laceration-haemorrhage syndrome
K73, K74	Unspecified liver disease
K85, K86.1	Acute and chronic pancreatitis
I85	Oesophageal varices
Cancer	
C00-C14	Malignant neoplasm of lip, oral cavity and pharynx
C15	Malignant neoplasm of oesophagus
C32	Malignant neoplasm of larynx
C18	Malignant neoplasm of colon
C20	Malignant neoplasm of rectum
C22	Malignant neoplasm of liver and intrahepatic bile ducts
C50	Malignant neoplasm of breast
Hypertensive diseases	
I10-I15	Hypertensive diseases
Cardiac arrhythmias	
I47-I48	Cardiac arrhythmias
Other partly-attributable conditions	
G40-G41	Epilepsy and Status epilepticus
I60-I62, I69.0-I69.2	Haemorrhagic stroke
I63-I66, I69.3, I69.4	Ischaemic stroke
L40 excluding cirrhosis	Psoriasis
L40.5	

Note: ICD-10 codes for non-predestrian road traffic accidents are V12-V14 (.3 -.9), V19.4-V19.6, V19.9, V20-V28 (.3 -.9), V29-V79 (.4 -.9), V80.3-V80.5, V81.1, V82.1, V82.9, V83.0-V86 (.0 -.3), V87.0-V87.9, V89.2, V89.3, V89.9

Table A.3 Indicator Conditions and Fractions

Category	ICD code	ICD name	Alcohol Attributable Fraction														Change from previous definition				
			0-15		16-24		25-34		35-44		45-54		55-64		65-74		75+				
			M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F			
Alcohol specific (Chronic)	1 E24.4	Alcohol-induced pseudo-Cushing's syndrome	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	1 G31.2	Degeneration of nervous system due to alcohol	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	1 G62.1	Alcoholic polyneuropathy	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	1 G72.1	Alcoholic myopathy	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	1 I42.6	Alcoholic cardiomyopathy	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	1 K29.2	Alcoholic gastritis	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	1 K70	Alcoholic liver disease	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	1 K86.0	Chronic pancreatitis (alcohol induced)	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	Alcohol specific (Mental/Beh)	2 F10	Mental and behavioural disorders due to use of alcohol	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00			
		3 T51.0	Ethanol poisoning	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00			
Alcohol specific (Acute)	3 T51.1	Methanol poisoning	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	3 T51.9	Toxic effect of alcohol, unspecified	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	3 X45	Accidental poisoning by and exposure to alcohol	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00				
	Accidents & Injury (Acute)	4 W00-W19	Fall injuries	0.00	0.00	0.22	0.14	0.22	0.14	0.22	0.14	0.22	0.14	0.22	0.14	0.12	0.04	0.12	0.04		
4 W24-W31		Work/machine injuries	0.00	0.00	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07			
4 W32-W34		Firearm injuries	0.00	0.00	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25			
4 W65-W74		Drowning	0.00	0.00	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34	0.34			
4 W78-W79		Inhalation of gastric contents/Inhalation and ingestion of food causing obstruction of the respiratory tract	0.00	0.00	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25			
4 X00-X09		Fire injuries	0.00	0.00	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38			
4 X31		Accidental excessive cold	0.00	0.00	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25			
Violence (Acute)		5 X60-X84, Y10-Y33	Intentional self-harm/Event of undetermined intent	0.00	0.00	0.34	0.35	0.34	0.33	0.35	0.34	0.37	0.34	0.36	0.32	0.31	0.25	0.27	0.20		
		5 X85-Y09	Assault	0.00	0.00	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.27		
Transport accidents (Acute)		6 §§	Pedestrian traffic accidents	0.00	0.00	0.35	0.16	0.45	0.19	0.46	0.21	0.46	0.21	0.23	0.03	0.23	0.03	0.23	0.03	0.03	All AFs have changed
	6 §	Road traffic accidents (driver/rider)	0.00	0.00	0.21	0.09	0.33	0.15	0.24	0.12	0.24	0.12	0.09	0.03	0.09	0.03	0.09	0.03	0.03	All AFs have changed	
	6 V90-V94	Water transport accidents	0.00	0.00	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	
	6 V95-V97	Air/space transport accidents	0.00	0.00	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16	
Spontaneous abortion (Acute)	7 O03	Spontaneous abortion	0.00	0.00	0.00	0.23	0.00	0.21	0.00	0.22	0.00	0.21	0.00	0.20	0.00	0.15	0.00	0.12			
	Digestive (Chronic)	8 K22.6	Gastro-oesophageal laceration-haemorrhage syndrome	0.00	0.00	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47	0.47			
8 K73, K74		Chronic hepatitis, not elsewhere classified and Fibrosis and cirrhosis of liver	0.00	0.00	0.77	0.67	0.76	0.59	0.74	0.60	0.79	0.59	0.77	0.57	0.71	0.48	0.61	0.38		K74 split out from K70+K74 and K73 added. AFs differ to those for K70+K74	
8 K85, K86.1		Acute and chronic pancreatitis	0.00	0.00	0.27	0.19	0.27	0.16	0.26	0.16	0.30	0.16	0.27	0.14	0.22	0.10	0.16	0.07	All AFs have changed		
8 I85		Oesophageal varices	0.00	0.00	0.77	0.67	0.76	0.59	0.74	0.60	0.79	0.59	0.77	0.57	0.71	0.48	0.61	0.38	All AFs have changed		
Cancer (Chronic)		9 C00-C14	Malignant neoplasm of lip, oral cavity and pharynx	0.00	0.00	0.50	0.40	0.50	0.35	0.49	0.36	0.53	0.35	0.50	0.33	0.44	0.26	0.36	0.20		All AFs have changed
		9 C15	Malignant neoplasm of oesophagus	0.00	0.00	0.32	0.23	0.31	0.20	0.30	0.20	0.34	0.20	0.32	0.18	0.26	0.14	0.20	0.10	All AFs have changed	
Other chronic diseases (low AF)		9 C32	Malignant neoplasm of larynx	0.00	0.00	0.34	0.25	0.33	0.21	0.32	0.22	0.36	0.21	0.34	0.20	0.28	0.15	0.22	0.11	All AFs have changed	
		10 C16	Malignant neoplasm of stomach																	No longer included	
		10 C18	Malignant neoplasm of colon	0.00	0.00	0.05	0.03	0.05	0.03	0.04	0.03	0.05	0.03	0.05	0.03	0.04	0.02	0.03	0.01	All AFs have changed	
		10 C20	Malignant neoplasm of rectum	0.00	0.00	0.08	0.06	0.08	0.05	0.08	0.05	0.09	0.05	0.08	0.05	0.07	0.03	0.05	0.03	All AFs have changed	
	10 C22	Malignant neoplasm of liver and intrahepatic bile ducts	0.00	0.00	0.16	0.11	0.15	0.10	0.15	0.10	0.17	0.10	0.16	0.09	0.13	0.07	0.10	0.05		All AFs have changed	
	10 C50	Malignant neoplasm of breast	0.00	0.00	0.00	0.09	0.00	0.08	0.00	0.09	0.00	0.09	0.00	0.08	0.00	0.06	0.00	0.04	All AFs have changed		
	10 I10-I15	Hypertensive diseases	0.00	0.00	0.34	0.24	0.33	0.19	0.32	0.20	0.37	0.20	0.34	0.18	0.27	0.13	0.20	0.09	All AFs have changed		
	10 I47-I48	Cardiac arrhythmias	0.00	0.00	0.35	0.36	0.36	0.35	0.37	0.35	0.38	0.35	0.37	0.33	0.34	0.27	0.30	0.22			
Other diseases (low AF)	10 I50-I51	Heart failure	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			
	11 G40-G41	Epilepsy and Status epilepticus	0.00	0.00	0.56	0.64	0.58	0.59	0.58	0.61	0.61	0.61	0.61	0.57	0.51	0.45	0.42	0.35			
	11 I60-I62, I69.0-I69.2	Haemorrhagic stroke	0.00	0.00	0.31	0.20	0.30	0.15	0.27	0.15	0.34	0.15	0.30	0.13	0.24	0.10	0.16	0.06	All AFs have changed		
	11 I63-I66, I69.3, I69.4	Ischaemic stroke	0.00	0.00	0.16	0.03	0.13	0.00	0.08	0.00	0.18	0.00	0.12	0.00	0.06	0.00	0.00	0.00	All AFs have changed		
	11 L40 excluding cirrhosis L40.5	Psoriasis	0.00	0.00	0.34	0.33	0.34	0.33	0.35	0.33	0.36	0.32	0.35	0.31	0.33	0.26	0.30	0.22			

§ V12-V14 (.3 -.9), V19.4-V19.6, V19.9, V20-V28 (.3 -.9), V29-V79 (.4 -.9), V80.3-V80.5, V81.1, V82.1, V82.9, V83.0-V86 (.0 -.3), V87.0-V87.9, V89.2, V89.3, V89.9
 §§ V02-V04 (.1, .9), V06.1, V09.2, V09.3

Table A.4 National Statistics definition of alcohol-related deaths

ICD-10 code and definition	
F10	Mental and behavioural disorders due to use of alcohol
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K70	Alcoholic liver disease
K73	Chronic hepatitis, not elsewhere classified
K74	Fibrosis and cirrhosis of liver (Excluding K74.3–K74.5 – Biliary cirrhosis)
K86.0	Alcohol induced chronic pancreatitis
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent

Table A5 Alcohol use disorders identification test (AUDIT)

Question and responses	Score	Question and responses	Score
How often do you have a drink containing alcohol?		How often during the last year have you needed a drink first thing in the morning to get you going after a heavy drinking session?	
Never	0	Never	0
Monthly or less	1	Less than monthly	1
Two to four times a month	2	Monthly	2
Two to three times a week	3	weekly	3
Four or more times a week	4	Daily or almost daily	4
How many standard drinks containing alcohol do you have on a typical day when you are drinking?		How often during the last year have you had a feeling of guilt or remorse after drinking?	
1 or 2	0	Never	0
3 or 4	1	Less than monthly	1
5 or 6	2	Monthly	2
7 to 9	3	weekly	3
10 or more	4	Daily or almost daily	4
How often do you have six or more drinks on any one occasion?		How often during the last year have you been unable to remember what happened the night before because you had been drinking?	
Never	0	Never	0
Less than monthly	1	Less than monthly	1
Monthly	2	Monthly	2
weekly	3	weekly	3
Daily or almost daily	4	Daily or almost daily	4
How often during the last year have you found that you were unable to stop drinking once you had started?		Have you or someone else been injured because of your drinking?	
Never	0	No	0
Less than monthly	1	Yes, but not in the last year	2
Monthly	2	Yes, during in the last year	4
weekly	3		
Daily or almost daily	4		
How often during the last year have you failed to do what was expected of you because of drinking?		Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested that you should cut down?	
Never	0	No	0
Less than monthly	1	Yes, but not in the last year	2
Monthly	2	Yes, during in the last year	4
weekly	3		
Daily or almost daily	4		

1. A standard drink is half a pint of beer, a single measure of spirits or a small glass of wine

Table A.6 Domains and item content of Alcohol Use Disorders Identification Test

Domains	Question number	Item Content
Hazardous alcohol use	1	Frequency of drinking
	2	Typical quantity
	3	Frequency of heavy drinking
Dependence syndromes	4	Impaired control over drinking
	5	Increased salience of drinking
	6	Morning drinking
Harmful alcohol use	7	Guilt after drinking
	8	Blackouts
	9	Alcohol-related injuries
	10	Others concerned about drinking

Table A.7 Approximations used in Smoking, Drinking and Drug use among Young People, to calculate alcohol consumption

Types of drink and measures asked about	Alcohol units (original)	Alcohol units (revised)
Beer, Lager, Cider		
Less than half pint	0.5 units	0.5 units
Half pint	1 unit	1 unit
Small can	1 unit	1.5 units
Bottle	1 unit	1.5 units
Large can	1.5 units	2 units
Pint	2 units	2 units
Shandy		
Less than half pint	0.25 units	0.25 units
Half pint	0.5 units	0.5 units
Small can	0.5 units	0 units
Bottle	0.5 units	0 units
Large can	0.75 units	0 units
Pint	1 unit	1 unit
Wine¹		
Less than 1 glass	0.5 units	0.5 units
Glass	1 unit	2 units
Martini and Sherry		
Less than 1 glass	0.5 units	0.5 units
Glass	1 unit	1 unit
Spirits (e.g. whisky, vodka, gin) and liquers		
Less than 1 glass	0.5 units	0.5 units
Glass	1 unit	1 unit
Alcopops (e.g. hooch etc.) or pre-mixed alcoholic drinks (e.g. Barcardi Breezer, Metz, Smirnoff Ice etc.)		
Less than 1 bottle	0.5 units	0.75 units
Can	1 unit	1.5 units
Bottle	1 unit	1.5 units

1. In calculating alcohol consumption, a 125ml glass of wine is treated as containing one unit of alcohol

Appendix B: Cross-Departmental policy 2011/12

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; and
- 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

Cross-Departmental Alcohol Strategy

The Government's alcohol strategy was published on 23 March 2012 and is available at: www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy

The Alcohol Strategy is targeted at harmful drinkers, problem pubs and irresponsible shops and sets out radical plans to turn the tide against irresponsible drinking. 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

The Public Health Responsibility Deal (PHRD) is intended to bring together Government action, with social responsibility on the part of the corporate sector and Non-Governmental Organisations (NGO), and personal responsibility from everyone in society for their own lifestyle choices. Being part of the PHRD is an acceptance by an organisation that they have a role to play in improving the health of the nation and that they are committed to action to fulfil that role.

The approach starts from a recognition of individual responsibility. Partners' role will be to assist and enable people to make and implement choices that will improve their health.

The PHRD was formally launched on 15 March 2011². So far over 380 companies have signed up as partners to at least one of the collective pledges, including 125 that have signed up to at least one of the eight collective alcohol pledges.

The most recently agreed pledge, which was announced on 23 March, aims to cut a billion units from the nation's alcohol intake by 2015. At the time of launch 34 leading brands and retailers had already signed up to this by making a commitment to provide a greater choice of lower strength alcohol products and smaller measures by 2015.

Improving Information

Clear and easily understood information is central to ensuring that everyone is aware of the risks of excessive alcohol consumption, as many people who drink do not realise how much they are drinking.

In May 2007, the Government reached a voluntary agreement with the alcohol industry to introduce labels on alcoholic drinks that incorporate unit and health information, including guidelines for lower risk consumption and advice on alcohol and pregnancy.

An announcement was made on 15 March 2011 that a new, strengthened voluntary labelling agreement had been reached with industry and would form one of the collective pledges under the Public Health Responsibility Deal.

A large number (91) of major producers and retailers have already signed up to this pledge and supporting guidance³ has been produced by the Portman Group to help companies seeking to implement this on their labels.

A Change4Life campaign was launched in February advising people of the health risks of drinking above the lower-risk guidelines and provides a range of hints, tips and tools to encourage people to drink within the guidelines.

The Government has 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.

Licensing

The Government has legislated via the Police Reform and Social Responsibility Act 2011⁴ to overhaul the Licensing Act 2003 and to rebalance it 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. The Government will introduce a new density power that will enable licensing authorities to consider local health harms specifically when introducing Cumulative Impact Policies. This will be framed under a limited licensing objective 'protecting and improving public health'.

Pricing

The Government is concerned by those businesses that sell alcohol at a loss in order to gain wider trade. Action set out in the Government's Alcohol Strategy aims to stem the flow of cheap alcohol, ensuring for the first time alcohol is sold at a sensible and appropriate price by:

- introducing a minimum unit price for alcohol; and

- consulting on a ban on multi-buy price promotions in shops.

The Government has also made a commitment to raise alcohol duty by 2% above inflation each year to 2014-15 and from Budget 2011 introduced a new additional duty on beers over 7.5% abv and a reduced rate of duty on beers at a strength of 2.8% abv or below.

Identification and brief advice

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.

Undergraduate medical training has been developed to help all new doctors identify and handle substance misuse problems, including alcohol. E-learning modules to aid delivery of Identification and Brief Advice (IBA) in primary care, community pharmacy and hospital settings are available.

The Department of Health is also adding an element on alcohol consumption into the NHS Health Check from 2013/14, 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

The Government is committed to challenging the assumption that the only way to change people's behaviour is through adding to rules and regulations. In future, solutions to address alcohol-related problems will need also to be found locally, and by seeking to change individuals' relationship and behaviours with alcohol.

The Department of Health has been providing local NHS organisations with the support and tools needed to provide services in their own areas effectively according to local needs. The Department of Health has identified three key High Impact Changes (HICs) on alcohol. The HICs are calculated to be the most effective actions for local areas seeking to reduce alcohol related harm. They include improving the effectiveness and capacity of specialist treatment and appointing alcohol health workers to work across acute hospital settings.

A range of support is available to inform local planning and commissioning including:

- The Alcohol Learning Centre, an online resource which promotes sharing of practice
- The Local Alcohol Profiles for England (LAPE)⁵. The profiles contain 23 alcohol-related indicators for every Local Authority (LA) and 22 for every Primary Care Trust (PCT) in England. Profiles are available online via dynamic PDF and with a range of download options:
- The National Alcohol Treatment Monitoring System (NATMS), which provides information for commissioners and providers on specialist alcohol treatment in each area, including completion rates and waiting times for treatment.

References

1. <http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx>
2. <http://www.dh.gov.uk/en/Publichealth/Publichealthresponsibilitydeal/index.htm>
3. <http://www.portman-group.org.uk/assets/documents/Alcohol%20labelling%20compliance%20and%20monitoring%20process%202011.pdf>
4. <http://services.parliament.uk/bills/2010-11/policereformandsocialresponsibility.html>
5. www.nwph.net/alcohol/lape

Appendix C: United Kingdom Statistics Authority Assessment of the Statistics on Alcohol: England publication

During 2010, the *Statistics on Alcohol: England* report, along with the three other publications (drug misuse, smoking and obesity) that comprise the Lifestyles Compendium Publications published by the Health and Social Care Information Centre (HSCIC) underwent assessment by the United Kingdom Statistics Authority (UKSA). Following assessment, the publication was designated continued National Statistics status (see below):

The UKSA has designated these statistics as National Statistics, subject to meeting the requirements below, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- 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.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

The designation of National Statistics status was subject to a number of requirements and the UKSA report also contained a number of suggestions for improvements. These, together with detail on how these addressed by the NHS IC are below:

Requirement 1 Take steps to develop a greater understanding of the use made of the statistics; publish the relevant information and assumptions, and use them to better support the use of the statistics (para 3.2)

A public consultation was launched by the HSCIC on 1 April 2011 and ran for 12 weeks until 24 June 2011. Responses have been collated and assessed.

www.ic.nhs.uk/work-with-us/consultations/lifestyles-statistics-compendia-publications-consultation

The consultation aimed to engage with users of the reports to develop further understanding of how the reports are used, by whom, and for what purposes in order to also ensure the reports maintain their relevance and usefulness.

We place a feedback form on each of our statistical release web pages inviting comments and suggestions for improvements to our Official Statistics. A summary of queries and comments received by the statistical production team are published alongside this report.

Requirement 2 Include an explanation of the distinction between National Statistics, other Official Statistics and statistics that are not official, and comment on the extent to which they are reliable (para 3.11).

Addressed in the 'Introduction' and Appendix A. A 'Data Quality' statement accompanies this report.

Requirement 3 Determine the most appropriate format for the compendia, in consultation with users (para 3.22).

This was determined by the public consultation launched by the Health and Social Care Information Centre and was implemented from August onwards.

Requirement 4 Include the name of the responsible statistician in the *Statistics on Drug Misuse: England* compendium (para 3.28).

Actioned in 'Statistics on Drug Misuse: England, 2010' published on 27 January 2011, and has also been included in all subsequent publications since.

Requirement 5 Complete their Statement of Administrative Sources so that it covers all the sources currently used (para 3.29).

This has been completed and is available at:

<http://www.ic.nhs.uk/statistics-and-data-collections/publications-calendar/administrative-sources>

Suggestion 1 Publish the information about users gained from the contact centre and via the website (para 3.3).

Aggregated information for this publication accompanies this report.

Suggestion 2 Seek user input into the data accuracy measures that would best meet user needs (para 3.10).

This was captured via the compendia consultation:

www.ic.nhs.uk/work-with-us/consultations/lifestyles-statistics-compendia-publications-consultation

Suggestion 3 Review the graphs and tables in the compendia in order to make presentation consistent (para 3.22).

The results are reflected in this publication wherever possible.

A copy of the full UKSA assessment report is available on the following link:

<http://www.statisticsauthority.gov.uk/assessment/assessment/assessment-reports/index.html>

Appendix D: Editorial notes

Editorial Notes

For the purpose of clarity, prevalence figures in the bulletin are shown in accordance with the Health and Social Care Information Centre publication conventions.

These are as follows:

- . not available
- zero
- 0 less than 0.5

Numbers greater than or equal to 0.5 are rounded to the nearest integer, ten or hundred. Totals may not sum due to rounding.

Most numbers in the bulletin discussed in the text are presented in a table; the relevant table number is given at the end of the last paragraph in the discussion around each table. If data described in a chapter are not presented in a table, appropriate references are provided to indicate the source used to obtain this information.

Appendix E: Further information

This annual report draws together statistics on alcohol. It is expected the next report will be published in 2013. This report forms part of a suite of statistical reports. Other reports cover smoking, drug use and obesity, nutrition and physical activity. All reports are currently updated annually and are available on the Health and Social Care Information Centre website.

We value your feedback and your constructive comments on this report would be welcomed. Questions concerning any data in this publication, or requests for further information, should be addressed to:

The Contact Centre
Health and Social Care Information Centre
1 Trevelyan Square
Boar Lane
Leeds
West Yorkshire
LS1 6AE

Telephone: 0845 300 6016

Email: enquiries@ic.nhs.uk

The 2006, 2007, 2008, 2009, 2010 and 2011 reports, also published by the Health and Social Care Information Centre can be found at:

www.ic.nhs.uk/pubs/alcohol11

www.ic.nhs.uk/pubs/alcohol10

www.ic.nhs.uk/pubs/alcohol09

www.ic.nhs.uk/pubs/alcohol08

www.ic.nhs.uk/pubs/alcohol07

www.ic.nhs.uk/pubs/alcohol06

Earlier editions of this report were published by the Department of Health (DH). Information about their statistics and surveys is available on the DH website at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_4032542

Alcohol Concern

Alcohol Concern is a national agency working to reduce the level of alcohol misuse. It has a library in which most of the source documents cited in this bulletin are available.

www.alcoholconcern.org.uk/

Crime in England and Wales

The British Crime Survey (BCS) and police recorded crime statistics are complementary series, and together these two sources provide a more comprehensive picture of crime than could be obtained from either series alone.

For the crime types it covers, the BCS can provide a better reflection of the extent of household and personal crime because it includes crimes that are not reported to the police and crimes which are not recorded by them. The BCS does not aim to provide a total count of crime, but to give robust and consistent estimates of trends in crime over time.

Crime in England and Wales 2010/11: Findings from the British Crime Survey and police recorded crime. Home Office 2011. Available at:

<http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1011/hosb1011?view=Binary>



Further information on the collection can be found here:

<http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb1011/>

Department for Transport

The Department for Transport website contains material for local government, the transport sector, passengers and motorists.

www.dft.gov.uk/

HM Revenue and Customs

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

www.hmrc.gov.uk/

Home Office

Further information and other research and development statistics (RDS) Home Office publications can be found on the internet at:

www.homeoffice.gov.uk/rds/index.html

Mental health of children and young people in Great Britain, 2004

Mental Health of Children and Young People in Great Britain, 2004 carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive provides information about the prevalence of mental disorders among young people aged 5 to 16 in Great Britain living in private households. The survey examines the relationship between mental disorder and aspects of children's lives, including alcohol consumption. It was carried out between March and June 2004 and a sample size of around 8,000 children and young people aged 5 to 16 was achieved. It also provides profiles of children in each of the main disorder categories; emotional, conduct, hyperkinetic and autistic spectrum disorders, including comparisons with alcohol consumption. The report uses the term 'mental disorders' as defined by the International Classification of Diseases, tenth revision (ICD-10).

Mental health of children and young people in Great Britain, 2004, Office for National Statistics
Available at:

<http://www.esds.ac.uk/doc/5269/mrdoc/pdf/5269technicalreport.pdf>

and

Three years on: Survey of the development and emotional well-being of children and young people. Office for National Statistics. Available at:

<http://www.ons.gov.uk/ons/guide-method/user-guidance/well-being/about-the-programme/children-and-young-people/three-years-on--survey-of-the-development-and-emotional-well-being-of-children-and-young-people.pdf>



Office for National Statistics

Information about National Statistics can be found at:

www.ons.gov.uk

Public Health Observatories

The Association of Public Health Observatories (APHO) represents and co-ordinates the work of 12 Public Health Observatories (PHOs) working across England, Scotland, Wales, Northern Ireland and the Republic of Ireland. In England there are nine PHOs and each one has a national lead role in a key policy area to:

- Develop expertise and in-depth knowledge
- Provide a single point of contact and information source
- Publicise significant work
- develop training programmes for health intelligence staff and public health researchers and practitioners

The North West PHO has the lead role on alcohol and has information about local alcohol indicators, the Alcohol Needs Assessment Research Project and an evidence based information tool for public service agreements:

www.nwph.net/alcohol/

The Institute of Alcohol Studies

The Institute of Alcohol Studies (IAS) is an educational body with the basic aims of increasing knowledge of alcohol and the social and health consequences of its misuse, encouraging and supporting the adoption of effective measures for the management and prevention of alcohol-related problems. The Institute is financially independent of both Government and the drinks industry, limited by guarantee and is supported by the Alliance House Foundation, a registered educational charity.

www.ias.org.uk

The Portman Group

The Portman Group is not a trade association, but a pan-industry organisation whose purpose is to help prevent misuse of alcohol and to promote sensible drinking. An independent company, limited by guarantee, The Portman Group was set up in 1989 by the UK's leading drinks manufacturers, which together supply about 95% of the alcohol sold in the UK.

www.portman-group.org.uk/

Psychiatric morbidity surveys

A survey in 1997 of psychiatric morbidity among prisoners shows prevalence figures of drinking among people before being sentenced to prison. Similar surveys of adults living in institutions, homeless people and people with psychotic disorders have also been carried out. An overview of alcohol dependence in these surveys was published in 1998. These surveys are listed below

Psychiatric morbidity among prisoners in England and Wales, 1997. Office for National Statistics, 1998. Available at:

<http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-prisoners/psychiatric-morbidity-among-prisoners--summary-report/psychiatric-morbidity---among-prisoners--summary-report.pdf>

Adults with a psychotic disorder living in households, 2000. Office for National Statistics, 2002. Available at:

<http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/adults-with-a-psychotic-disorder-living-in-private-households/adults-with-a-psychotic-disorder-living-in-private-households/adults-with-psychotic-disorder-living-in-private-households.pdf>

Farrell, M. et al. Substance Misuse and Psychiatric Co-morbidity: An Overview of the OPCS National Psychiatric Morbidity Survey. *Addictive Behaviours*. 1998. 23:909-918.

Reported Road Casualties Great Britain 2010

This report provides more detailed information about accident circumstances, vehicle involvement and the consequent casualties in 2010, along with some of the key trends in accidents and casualties.

Reported Road Casualties Great Britain: 2010 - Annual Report. Department for Transport. Available at:

<http://assets.dft.gov.uk/statistics/releases/road-accidents-and-safety-annual-report-2010/rrcgb2010-00.pdf>



Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) National Report: Smoking, Drinking and Drug Use among 13 and 15 Year Olds in Scotland in 2008

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) was established by the Scottish Executive to provide a broad-based approach to the monitoring of substance use in the context of other lifestyle, health and social factors.

SALSUS continues the national series of biennial surveys of smoking, drinking and drug use among secondary school children which began in 1982 in order to obtain information on smoking. In 1990, the survey included questions to establish alcohol prevalence and in 1998 questions on drug use were introduced. The survey became known as the Scottish Schools Adolescent and Lifestyle Survey (SALSUS) in 2002 with the introduction of other lifestyle and social factors. The survey in 2010 provides information at national level only. All secondary schools (both state and independent) were invited to take part in SALSUS, with a target sample of 37,000 pupils.

Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) - National Report 2010. The Scottish Executive. Available at:

http://www.drugmisuse.isdscotland.org/publications/abstracts/salsus_national10.htm



Young people and crime: findings from the 2006 Offending, Crime and Justice Survey

The Offending, Crime and Justice Survey (OCJS) is the national longitudinal, self-report offending survey for England and Wales. The survey, covering people living in private households, was first conducted in 2003 and was repeated annually until 2006.

The main aim of the survey is to examine the extent of offending, anti-social behaviour and drug use among the household population, particularly among young people aged from 10 to 25. The survey covers offences against households, individuals and businesses. In addition to 'mainstream' offences such as burglary, shoplifting and assault, it also covers fraud and technology offences.

Young People and Crime: Findings from the 2006 Offending, Crime and Justice Survey. Home Office. Available at:

http://www.homeoffice.gov.uk/rds/offending_survey.html

World Health Organisation

Hazardous, harmful and dependent drinking are defined by the World Health Organisation in the Alcohol Use Disorders identification Test (AUDIT) manual. Available at:

whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

Sensible Drinking: Report of an inter-departmental working group

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084701

Appendix F: Update on the Public User Consultation

Between April and June 2011, the Health and Social Care Information Centre (HSCIC) consulted on the suite of Lifestyle Compendia publications. The consultation was conducted in accordance with the Code of Practice for Official Statistics and is available via the following link:

<http://www.ic.nhs.uk/work-with-us/consultations/lifestyles-statistics-compendia-publications-consultation>

The consultation contained a proposal (provided below with each outcome) and invited users of the statistics to comment. The consultation also sought to engage with users to develop a further understanding of the users and uses of the reports and also encouraged views on the methodologies used within the reports.

The consultation closed on 24 June 2011. We received five responses to the consultation (not all respondents answered all the questions).

The outcome to the proposal was published in August 2011. A number of responses were specific to the *Statistics on Alcohol: England* publications, therefore an update to how these have been addressed in this publication is provided below

Proposal and Outcome

1)

- a. To continue to publish the four compendia reports annually. The expected publication months would be:
- Statistics on Obesity, Physical Activity and Diet – February
 - Statistics on Alcohol – May
 - Statistics on Smoking – August
 - Statistics on Drug Misuse – November

All the above publications were confirmed as being used and useful by respondents. Therefore we will continue to publish the four compendia publications annually.

- b. To continue the signposting approach wherever possible, summarising the key facts and linking to the original source of information rather than re-publishing the data in the compendium publications.

Comments were in favour of this approach agreeing that it reduces repetition to signpost to previously published data. Therefore we will continue this approach.

- c. To discontinue secondary analyses of the GLF datasets to produce England level data and further detailed analyses for inclusion in 'Statistics on Alcohol' and 'Statistics on Smoking'.
Note: for some of these proposed discontinued England level tables, we propose to signpost

to the GLF report where a GB level equivalent table exists, other tables do not have a GB level equivalent to signpost to and we propose not to carry out these additional analyses. Links to the GLF data deposited in UK Data Archive will be provided to allow users to perform their own analyses if required. (Appendix A details the tables that are proposed to be discontinued. It is indicated where a GB level equivalent exists in the GLF reports). Note that the future of the GLF itself is under discussion (see proposal 'e').

We received comments from users that the England level data and the additional analyses are useful. We will therefore continue to produce and publish all the analyses listed in Appendix A of the original consultation at England level. (Note: we will continue to review the outcome of the consultation on the General Lifestyle Survey (GLF) by the Office for National Statistics (ONS) to see how this may impact on future publications – see link under part (e)).

- d. To discontinue secondary analyses of the HSE datasets to produce cross tabulations on blood pressure and longstanding illness (not included in the HSE reports) from inclusion in 'Statistics on Obesity, Physical Activity and Diet'. (Information on Body Mass Index by GHQ12 is proposed to be continued). Links to the HSE datasets deposited in UK Data Archive will be provided to allow users to perform their own analysis if required. (Appendix A details the tables that are proposed to be discontinued).

We didn't receive any specific comments on these data, however, as the general comments we received favoured the new analyses and consistent time series we will continue to produce these analyses.

- e. To continue to monitor the Office for National Statistics (ONS) consultation 'The Future of the General Lifestyle Survey' to determine if necessary and where possible any alternative sources of information or dissemination for the compendia reports. The ONS consultation closed on 6 May 2011 and the response to the consultation can be accessed via the following link: <http://www.ons.gov.uk/about/consultations/closed-consultations/the-future-of-the-qlf-survey/index.html>

We will continue to monitor this and may need to amend our publications accordingly in the future.

- f. Only new analyses will be presented as detailed tables within the compendia publications. As the data obtained from HES and the Prescribing data are previously unpublished at this level of detail, it is proposed to continue with these analyses and the detailed tables will be included in full in the reports. Alcohol related hospital admissions currently published via HES at Strategic Health Authority (SHA) level will continue to be included in 'Statistics on Alcohol' analysed further by age, gender and condition. We welcome the views of users as to what level of regional analysis is required.

We received comments that stated that the new analyses were the most useful element of the publications and also received comments in favour of local level analyses. We will therefore continue to publish the above information and examine whether any further regional analyses can be included (or signposted to if available elsewhere). We will signpost the local level data on alcohol and smoking related admissions published by North West Public Health Observatory (<http://www.nwph.net/alcohol/lape/download.htm>) and London Health Observatory (http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Tobaccocontrolprofiles/) respectively in future reports.

- g. To continue the appendices in their current form. We welcome comments from users on how useful they find each appendix.

We didn't receive any specific comments on the appendices (apart from general comments that the publications were useful) so will continue all appendices in their current form.

Other Responses to the Consultation

- 2) Which publications you use, how often and for what purpose?

Respondents reported that they used all four publications. They are used throughout the year to inform decision making, benchmarking and planning and also to develop greater understanding of the subject.

- 3) Which chapters / sections in particular do you find most useful and why?

The sections respondents stated as being the most useful were the new analyses/data, particularly the tables.

- 4) How would you be impacted by the proposal contained above?

Respondents indicated the proposal would have little impact on them providing that the signposting approach continued within the reports.

- 5) What would be the impact on you if GLF data was no longer available?

Respondents stated the GLF highlighted important trend information and provided a useful insight. A respondent noted that without the England level GLF data, this would result in them having to perform their own analyses.

We will continue to follow the GLF consultation by ONS and may need to amend our publication in the future.

- 6) Are there any additions you would like to see included in the publications? (We can not guarantee to meet all requests but will consider all that we receive).

We received a number of requests:

Additional commentary and analysis linking the alcohol consumption and trends and the health indicators presented (little correlation between the two – possible explanations would add value).

This has not been included in this report as the preferred approach is to present the information in an easy to understand way that allows the users to make their own comparisons and conclusions.

To include (or signpost) the total number of admissions to hospital to give context to the alcohol-related admissions.

This has been included in [Chapter 4](#) and [Table 4.9](#).

Alcohol-related admissions presented by acute/chronic conditions to help understanding of the effects of alcohol.

This has been included in [Chapter 4](#) and [Tables 4.2](#) and [4.7](#).

Consider using sales data alongside the survey data to estimate population alcohol consumption.

This is something we might look to include in the future subject to resources.

Additional local level analyses (or signposting) where possible.

A link to the Local Alcohol Profiles for England hosted by the North West Public Health Observatory has been included in the publication. Primary Care Trust and Local Authority level data are available from this site.

- 7) We would like your views on the methodologies and data accuracy measures which are or might be used in the reports to ensure these remain up to date and fit for purpose. Please provide any comments you may have on any of the methodologies included in the reports. In particular, due to methodological developments in the affordability of alcohol (<http://alcalc.oxfordjournals.org/content/45/6/581.full.pdf>) we would welcome views on the affordability of alcohol and tobacco indices published in 'Statistics on Alcohol' and 'Statistics on Smoking'. (N.B Statistics on Alcohol 2011 expected to be published on 26th May 2011 will include a methodological revision which makes the affordability index insensitive to population changes over time when all other variables remain constant in addition to the existing measure).

We received a number of comments on the methodologies. These focussed on either the Affordability of alcohol/tobacco (alcohol in the responses) or the Alcohol-related hospital admissions.

Affordability of alcohol/tobacco – all respondents were in favour of the adjustment made to the measure in Statistics on Alcohol: England, 2010 to calculate on a per capita basis.

We also received other comments on the methodology. Some of the comments were in favour of the additional changes proposed by the Institute of Alcohol Studies (2010) considering the inflation calculation unnecessary and potentially misleading, however, other comments also urged caution in overdeveloping the index and stated that removing the inflation adjusters would make the metric conceptually more difficult to appreciate and that the adjustments were necessary. Comments also stated that further consideration to the users and uses of the measure needed consideration (other measures were also suggested) – there are various variations or refinements that could be made, but the benefits of these need consideration.

In response to these comments, we will continue to use the measure with the recent per capita adjustment applied to it. Additional information has been included to explain and describe the affordability index, and how it should (and should not) be used. Further refinements/amendments or additional measures may be considered in the future as a separate piece of work when resources allow.

Alcohol-related hospital admissions – we received comments relating to both the methodology, and the presentation and interpretation of the estimates. Whilst the estimates were recognised as having some merit a respondent noted the complex nature of the underpinning methodology and its limitations, in particular the methods underpinning the derivation of the attributable fractions. It was stated that ideally, the estimate would allow comparisons with other countries and the complex nature necessitates careful interpretation and presentation, including reference to the necessary limitations associated with the methodology. We also received feedback indicating that the estimates that display alcohol-related admissions based on all diagnosis (i.e. both primary and secondary) may have been affected over time by changes in recording practices more so than the primary admissions only. Ideally the impact of such factors should be established and explained in the commentary where possible.

We still consider the alcohol attributable fractions (developed by the North West Public Health Observatory (NWPHO)) to provide the best estimates currently available. Additional information has been included in the publication to describe the methodology in detail. The measures (and uses) have also been described in greater detail and the benefits and limitations of each explored.

In order to assess any effect of changes in recording practices and to assist in the interpretation of the primary and secondary admission estimates over time, we have completed some analyses to attempt to quantify the impact of these changes in the recording of secondary diagnoses. We have therefore produced estimates of what the admission numbers in previous years would have been had the current level of recording of secondary diagnoses existed in those years. These figures are provided in Chapter 4 and a detailed technical appendix describing the analyses in detail is provided in [Appendix G](#).

The methodology for calculating alcohol related admissions to hospital is currently subject to a public consultation. The consultation is being led by the NWPHO working with the Department of Health and the HSCIC. The consultation was launched on 31 May 2012, and will run for 12 weeks. Full details can be found on the NWPHO website: www.lape.org.uk

We welcome any comments you may have on this subject.

8) Are there any other comments you would like to make?

We received a comment from one organisation that welcomed dialogue with us on the various measures and how these are presented in the report – we do consider how external organisations can contribute to our report and will continue to do so where appropriate, following the Code of Practice for Official Statistics. We feel that this consultation exercise has already provided all relevant comments for us to consider at present, but will also respond to any further comments/suggestions in the future.

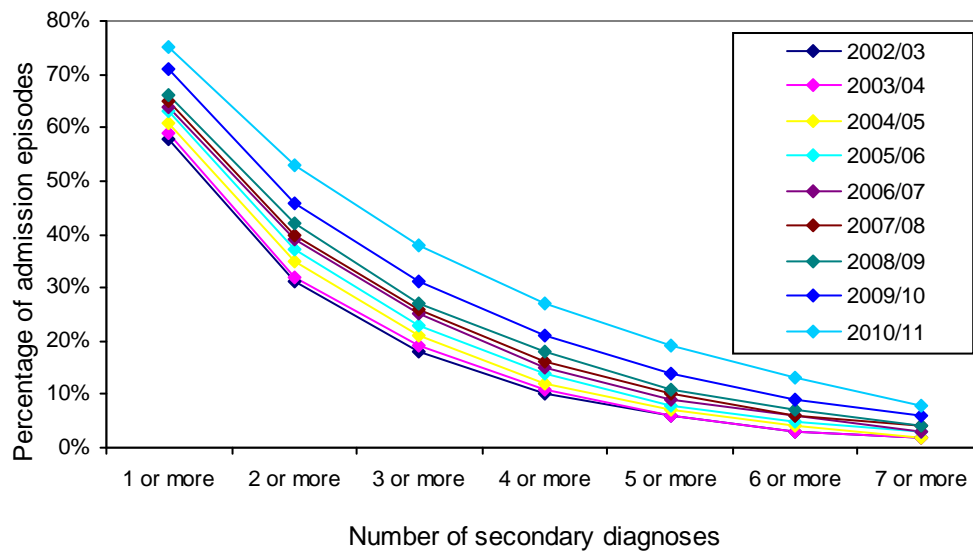
One respondent stated that at present, there was no standardised approach in the UK for reporting of alcohol related admissions, and asked if we were interested in discussing the benefits of a more harmonised approach.

We are interested in such an approach and will be discussing this with the responder and contacts in the other countries in the UK.

Appendix G: Quantification of the impact of changes in recording practices of secondary diagnoses on national alcohol related admission (ARA) estimates

- A2.1. The alcohol-related hospital admissions figures presented in [tables 4.1 to 4.5](#) of this report were derived by summing the alcohol attributable fraction (AAF) associated with each admission based on the diagnosis most strongly related to alcohol (the one with the highest AAF) out of both the 'primary diagnosis' and 'secondary diagnoses'. This is known as the 'broad measure'. There is also an alternative measure of alcohol related admissions, known as the 'narrow measure' based on the primary diagnosis field only. This is discussed in paragraph A2.6 below and figures based on the narrow measure are available in [tables 4.6 to 4.10](#).
- A2.2. Up to 20 diagnoses can be recorded for each hospital episode. The 'primary diagnosis' is defined as the main condition treated or investigated during the relevant episode of healthcare. There are also up to 19 'secondary diagnoses', which describe other conditions the patient may have that are relevant to the treatment being provided. All episodes have a primary diagnosis, but the number of secondary diagnoses used (if any) depends on the circumstance. In 2010/11, three quarters of admission episodes involved at least one secondary diagnosis, over half had two or more, over a third had three or more, and over a quarter had four or more. Less than one per cent had twelve or more. The average (mean) number of secondary diagnoses was 2.5.
- A2.3. At a national level there have been improvements in recording practices in relation to secondary diagnoses in recent years. This has led to increases in the proportion of admissions which have secondary conditions associated with them. This is illustrated in [figure G.1](#) below, which is based on all admission episodes (not just those that are alcohol related).
- A2.4. Between 2002/03 and 2010/11, the percentage of admission episodes with at least one secondary diagnosis increased from 58% to 75% and the number with four or more secondary diagnoses increased from 10% to 27%.

Figure G.1. Growth in coding of secondary diagnoses, 2002/03 to 2010/11



Source: Hospital Episode Statistics, The Health and Social Care Information Centre

A2.5. Table 4.1 of this report shows that the overall number of alcohol related admissions increased from 510,800 in 2002/03 to 1,168,300 in 2010/11, in percentage terms an increase of 129%. However, it is likely that this increase is at least partly the result of improvements in recording practices in relation to secondary diagnoses, and that alcohol related admissions figures for earlier years would have been higher had 2010/11 recording conditions existed in those years.

A2.6. The alcohol related admission estimates presented in tables 4.6 to 4.10 are 'primary only' estimates and are assumed to be unaffected by the changes in recording practices which affect figures in tables 4.1 to 4.5. 'Primary only' estimates are derived by summing the AAF associated with the alcohol related condition which appears in the primary diagnosis field (where there is one) regardless of whether or not there is an alcohol related condition with a higher AAF in one of the secondary diagnosis positions. Based on table 4.5 figures, the overall number of alcohol related admissions increased from 141,700 in 2002/03 to 198,900 in 2010/11, an increase of 40%. This is substantially less than the 129% increase shown in table 4.1 figures (broad measure) over the same period.

A2.7. In spite of the difficulties associated with the broad measure, both the broad and narrow measure are presented in 'Statistics on Alcohol: England' compendia reports. The broad measure is 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. The narrow measure provides an uncomplicated picture of trends in alcohol-related admissions over time and offers some benefits for direct comparisons between areas.

A2.8. In order to aid interpretation of the observed figures, a methodology has been devised to estimate what the overall table 4.1 figures would have been for each year from 2002/03 to 2009/10 had the secondary coding conditions that existed in 2010/11 existed in each of these years. This methodology has only been applied to overall estimates which relate to all conditions as there is a possibility that unreliable results would occur if applied to individual conditions or groups of conditions.

A2.9. This methodology is intended to be applied annually as, in spite of the improvements in the recording of secondary diagnoses illustrated in [figure G.1](#), there are likely to be further improvements in the future. It should also be borne in mind that since the adjustment for any given year is affected by the data for the most recent year in the series, adjusted data will be subject to revision when the next year's data is available.

A2.10. The methodology is underpinned by the following important assumptions:

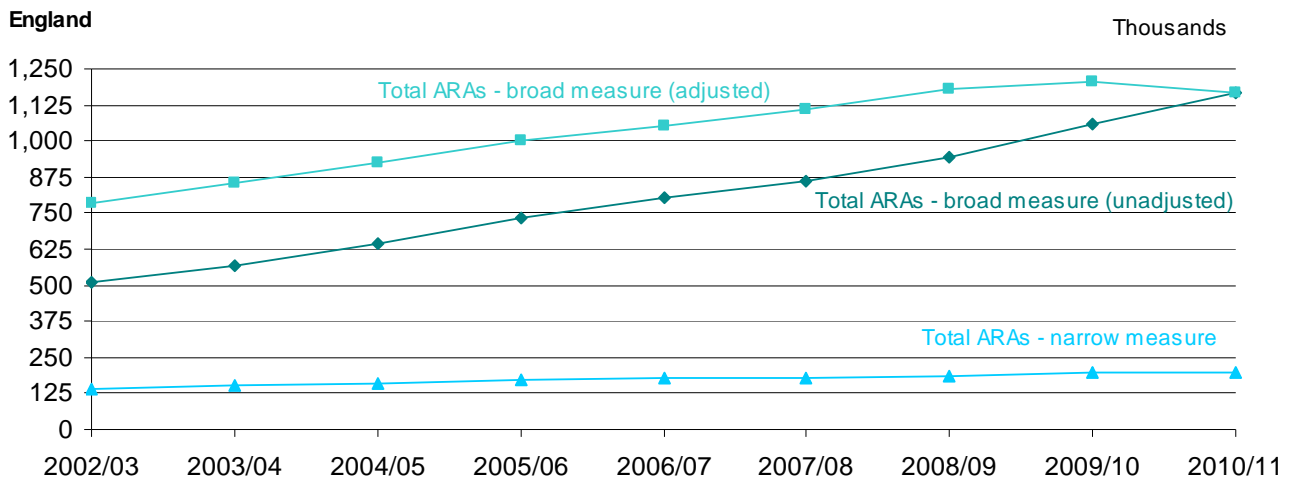
- The overall count of secondary diagnoses of all types of conditions (not just those that are alcohol related) was under recorded in all secondary diagnosis positions (2 to 20) in each year from 2002/03.
- This can be adjusted for by obtaining the number of secondary diagnoses counts as a proportion of the number of the primary diagnosis count for every secondary diagnosis position in 2010/11. This proportion was 75.2% for the first secondary diagnosis position, 52.8% for the second secondary diagnosis position, etc.
- The corresponding proportions for 2002/03 based on observed data are only 58.0% and 31.4% for the first and secondary diagnosis positions respectively. Had 2010/11 secondary recording conditions existed in each of the other years, it is assumed that the count for the first and second secondary diagnosis positions would also have been 75.2% and 52.8% of the primary diagnosis count respectively in those years too (and similarly for all the other secondary diagnosis positions).
- This effectively means there are extra secondary diagnosis counts to disperse for every secondary diagnosis position for each year from 2002/03 to 2009/10. Once done, this is assumed to account for the under reporting in each year from 2002/03 to 2009/10.
- Having adjusted for the overall shortfall in secondary diagnoses counts (for all conditions) for each year from 2002/03 to 2009/10, the number of secondary diagnoses relating to just conditions which are related to alcohol consumption (47 are identified in [table A.3](#) in [Appendix A](#) of this report) needs to be calculated.
- This is done by calculating the proportion of all secondary diagnoses counts in the observed data (ie data unadjusted for the shortfall in secondary diagnoses counts) which occur due to mentions of conditions which are related to alcohol consumption (termed 'probability of a mention of an alcohol-related condition') and applying this to newly adjusted secondary diagnosis count. This is done for every secondary diagnosis position in each year.
- This requires an assumption to be made that the proportion of alcohol related conditions that were under reported in each year was exactly the same as the proportion of non-alcohol related conditions that were under reported. Therefore the observed probability of a mention of an alcohol-related condition is equal to the true probability (ie the probability had there not been any under reporting).¹

¹ There is some evidence to suggest that this assumption may not hold true, resulting in further uncertainty around the adjustment method. The observed data shows that the standard deviation in the probability of a mention of an alcohol-related condition in the primary position was approximately 7 times less than the equivalent figure for secondary diagnosis positions, suggesting that the probabilities calculated for secondary diagnosis positions may themselves have been affected by changes in recording practices over time. This

- By definition, 2010/11 cannot be adjusted for any shortfall in secondary diagnosis recording (although it will need to be if there are further improvements in coding in future years). In this year, there were 743,800 mentions of an alcohol related condition in the primary diagnosis fields (one of the 47 identified in [table A.3](#) in [Appendix A](#) of this report). In total, there were also 4,668,400 mentions of an alcohol related condition in one of the secondary diagnosis fields. Together, there were 5,412,100 mentions of an alcohol related condition in any diagnosis position. Once adjusted for shortfalls in secondary diagnosis recording in each year from 2002/03 to 2009/10, it is estimated that the number of mentions of an alcohol related condition in any diagnosis position ranged from 3,628,800 in 2002/03 to 5,596,800 in 2009/10.
- It is important to recognise that none of the figures in the bullet point above tells us how many admissions there were with at least one alcohol related condition in either the primary or one of the 19 secondary diagnosis positions. This is because there may be more than one mention of an alcohol related condition for any given admission. Where there is just one mention, it's possible for this to occur in the primary position only, or in one of the secondary positions only.
- As stated earlier, the methodology used to derive the figures in [table 4.1](#) involves assigning an AAF to each admission based on the diagnosis most strongly related to alcohol across both the primary and 19 secondary diagnosis positions. Where there is more than one mention of an alcohol related condition, the one with the highest AAF is used. Using this method, it is estimated that there were 1,168,300 alcohol related admissions in 2010/11.
- In 2010/11, the overall ratio of mentions of an alcohol related condition in any of the diagnosis positions to the estimated number of alcohol related admissions was 4.63 (5,412,100 divided by 1,168,300). Although the observed data shows that this ratio increased from 4.43 in 2002/03 to 4.60 in 2009/10, had the secondary coding conditions that existed in 2010/11 existed in each year from 2002/03 to 2009/10, it is assumed that this ratio would also have been 4.63 (ie equal to the 2010/11 ratio) in each of these years too.
- As described above, after adjustment it is estimated that the number of mentions of an alcohol related condition in any diagnosis position was 3,628,800 in 2002/03 and 5,596,800 in 2009/10. By assuming that the true ratio of mentions of an alcohol related condition in any of the diagnosis positions to the number of alcohol related admissions was 4.63 throughout the series, we conclude that the adjusted estimate of alcohol related conditions was 783,300 in 2002/03 and 1,208,100 in 2009/10. Overall, the adjusted series shows an increase from 783,300 in 2002/03 to 1,168,300 in 2010/11, an increase of 49.1%. Adjusted estimates for each year from 2002/03 to 2009/10 are presented in [table 4.11](#) and [figure G.2](#) below.

reflects the difficulty in separating any trend in differential under-recording of alcohol-related conditions from trends in the conditions themselves.

Figure G.2 Alcohol-related NHS hospital admissions (ARAs) 2002/03 to 2010/11



Source: Hospital Episode Statistics, The Health and Social Care Information Centre and North West Public Health Observatory attributable fractions

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The HSCIC welcomes comments from users on this methodology with a view to refining it in the future should this lead to an improvement. Comments can be sent by email to enquiries@ic.nhs.uk

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Responsible Statistician

Paul Eastwood, Lifestyle Statistics Section Head

For further information:

www.ic.nhs.uk

0845 300 6016

enquiries@ic.nhs.uk

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