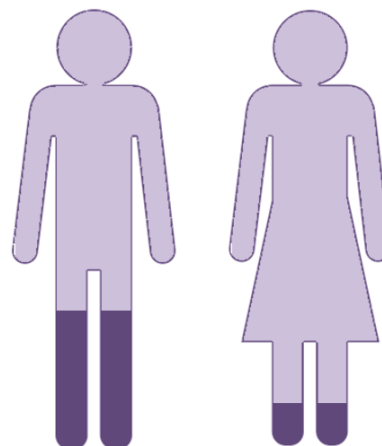




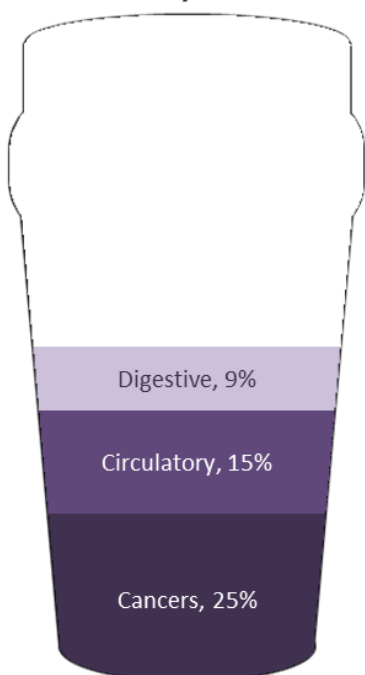
Year 10 pupils drinking alcohol in the last 7 days



Risk profile of male and female drinkers

■ Low risk drinking
■ Higher risk drinking

Alcohol-related admissions caused by disease



Alcohol health harm

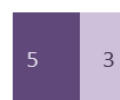
East Sussex



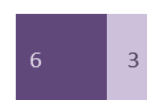
Average monthly alcohol-related call-outs

Excess deaths in the most deprived areas due to alcohol-specific causes, 2012-2014

■ Males
■ Females



Wealden



Rother



Lewes



Hastings



Eastbourne



Low mood/
depression

Drinking
culture

Boost
confidence

Available &
affordable

Why drink?

Boredom

Peer
pressure

Sociable

Coping
mechanism

Wind down at the
end of the day

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Executive Summary

This report provides an update to the report *Alcohol related health harm in East Sussex, February 2015*.

The key findings from this year's report are as follows:

Consumption

- Young people (15 year olds) in East Sussex have significantly higher alcohol consumption compared to the England average. Year 10 pupils reporting that they had had a drink in the last 7 days was highest in Wealden and Hastings.
- Over a third of adults drink alcohol every week. Notable differences between males and females – more males drink alcohol, more regularly and at higher risk – 1 in 3 males compared to 1 in 10 females who drink are drinking at higher risk.

Reasons for drinking

- The reasons local people give on why they find alcohol attractive include: low mood/depression; boredom; coping mechanism; peer pressure; availability and affordability and boosts confidence.

Levels of understanding of safe drinking

- There is confusion around safe drinking limits with both adults and young people not understanding how to measure the units they are consuming.
- Although limited, there is some awareness of health risks but this is not a deterrent, with young people in particular feeling confident that health problems won't happen to them.

Alcohol-related harm

- Alcohol-related health harms (admissions and deaths) are significantly worse than England in Hastings. Eastbourne generally has similar levels of alcohol-related health harm to England, with Lewes, Rother and Wealden either similar too or significantly better compared to the national average. Alcohol health harm is higher for males.

Impact on health services

- A&E attendances during the night-time economy due to assaults are higher for males and for 15-24 year olds. Attendance rates are significantly higher

than the county average in Eastbourne and Hastings. There are higher rates for persons from more deprived areas.

- Alcohol-related ambulance call-outs have seen a 17% increase in 2015/16 compared to 2014/15. Half are between 8pm and 4am with a further 1 in 5 between 4pm and 8pm. Numbers are highest in Eastbourne and Hastings town centres and in the month of August.

Inequality in life expectancy

- Deaths from alcohol contribute to the gap in life expectancy between the most and least deprived areas within districts and boroughs. In East Sussex the largest impact is on males living in the most deprived parts of Hastings.

Introduction

The overarching aim of the East Sussex Alcohol Strategy 2014-2019 is to make East Sussex a safer and healthier place; it has 3 priority areas:

1. Develop individual and collective knowledge, skills and awareness towards alcohol
2. Provide early help, intervention and support for people affected by harmful drinking
3. Create better and safer socialising

This report focuses on the health aspects of alcohol and pulls together information on alcohol-related behaviours and health outcomes in East Sussex. It provides an update to *Alcohol related health harm in East Sussex, February 2015*. Updates include: alcohol consumption in East Sussex, A&E attendances due to assaults, alcohol suspected ambulance call-outs, alcohol-related hospital admissions and deaths from alcohol. Where there is no new data, it has been stated within the report and information from the previous report has been presented.

The report draws on local and nationally produced data from lifestyle surveys, the 'East Sussex Drink Debate', ambulance call-outs, A&E attendances, hospital inpatient admissions and mortality data. Due to the complexity of the issues and limitations of data (despite using a range of data sources) it cannot capture the full extent of the burden that alcohol places on health in East Sussex, but only that which can be measured. Within each section the relevant key objective or outcome from the alcohol strategy has been highlighted.

Alcohol consumption – young people

Key strategy outcome: reduce number of young people & adults drinking above safe limits (priority 1)

70% of 15-year olds in East Sussex have ever had an alcoholic drink. This is significantly higher than the England average of **62%**

8% of 15-year olds in East Sussex report drinking regularly, significantly higher than the England average of **6%**

Data source: What about YOUTH? survey, 2014/15.
Public Health England.

1 in 5 15-year olds in East Sussex have been drunk in the last 4 weeks, significantly higher than **1 in 7** for England.

Year 10 pupils reporting they had had an alcoholic drink in the last 7 days ranges from 28% in Eastbourne to 39% in Hastings and Wealden (Figure 1).

Figure 1



Data source: The Schools Health Education Unit. Young People in East Sussex Schools: A report on the health behaviour of young people aged 14-15 in 2012 (85% of Year 10 pupils participated).

Alcohol consumption - adults

Key strategy outcome: reduce number of young people & adults drinking above safe limits (priority 1)

Based on the Local Alcohol Consumption Survey, for East Sussex adults:



20% never drink alcohol

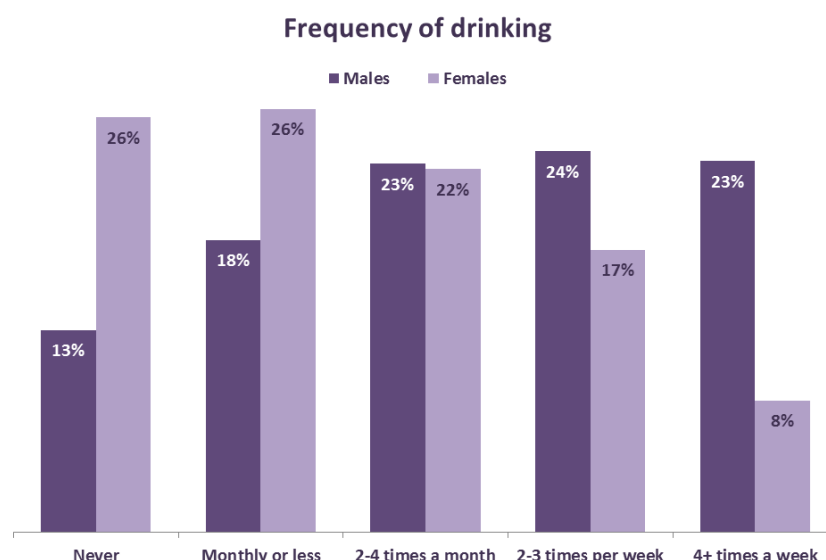


35% drink alcohol every week

Data source: Local Alcohol Consumption Survey undertaken by Ipsos-MORI on behalf of Public Health England, 2016

There are clear differences in the frequency of drinking between males and females with a higher proportion of males drinking alcohol and drinking it more regularly.

Figure 2



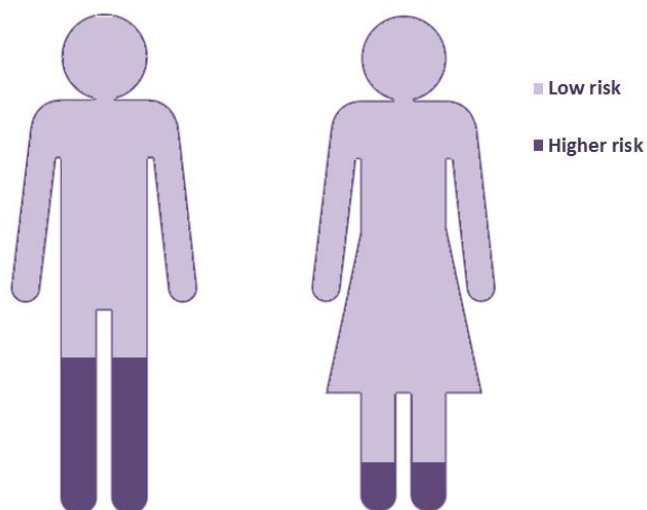
Almost 1 in 4 (23%) males are drinking 4 or more times a week compared to **fewer than 1 in 10 (8%) females**. These are higher proportions compared to the survey averages (17% and 7% respectively).

The Local Alcohol Consumption Survey sampled adults in 25 local authorities. East Sussex data is based on 346 postal survey responses and 305 face-to-face interviews during 29th Feb – 25th April 2016. Analyses are based on data weighted by gender, age and ethnicity.

Data source: AUDIT (Alcohol Use Disorders Identification Test) score from Local Alcohol Consumption Survey, 2016

Of those who report consuming alcohol, **1 in 5** are doing so at **higher risk**.

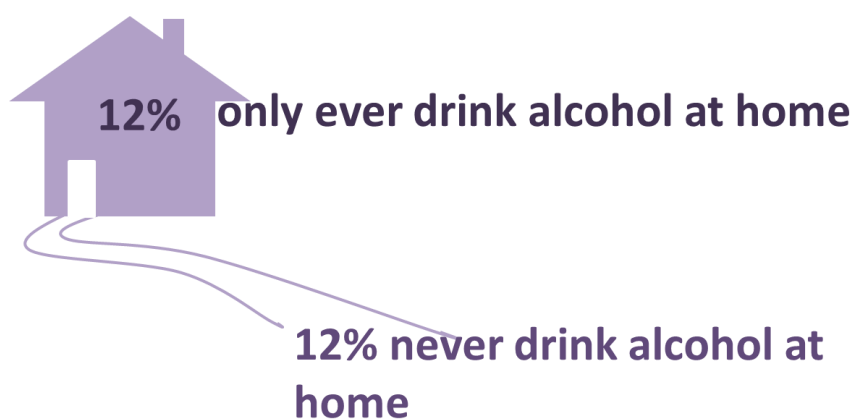
Figure 3



For East Sussex **males** who drink, **32%** are doing so at higher risk compared to **10%** for **females**

Of adults who drink alcohol:

more than half the time people are doing so at home

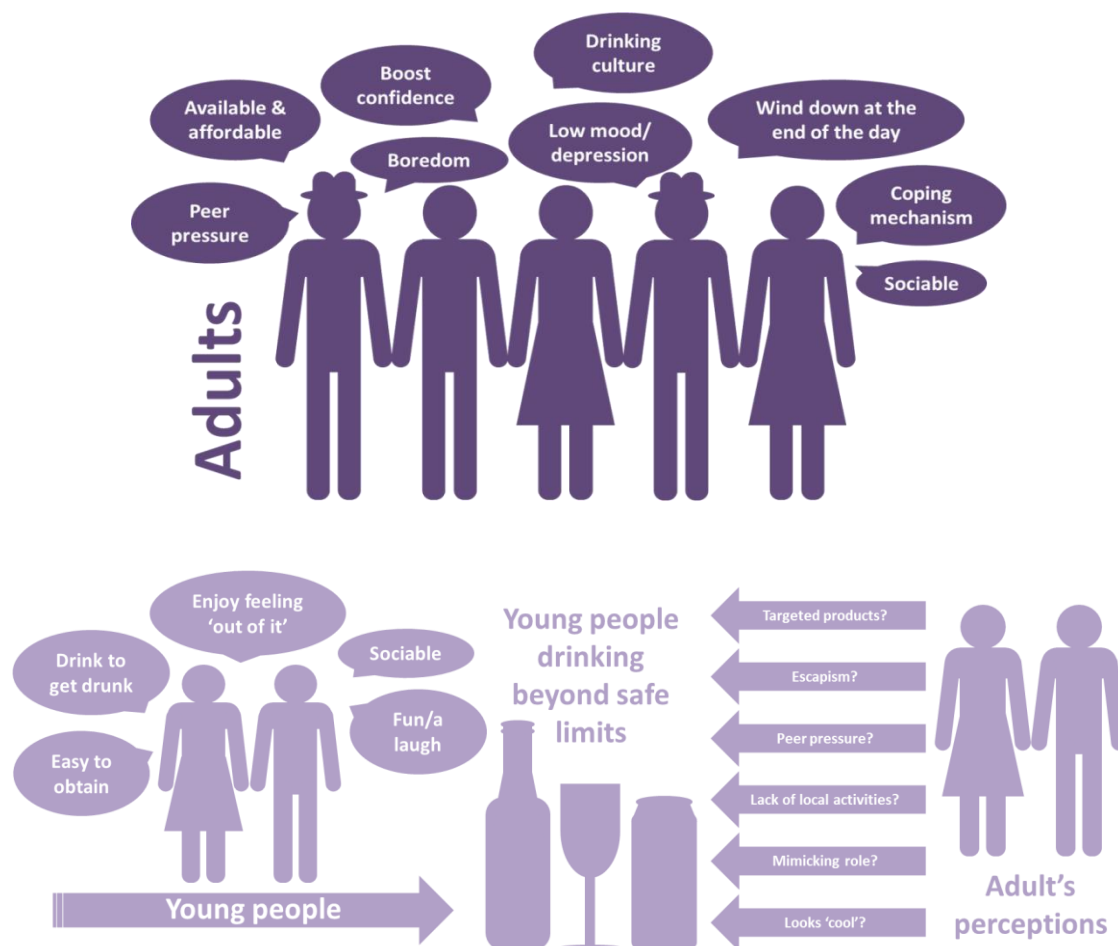


Low risk = Zone 1 from AUDIT (lower risk)
Higher risk = Zone 2, 3 & 4 from AUDIT (increasing risk, higher risk and possible dependent)
For further information about AUDIT http://www.talkingalcohol.com/files/pdfs/WHO_audit.pdf

Why do people find alcohol attractive?

NO UPDATE

Key strategy outcome: reduce number of young people & adults drinking above safe levels (priority 1)



The main reasons participants gave for drinking alcohol

Data source: East Sussex Drink Debate Report 2013: Report on qualitative research, Abacus Insight



East Sussex Safer Communities Partnership conducted the East Sussex Drink Debate for 6 weeks from April 2013. The Debate asked people how alcohol features in the lives of individuals, families and communities. Responses were elicited online or in printed forms. Residents and stakeholders were engaged in an open discussion on a range of alcohol-related issues through qualitative research with 136 participants in focus groups and telephone interviews.

Understanding units and safe drinking limits

NO UPDATE

Key strategy objective: increase knowledge, understanding and awareness of healthy drinking limits (priority 1)

Data source: East
Sussex Drink Debate
Report 2013: Report on
qualitative research,
Abacus Insight

Local research shows that although a few adults were able to cite recommended safe limits, there is a widespread lack of understanding for both adults and young people about how people measure the units they are consuming.

**“You get different quantities and strengths of drink when home and out. It’s impossible to keep count of units”
(Adult)**

**“I don’t even think about them”
(Young person)**

**“People don’t know what a unit is. We’re working with clients to explain the recommended guidelines and we are working with the police who pick up people who are drunk and disorderly. We try to educate.”
(Frontline worker)**

Although limited, there was some awareness of health risks and young people in particular were confident that health problems wouldn’t happen to them so knowledge of some of the health consequences doesn’t deter them.

A&E attendances between 8pm and 4am due to assault

Key strategy outcome: reduce demand on emergency services (priority 3)

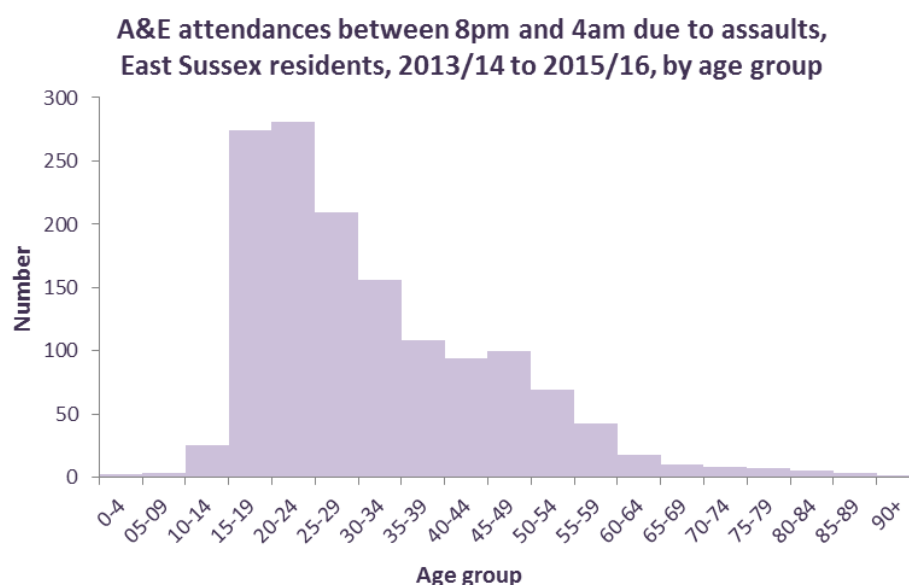
Data source: Public Health SUS extracts 2013/14 to 2015/16.
Note analysis by geography is based on the postcode of the patient, not where the assault took place.

7 in 10 (71%) A&E attendances between 8pm and 4am due to an assault are for males.



1 in 5 attendances are for each of the age groups 15-19 year-olds (19%) and 20-24 year olds (20%). Three-quarters (73%) of the total attendances during the 3-year period were for persons aged 15-39 years with only small numbers for under 15s and over 60s.

Figure 4



Due to the limitations of national coding that is used for A&E data, it is not possible to capture alcohol-related A&E attendances. Attendances at A&E during the night time economy (8pm to 4am) as a result of an assault is a proxy measure for a very specific aspect of alcohol-related harm. A&E attendance data does not include data for Minor Injury Units (open 8am-8pm only).

The rate of A&E attendances during the night-time economy (8pm-4am):

- For 15-59 year olds, rates for residents in Eastbourne and Hastings boroughs are significantly higher than the East Sussex average. Rother and Wealden have significantly lower rates than East Sussex.
- For 15-24 year-olds, Hastings has the highest rate and a significantly higher rate than East Sussex; Rother and Wealden have the lowest rates which are significantly lower than East Sussex.

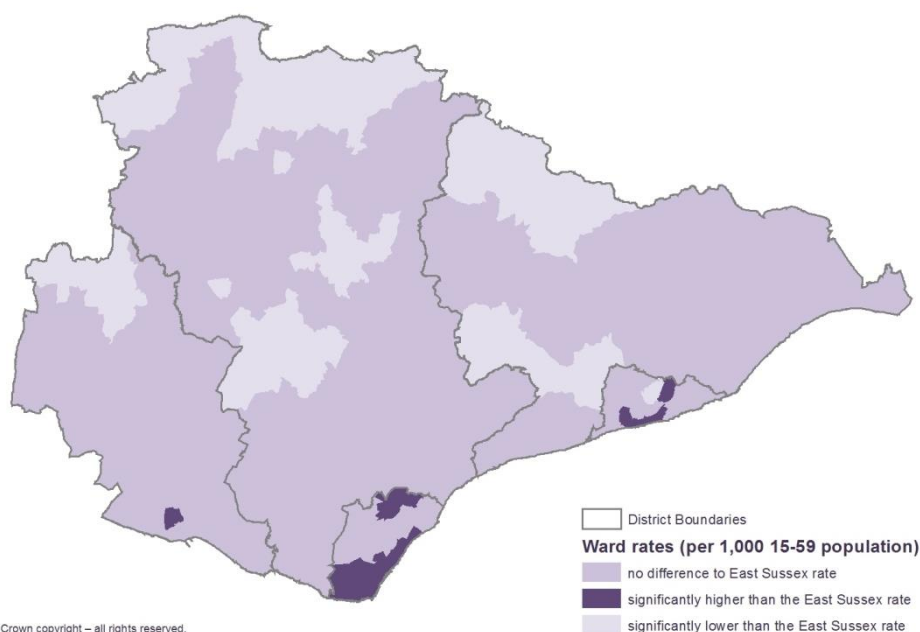
Table 1

	Number of attendances		Rate per 1,000 population	
	15-24 years	15-59 years	15-24 years	15-59 years
Eastbourne	145	394	4.0	2.4
Hastings	142	349	4.3	2.2
Lewes	93	214	3.0	1.3
Rother	61	150	2.3	1.1
Wealden	114	226	2.4	0.9
East Sussex	555	1333	3.2	1.6
Significantly higher than East Sussex				
No significant difference to East Sussex				
Significantly lower than East Sussex				

There are 9 wards that have significantly higher rates of A&E attendances for 15-59 year-olds compared to East Sussex: Devonshire, Hampden Park, Langney and Meads in Eastbourne; Baird, Castle, Central St Leonards and Maze Hill in Hastings and Newhaven Valley in Lewes.

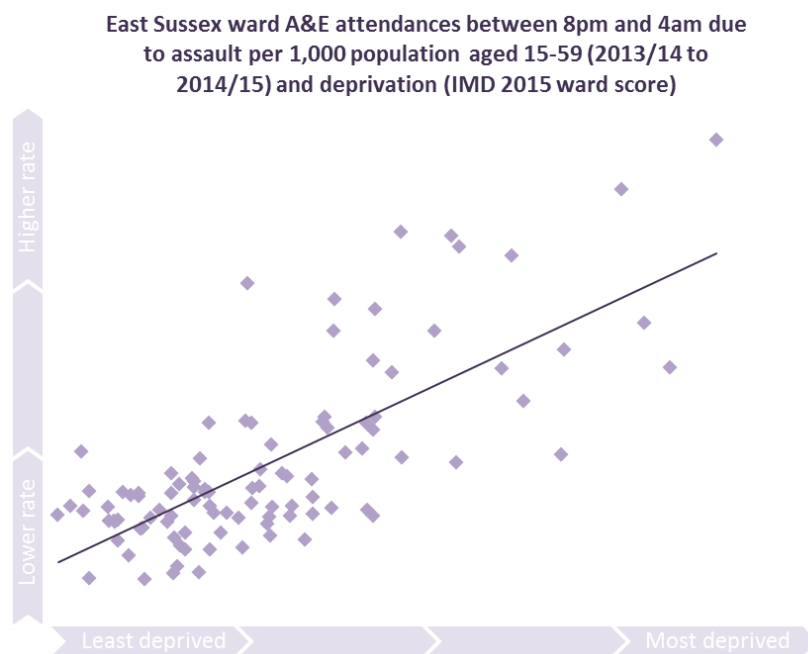
Figure 5

A&E attendances between 8pm and 4am due to assaults, 2013/14 to 2015/16



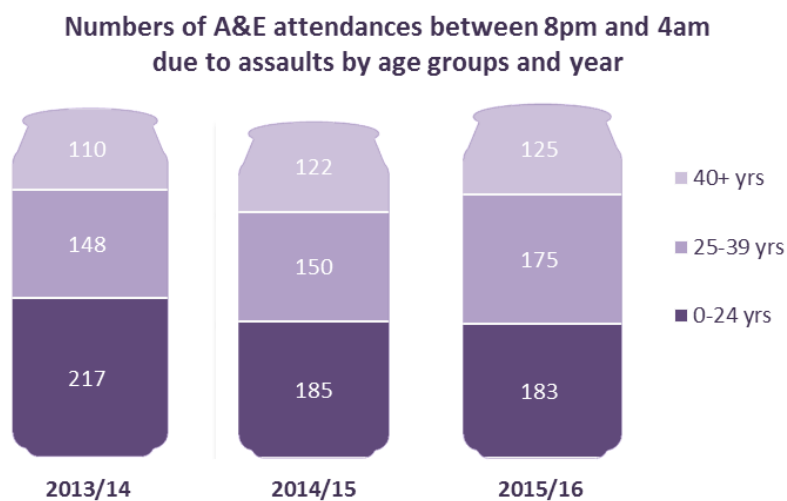
There is an association between A&E attendances for assault during the night-time economy (NTE) and the deprivation profile of the area where patients live. Figure 6 shows that the least deprived wards have the lower rates and the most deprived ward (Central St Leonards) has the highest rate in all of East Sussex.

Figure 6



The number of assault attendances during the NTE slightly decreased in 2014/15 from 2013/14 but increased in 2015/16 to the highest number during the 3-year period with the highest increase in the 25-39 years age band.

Figure 7



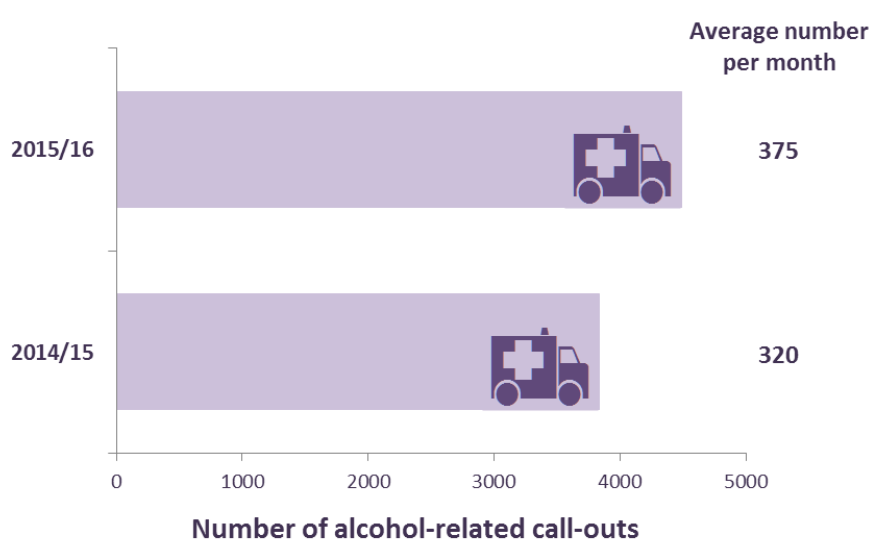
Alcohol-related ambulance call-outs

Key strategy outcome: reduce demand on emergency services (priority 3)

Data source: South East Coast Ambulance 2014/15 and 2015/16.
Note call out data relates to incidents that were attended to in East Sussex, and therefore do not necessarily relate to East Sussex residents.

During 2014/15 there were 3,834 alcohol-related ambulance call-outs and in 2015/16 this increased to 4,485 (a 17% increase) (Figure 8). In both years numbers were highest in August.

Figure 8



Half of the alcohol-related call-outs are during the night-time economy (20:00 – 04:00); a further 21% are between 16:00 and 20:00. There are more alcohol-related call-outs during some hours not in the night-time economy (17:00, 18:00 and 19:00) than in some that are (02:00 and 03:00). Of the night-time economy alcohol-related call-outs around a quarter (26%) are on a Saturday night and a further fifth (21%) on a Friday night. (Figure 9 and 10)

Ambulance patient clinical records (PCR) contain an indicator for whether the crew on the scene suspect that alcohol has been involved with the incident, and since March 2013 there is a crew condition code for an alcohol-related call-out. There is an element of the crew on the scene making a judgement call as to the involvement of alcohol and as the PCR relates to the patient, not the perpetrator in the case of an assault for example, it is very likely to underestimate call outs that are attributable to alcohol.

Figure 9

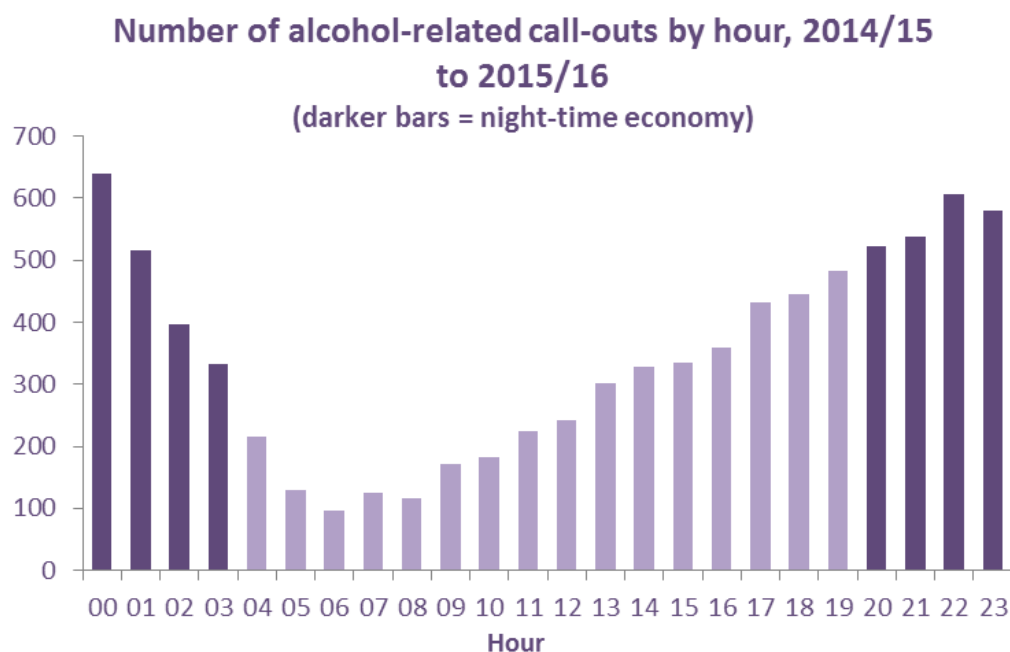


Figure 10

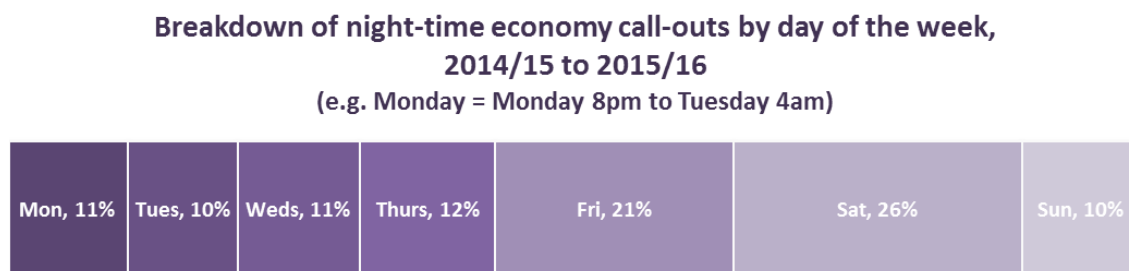


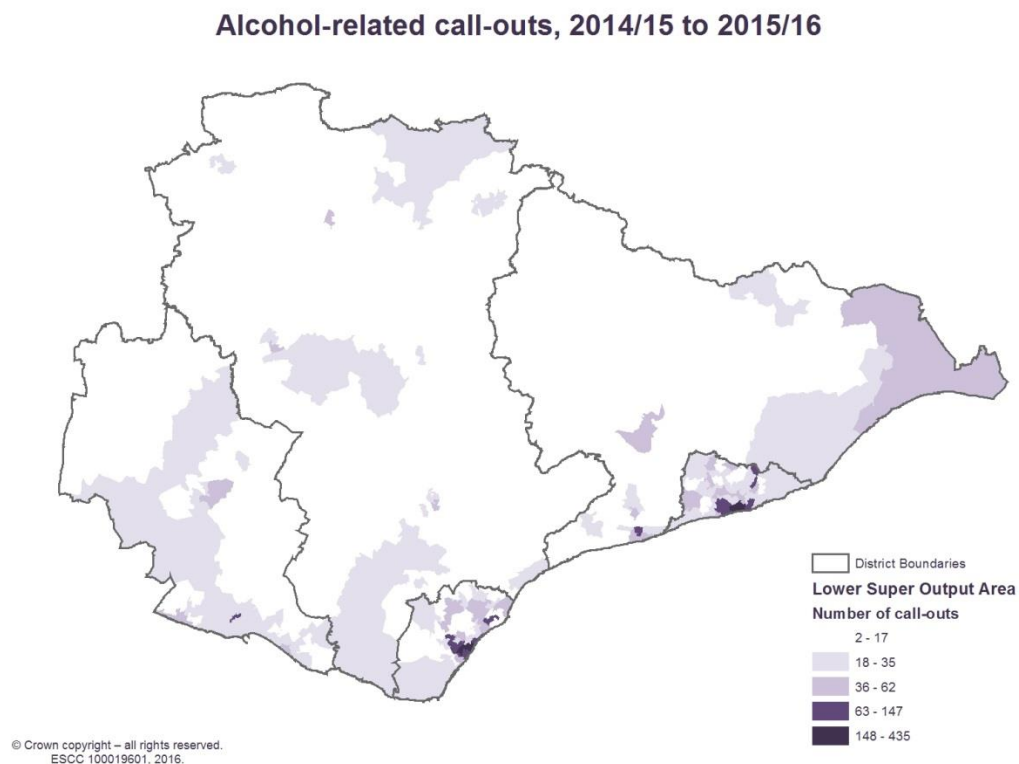
Table 2 shows the main reasons/problems for an alcohol-related call-out during the two-year period 2014/15 and 2015/16. Around 1 in 10 call-outs were for each of: mental health problems, trauma, unconscious/faint and falls<12ft.

Table 2

Reason/problem	% call-outs
Mental Health Issues	11%
Trauma	11%
Unconscious/Faint	10%
Falls <12ft	9%
NHS 111	7%
Generally Unwell	6%
Alcohol Intoxication/Related	6%
Chest Pain/Cardiac Prob	6%
Limb/Pain Injury	4%

Figure 11 is a map showing the areas with the highest numbers of alcohol-related ambulance call-outs during 2014/15 to 2015/16. Numbers are based on lower super output area¹ (LSOA) with the darker the area the higher the number. Numbers are generally highest in Eastbourne and Hastings town centres (see figures 12 and 13).

Figure 11



¹ Lower Super Output Areas (LSOAs) are statistical geographies with an average resident population of 1,500

Figure 12

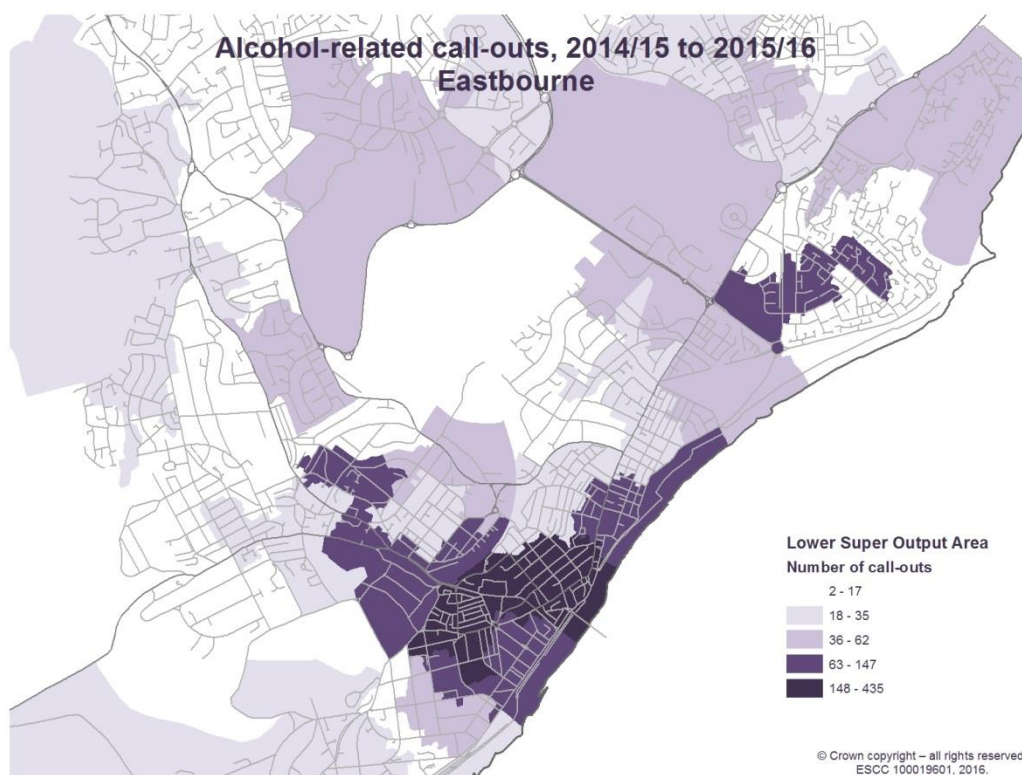
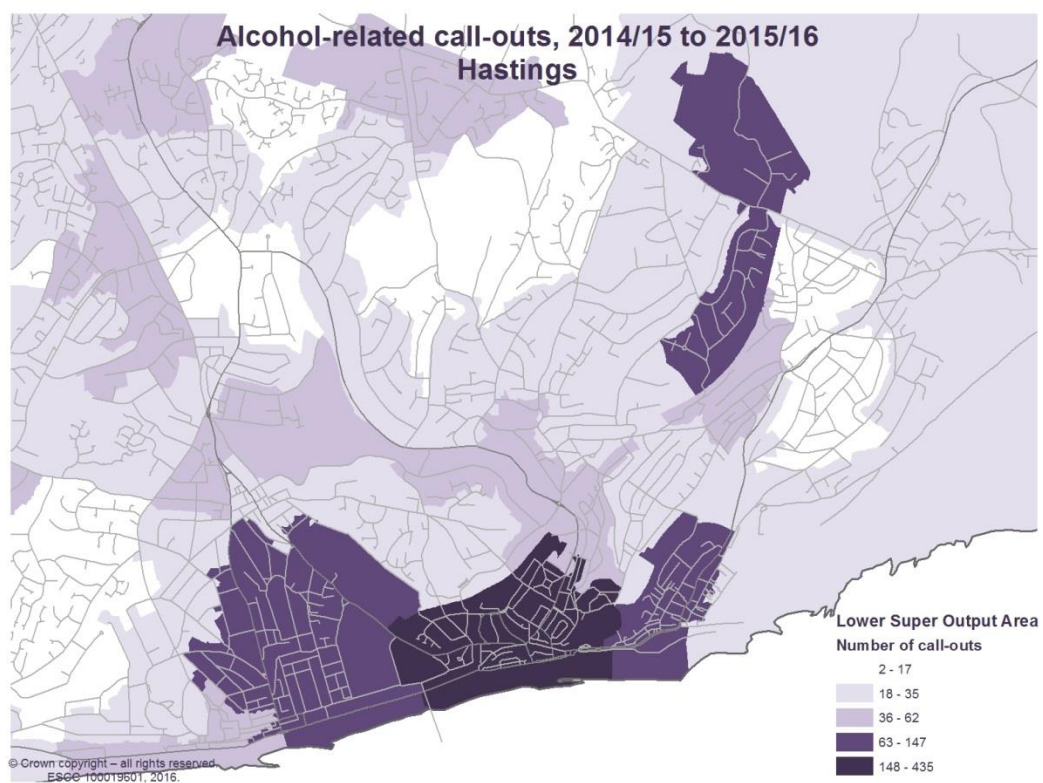


Figure 13



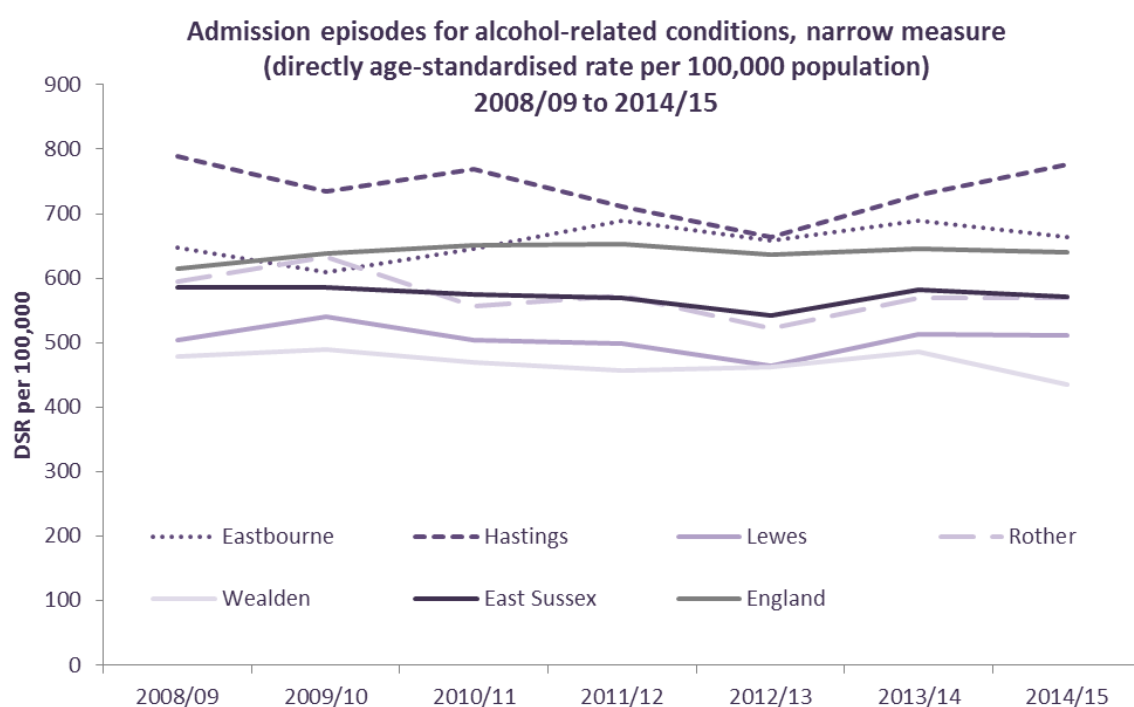
Alcohol-related hospital admissions

Key strategy outcome: reduced alcohol related hospital admissions (priority 2)

Data source: Local Alcohol Profiles for England, PHE.

At an East Sussex level the alcohol-related hospital admission rate largely follows the national trend. At a district and borough level, Lewes, Rother and Wealden districts have always had lower rates than the national average and Lewes and Wealden have also always had lower rates than East Sussex. Hastings has always had the highest rate and consistently higher than the national average and East Sussex. (Figure 14)

Figure 14



There are different ways to capture alcohol related hospital admissions from looking at alcohol specific reasons only (such as alcoholic liver disease), to diseases and injuries where alcohol can play a part (such as breast cancer or falls). In this report the definition for alcohol related hospitals admission is as per the Public Health Outcomes Framework indicator, a 'narrow measure', and includes admissions where the *primary reason* for admission is an alcohol specific or alcohol-attributable condition. See Appendix for further details.



60% of alcohol-related hospital admissions (narrow measure) are for males.

At a district/borough level, Hastings (44%) has the largest proportion of admissions for females and Lewes (34%) the smallest.

The most recent data (2014/15) shows that for both males and females the alcohol-related hospital admission rates in Hastings are significantly higher than England and in Wealden they are significantly lower. In Lewes, admission rates for females are significantly lower than England. (Figure 15)

Across the county the age profile of these admissions varies with Hastings admissions comprising a younger age profile compared to the rest of East Sussex. In Wealden almost half of admissions for males are for those aged 65 years and over. Admissions for females have a slightly younger age profile compared to males. (Figure 16 and 17)

Figure 15

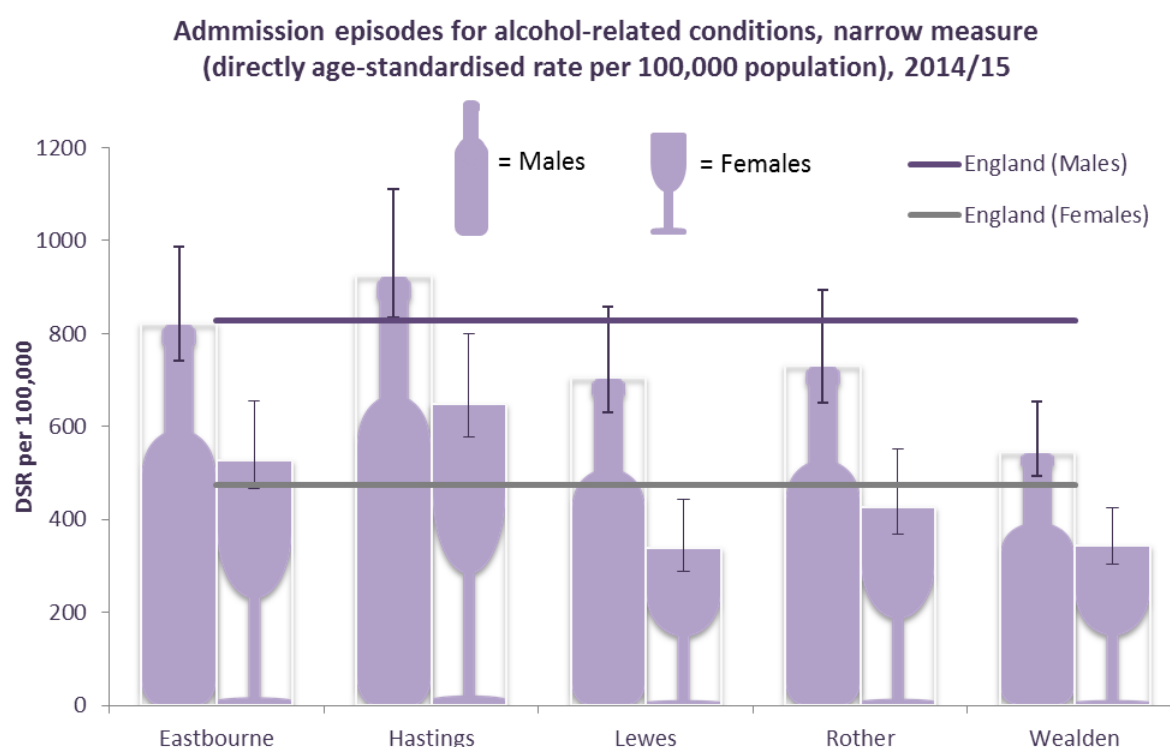


Figure 16

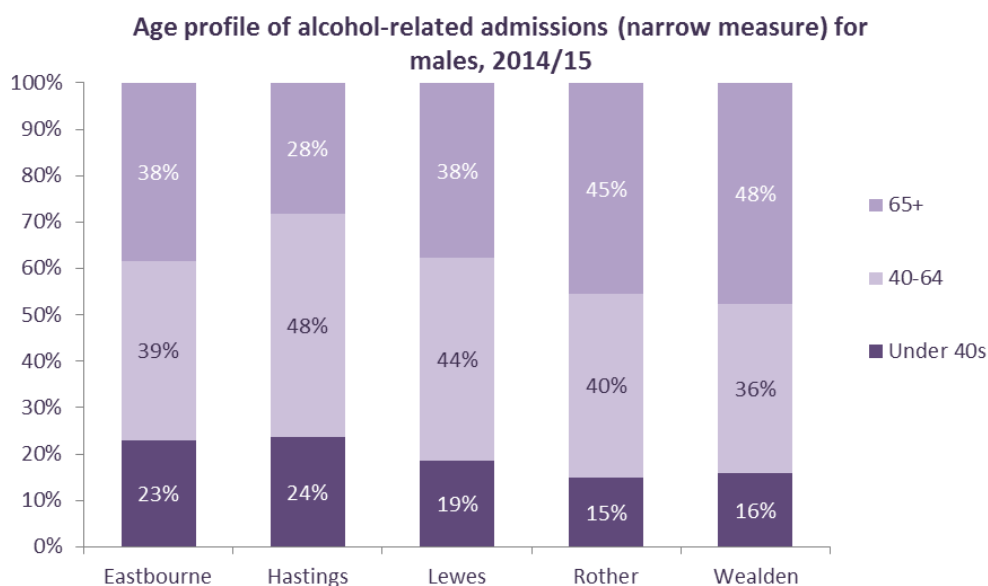
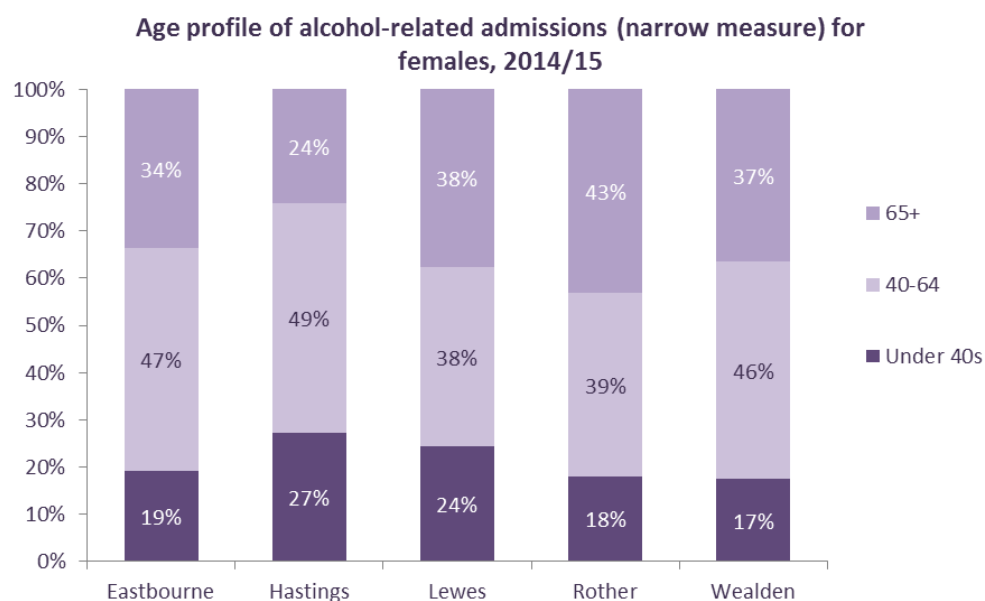


Figure 17



Public Health England produces *Local Alcohol Profiles for England (LAPE)* which contain a range of indicators around the harm and impact of alcohol. Table 3 is a summary of hospital admission indicators from the profiles for East Sussex and its districts and boroughs.

Eastbourne has similar rates to England for all indicators; Hastings is significantly worse than England for most indicators and Wealden significantly better. Lewes and Rother districts are either similar to or significantly better than England.

Admissions for under 18s are significantly higher than England in both Hastings and Lewes although numbers are small (relates to around 11 young people per year being admitted in each authority).

Table 3

Alcohol hospital admissions indicator	England	East Sussex	Eastbourne	Hastings	Lewes	Rother	Wealden
Persons admitted for alcohol-specific conditions	364	302	372	503	270	266	181
Males admitted for alcohol-specific conditions	502	405	528	679	368	331	237
Females admitted for alcohol-specific conditions	235	209	232	341	183	205	130
Persons admitted for alcohol-related conditions	438	405	462	526	382	384	325
Males admitted for alcohol-related conditions	586	538	614	685	523	515	428
Females admitted for alcohol-related conditions	306	290	332	388	257	270	237
Admission episodes for alcohol-related conditions	641	571	663	776	512	569	436
Admission episodes for alcohol-related conditions - Males	827	721	822	924	705	731	546
Admission episodes for alcohol-related conditions - Females	474	442	527	650	339	428	343
Persons under 18 admitted to hospital for alcohol-specific conditions	37	44	49	56	58	37	30
Under 40s - admission episodes for alcohol-related conditions	151	147	157	199	138	151	101
Under 40s admission episodes for alcohol-related conditions - Males	181	172	199	215	164	176	119
Under 40s admission episodes for alcohol-related conditions - Females	120	123	116	184	113	127	85
40-64 yrs admission episodes for alcohol-related conditions	300	248	305	367	213	241	176
40-64yrs admission episodes for alcohol-related conditions - Males	371	297	340	421	300	306	194
40-64 yrs admission episodes for alcohol-related conditions - Females	230	203	274	317	130	181	160
Over 65s admission episodes for alcohol-related conditions	191	177	202	209	161	177	158
Over 65s admission episodes for alcohol-related conditions - Males	275	253	282	287	241	249	233
Over 65s admission episodes for alcohol-related conditions - Females	124	116	138	149	96	120	99
Significantly worse compared to England	All indicators (except admissions for under 18s) are directly age-standardised per 100,000 and for 2014/15						
No significant difference compared to England	Admissions for under 18s are 3 years pooled (2012/13-2014/15) and is a crude rate						
Significantly better compared to England	All alcohol-related admissions are as per the narrow measure Source: Local Alcohol Profiles for England, PHE						

Figures 18 and 19 show the proportion of alcohol-related admissions that were due to accidents and injuries, mental and behavioural disorders and alcohol poisoning for both males and females in each district/borough. In all districts and boroughs the highest percentages of alcohol-related admissions in both males and females are for accidents and injuries, except for females in Hastings where alcohol poisoning made up the highest percentage.

Alcohol-related accidents and injuries make up a larger proportion of admissions in males and alcohol poisoning a larger proportion of admissions in females.

The percentages of alcohol-related admissions due to accidents and injuries are highest in Wealden and the percentages due to mental and behavioural disorders highest in Hastings and Eastbourne. Alcohol poisoning is highest amongst males in Hastings comprising over 1 in 10 admissions, and amongst females in Lewes, comprising 1 in 6 admissions.

Figure 18

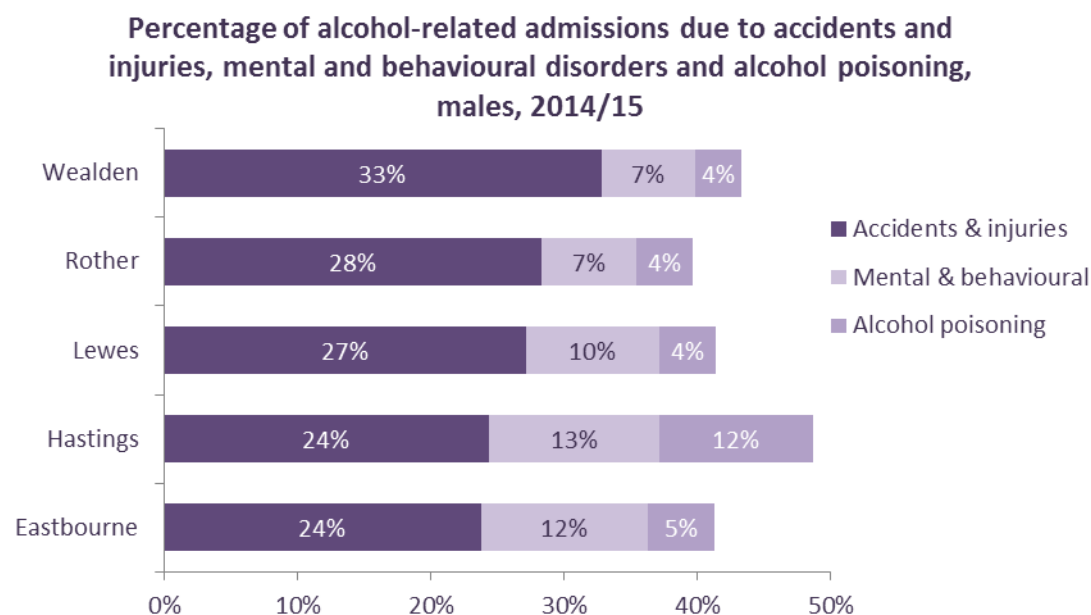
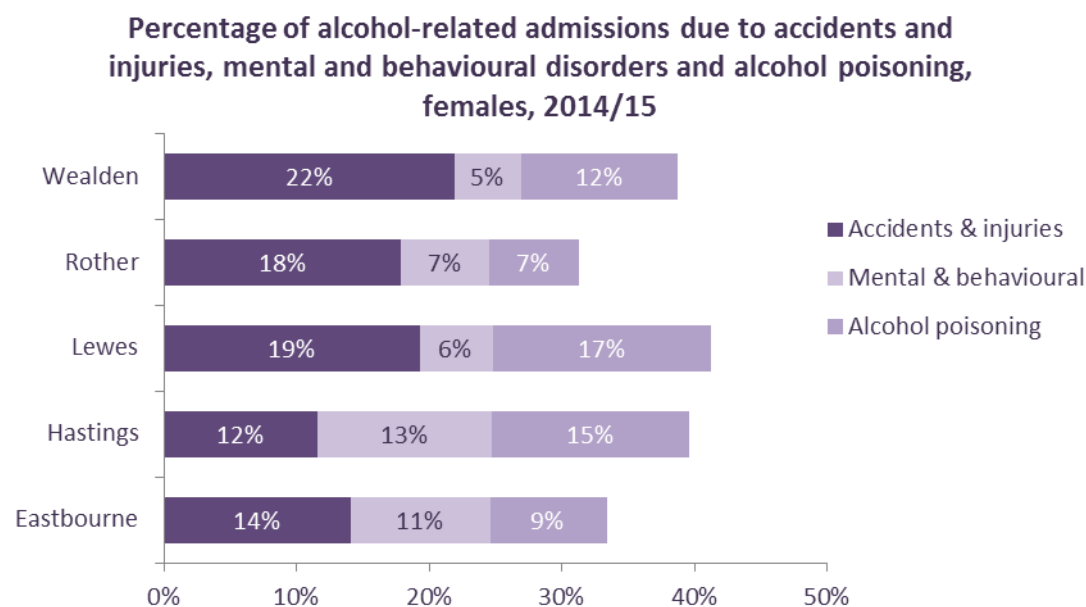


Figure 19



Compared to England, the alcohol-related admission rate for mental and behavioural disorders is significantly lower for males in Lewes, Wealden and in Rother; the rate is significantly higher for females in Hastings. Admissions for alcohol poisoning are significantly higher for both males and females in Hastings but significantly lower for males in Wealden. (Table 4)

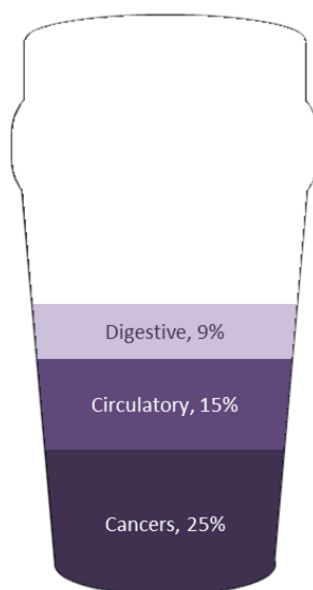
Table 4

Alcohol hospital admissions indicator	England	East Sussex	Eastbourne	Hastings	Lewes	Rother	Wealden
Admissions for alcohol-related unintentional injuries	140	131	130	146	124	141	125
Admissions for alcohol-related unintentional injuries - Males	212	200	194	226	195	216	184
Admissions for alcohol-related unintentional injuries - Females	74	71	73	74	60	74	73
Admissions for mental & behavioural disorders due to use of alcohol	84	56	79	96	50	46	29
Admissions for mental & behavioural disorders due to use of alcohol - Males	120	74	105	112	79	60	40
Admissions for mental & behavioural disorders due to use of alcohol - Females	50	40	57	84	24	33	18
Admissions for intentional self-poisoning by/& exposure to alcohol	52	54	52	98	48	43	35
Admissions for intentional self-poisoning by/& exposure to alcohol - Males	45	48	49	99	31	40	25
Admissions for intentional self-poisoning by/& exposure to alcohol - Females	59	61	55	96	65	46	45
Significantly worse compared to England	All indicators are directly age-standardised per 100,000 and for 2014/15						
No significant difference compared to England	All alcohol-related admissions are as per the narrow measure						
Significantly better compared to England	Source: Local Alcohol Profiles for England, PHE						

Alcohol-related admissions also include diseases where alcohol can play a part. Previous analysis of 2013/14 admissions data showed that half of alcohol-related admissions in East Sussex were due to alcohol-attributable cancers, circulatory diseases and digestive diseases.

Figure 20

Alcohol-related admissions caused by diseases
2013/14 East Sussex



Dependent drinkers

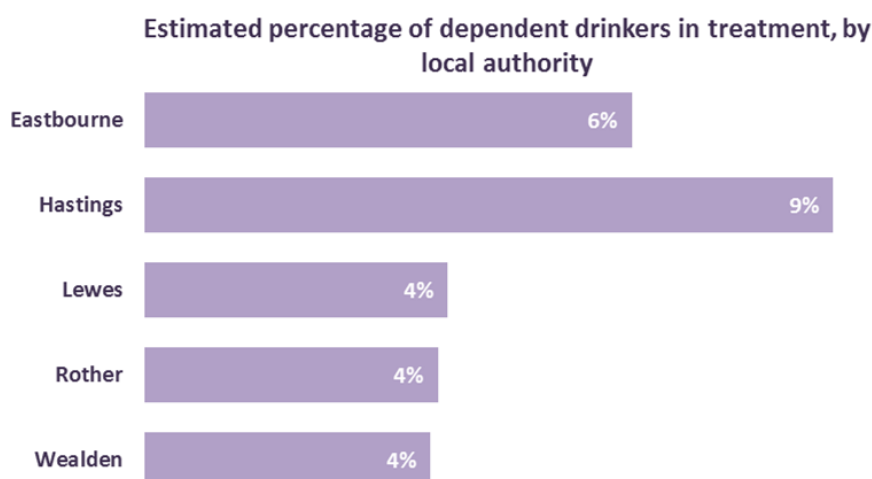
Key strategy outcome: local people who need help from alcohol misuse can quickly access treatment (priority 2)

Data source: Adults – alcohol JSNA support pack: key data, PHE 2016. Alcohol-use disorders: alcohol dependence; costing template, NICE. ONS Mid-Year Estimates 2015. CGL/NDTMS.



It is estimated that around 5% of dependent drinkers are in treatment. There is variation across the districts and boroughs.

Figure 21



The previous alcohol health harm report suggested an estimate of 6,600 dependent drinkers in East Sussex. This estimate was based on the JSNA support pack for strategic partners – data for alcohol - East Sussex, 2013. NICE (The National Institute for Health and Care Excellence) suggest that 3.8% of the adult population are dependent drinkers (17,100) with 84% of these mildly dependent (14,400), 14% moderately dependent (2,400) and 2% severely dependent (300) (based on data from the Adult Psychiatric Morbidity Survey 2007). These prevalence estimates have been used for the updated figures presented in this report.

The majority of the adult in-treatment population are males (60%). In terms of age, 1 in 10 (10%) of the adult in-treatment population are aged under 30 years, a third (32%) aged 40-49 years and 1 in 7 (15%) aged 60 years or over.

Of adults entering treatment during 2015/16 (new presentations):

21% live with children (own or other), this compares to 24% nationally.

21% are parents not living with children, this compares to 27% nationally.

During 2015/16 there were **215** children living with adults who were receiving alcohol treatment.

Alcohol-related deaths

Data source: ONS Public Health Mortality Files. ONS national statistics definition used – includes causes regarded as being most directly due to alcohol consumption, differs from definition used in local alcohol profiles. (See appendix)

There are on average around 68 alcohol-related deaths per year in East Sussex ranging from an average of 11 per year in Lewes to 17 per year in Hastings. During 2011-2015, 63% of deaths were due to alcoholic liver disease, 22% from fibrosis and cirrhosis of the liver, 7% from mental and behavioural disorders due to alcohol use and 4% from accidental alcohol poisoning.

Table 5

Alcohol-related deaths by year of death (2011-2015)						
	2011	2012	2013	2014	2015	Grand Total
Eastbourne	15	8	12	15	15	65
Hastings	14	17	17	18	17	83
Lewes	11	10	9	13	12	55
Rother	13	16	9	19	8	65
Wealden	14	12	24	13	9	72
Grand Total	67	63	71	78	61	340

Two-thirds (67%) of alcohol-related deaths are for males. Around 1 in 10 (11%) are for persons aged under 45 years with the majority being for persons aged 45-74 years.

Table 6

Alcohol-related deaths (2011-2015)				
Age group	Males	Females	Total	%
Under 45s	24	14	38	11%
45-54	57	27	84	25%
55-64	62	32	94	28%
65-74	53	19	72	21%
75+	32	20	52	15%
Grand Total	228	112	340	100%

The Local Alcohol Profiles for England (LAPE, Source: Public Health England) show that across East Sussex mortality rates from alcohol-specific causes, alcohol-related causes and from chronic liver disease are generally similar to the England rates except in Hastings which has significantly higher rates of alcohol-specific mortality and chronic liver disease, particularly in males.

Alcohol and inequality in life expectancy

Data source: The Segment Tool
– segmenting life expectancy
gaps by cause of death, May
2016, PHE.

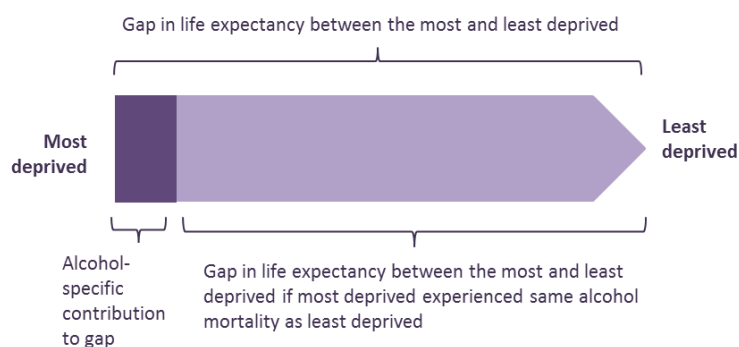
Inequalities exist within districts and boroughs with the most deprived areas experiencing lower life expectancies compared to the least deprived areas. Public Health England have developed a tool that breaks down the life expectancy gap by

cause of death and have identified the contribution of alcohol-specific deaths to gaps in life expectancy at a local authority level.

Figures 23 and 24 show the life expectancy at birth for males and females in the most and least deprived quintiles (20%) for each local authority area, as well as the contribution to the gap from alcohol-specific mortality.

Figure 22 explains how the data has been presented.

Figure 22



For example, for males in Rother, the life expectancy in the least deprived quintile is 83 years and in the most deprived quintile it is 76.5 years, so there is a gap of 6.5 years, identified by the length of the whole arrow bar (both light and dark purple). The dark purple block at the end of the arrow is the potential gain in life expectancy in the most deprived area if it experienced the same alcohol-specific mortality as the least deprived area which for males in Rother this is 0.3 years. The light purple bar is the gap in life expectancy if the males in the most deprived areas had the same alcohol-specific mortality rate as the males in the least deprived areas (6.2 years).

Figure 23

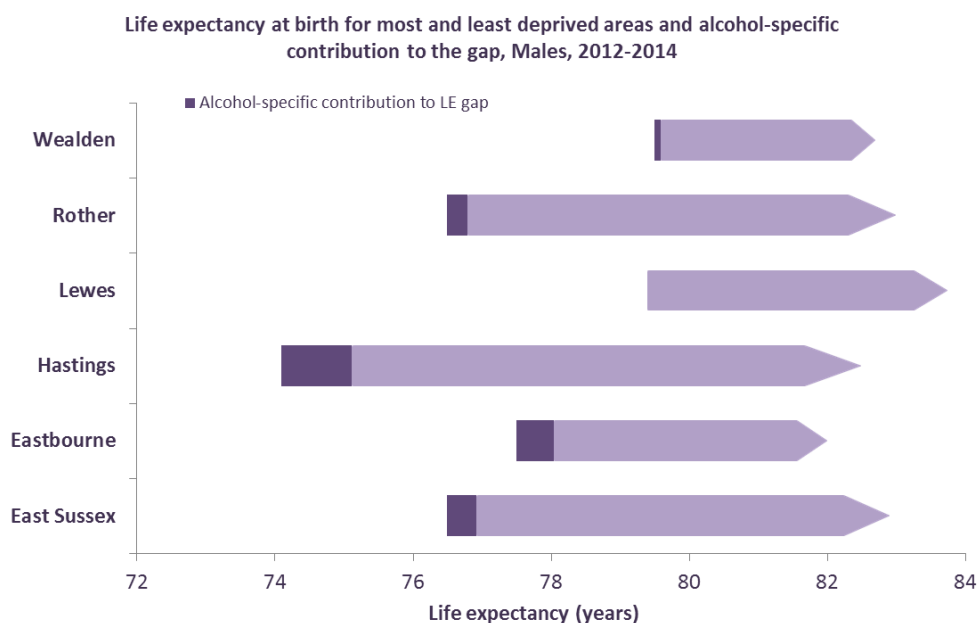
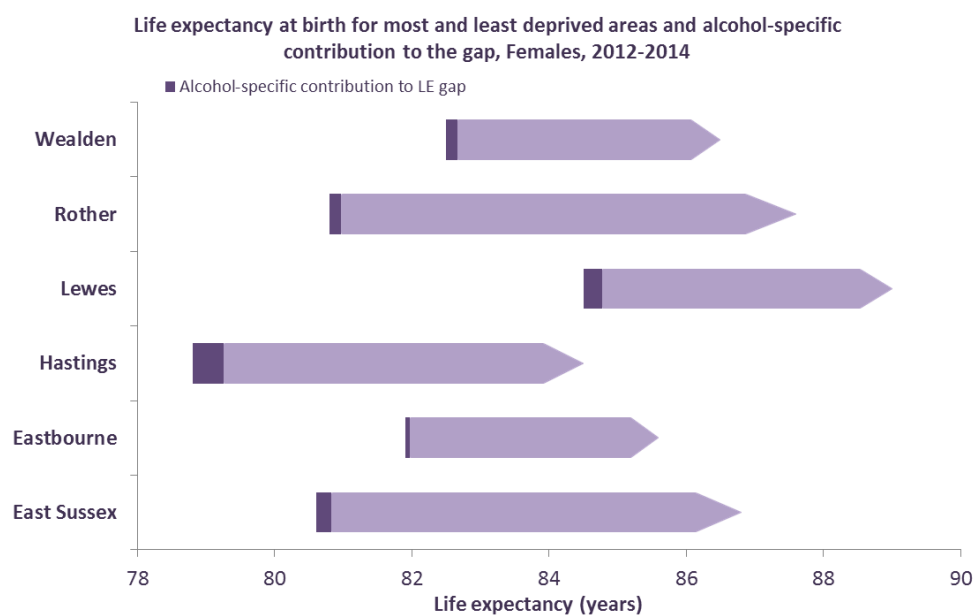


Figure 24



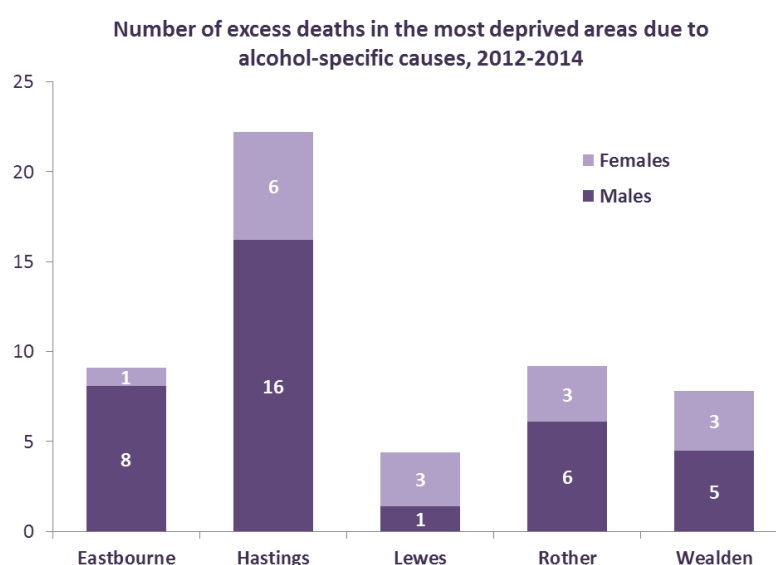
For both males and females the contribution of alcohol to the gap in life expectancy is greatest for those living in the most deprived areas of Hastings, with a potential gain in life expectancy of one year for males and half a year for females if they experienced the same alcohol-specific mortality rates as males and females living in the least deprived areas. For males in Lewes there is no potential gain (i.e. alcohol-specific deaths do not contribute to the gap and it is due to other causes of death).

Whilst Eastbourne has the second largest potential gain in life expectancy for males, it has the least for females.

Comparing the alcohol-specific death rates in the least deprived areas with the most deprived areas allows the number of 'excess deaths' to be calculated. For example, in 2012-14 in Eastbourne there were an 'extra' nine deaths due to alcohol-specific causes in the most deprived areas compared to the least deprived areas, eight for males and one for females. If these areas experienced exactly the same rates of alcohol-specific mortality the excess deaths would be zero.

Over the three-year period Lewes (4) had the fewest excess deaths due to alcohol-specific causes in its most deprived areas and Hastings (22) had the most. Eastbourne and Rother both had nine excess deaths but there were more for males in Eastbourne.

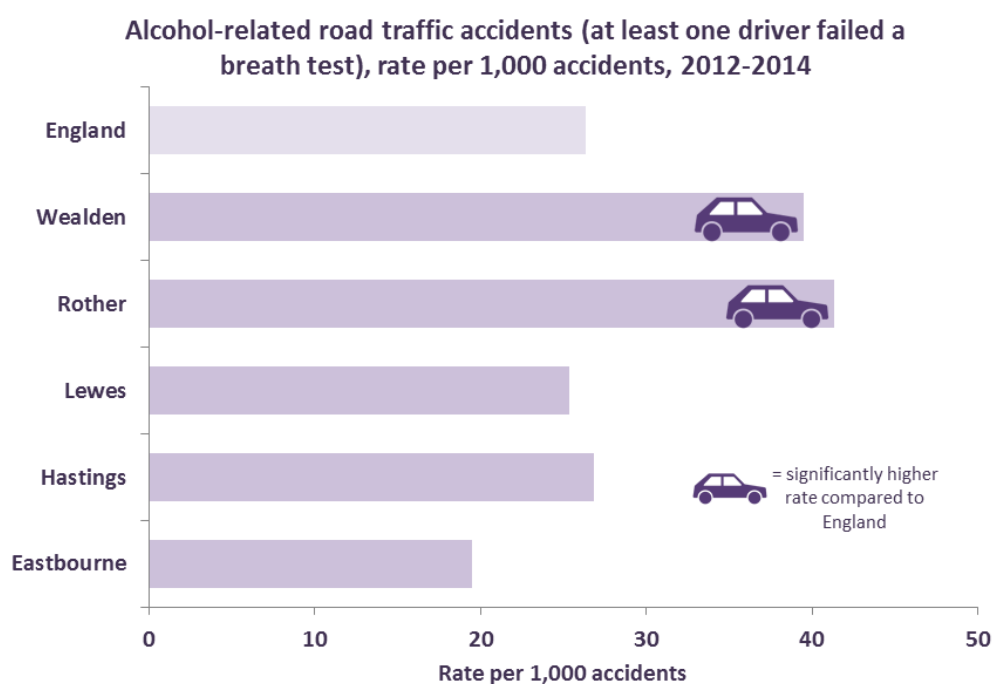
Figure 25



Alcohol-related road traffic accidents

Compared to England, alcohol-related road traffic accidents are significantly higher in Wealden and Rother districts. (Source: Local Alcohol Profiles for England, PHE 2016)

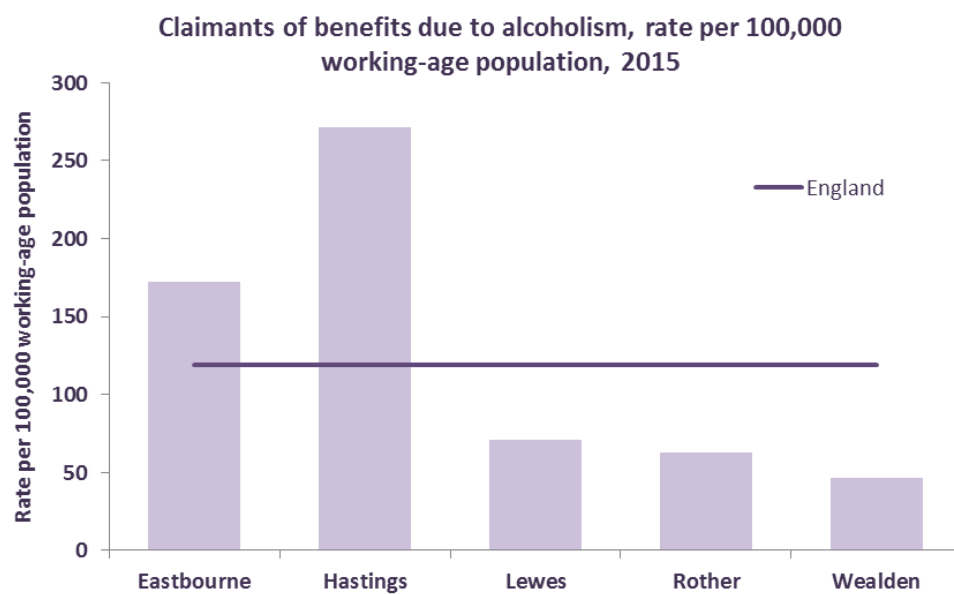
Figure 26



Claimants of benefits due to alcoholism

Eastbourne and Hastings have significantly higher rates of claimants of benefits where alcohol misuse is the main disabling condition and Lewes, Rother and Wealden have significantly lower rates, when compared to the national average. (Source: Local Alcohol Profiles for England, PHE 2016)

Figure 27



Key findings

Consumption

- Young people (15 year olds) in East Sussex have significantly higher alcohol consumption compared to the England average. Year 10 pupils reporting that they had had a drink in the last 7 days was highest in Wealden and Hastings.
- Over a third of adults drink alcohol every week. Notable differences between males and females – more males drink alcohol, more regularly and at higher risk – 1 in 3 males compared to 1 in 10 females who drink are drinking at higher risk.

Reasons for drinking

- The reasons local people give on why they find alcohol attractive include: low mood/depression; boredom; coping mechanism; peer pressure; availability and affordability and boosts confidence. NO UPDATE

Levels of understanding of safe drinking

- There is confusion around safe drinking limits with both adults and young people not understanding how to measure the units they are consuming. NO UPDATE
- Although limited, there is some awareness of health risks but this is not a deterrent, with young people in particular feeling confident that health problems won't happen to them. NO UPDATE

Alcohol-related harm

- Alcohol-related health harms (admissions and deaths) are significantly worse than England in Hastings across a range of indicators. Eastbourne generally has similar levels of alcohol-related health harm to England, with Lewes, Rother and Wealden either similar too or significantly better than the national average. Alcohol health harm is higher for males than females.

Impact on health services

- A&E attendances during the night-time economy due to assaults are higher for males and for 15-24 year olds. Attendance rates are significantly higher than the county average in Eastbourne and Hastings. There are higher rates for persons from more deprived areas.
- Alcohol-related ambulance call-outs have seen a 17% increase in 2015/16 compared to 2014/15. Half are between 8pm and 4am with a further 1 in 5 between 4pm and 8pm. Numbers are highest in Eastbourne and Hastings town centres and in the month of August.

Inequality in life expectancy

- Deaths from alcohol contribute to the gap in life expectancy between the most and least deprived areas within districts and boroughs. In East Sussex the largest impact is on males living in the most deprived parts of Hastings.

What does this mean for local action?

The findings of this report indicate that local action needs to focus on the following:

- Delaying onset of drinking and reducing alcohol consumption in young people
- Helping people to understand safe drinking limits in line with Chief Medical Officer guidelines
- Reducing alcohol-related harm where need is greatest, that is, in Hastings Borough where interventions need to be targeted in the more deprived areas and with a particular focus on men.
- Working to address the underlying reasons why people use alcohol as a coping mechanism and enabling those who are drinking at unsafe levels due to mental health issues to access other means of support and intervention.
- Addressing alcohol-related A&E attendances and ambulance call-outs in Hastings and Eastbourne town centres both during the night-time economy and early evening, particularly on Friday and Saturday nights with the month of August requiring particular attention. Particular attention to be given to reducing levels of accidents and injuries.
- Encouraging dependent drinkers to access treatment and health professionals to raise the issue of alcohol intake with their patients, making every contact count.
- Targeting drink-driving in the rural areas of Rother and Wealden.

All interventions to tackle alcohol-related harm should be based on the best available evidence. *The international evidence on the prevention of drug and alcohol use* (PHE, 2015) can be used as a guide. This classifies interventions as:

- 'Universal', where they address an entire population (e.g. TV audience, local community, school pupils);
- 'Selective', where they serve specific sub-populations (e.g. individuals, groups, families and communities, whose risk of substance misuse is known to be higher than average, either imminently or over a lifetime) and
- Indicated, where prevention is aimed at people who are already using substances, are not yet experiencing dependence, but who may be showing

signs of problematic use (e.g. falling grades at school, absenteeism from work, antisocial behaviour, mental health problems).

When designing interventions, it is important to bear in mind that:

- The social, economic and environmental circumstances within which people live and work impact on their vulnerability and exposure to problems or stressful life events, which in turn influence alcohol-related health harm. (See appendix III for further detail)
- Many of the prevention interventions that influence alcohol use may not be alcohol-specific and may already exist as broader interventions (such as parenting programmes, education in schools around personal and social skills, increasing social support to people who are isolated and lonely).
- Evidence and good practice guidance indicates that communities should be involved in the co-production of solutions to address alcohol issues in their own area (an important consideration for work in Hastings).
- In tackling alcohol misuse and associated harm and disorder, partnership work is key as it requires education, awareness-raising, enforcement, industry involvement, community initiatives, and care and treatment provision.

Interventions should be carefully monitored and evaluated to assess they are meeting identified need and achieving intended outcomes.

Appendix I – alcohol-related admissions and alcohol-specific deaths definition

<https://publichealthmatters.blog.gov.uk/2014/01/15/understanding-alcohol-related-hospital-admissions/>

Alcohol causes, or can contribute to the development of, many health conditions. Academics have been able to use high quality research evidence to estimate what proportion of cases of a health condition are alcohol-related. Conditions such as alcoholic liver disease where alcohol is the sole cause are known as *alcohol-specific* or *wholly alcohol-attributable* conditions and their alcohol-attributable fraction is 1.0 (100 per cent). For other conditions, where alcohol has a proven relationship but it is one of a range of causative factors, an estimate of the contribution alcohol makes is calculated. For example, it is estimated that alcohol plays a causative role in 25-33 per cent of cardiac arrhythmias. These are the *partially alcohol-attributable conditions* and the alcohol-attributable fractions would be 0.25-0.33. Fractions differ slightly for men and women. Some *external cause codes* also have an alcohol-attributable fraction (for example, 27 per cent of assaults are estimated to be alcohol-related and therefore the alcohol-attributable fraction is 0.27).

The total number of alcohol-related hospital admissions, as described by the indicator, **is not a number of actual people or a number of actual admissions but an estimated number of admissions calculated by adding up all of the fractions we have identified.**

In this report, alcohol related admissions are the number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (referred to as a narrow measure, and is used in the Public Health Outcomes Framework). The indicator is a directly age-standardised rate per 100,000 population, standardised to the 2013 European Standard population (2013 ESP).

See the Local Alcohol Profiles for England (LAPE) user guide for further details:
http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf

Alcohol-attributable fractions used to calculate alcohol-related hospital admissions

Condition	ICD10 code(s)	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
Wholly attributable conditions																	
Alcohol-induced pseudo-Cushing's syndrome	E24.4	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	1.00
Mental and behavioural disorders due to use of alcohol	F10	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	1.00
Degeneration of nervous system due to alcohol	G31.2	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	1.00
Alcoholic polyneuropathy	G62.1	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	1.00
Alcoholic myopathy	G72.1	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	1.00
Alcoholic cardiomyopathy	I42.6	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	1.00
Alcoholic gastritis	K29.2	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	1.00
Alcoholic liver disease	K70	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	1.00
Alcohol-induced acute pancreatitis	K85.2	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	1.00
Alcohol-induced chronic pancreatitis	K86.0	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	1.00
Fetal alcohol syndrome (dysmorphic)	Q86.0	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	1.00
Excess alcohol blood levels	R78.0	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	1.00
Ethanol poisoning	T51.0	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	1.00
Methanol poisoning	T51.1	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	1.00
Toxic effect of alcohol, unspecified	T51.9	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	1.00
Accidental poisoning by and exposure to alcohol	X45	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	1.00
Intentional self-poisoning by and exposure to alcohol	X65	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	1.00
Poisoning by and exposure to alcohol, undetermined intent	Y15	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	1.00
Evidence of alcohol involvement determined by blood alcohol level	Y90	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	1.00
Evidence of alcohol involvement determined by level of intoxication	Y91	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	1.00

*note for alcohol-specific deaths and inequality in life expectancy definition uses all wholly attributable conditions except T51.0 and T51.1

Condition	ICD10 code(s)	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
Partially attributable conditions - chronic conditions																	
Infectious and parasitic diseases																	
Tuberculosis	A15-A19	0.00	0.00	0.30	0.19	0.33	0.17	0.34	0.21	0.35	0.22	0.35	0.20	0.31	0.14	0.22	0.11
Malignant neoplasm of:																	
Lip, oral cavity and pharynx	C00-C14	0.00	0.00	0.53	0.38	0.44	0.35	0.44	0.42	0.46	0.43	0.47	0.40	0.40	0.31	0.29	0.24
Oesophagus	C15	0.00	0.00	0.58	0.49	0.61	0.48	0.61	0.53	0.63	0.53	0.63	0.51	0.60	0.45	0.52	0.38
Colorectal	C18-C20, C21	0.00	0.00	0.16	0.11	0.18	0.12	0.18	0.13	0.19	0.14	0.19	0.13	0.17	0.11	0.13	0.11
Liver and intrahepatic bile ducts	C22	0.00	0.00	0.15	0.11	0.17	0.11	0.17	0.12	0.18	0.13	0.18	0.12	0.16	0.10	0.12	0.11
Larynx	C32	0.00	0.00	0.35	0.25	0.39	0.23	0.39	0.28	0.41	0.29	0.41	0.27	0.36	0.21	0.28	0.17
Breast	C50	0.00	0.00	0.00	0.12	0.00	0.13	0.00	0.14	0.00	0.15	0.00	0.14	0.00	0.12	0.00	0.11
Diabetes mellitus																	
Diabetes mellitus (type II)	E11	0.00	0.00	-0.04	-0.20	-0.04	-0.21	-0.04	-0.22	-0.04	-0.22	-0.03	-0.22	-0.04	-0.20	-0.03	-0.15
Diseases of the nervous system																	
Epilepsy and Status epilepticus	G40-G41	0.00	0.00	0.32	0.22	0.35	0.20	0.35	0.24	0.37	0.25	0.37	0.23	0.33	0.18	0.24	0.15
Cardiovascular disease																	
Hypertensive diseases	I10-I15	0.00	0.00	0.22	0.26	0.25	0.17	0.25	0.30	0.27	0.31	0.27	0.25	0.23	0.09	0.15	-0.06
Ischaemic heart disease	I20-I25	0.00	0.00	-0.10	-0.10	-0.10	-0.08	-0.10	-0.10	-0.10	-0.10	-0.10	-0.09	-0.11	-0.07	-0.10	-0.02
Cardiac arrhythmias	I47-I48	0.00	0.00	0.15	0.10	0.17	0.11	0.17	0.12	0.18	0.13	0.18	0.12	0.16	0.10	0.12	0.11
Haemorrhagic stroke - mortality	I60-I62, I69.0-I69.2	0.00	0.00	0.18	0.25	0.20	0.22	0.20	0.27	0.21	0.28	0.22	0.26	0.19	0.19	0.15	0.13
Haemorrhagic stroke - morbidity	I63-I66, I69.3-I69.4	0.00	0.00	0.20	-0.11	0.22	-0.14	0.23	-0.11	0.24	-0.10	0.24	-0.12	0.21	-0.16	0.17	-0.15
Ischaemic stroke - mortality	I63-I66, I69.3-I69.4	0.00	0.00	0.01	-0.09	0.02	-0.14	0.02	-0.09	0.03	-0.08	0.04	-0.10	0.01	-0.16	0.00	-0.14
Ischaemic stroke - morbidity	I63-I66, I69.3-I69.4	0.00	0.00	0.00	-0.06	0.01	-0.07	0.01	-0.06	0.02	-0.06	0.03	-0.07	0.00	-0.07	-0.01	-0.06
Oesophageal varices - mortality	I85	0.00	0.00	0.70	0.64	0.73	0.62	0.74	0.68	0.76	0.69	0.76	0.66	0.70	0.58	0.55	0.57
Oesophageal varices - morbidity		0.00	0.00	0.44	0.31	0.47	0.41	0.48	0.38	0.50	0.40	0.50	0.41	0.44	0.42	0.33	0.51
Respiratory infections																	
Pneumonia	J10.0, J11.0,	0.00	0.00	0.12	0.07	0.14	0.06	0.14	0.08	0.15	0.08	0.15	0.08	0.13	0.05	0.10	0.03

Condition	ICD10 code(s)	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
	J12-J15, J18																
Digestive disease																	
Unspecified liver disease - mortality	K73, K74	0.00	0.00	0.70	0.64	0.73	0.62	0.74	0.68	0.76	0.69	0.76	0.66	0.70	0.58	0.55	0.57
Unspecified liver disease - morbidity	K74	0.00	0.00	0.44	0.31	0.47	0.41	0.48	0.38	0.50	0.40	0.50	0.41	0.44	0.42	0.33	0.51
Cholelithiasis (gall stones)	K80	0.00	0.00	-0.25	-0.17	-0.28	-0.17	-0.28	-0.19	-0.30	-0.19	-0.30	-0.18	-0.27	-0.16	-0.21	-0.14
Acute and chronic pancreatitis	K85, K86.1 (excl. K85.2)	0.00	0.00	0.35	0.17	0.39	0.14	0.40	0.20	0.43	0.21	0.43	0.18	0.35	0.12	0.20	0.10
Pregnancy and childbirth																	
Spontaneous abortion	O03	0.00	0.00	0.00	0.08	0.00	0.08	0.00	0.11	0.00	0.11	0.00	0.00	0.00	0.00	0.00	0.00
Low birth weight	P05-P07	0.05	0.05	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
Partially attributable conditions - acute conditions																	
Unintentional injuries																	
Road/pedestrian traffic accidents - mortality	§	0.00	0.00	0.42	0.25	0.46	0.22	0.39	0.22	0.41	0.23	0.28	0.14	0.16	0.07	0.06	0.03
Road/pedestrian traffic accidents - morbidity		0.00	0.00	0.28	0.17	0.31	0.15	0.26	0.15	0.27	0.15	0.19	0.09	0.11	0.05	0.04	0.02
Poisoning - mortality	X40-X49 (excl. X45)	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Poisoning - morbidity	X40-X49 (excl. X45)	0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Fall injuries - mortality	W00-W19	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Fall injuries - morbidity	W19	0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Fire injuries - mortality	X00-X09	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Fire injuries - morbidity	X09	0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Drowning - mortality	W65-W74	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Drowning - morbidity	W74	0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Other unintentional injuries - mortality	Rest of 'v' series §§	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Other unintentional injuries - morbidity	Rest of 'v' series §§	0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02

Condition	ICD10 code(s)	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
Intentional injuries																	
Intentional self-harm – mortality	X60-X84, Y87.0 (excl. X65)	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Intentional self-harm - morbidity	X60-X84, Y87.0 (excl. X65)	0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Event of undetermined intent - mortality	Y10-Y34, Y87.2 (excl. Y15)	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Event of undetermined intent - morbidity	Y10-Y34, Y87.2 (excl. Y15)	0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02
Assault - mortality	X85-Y09, Y87.1	0.00	0.00	0.32	0.18	0.37	0.17	0.37	0.20	0.40	0.19	0.38	0.14	0.26	0.08	0.12	0.04
Assault - morbidity	X85-Y09, Y87.1	0.00	0.00	0.14	0.08	0.17	0.08	0.16	0.09	0.18	0.08	0.17	0.06	0.12	0.04	0.05	0.02

§ = V021-V029, V031-V039, V041-V049, V092, V093, V123-V129, V133-V139, V143-V149, V194-V196, V203-V209, V213-V219, V223-V229, V233-V239, V243-V249, V253-V259, V263-V269, V273-V279, V283-V289, V294-V299, V304-V309, V314-V319, V324-V329, V334-V339, V344-V349, V354-V359, V364-V369, V374-V379, V384-V389, V394-V399, V404-V409, V414-V419, V424-V429, V434-V439, V444-V449, V454-V459, V464-V469, V474-V479, V484-V489, V494-V499, V504-V509, V514-V519, V524-V529, V534-V539, V544-V549, V554-V559, V564-V569, V574-V579, V584-V589, V594-V599, V604-V609, V614-V619, V624-V629, V634-V639, V644-V649, V654-V659, V664-V669, V674-V679, V684-V689, V694-V699, V704-V709, V714-V719, V724-V729, V734-V739, V744-V749, V754-V759, V764-V769, V774-V779, V784-V789, V794-V799, V803-V805, V811, V821, V830-V833, V840-V843, V850-V853, V860-V863, V870-V876, V892. §§ = V01, V090, V091, V099, V100-V109, V110-V119, V120-V122, V130-V132, V140-V142, V150-V159, V160-V169, V170-V179, V180-V189, V191-V193, V20-V28: 0.1-0.2; V290-V293, V30-V38: 0.1-0.2; V390-V393, V40-V48: 0.1-0.2; V490-V493, V50-V58: 0.1-0.2; V590-V593, V60-V68: 0.1-0.2; V690-V693, V70-V78: 0.1-0.2; V790-V793, V800, V801, V806-V809, V810, V812-V819, V820, V822-V829, V834-V839, V844-V849, V854-V859, V864-V869, V879, V88, V890, V891, V893-V899, V90-V94, V95-V97, V98-V99, W20-W52, W75-W84, W85-W99, X10-X19, X20-X29, X30-X33, X50-X57, X58, X59, Y40-Y84, Y85, Y86, Y88, Y89

Appendix II – alcohol-related deaths definition

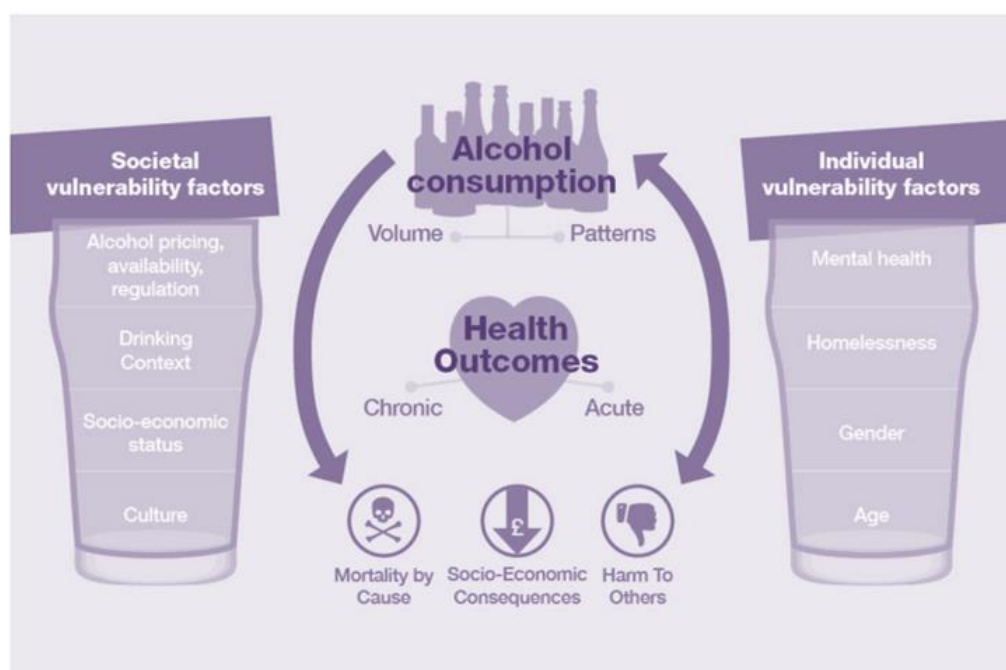
The Office for National Statistics (ONS) definition for alcohol-related deaths is where the underlying cause is one of:

- mental & behavioural disorders due to use of alcohol (ICD10 F10)
- degeneration of nervous system due to alcohol (ICD10 G312)
- alcoholic polyneuropathy (ICD10 G621)
- alcoholic cardiomyopathy (ICD10 I426)
- alcoholic gastritis (ICD10 K292)
- alcoholic liver disease (ICD10 K70)
- chronic hepatitis, not elsewhere classified (ICD10 K73)
- fibrosis and cirrhosis of liver (ICD10 K74, excluding K743-K745 – biliary cirrhosis)
- alcohol induced chronic pancreatitis (ICD10 K860)
- accidental poisoning by and exposure to alcohol (ICD10 X45)
- intentional self-poisoning by and exposure to alcohol (ICD10 X65)
- poisoning by and exposure to alcohol, undetermined intent (ICD10 Y15)

Appendix III – alcohol harm and influencing factors

Source: Public Health England, Health matters: harmful drinking and alcohol dependence, January 2016

Although the volume of alcohol consumed is a clear indicator of potential harm to health, other factors affect the relationship. The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation. The reasons for this are not fully understood. People on low income do not tend to consume more alcohol than people from higher socio-economic groups. The increased risk is likely to relate to the effects of other issues affecting people in lower socio-economic groups.



For further detail on the impact of social determinants and alcohol harm please see *Alcohol and inequities. Guidance for addressing the inequities in alcohol-related harm. World Health Organization (WHO), 2014.*