All-age Alcohol JSNA

Supplementary material

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Nottingham City Council

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1. Methodology

The JSNA was developed using multiple methods, combining quantitative data, stakeholder expertise, lived experience, and evidence from published literature to provide a comprehensive assessment of alcohol-related harm, service provision, and unmet need in Nottingham. Findings were used to develop recommendations for reducing alcohol-related harm across the city.

Steering group

A multi-agency steering group was convened to guide the development of the JSNA. Members contributed specialist expertise and local intelligence and data, helping to shape the scope of the assessment, review emerging findings, and provide assurance on the accuracy, relevance and interpretation of the final analysis.

Lived experience

The draft scope for the alcohol JSNA was shared with an Expert Citizen Group to ensure that people with lived experience could inform the focus and priorities of the assessment. Feedback from the group was used to refine the scope and identify key issues for further exploration. The findings and recommendations were subsequently presented back to the group to test their relevance, seek further challenge and ensure that the proposed actions reflected community needs and lived experience perspectives.

Literature reviews

Reviews of academic literature published between 2015 and 2026 were undertaken to address gaps in the data, inform the focus of the JSNA, and ensure that recommendations are evidence-based. Healthcare databases and the grey literature were searched by Sherwood Forest Hospitals NHS Foundation Trust Library and Knowledge Services, and the best available evidence was subsequently synthesised by the JSNA authors. Where indicated, the quality of included studies was assessed using recognised critical appraisal checklists to support interpretation of the findings.

Use of routine data

The JSNA draws on a range of routine data sources to describe the scale, distribution and impact of alcohol-related harm in Nottingham. These included national and local datasets relating to alcohol consumption, alcohol-related morbidity and mortality, service utilisation, crime, and wider social outcomes. Where possible, analyses were undertaken by population group to identify inequalities and understand how alcohol-related harm varies across the population.

2. Health & Wellbeing Overview

2.1 Why is alcohol a priority now?

Alcohol-related harm is a significant public health issue. It contributes to[5]:

- Preventable illness
- Premature mortality
- Widening health inequalities
- Avoidable pressure on health and wider public services.

Nationally, alcohol-related harm has worsened in recent years, particularly following the COVID-19 pandemic. Locally, Nottingham city experiences **higher levels of alcohol-related harm** than the national average and many other comparable cities, and in particular, there has been a steep increase in hospital admissions for alcoholic liver disease.[6,7] This highlights the growing severity of alcohol-related harm and reinforces the need for renewed and co-ordinated local action.[7]

Key national strategies include:

- ***The Government's Alcohol Strategy (2012).***[8]
- ***From Harm to Hope* (2021)**[9], the Government's 10-year drugs strategy which includes alcohol dependence within its scope and reinforces the importance of improving access to treatment, strengthening recovery support and adopting integrated, whole-system approaches.

Local action:

- In the absence of an updated national alcohol policy, there is increased responsibility on local systems to lead action on alcohol-related harm.
- Alcohol is recognised as a priority within Nottingham city's **Joint Local Health and Wellbeing Strategy** and the work of the Health and Wellbeing Board.
- The **Nottingham City Alcohol Delivery Plan** outlines the system-wide actions that will be taken to reduce alcohol-related harm through prevention, early intervention, treatment, and recovery support.

2.2 Health impacts of harmful alcohol use

Drinking alcohol is causally linked to more than **200 health conditions**, 30 of which would not exist without alcohol consumption.[2] High alcohol use is one of the top 10 risk factors contributing to poor health and death in England[3], and among 15–49-year-olds in the UK, it is the biggest risk factor for early mortality, ill health and disability.[10]

Non-communicable diseases

Alcohol consumption increases the risk of developing a wide range of non-communicable diseases, including liver disease, cardiovascular diseases, seven types of cancer, and mental health conditions.[5]

Table 1 shows the 15 non-communicable diseases with the greatest burden attributable to high alcohol use in England in 2023, ranked by disability adjusted life years (DALYs) per 100,000 population and deaths per 100,000 population.[3] Liver cirrhosis and other chronic liver diseases attributable to high alcohol use accounted for the highest mortality rate, whilst alcohol use disorders (AUDs) accounted for the highest DALY rate.[3] AUDs encompass the wide range of mental health problems associated with alcohol use.[1] The relationship between mental health conditions and alcohol consumption is bidirectional – drinking too much can negatively affect wellbeing, and people may drink to try to manage the symptoms of mental ill health.[11]

	Non-communicable disease	DALYs per 100,000	Non-communicable disease	Deaths per 100,000
1	AUDs	350.75	Liver cirrhosis	8.70
2	Liver cirrhosis	268.32	Oesophageal cancer	4.00
3	Oesophageal cancer	93.38	Liver cancer	3.77
4	Liver cancer	78.91	AUDs	2.80
5	Colorectal cancer	63.89	Stroke	2.59
6	Stroke	47.39	Colorectal cancer	2.45
7	Breast cancer	39.19	Breast cancer	1.19
8	Idiopathic epilepsy	24.77	Hypertensive heart disease	0.92
9	Cardiomyopathy	21.62	Other pharynx cancer	0.75
10	Other pharynx cancer	21.17	Cardiomyopathy	0.71
11	Hypertensive heart disease	19.47	Atrial fibrillation	0.59
12	Atrial fibrillation	18.66	Lip and oral cavity cancer	0.58
13	Lip and oral cavity cancer	15.18	Pancreatic cancer	0.56
14	Pancreatitis	15.14	Prostate cancer	0.53
15	Pancreatic cancer	13.83	Pancreatitis	0.53

Table 1: non-communicable diseases with the greatest burden attributable to high alcohol use in England, 2023[3]

Acute effects and communicable diseases

In the short term, alcohol can lower inhibitions and increase impulsive behaviour, raising the risk of:

- Injuries[4,5]
- Road traffic accidents[5]
- Self-harm and suicide[5]
- Alcohol poisoning[4]
- Engaging in unprotected sex.[4]

Globally, alcohol consumption contributes significantly to the burden of communicable disease[12], with established causal links to infections such as TB and HIV.[5]

Harm to others

Alcohol consumption can negatively affect people other than the individual drinking, including through[5]:

- Injuries in road traffic accidents
- Violent incidents
- Sexual assault.

Alcohol consumption during pregnancy is associated with harm to the fetus[5]:

- It increases the risk of miscarriage, stillbirth and premature delivery
- It increases the risk of a child being born with FASD; a range of lifelong physical, mental and behavioural problems.
- It is the leading preventable cause of acquired learning disabilities.

The level of harm is affected by the amount of alcohol consumed and the stage of pregnancy at the time of exposure.[4]

Wider impacts of harmful alcohol use

Harmful and hazardous consumption of alcohol can lead to a wide range of significant consequences for individuals, families, and communities:

- Issues at work[5]
- Financial problems[5]
- Unemployment[5]
- An increased risk of suicide [13]
- An increased risk of homelessness[5]
- Anti-social behaviour, public nuisance and violent crime[14]
- Emotional distress and conflict within families and friendship networks[15]
- Domestic and sexual violence and abuse (DSVA), noting that those experiencing DSVA may subsequently use alcohol as a coping strategy[16]
- Negative impacts on children living with parental alcohol use:
    - Twice the incidence of child maltreatment[17]
    - An increased risk of physical, psychological and behavioural problems[16]
    - An increased risk of drinking harmfully themselves.[16]

2.3 Cost of alcohol harm

Alcohol harm carries major economic costs to society.

Calculating the total cost is challenging: there are clear direct costs (such as costs to health services), but also many indirect costs that can be difficult to estimate accurately, and there is often debate about which types of costs should be included.[18]

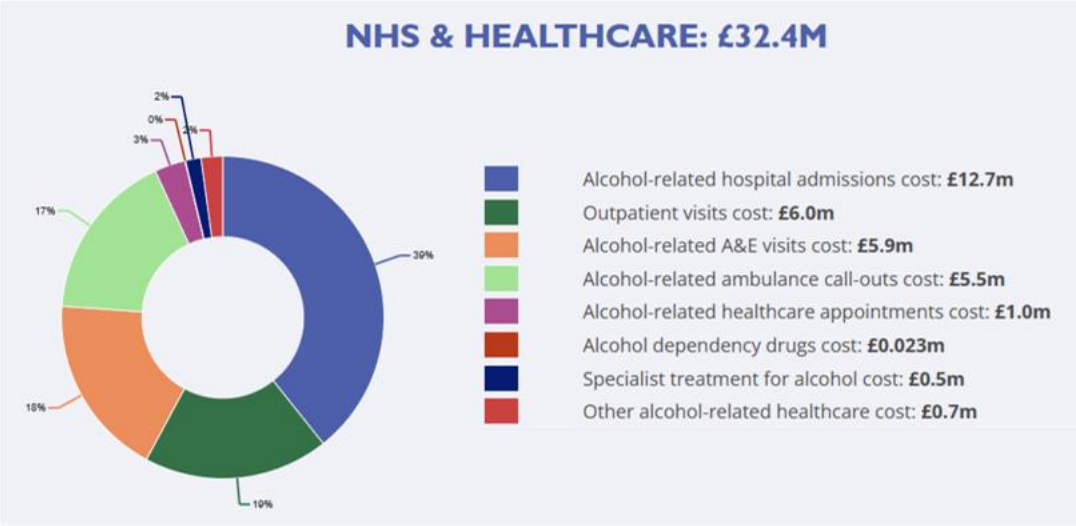
The Institute of Alcohol Studies worked with Balance to produce national and local estimates.

Each year, the cost of alcohol to society is:

- **England:** £27.4 billion (£485 per resident)[17]
- **East Midlands:** £2.41 billion (£494 per resident)[18]
- **Nottingham:** £203.1 million (£636 per resident). This is the 16th highest per-head cost of any local authority in England, and it exceeds the national and regional averages.[17,18]

Cost breakdown in Nottingham:

- **Crime and disorder** - £117.2 million, 58% of the total burden. Costs include investment in crime prevention, the consequences of crime such as property damage, and the operational response from the police and wider criminal justice system. A larger proportion of the overall cost is related to crime and disorder in Nottingham than nationally (50%) or regionally (53%).[18]
- **NHS and healthcare services** - £32.4 million, 16% of total costs. Most of this is associated with hospital visits and admissions, as illustrated in Figure 1.[18] The proportion is slightly lower than the national (18%) and regional (21%) averages.
- **Wider economy** - £29.7 million, 15% of the total burden. This includes costs associated with presenteeism, absenteeism and unemployment.
- **Social services** - £23.8 million, 12% of total costs.[18]



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Figure 1: estimated costs of alcohol to the NHS in Nottingham 2024

3. Populations at increased risk of alcohol harm

3.1 Drivers of alcohol-related harm

The level of harm caused by alcohol consumption varies according to a number of factors. It is determined by the amount of alcohol consumed and the pattern of drinking, which in turn are influenced by the availability, accessibility and social acceptability of alcohol within a given context.[15] In addition, alcohol disproportionately affects certain individuals and populations.

A literature review was completed to better understand the drivers of alcohol-related harm. The findings should be interpreted with caution given the predominantly observational nature of many included studies and the limited evidence available for some demographic characteristics.

3.1.1 Demographic factors

Patterns of alcohol consumption and alcohol-related harm vary across the protected characteristics as defined by the Equality Act 2010. Tables 2 and 3 summarise findings from a literature review, highlighting differences in both alcohol consumption and alcohol-related harm. Some protected characteristics have been combined in line with the evidence base.

Protected characteristic	Alcohol consumption
Age	• Older age has been associated with a very small reduction in the odds of developing (OR 0.97, 95% CI 0.95-0.98) and continuing (OR 0.99, CI 0.97-1.00) harmful alcohol use.[19]
Gender reassignment & sexual orientation	• Harmful alcohol use is consistently reported to be higher among LGBTQ+ communities in the UK.[20] • Trans and non-binary people have been found to have an average AUDI score that falls within the increasing-risk range.[21] • Asexual people have been found to drink less than allosexual groups.[20] • No evidence relating to alcohol consumption in intersex people was identified.[20] • Alcohol can serve as a form of emotional coping for some LGBTQ+ people, and it has a prominent role in some LGBTQ+ social environments.[20]
Marriage & civil partnership	• The presence of a partner was not found to affect the odds of developing (OR 1.04, 95% CI 0.81-1.33) or continuing (OR 1.00, 95% CI 0.83-1.22) harmful alcohol use.[19]
Pregnancy & maternity	• Alcohol consumption during pregnancy remains relatively common in the UK, with an estimated prevalence of 41.3% (95% CI 32.9-49.9). This is significantly higher than the global prevalence estimate of 9.8% (95% CI 8.9-11.1).[22]
Race & Religion	• People from ethnic minority backgrounds are generally less likely to drink at hazardous, harmful or dependent levels than White British individuals, although higher risk drinking has been observed in certain groups, such as older Irish men and Sikh men.[23]
Sex	• Male sex was associated with an increased odds of developing (OR 1.67, 95% CI 1.46-1.92) and continuing (OR 1.67, CI 1.34-2.08) harmful use of alcohol.[19]

Table 2: variation in alcohol consumption by protected characteristic (1)

Protected characteristic	Impact on alcohol harm
Age	• Older adults are more susceptible to chronic conditions associated with long-term alcohol use, whereas working-age adults have a higher risk of alcohol-related accidents and injuries.[15] • Children and young people are particularly vulnerable to both immediate harms and the development of long-term drinking behaviours.[15]
Gender reassignment & sexual orientation	• People from LGBTQ+ communities have around twice the odds of alcohol dependence than the overall population.[24] • Alcohol can play a significant role in risky sexual behaviours in LGBTQ+ communities, increasing the risk of STIs and HIV.[24] • A higher risk of alcohol-related harm in the trans and non-binary community was associated with experiences of discrimination and certain motives for drinking (social, enhancement, drinking to cope, and drinking to have sex).[21]
Marriage & civil partnership	• There was no research evidence identified relating to marriage & civil partnership as a driver of alcohol-related harm.
Pregnancy & maternity	• There was no research evidence identified relating to pregnancy as a driver of alcohol-related harm.

Race & Religion	• Compared to the White Scottish population and once fully adjusted for confounders:
	  ○ White Irish individuals had around twice the risk of alcohol-related diseases (RR 1.82, 95% CI 1.61-2.06 (men), RR 1.55, 95% CI 1.27-1.88 (women)).[25]
	  ○ White Irish individuals had a 20% higher risk of alcoholic liver diseases (RR 1.21, 95% CI 0.94-1.56 (men), RR 1.18, 95% CI 0.88-1.57 (women)), noting the elevated risk in women is not statistically significant once adjusted.[25]
	  ○ Indian males had a markedly elevated risk of alcoholic liver diseases (RR 1.75, 95% CI 1.07-2.87).[25]
	  ○ There were increased risks of alcohol-related diseases in the Mixed Background group (RR 1.42, 95% CI 1.08-1.85 (men), RR 1.99, 95% CI 1.52-2.61 (women)).[25]
	  ○ Chinese and Pakistani individuals had around half the risk of alcohol-related disease, and the Other British group had a reduced risk of alcoholic liver disease (RR 0.63, 95% CI 0.50-0.78 (men), RR 0.84. 95% CI 0.66-1.08 (women)).[25]

Sex	• Males experience higher levels of alcohol-related morbidity, mortality, and dependence than females.[26] • Males had nearly three times the risk of developing alcohol-related liver disease compared with females (RR 2.84, 95% CI 1.86-4.36).[27] • Females face greater susceptibility to dependence and physical health harms at lower levels of consumption than males.[28]

Table 3: variation in alcohol consumption by protected characteristic (2)

3.1.2 Socio-economic factors

People in lower socio-economic groups experience higher rates of alcohol-related harm than those in higher socio-economic groups, despite having similar or lower average levels of alcohol consumption. This is known as the **alcohol harm paradox**.[15] Evidence supporting this finding includes:

- People in the most deprived groups (measured through education, income and occupation) were found to experience a three-fold higher risk of alcohol-attributable mortality compared with those in the least deprived groups (RR 3.31, 95% CI 2.56-4.29).[29] Education had the strongest impact – people with a low or medium level of education experienced 3-5 times the risk of alcohol-attributable mortality than those with a high level.[29]
- Individuals with a low socio-economic status had a 1.6–3.6 times higher risk of all-cause mortality (RR 1.58, 95% CI 1.37-1.83 to RR 3.58, 95% CI 3.52-3.63) and a 3.8–5.2 times higher risk of alcohol-attributable mortality (RR 3.76, 95% CI 2.96-4.77 to RR 5.22, 95% CI 3.28-8.30) compared with those in higher socio-economic status groups.[30]
- Alcohol-related liver disease incidence was three times higher in the most deprived quintile compared with the least deprived quintile (incidence RR 3.30, 95% CI 3.21-3.38), and that the post-diagnosis mortality risk was 20% higher in the most deprived group (HR 1.22, 95% CI 1.18-1.27).[32] Inequalities in alcohol-related liver disease incidence were more pronounced at younger ages (18-54 years) than in older adults.[31]

Patterns of inequality are even more pronounced among people experiencing homelessness. A study of nearly 1,000 individuals registered with a specialist primary healthcare centre in the West Midlands found that 21% were dependent on alcohol, and nearly one-third (32%) had attended an emergency department, with alcohol dependence significantly associated with attendance.[32]

Attempts have been made to explain the alcohol harm paradox. Behavioural factors (including drinking history, drinking mostly spirits, an unhealthy BMI and smoking) likely contribute to some of the excess harm experienced by lower socio-economic groups[33], and although alcohol consumption volume explains little of the observed inequalities, drinking patterns (particularly quantity consumed per occasion and frequency of HED) have been shown to account for around 15–30% of inequalities.[33] A substantial proportion of the disparity remains unexplained and is likely to be driven by multiple intersecting risk factors including poor housing, unemployment, psychosocial stress, higher density of alcohol outlets, and reduced access to healthcare.[34,35]

3.1.3 Health factors

Table 4 summarises the evidence relating to physical and mental health factors that can drive alcohol-related harm.

Table 4: associations between physical and mental health conditions and alcohol harm

Factor	Association with alcohol harm
Physical health conditions	• In individuals with long-term conditions, mortality was around 20% higher for those consuming 24-34 units per week (HR 1.26, 95% CI 1.12-1.42), and 70% higher for individuals consuming 35+ units per week (HR 1.71, 95% CI 1.51-1.94). Mortality was also elevated among non-drinkers and former drinkers compared with those drinking 1-7 units per week.[38]
Overweight & obesity	• A high BMI is likely to increase the risk of alcohol-related liver disease.[28] • The effects of weight and alcohol are multiplicative: compared with healthy weight lower risk drinkers, those who were overweight and drinking above recommended limits have been seen to experience more than triple the risk of chronic liver disease (RR 3.32, 95% CI 2.88-3.83), while obese individuals drinking above recommended limits had over five times the risk (RR 5.39, 95% CI 4.62-6.29).[39] • Individuals who were overweight or obese and drank above recommended alcohol limits have been shown to experience an increased risk of cancer (HR 1.61, 95% CI 1.30-2.00)[40] and liver disease incidence (HR 1.52, 95% CI 1.32-1.75) and mortality (HR 2.20, 95% CI 1.41-3.44)[41] compared with normal-weight non-drinkers.
Smoking	• Smoking has been found to be associated with an increased odds of developing (OR 1.51, CI 1.39-1.65) and continuing (OR 1.28, CI 1.03-1.59) harmful use of alcohol.[20] • People who smoke have been shown to have twice the risk of developing alcohol-related liver disease compared with non-smokers (RR 2.39, 95% CI 1.97-2.89).[28] • Smoking can amplify the harmful effects of alcohol in individuals with long-term conditions, increasing the risk of all-cause mortality across all drinking categories. The association between drinking and mortality was strongest for those who smoked and drank 35+ units per week (HR 4.04, 95% CI 3.41-4.79).[38]
Mental health conditions	• Psychological distress has been found to be associated with an increased odds of developing (OR 1.21, CI 1.12-1.30) and continuing (OR 1.08, CI 1.02-1.14) harmful use of alcohol.[20] • Individuals with a common mental disorder have been shown to have twice the odds of experiencing an alcohol use disorder (AUD) (OR 2.02, 95% CI 1.72-2.36), with the strongest associations seen for moderate and severe AUD.[42] • Individuals with a history of psychiatric hospitalisation have been found to have an 8% higher rate of AUD rehospitalisation than those without such a history (HR 1.08, 95% CI 1.01-1.14).[43] The impact depended on diagnosis: mood disorders and neurotic, stress-related or somatoform disorders were linked to a substantially higher risk of a first AUD rehospitalisation (by 54% and 39%, respectively), whilst disorders due to psychoactive

	substance use were associated with a lower risk of subsequent AUD rehospitalisation.[43] • Individuals with co-occurring mental health problems and problematic alcohol use have been found to experience around twice the odds of hypertension, bronchitis or emphysema, stomach ulcers or digestive issues, heart attack or angina, and bowel or colon problems. The odds of liver problems were six times higher (OR 6.14, 95% CI 3.71-10.15) and these individuals were more likely to experience physical multimorbidity.[44]

4. Patterns of alcohol consumption

4.1 National and regional drinking patterns – adult alcohol consumption

4.1.1 Health Survey for England (HSE)

The 2024 HSE provides national and regional data on adult (16 years and over) alcohol consumption.[51]

Overall findings

- Most adults drink alcohol - 77% reported consumption in the previous year
- The proportion of non-drinkers has been rising, increasing from around one-fifth of adults in 2022 to almost one-quarter (24%) in 2024
- Just under a third of adults (30%) reported drinking more than the recommended daily limit in a single day
- Based on typical weekly consumption, 16% drank at levels that put them at increasing risk of harm, and 4% at higher risk of harm
- At a regional level, age-standardised estimates for the East Midlands indicate that around one-fifth of adults drank alcohol at increasing or higher-risk levels (19%)—broadly in line with the national average of 21%.[51]

Age and sex

- Men were more likely than women to have drunk alcohol in both the last year (78% of men vs 75% of women) and last week (50% of men vs 38% of women)
- Men were more likely than women to drink more frequently, and at increasing (27% of men vs 15% of women) or higher risk levels (5% of men vs 3% of women).
- Alcohol consumption varied with age, with older age groups generally showing the most concern.
- Adults aged 55–64 were the most likely to have consumed alcohol in the past year (85% of this age group) and to have exceeded daily recommended limits (39% of this age group)
- The highest prevalence of increasing or higher-risk weekly drinking was seen among those aged 65–74 (29%).
- The lowest prevalence of increasing or higher-risk weekly drinking was observed among adults aged 25–34 (14%).[51]

Deprivation

- Patterns of drinking alcohol varied by deprivation
- Those living in the most deprived areas were more likely to be non-drinkers (39%) than those living in the least deprived areas (16%)
- Those living in the most deprived areas were less likely to drink at increasing or higher risk levels (14%) than those living in the least deprived areas (ranging from 22-23% in the three least deprived quintiles).[51]

4.1.2 Adult Psychiatric Morbidity Survey (APMS)

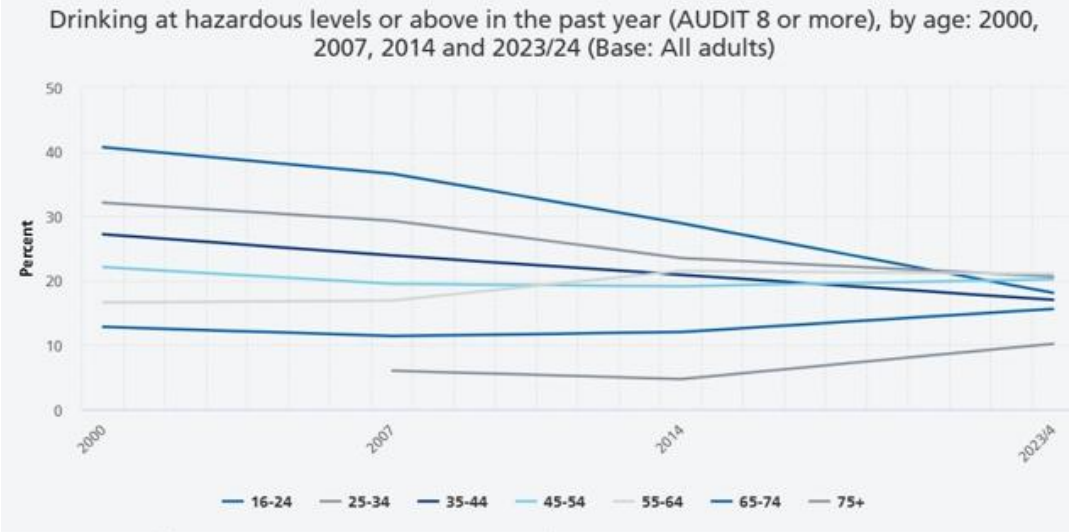
The 2023-24 APMS also provides national and regional data on adult (16 years and over) alcohol consumption, based on use of the AUDIT questionnaire to categorise respondents according to their level of alcohol-related risk.[52]

Overall findings

- Most adults drink alcohol. Similar to the HSE, the APMS found that 76.4% of respondents drank alcohol in the past year.
- In line with the HSE, 15.3% drank at levels associated with an increased risk of harm (hazardous drinking).
- 1.8% drank at levels associated with a higher risk of harm (harmful drinking) and 0.9% had an AUDIT score indicative of probable alcohol dependence.
- The prevalence of drinking at hazardous levels or above (AUDIT of 8+) has declined substantially over time, falling from over a quarter of 16-to-74-year-olds in 2000 (26.1%) to less than one fifth in 2023-24 (18.9%).
- Regionally, age-standardised estimates for the East Midlands indicate that 14.4% of adults drink at hazardous levels or above. This prevalence is lower than the national average (18.0%), ranks as the second lowest across the nine English regions analysed, and is below estimates from the HSE.[52]

Age and sex

- Men were twice as likely as women to drink at increasing risk levels or above (24.8% pf men vs 11.7% of women), and higher risk levels (3.8% of men vs 1.7% of women).
- Drinking at increasing risk levels or above was most common among adults aged 55-64 years (21.0%), with similarly high prevalence among those aged 25-34 years (20.6%) and 45-54 years (20.2%).
- In contrast, adults aged 75 years and over were substantially less likely to drink at increasing risk levels or above (10.2%), the lowest prevalence of all age groups.
- Drinking at higher-risk levels also varied by age, with prevalence highest among adults aged 45-54 years (3.9%), followed by those aged 25-34 years and 35-44 years (both 3.7%). In contrast, adults aged 75 years and over were the least likely to drink at these levels (0.9%).
- Prevalence of probable alcohol dependence was highest among adults aged 45-54 years (1.8%) and 35-44 years (1.4%), and lowest among 16–24-year-olds (0%).[52]
- As seen in Figure 2, the decline in drinking at increasing risk levels or above (hazardous drinking) since 2000 has been driven by changes in younger adults' drinking patterns, with prevalence halving among 16-24-year-olds (from 40.7% to 18.1%) and substantially reducing among 25-to-34-year-olds (from 32.1% to 20.6%). Hazardous consumption in adults aged 45-74 years has remained broadly stable over time, whereas there has been an increase in adults aged 75 years or over drinking at increasing risk levels or above (from 6.0% in 2007 to 10.2% in 2023-24).[52]



Source: APMS, licensed under the Open Government License v3.0

Figure 2: Drinking at hazardous levels or above in the past year (AUDIT 8 or more), by age: 2000, 2014 and 2023/24

Deprivation

- Adults living in the least deprived quintile had the highest prevalence of drinking at increasing-risk levels or above (23.5%).
- Prevalence was lower in more deprived areas, at 16.5% in the most deprived quintile and 13.9% in the second most deprived quintile.[52]

Ethnicity

- Drinking at increasing-risk levels or above was most prevalent among White British adults (21.3%) followed by adults from Mixed, Multiple or Other ethnic groups (16.4%).
- Prevalence was lowest among Asian/Asian British adults (4.3%) then Black/Black British adults (5.8%).[52]

4.2 Alcohol consumption in young people

The 2023 **Smoking, Drinking and Drug Use among Young People in England survey** provides regional and national data on alcohol consumption in young people aged 11-15 years.[53]

Overall findings

- Prevalence of ever having an alcoholic drink, and of having an alcoholic drink in the past week, has reduced over time, from 44% in 2016 to 37% in 2023, and 9% in 2021 to 7% in 2023, respectively
- Regional data on prevalence of drinking alcohol in the past week mirrored the national average (7% in 2023).
- Nationally, among those who consumed alcohol in the past week, the median intake was 6.4 units, and just over a quarter (26%) were estimated to have drunk at least 15 units of alcohol
- 7% of pupils reported being drunk in the past 4 weeks.[53]

Age and sex

- Drinking increases sharply with age:
    - Older pupils were far more likely than younger pupils to have ever tried alcohol (62% of 15-year-olds vs 15% 11-year-olds)
    - Older pupils were also considerably more likely to have drunk in the last week (16% of 15-year-olds vs 2% 11-year-olds)
    - Older pupils were more likely to report higher levels of consumption than younger pupils (31% of 15-year-olds drank 15+ units in the last week vs 19% 11–13-year-olds)
    - Finally, older pupils were more likely to have been drunk in the last four weeks (19% of 15-year-olds vs 1% of 11–12-year-olds).
- There were no statistically significant differences in drinking patterns between girls and boys
- Pupils with another gender identity were more likely to have ever consumed alcohol (48% vs 36% for boys and 38% for girls)
- Pupils with another gender identify were more likely to have drank in the last week (11% vs 7%).[53]

Ethnicity and deprivation

- Clear differences were seen by ethnicity and deprivation
- White pupils were most likely to have drunk alcohol in the last week (10%), compared with 6% of pupils of mixed ethnicity and 2% or fewer among Asian, Black or other ethnic groups
- Pupils attending schools in the least deprived areas were more than twice as likely to have drunk alcohol in the last week as those in the most deprived areas (9% vs 4%).[53]

4.3 Alcohol consumption in Nottingham

Understanding alcohol consumption patterns in Nottingham is challenging due to limitations in the available data. However, insights can be drawn by bringing together information from several sources.

4.3.1 Adult alcohol consumption in Nottingham

Insights drawn from various targeted surveys of specific population groups, findings from the most recently completed Citizens' Survey, and synthetic estimates based on the APMS can help build a partial picture of current behaviours, albeit with important limitations and caveats regarding their scope and representativeness.

Synthetic estimates of harmful and dependent drinking

National prevalence estimates from the APMS 2023/24 for harmful drinking (AUDIT score 16–19) and probable dependence (AUDIT score 20+) have been applied to Nottingham's 2024 mid-year population estimates to generate local synthetic estimates of alcohol-related need by sex, age and ethnicity within Nottingham's population. These estimates are the best measure of local alcohol consumption that we have, but they should be viewed as indicative rather than definitive, and used alongside other sources of evidence.

While the APMS provides a valuable national benchmark for estimating alcohol-related need, there are limitations to its application at a local level, particularly for inclusion health groups. These include:

- Exclusion of non-household populations, such as people sleeping rough or living in temporary accommodation.
- Data collection being conducted in English only, which may limit participation among some communities.
- Limited granularity regarding ethnic and cultural diversity.
- Potential under-representation of some marginalised populations with higher levels of alcohol-related harm.

Age

Overall, there are an estimated 7,220 harmful and dependent drinkers in Nottingham, 2.7% of the overall adult population.

Table 5 shows the estimated number of harmful and dependent drinkers by age group, as well as the proportion of drinkers in this category in each age group, and the estimated prevalence of harmful or dependent drinking in each age group.

Table 5: estimated number of harmful and dependent drinkers by age group, based on APMS and ONS mid-year population estimates

Age band	ONS 2024 mid-year population estimate	APMS harmful and dependent drinking estimates		
		Number of harmful and dependent drinkers	Harmful/probable dependent drinkers as % of all harmful/probable dependent drinkers	Harmful/probable dependent drinkers as % of age group population
16-24	75,914	1,356	18.8%	1.8%
25-34	47,107	1,722	23.9%	3.7%
35-44	42,691	1,578	21.9%	3.7%
45-54	33,691	1,352	18.7%	4.0%
55-64	31,498	729	10.1%	2.3%
65-74	21,096	318	4.4%	1.5%
75+	18,066	165	2.3%	0.9%
Total	**270,063**	**7,220**	**100.0%**	**2.7%**

The synthetic estimates indicate that the **highest proportion of harmful or probable dependent drinkers is within the 25–34-year age group** (23.9% of all harmful or dependent drinkers). Thereafter, the estimated proportion decreases progressively across successive age bands, suggesting that alcohol-related treatment need is concentrated among younger working-age adults.

When prevalence is considered within each age group, the highest rate is among those aged 45-54, with an estimated 4.0% of this population classified as harmful or probable dependent drinkers. This suggests that, although the largest number of people requiring support are aged 25-34, the burden of harmful drinking relative to population size is greatest among 45-54-year-olds.

Sex

When APMS 2023/24 prevalence estimates are applied to Nottingham's population, an estimated **68% of harmful or probable dependent drinkers are male**, compared with **32% who are female**. This suggests that men continue to experience substantially higher levels of harmful and dependent drinking and are likely to account for the majority of alcohol treatment need.

Ethnicity

Table 6 shows the estimated proportion of harmful or probable dependent drinkers in each ethnic group, produced by applying APMS prevalence estimates to Nottingham's population.

Table 6: estimated proportion of harmful or probable dependent drinkers in each ethnic group, based on APMS and ONS mid-year population estimates

Ethnic Group	Harmful or dependent drinkers (%)
White British	78.3%
Asian/Asian British	7.7%
Black/Black British	5.5%
Mixed/Multiple/Other	3.4%
White Other	5.1%
Total	100%

Synthetic estimates of alcohol dependence

These estimates have been produced by the University of Sheffield using data from the APMS.[49] Where possible, upper and lower CIs have been applied to the data (presented as error bars).

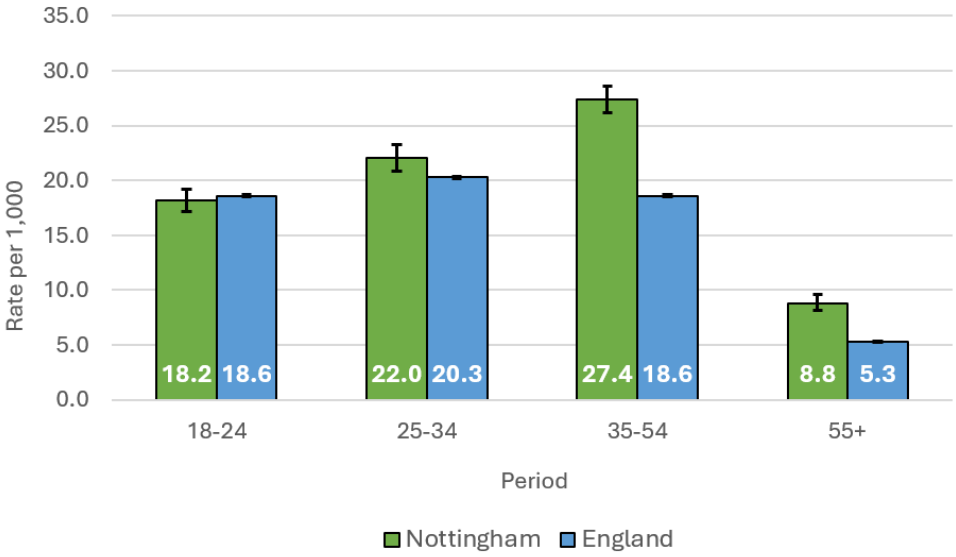
Although these synthetic estimates partially overlap with the previous analysis which combines harmful and probable dependent drinkers, examining dependent drinkers separately provides additional valuable insight as this pattern of drinking is typically associated with high levels of harm and complex support and treatment needs.

The latest available local authority level data (2019-20) suggest that Nottingham has a mid-point estimate of 5,047 alcohol-dependant adults (95% CI: 3,881-6,959).[49] This is statistically similar to previous years and represents 1.9% of Nottingham's adult population (18+) based on the 2019 mid-year estimate. The crude rate is 19.1 dependent adults per 1,000 people, which is higher but statistically similar to the England rate of 13.7 per 1,000. Nottingham's rate has remained consistent between 2016 and 2020, with no statistical difference between years or when compared to England.

Age

Figure 3 shows that the highest rate of alcohol-dependent adults in Nottingham was in those aged 35-54 years, at 27.4 alcohol dependant adults per 1,000 people. This is statistically significantly higher than the England rate for the same age group. 40% of Nottingham's alcohol-dependent adults fall within this age group, whereas the 18-24 and 25-34 age groups each account for approximately one quarter of alcohol-dependent adults in the city (24% and 25%, respectively).

Figure 3: rate of alcohol-dependent adults in Nottingham per 1,000 by age group

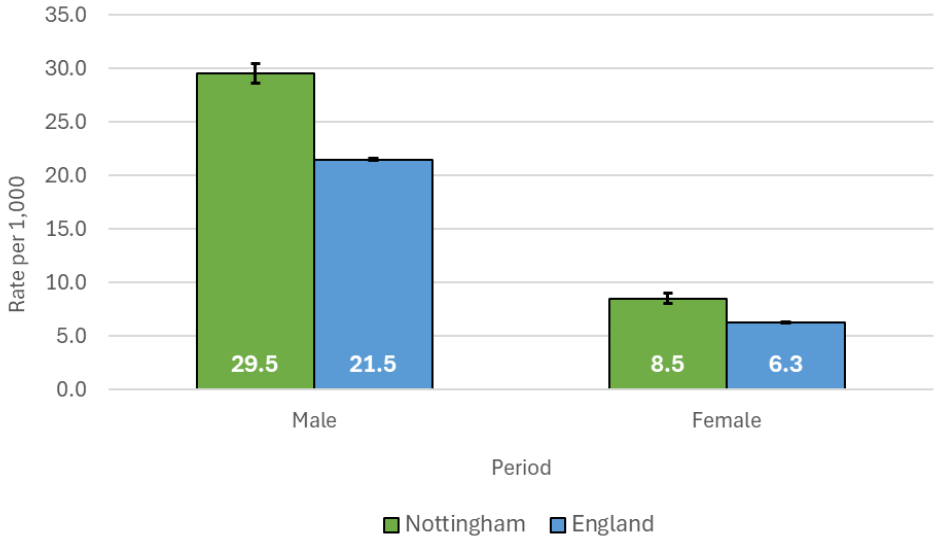


Sex

Of the estimated 5,047 alcohol-dependent adults in Nottingham, 78% were male and 22% were female. Based on the 2019 mid-year estimate, this equates to 3% of adult males and 0.9% of adult females in the city.

As shown in Figure 4, the crude rate of alcohol dependent males was 29.5 per 1,000 people, which is statistically significantly higher than the female rate of 8.5 per 1,000. Nottingham's rates for both genders were statistically significantly higher than the England rates.

Figure 4: rate of alcohol-dependent adults in Nottingham per 1,000 by sex



Nottingham Citizens' Survey 2022

The Citizen's Survey was an annual council-commissioned survey conducted until 2022. It gathered information from residents aged 16 and over on a range of topics, including alcohol consumption. In 2022, data were collected through face-to-face doorstep interviews using a random sample of 1,800 households that ensured coverage was evenly spread across the city's 20 wards.[54]

Overall findings

- Just over half of residents (51%) drank alcohol—the lowest proportion recorded and a decrease from 59% in 2019.
- Among those who did drink, the proportion consuming alcohol at increasing or higher risk levels rose from 8% in 2019 to 11%, and binge drinking increased from one fifth to one quarter of drinkers.[54]
- 2.2% of those who drink alcohol were drinking at harmful levels.[54] This is similar to the synthetic estimate of harmful and dependent drinkers in the city (2.8%).

Age and sex

- Males (56%) were more likely to drink alcohol than females (45%)
- Contrary to much of the available data, females were more likely to drink at increasing or higher risk levels than males.
- In contrast to national data, younger adults aged 16-24 were the most likely to drink alcohol (60% of this age group), to drink at increasing or higher risk levels (14.7%), and to binge drink (31.8%).
- The 65+ age group had the lowest proportion of drinkers, and the lowest proportion of binge drinkers (16.4%)
- The 25–44-year age group had the lowest proportion of individuals drinking at increasing or higher risk levels (5.5%).[54]

When looking specifically at the proportion of higher risk (harmful) drinkers, the age groups ranked as follows[54]:

1. 45–64-year-olds: 4.3%
2. 65 years and over: 3.3%
3. 16–24-year-olds: 2.4%
4. 25–44-year-olds: 0.3%

Although direct comparison with the synthetic estimates of harmful drinking is limited by differences in age-group classifications, the findings are broadly consistent in identifying the highest prevalence of harmful drinking among those aged 45-54 years (4.0% in the synthetic estimates).

However, the synthetic estimates suggest lower proportions among older adults (1.5% among 65–74-year-olds and 0.9% among those aged 75 years and over) and higher proportions among working-age adults, with 3.7% of both 25-34- and 35–44-year-olds estimated to be harmful drinkers.

Ethnicity

In line with other data, alcohol consumption and risky drinking behaviours were more prevalent among White British residents than among residents from Black, Asian and Minority Ethnic groups. Specifically, White British residents were more likely to[54]:

- Consume alcohol
- Drink at increasing risk levels (11.7% vs 4.2%)
- Drink at higher risk levels (2.9% vs 0.8%)
- Binge drink (28.4% vs 16.0%).

Geographic variation

- Residents in Castle, Hyson Green & Arboretum, and Radford had the highest prevalence of drinking (61%), as well as the highest proportions drinking at increasing or higher risk levels (16%) and binge drinking (37.1%)
- In contrast, the Aspley, Bilborough and Leen Valley area had the lowest proportion of residents who drank alcohol (39%) and who drank at increasing or higher risk levels (7.6%)
- Clifton East and Clifton West had the lowest proportion of alcohol drinkers who binge drink (14.7%).[54]

Employment status

- People in full-time education had the highest rates of drinking and binge drinking, with 34.8% reporting binge drinking.
- Those reporting an employment status of 'otherwise not in paid work' were the least likely to drink alcohol, but amongst those who did, 17.7% drank at increasing or higher risk levels—the highest of any employment group.
- Employed/self-employed people were the least likely to drink at increasing or higher risk levels (7.4%), whereas retired individuals were the least likely to binge drink (16.6%). [54]

4.3.3 Alcohol consumption amongst young people in Nottingham

Nottingham City Health and Wellbeing Survey for Schools 2025

Findings from this survey provide useful local insight into early alcohol use among primary and secondary pupils[55], although results should be interpreted with caution as they are based on 3,423 pupils from a subset of schools. Overall, alcohol consumption, measured by reported drinking in the past week, was low and below the national average, but demographic and social patterns were evident.

Among primary school pupils:

- 2% reported drinking alcohol in the past week
- Boys (3%) were more likely than girls (1%) to have drank alcohol in the past week.
- When compared to the entire sample, alcohol consumption was statistically significantly more prevalent in White British pupils (2%) and statistically significantly less common in Asian pupils (0%)
- When compared to the entire sample, alcohol consumption was statistically significantly more prevalent in pupils whose parents do not live together (3%).[55]

In secondary school pupils:

- 5% reported drinking alcohol in the past week
- In general, the proportion of pupils reporting alcohol use in the past week increased with age, reflecting national trends.
- By Year 10, gender differences reversed compared with primary school: girls were more likely than boys to have consumed alcohol in the past week (9% of girls and 6% of boys) and to have been drunk in the past week (5% of girls and 4% of boys).
- When comparing to the entire sample, marked differences in reported consumption in the past week were observed:
    - White British pupils were statistically significantly more likely to have reported drinking in the past week (15%), and Asian pupils were statistically significantly less likely to have done so (1%)
    - Pupils with no religious affiliation were statistically significantly more likely to have drank alcohol in the last week (13%), and those from minority religious backgrounds were statistically significantly less likely to have (1%).
    - As in primary school, pupils whose parents do not live together (10%), and those from single-parent families (13%), were significantly more likely to have consumed alcohol in the past week.[55]

2025 Students, Alcohol and Drugs Survey

Limited data are available from this survey, which is undertaken in universities nationally by SOS-UK.[56] Local findings from this survey should be interpreted with caution, as the number of respondents was low (346 University of Nottingham (UoN) students, and 425 Nottingham Trent University (NTU) students), and although respondents are in education at these universities, it is unclear whether they are Nottingham city residents.
With 30% of NTU students and 27% of UoN students abstaining from consuming alcohol, Nottingham's rates are broadly in line with the national average of 27%. However, a higher

proportion of Nottingham students reported drinking to intentionally get drunk once a week, at 33% for NTU and 32% for UoN, compared with the national average of 23%.

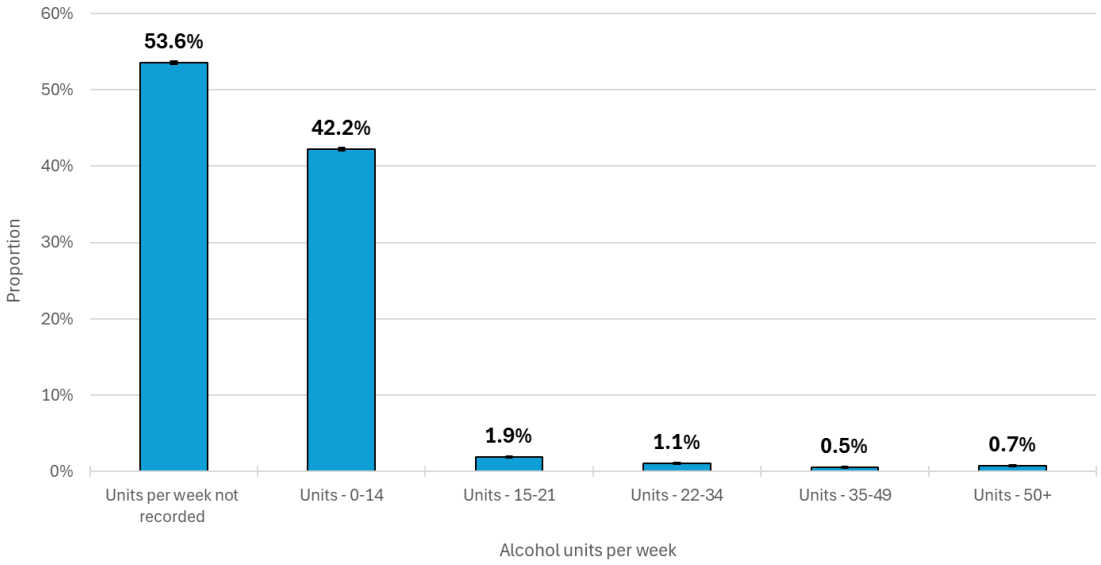
Over a quarter of respondents reported feeling pressure to drink alcohol, and the top three reasons for drinking alcohol were for recreation, to enhance social interaction, and to improve confidence.[56]

4.3.4 Healthcare data

eHealthScope

eHealthScope is a population health management system that brings together data from GPs and wider community services within Nottingham and Nottinghamshire, providing health and wellbeing insights about local residents. Data utilises SNOMED codes that are used within electronic health record systems across the NHS in England. Alcohol consumption data (units consumed per week) were extracted from eHealthScope for all active Nottingham city patients (a total of 370,770) on 12/06/26, and can be seen in Figure 5.

Figure 5: alcohol consumption in Nottingham by units per week, eHealthScope, 2026



In summary:

- Just over half of patients (approximately 198,610 patients) did not have any of the codes related to alcohol consumption recorded in their GP record.
- A further 42.2% of patients (90.9% of those with codes recorded) were documented as drinking 0-14 units per week, levels associated with a low risk of alcohol-related harm.
- Only a small proportion of patients were recorded in the higher-unit categories, with a combined total of 4.2% of patients recorded as drinking 15 units or more per week.
- 4,655 patients (1.2%) were recorded as potentially drinking harmfully (35 units or more per week). This is lower than the synthetic estimate of 7,218 harmful drinkers (2.8% of adults).

The eHealthScope findings should be interpreted with caution. Alcohol consumption data are not routinely or consistently collected by GPs, and patients with recorded data may differ from

those without. In addition, patients are only recorded for one category of alcohol units consumed per week based on the most recent code in their record, but the number of Nottingham City patients recorded in eHealthScope exceeds the ONS population estimate, suggesting list size inflation. Furthermore, the dataset cannot be broken down by demographic or socio-economic characteristics, so it is not able to tell us who within the city is drinking alcohol at harmful or hazardous levels.

Thriving Nottingham

Thriving Nottingham delivers free health and wellbeing programmes to adults, children and families across the city, including support for smoking cessation and weight management.

Of the 1,968 people in contact with Thriving Nottingham in 2025 who were asked about their alcohol consumption:

- Three in four (75.9%) reported drinking alcohol in the previous year
- Almost three in ten (564 people, 28.7%) screened positive for potentially risky drinking behaviour (AUDIT-C score ≥5 following the initial three screening questions).
- Further assessment found that nearly one in four individuals (474 people, 24.1%) had a total AUDIT score of 8 or above, indicating increasing or higher-risk alcohol consumption.

It should be noted that these findings relate to individuals accessing health and wellbeing services and therefore may not be representative of the wider Nottingham population.

4.4 Nottingham picture: At-risk populations

Local data on alcohol consumption and harm are available for certain populations who may be more vulnerable to alcohol-related harm.

4.4.1 People with Severe Mental Illness (SMI)

An annual physical health check is available for adults (18 and above) with SMI to help identify health problems early and ensure timely access to interventions.

Table 7 displays SMI health check data for Nottingham and for the Nottingham and Nottinghamshire Integrated Care Board (ICB). In 2025-26, out of the 2,909 people who had an assessment of alcohol consumption completed as part of their health check, 8.7% had an alcohol intervention need. Consistent with the ICB trend, the proportion of Nottingham patients identified as having an alcohol intervention need has fallen since 2022-2023, although there was a small increase in the last year.

Table 7: alcohol intervention need in SMI health checks

Alcohol Intervention Need		2022-2023	2023-2024	2024-2025	2025-2026
Nottingham City (%)	Number	258	212	232	253
	%	10.3	8.5	8.2	8.7
ICB (%)	Number	611	586	623	643
	%	9.2	8.8	8.3	8.5

4.4.2 People on probation

Table 8 displays data relating to individuals supervised by probation services, noting that the data are provisional and subject to change.

- In 2025-2026, substance use was identified as an issue in over two-thirds of all supervised cases, broadly consistent with the rates seen since 2022-2023. This suggests that substance use remains a persistent need within the probation population.
- The proportion of people with an identified need who are then referred to an Alcohol Treatment Requirement (ATR) or Drug Rehabilitation Requirement (DRR) is low, at 13.8% in 2025-2026. This suggests there are a substantial number of people on probation with identified needs for whom it is unclear whether they are receiving any support.
- Out of those referred to ATR or DRR, the proportion who successfully complete the intervention has reduced since 2022-2023, from over three quarters of cases to 57.8% in the most recent year.

It is important to note that the dataset does not distinguish between alcohol- and drug-related need, making it impossible to determine the proportion of supervised individuals that have alcohol-related issues specifically. Similarly, ATR outcomes cannot be separated from DRR outcomes, limiting the ability to assess whether alcohol-focused interventions perform differently from those focused on other substances.

Table 8: provisional probation services data on alcohol need in Nottingham

Year		April 2022-March 2023	April 2023-March 2024	April 2024-March 2025	April 2025-March 2026
Total cases supervised		2721	2906	2828	2538
Substance use	**Number**	1763	1965	2029	1710
	Proportion (%)	64.8	67.6	71.8	67.4
Referrals to ATR/DRR	**Number**	333	246	360	237
	Proportion (%)	18.9	12.5	17.7	13.8
Successful ATR/DRR completion	**Number**	256	152	197	137
	Proportion (%)	76.9	61.8	54.7	57.8

4.4.3 Drinking in pregnancy

Pregnant women typically have frequent contact with health services, providing valuable opportunities to identify and support those who are drinking during pregnancy. Unfortunately, 2025-2026 data from Nottingham University Hospitals NHS Trust digital records show that many women do not have information relating to alcohol consumption documented, suggesting potential missed opportunities:

- 66.9% had alcohol consumption information recorded at booking (5181 people)
- 21.6% had alcohol consumption information recorded at 36 weeks (1416 people)
- 44.6% had alcohol consumption information recorded at birth (3214 people).

While the data should be interpreted with caution due to small numbers and the potential inclusion of pregnant women from outside Nottingham city, they still offer valuable insight into patterns of alcohol consumption in this important population group.

Among those who were asked, reported alcohol use during pregnancy and at birth was low:

- 1.3% at booking (69 people)
- 0.9% at 36 weeks (13 people)
- 1.2% at birth (40 people).

These figures are significantly lower than the UK prevalence estimate (41.3%)[23], indicating that local data may be incomplete or inaccurate.

Weekly alcohol consumption data are available for the individuals who reported drinking at 36 weeks, although this was a very small number of women, so the results are unlikely to be generalisable. Overall, alcohol consumption appeared to be low, with most reporting drinking 1-6 units per week, although one individual reported substantially higher consumption at 22 units per week. No women accepted an alcohol referral at booking or 36 weeks, although it is unclear whether referrals were declined or not offered.

Foetal Alcohol Spectrum Disorder (FASD)

FASD is thought to be under-recognised, with no reliable national or local prevalence data.[45] It is likely that FASD is underdiagnosed, potentially because of limited awareness of the full scope of the condition among healthcare professionals, and because affected children present with behavioural difficulties later in childhood, when confirming key diagnostic information—such as evidence of prenatal alcohol exposure—may no longer be possible.[45]

National prevalence estimates:

- Prevalence has been estimated by researchers in a high-quality study. Using data on the number of women who consume alcohol in pregnancy and modelling the likely outcome in terms of FASD, they estimated the UK prevalence to be 3.2% (95% CI 2.0-4.9%).[46]
- A 2021 study of primary school children in Greater Manchester estimated a prevalence of 1.8%, rising to 3.6% when possible cases were included.[47] These findings should be applied with caution as the study was based on a small sample of mainstream schools in a single local area, which may not reflect patterns seen nationally.[47]
- Published audits completed in a UK community paediatric clinic in 2015 estimated FASD prevalence in children in care to be 27%.[48] The higher rate is thought to be linked to the circumstances leading to many children entering care, such as parental substance use, including drinking alcohol in pregnancy.[48]

Applying the estimated UK FASD prevalence rate of 3.2% to births at NUH in the 2025-26 financial year suggests that around 230 babies could have been born with FASD. This figure should be treated cautiously: it is an estimate, and NUH provides care to those who live outside Nottingham city, meaning the number may not directly reflect local prevalence.

4.4.4 Living with a parent or carer with alcohol use

The NDTMS has produced modelled parental alcohol prevalence estimates using University of Sheffield analyses of APMS data[49] applied to Nottingham Census population data and adjusted to account for children living with more than one alcohol-dependent adult.[50]

In Nottingham, data show a substantial number of children potentially affected by parental alcohol dependence.

The most recent data is from 2019-20. When analysing the total 1,200 new presentations to treatment during this year[50]:

- 15% were parents or adults living with children (182 people)
- 45% were parents not living with children (536 people).

In 2018-19, an estimated 1,577–1,705 children in Nottingham were living with at least one alcohol-dependent adult. This equates to 23–25 per 1,000 children, notably higher than the national rate of 16–17 per 1,000.[50]

Similarly, the rate of alcohol-dependent adults living with children in Nottingham was 4 per 1,000 people, higher than the national average of 3 per 1,000. Only 171 of the estimated 967 alcohol-dependent adults living with children were in treatment for alcohol use (18%), highlighting a substantial unmet treatment need.[50]

Additionally, as seen in Table 9, data from Children's Social Care assessments in Nottingham for the 2024-2025 financial year show that 21.1% of the total 3,526 episodes identified alcohol as a

risk factor of concern affecting either a child (2.0% of assessments), a parent (16.6% of assessments), or another household member (2.4% of assessments). Compared with statistical neighbours, the East Midlands, and England, Nottingham shows similar proportions of assessments identifying alcohol as a risk factor of concern affecting both children and other household members, but a notably higher proportion of parents with this risk factor.

Table 9: number and proportion of children's social care assessments where alcohol is a risk factor of concern, 2024-25

Area		Alcohol identified as a risk factor (%)			
		Child	Parent	Other	Total
Nottingham	Number	72	587	84	743
	%	2.0	16.6	2.4	21.1
Statistical Neighbours	Number	65.3	612.2	86.9	764.4
	%	1.8	15.3	2.2	19.3
East Midlands	Number	1,010	6,450	930	8,390
	%	2.4	15.4	2.2	20.0
England	Number	10,620	73,250	11,600	95,470
	%	2.1	14.3	2.3	18.6

CGL - The Place, Nottingham's specialist drug and alcohol service for children and young people, received 27 alcohol-related referrals from Social Care during the 2024-2025 financial year. Of these, 6 related to the child or young person's own alcohol use, while 21 involved a child or young person who was affected by another person's alcohol use. These figures are considerably lower than the number of assessments identifying alcohol as a risk factor of concern, indicating a gap between identified need and referrals to specialist support.

Overall, the data indicate a higher-than-average local prevalence of parental alcohol dependence and a significant gap between need and access to treatment, with clear implications for children's health, development, and long-term outcomes.

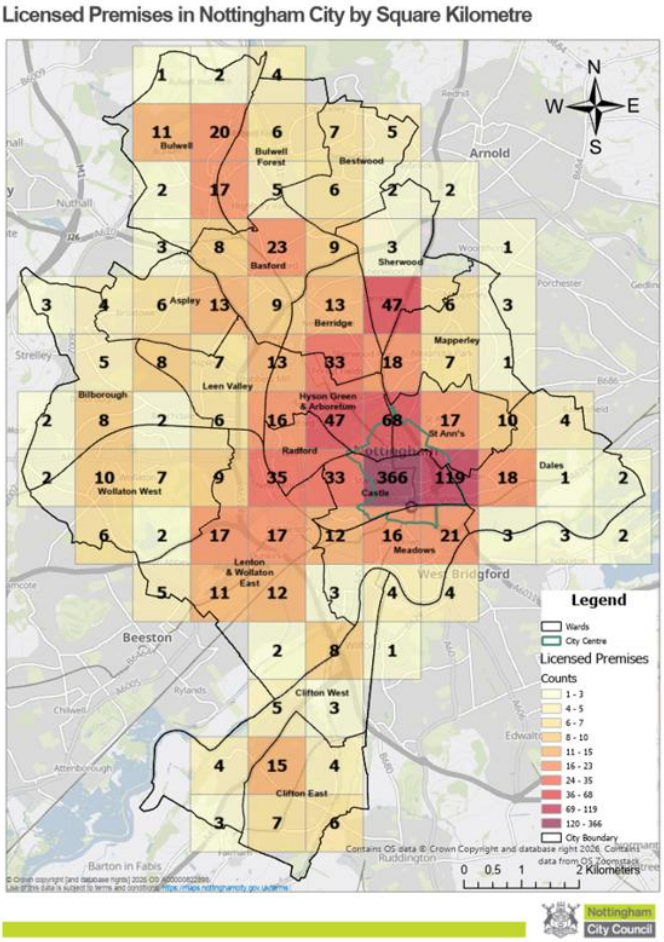
5. Accessing alcohol in Nottingham

Licensed Premises play an important role in the local and national economy, supporting employment, hospitality, tourism and the night-time economy. However, alcohol-related harm also places a significant burden on individuals, communities and public services, including healthcare, criminal justice and social care systems.

Figure 6 presents a heat map of Licensed Premises per square kilometre in Nottingham, produced using data from Nottingham City Council's Licensed Premises Register in June 2026, created using Arc GIS Pro mapping software.

The map shows a pronounced concentration of outlets in the city centre (green boundary line), with the highest density, 366 premises per square kilometre (28% of all licensed premises), located within part of the Castle ward. The centralised pattern reflects the city's night-time economy, where a large number of on- and off-license premises operate within a compact area. Outside of the city centre, premises are generally more dispersed, with small pockets of higher density appearing in some wards.

Figure 6: map of licensed premises per km2 in Nottingham, June 2026



In 2023-24, Nottingham overall had 15.3 licensed premises per square kilometre.[7] This is the second highest density in the East Midlands after Leicester at 16.6 premises per square kilometre, and higher than most of the city's statistical neighbours including major cities such as Birmingham (11.5 premises per square kilometre), Newcastle (10.8 premises per square kilometre) and Sheffield (4.8 premises per square kilometre).[7]

5.1 Modes of access and alcohol-related harm

A review of recent evidence was undertaken to assess whether different ways of accessing alcohol including through on-trade venues (e.g. pubs and bars), off-trade outlets (e.g. supermarkets and shops), and home delivery/online services are associated with differing levels of alcohol consumption and associated harms.

The studies and grey literature identified were generally of moderate quality and were conducted in several high-income countries, improving relevance for UK policy and practice. The evidence base was, however, limited, particularly regarding home delivery services, and tended to examine consumption levels rather than harm. Furthermore, all primary studies were descriptive observational designs which are susceptible to biases and cannot establish causality, so the findings should be interpreted with caution. Individual study quality assessments are presented in Appendix 1.

Key findings include:

- Evidence suggests that people in the UK are more likely to drink regularly at home than in pubs, bars or restaurants.[55]
- Most home drinking is likely to be moderate[57], but the majority of alcohol consumption and heavier drinking occasions are likely to occur in these off-trade settings.[56,57]
- Mixed on-trade and off-trade drinking occasions are particularly associated with high levels of alcohol consumption.[56]
- Greater alcohol availability from on-trade outlets, particularly where there are venues with extended trading hours, is associated with increases in alcohol-related injuries and violent incidents.[58]
- Reductions in on-trade availability, for example during COVID-19 restrictions, were associated with reductions in alcohol-related violence overall but did not significantly reduce alcohol-related domestic violence. This suggests off-trade alcohol consumption is likely to also play an important role in alcohol-related violence.[59]
- Frequent use of delivery services is likely to be associated with increased consumption of alcohol.[60]
- People consuming alcohol delivered to home are potentially more likely to drink more frequently and to binge drink.[61]
- Existing safeguards intended to prevent alcohol being delivered to underage or intoxicated individuals appear to not be applied consistently by delivery providers.[62]

Overall, the evidence suggests that different modes of alcohol access are linked to different patterns of harm rather than a single uniform effect. Across all access modes, a consistent theme is the role of availability, with greater access to alcohol associated with increased consumption.

6. Impacts of harmful alcohol use in Nottingham

6.1 Alcohol-related mortality

- Since 2016, alcohol-related mortality rates in Nottingham have remained **above the national average**, albeit not consistently statistically significantly higher, and there has been a slight overall downward trend over time.[7]
- Male rates in Nottingham are consistently significantly higher than rates in females, and year-on-year fluctuations are more pronounced in males.[7]
- A **spike in mortality rates** has been observed in recent years: between 2023 and 2024, male rates increased from 73 to 80.5 deaths per 100,000 people, and female rates from 25.8 to 31.7 deaths per 100,000 people.[7]

The remainder of this section explores the demographic profile and leading alcohol-related causes of death among Nottingham residents, using registered deaths data extracted from the PCMD for the 2022-2024 calendar years, and by applying alcohol-attributable fractions based on underlying cause of death, age group and gender.

Age and gender

Across the three-year period, 354.4 alcohol-related deaths in Nottingham residents were registered, equating to a directly age-standardised mortality rate of 61 deaths per 100,000 population.

- Males accounted for 71.7% of total deaths (254.1), with a mortality rate of 93.1 per 100,000 population
- Females accounted for 28.3% of total deaths (100.3), with a rate of 33.1 per 100,000 population.

Figure 7 displays the age-gender distribution of alcohol-related deaths in Nottingham residents aged 16 years and above, revealing **consistently higher proportions in males**. For both genders, the proportions rise through early adulthood, peak in middle age, and then gradually decrease in older age. **The highest proportions are seen in the 60-64 age group**, accounting for 10.5% of male deaths and 4.2% of female deaths.

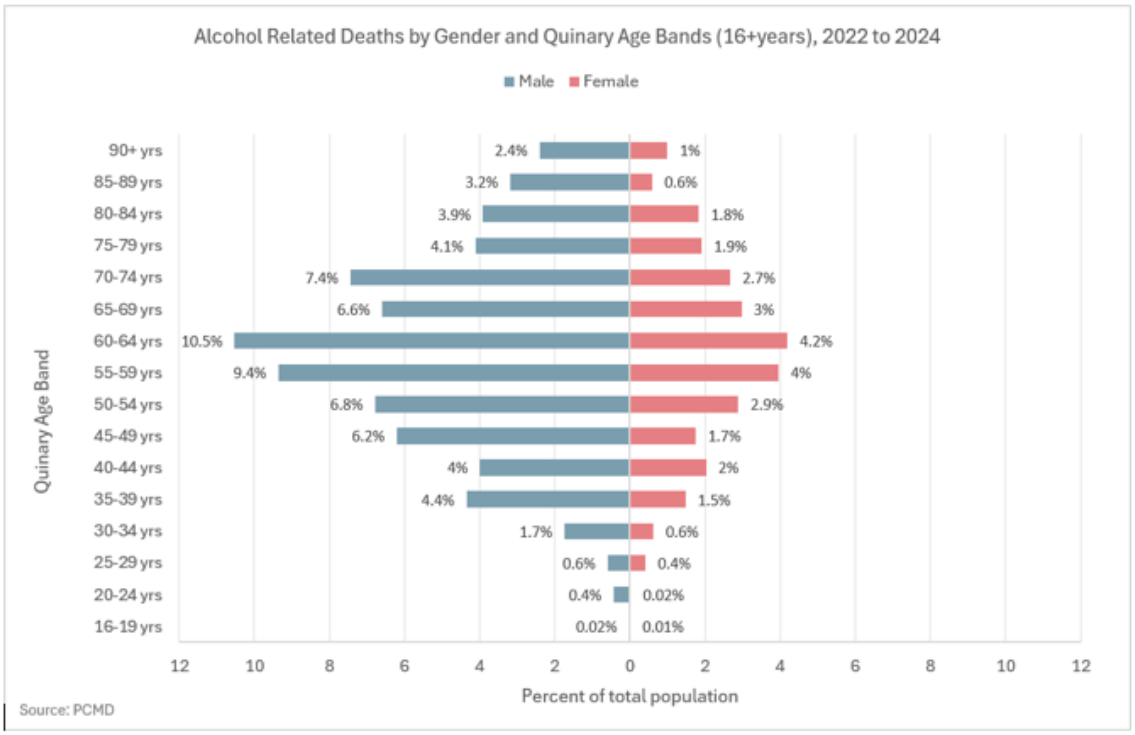


Figure 7: age-gender distribution of alcohol-related deaths in Nottingham residents aged 16 years and above, 2022-24, PCMD data

This figure identifies the age and gender groups contributing to the greatest number of deaths, but the proportions are influenced by the underlying population structure, with some age groups containing more residents than others.

After adjusting for the population size in each broader age group, the age-specific mortality rates in Figure 8 show a different distribution pattern that better reflects the risk of alcohol-related mortality across age groups and between genders:

- From 45 years onwards, rates in males are approximately three times higher than in females
- Below age 45, gender differences are not statistically significant
- Despite the clear age gradient among males, rates across the broad age bands are not statistically significantly different. The wide confidence intervals, particularly in the 75+ age group, indicate less precision in estimates due to the low number of deaths and small population size

- Among females, the mortality rates across the age bands show no statistically significant variation.

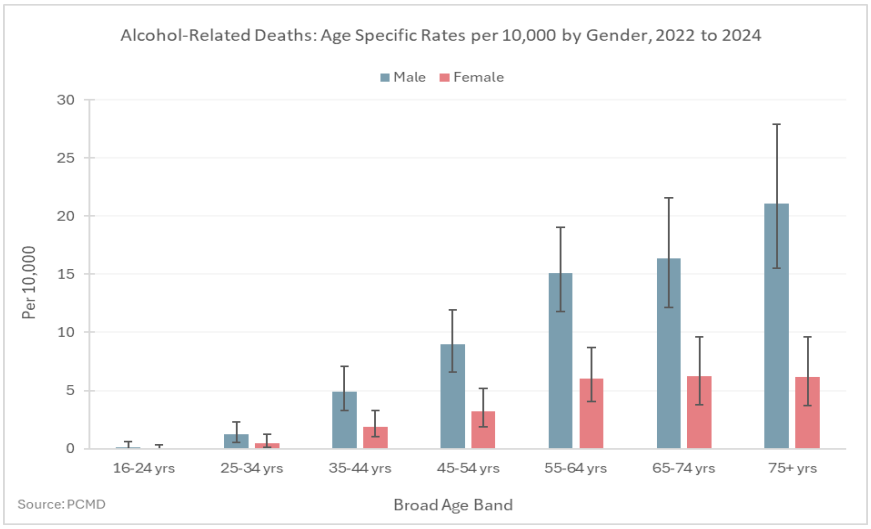


Figure 8: age specific rates of alcohol-related deaths in Nottingham per 10,000 by gender, 2022-24, PCMD

Overall, alcohol-related mortality in Nottingham is characterised by a pronounced gender inequality, with males experiencing higher mortality particularly from mid-life onwards. Although the largest proportion of deaths occur in people aged 60-64 years, age-specific rates demonstrate that the elevated risk extends across older working-age and older adults.

Deprivation

- 26.7% of alcohol-related deaths occurred among residents in the most deprived quintile in Nottingham, despite this group making up only 16.6% of the city's population aged 16 and over.
- 14.6% of deaths occurred in the least deprived quintile, even though these areas contain 21.8% of the adult population.

After adjusting for population size and age structure in each quintile, Figure 9 shows a clear **socio-economic gradient**, with age-standardised mortality rates decreasing as deprivation decreases.

The rate in the most deprived quintile (83 deaths per 100,000 population) is more than double that of the least deprived quintile (38 per 100,000 population). Mortality rates in the remaining quintiles do not differ significantly from those in the most deprived quintile.

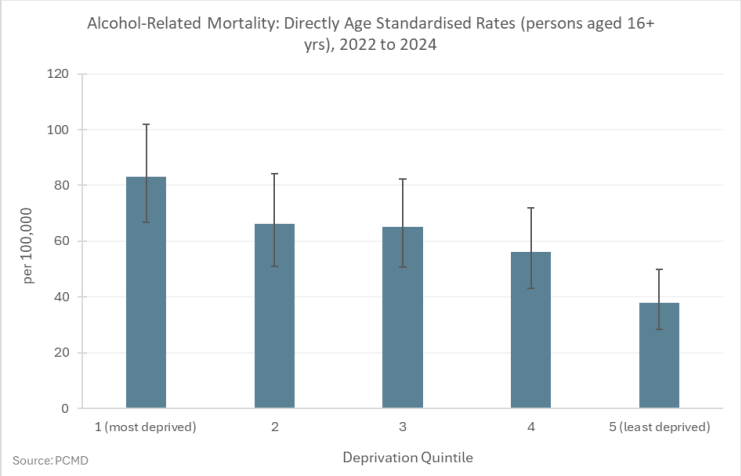


Figure 9: directly age standardised alcohol-related mortality in Nottingham, 2022-24, PCMD data

A gender-specific analysis was conducted:

Females:

- There were no statistically significant differences between all five quintiles
- The most deprived quintile had the highest age-standardised mortality rate (50 deaths per 100,000 female population)
- The least deprived quintile experienced the lowest rate (22 per 100,000 female population).

Males:

- Mortality rates in the most deprived quintile (121 deaths per 100,000 male population) were significantly higher than in the least deprived quintile (56 deaths per 100,000 male population)
- There were no statistically significant differences in rates observed between the most deprived quintile and the remaining quintiles.

Figure 10 shows the age-specific alcohol-related mortality rates across deprivation quintiles. The most deprived quintile experienced the highest mortality rates in four of the six age groups, spanning ages 35 to 74 years. The second most deprived quintile recorded the highest rates among individuals aged 25-34 years and those aged 75 years and over.

This shows us that the highest age-specific alcohol-related mortality rates are concentrated in the most deprived communities throughout most of adulthood.

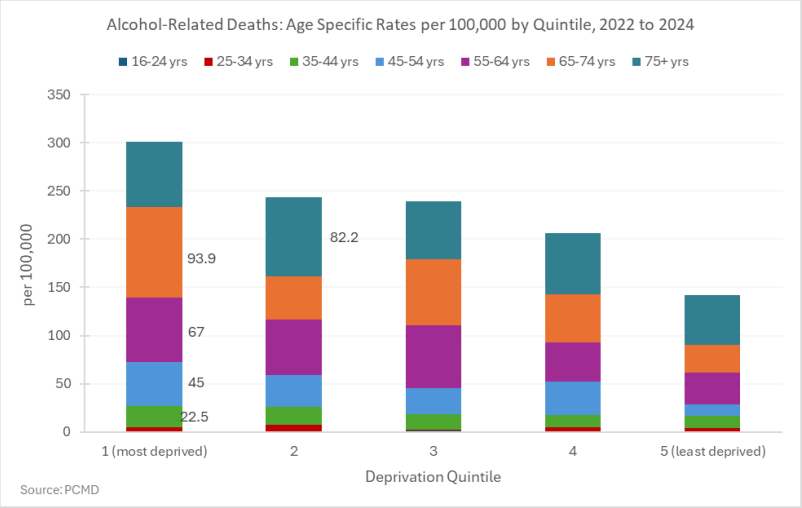


Figure 10: age-specific alcohol-related mortality rates across deprivation quintiles in Nottingham, 2022-24, PCMD data

Overall, a clear socio-economic gradient exists in alcohol-related mortality in Nottingham, with the burden of mortality falling disproportionately on residents in more deprived areas. This inequality is particularly pronounced among males and is evident across the adult life course.

Most common causes of alcohol-related deaths

The top 10 alcohol-related causes of death for 2022-2024 are displayed in Figure 11, and account for over three-quarters (77.3%) of alcohol-related deaths.

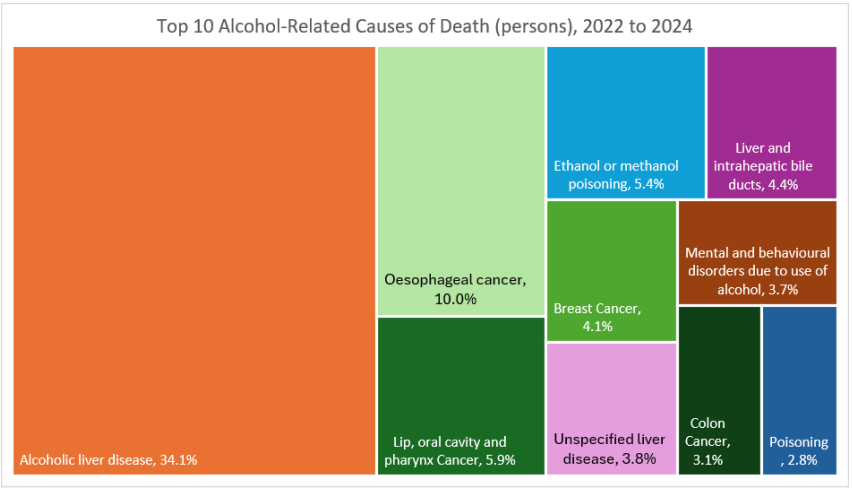


Figure 11: top 10 alcohol-related causes of death for 2022-2024 in Nottingham, PCMD data, 2022-24

Table 10 displays the top 10 most common causes of alcohol-related deaths overall, and for each gender. **Alcoholic liver disease is the most common cause of death**.

Deaths from acute causes (such as poisoning and self-harm) and upper aerodigestive cancers appear more common in males than in females. Breast cancer is the second most common

cause of alcohol-related deaths in females, and females experience more deaths from unspecified liver disease and conditions related to the cardiovascular system than males.

The overall profile is driven mainly by male patterns due to higher male mortality rates, but female-specific causes such as breast cancer still influence the population-level ranking.

Table 10: top 10 most common causes of alcohol-related deaths in Nottingham, PCMD data, 2022-24

	Males	Females	Overall
1	Alcoholic liver disease (32.3%)	Alcoholic liver disease (38.9%)	Alcoholic liver disease (34.1%)
2	Oesophageal cancer (11.2%)	Breast cancer (14.4%)	Oesophageal cancer (10.0%)
3	Lip, oral cavity and pharynx cancer (6.9%)	Unspecified liver disease (9.0%)	Lip, oral cavity and pharynx cancer (5.9%)
4	Ethanol or methanol poisoning (6.3%)	Oesophageal cancer (7.0%)	Ethanol or methanol poisoning (5.4%)
5	Liver and intrahepatic bile ducts (5.3%)	Mental and behavioural disorders due to use of alcohol (4.0%)	Liver and intrahepatic bile ducts (4.4%)
6	Poisoning (3.7%)	Cardiac arrythmias (3.6%)	Breast cancer (4.1%)
7	Mental and behavioural disorders due to use of alcohol (3.5%)	Lip, oral cavity and pharynx cancer (3.4%)	Unspecified liver disease (3.8%)
8	Colon cancer (3.4%)	Ethanol or methanol poisoning (3.0%)	Mental and behavioural disorders due to use of alcohol (3.7%)
9	Intentional self-harm (3.3%)	Colon cancer (2.4%)	Colon cancer (3.1%)
10	Pneumonia (2.7%)	Haemorrhagic stroke (2.2%)	Poisoning (2.8%)

6.2 Alcohol-specific hospital admissions

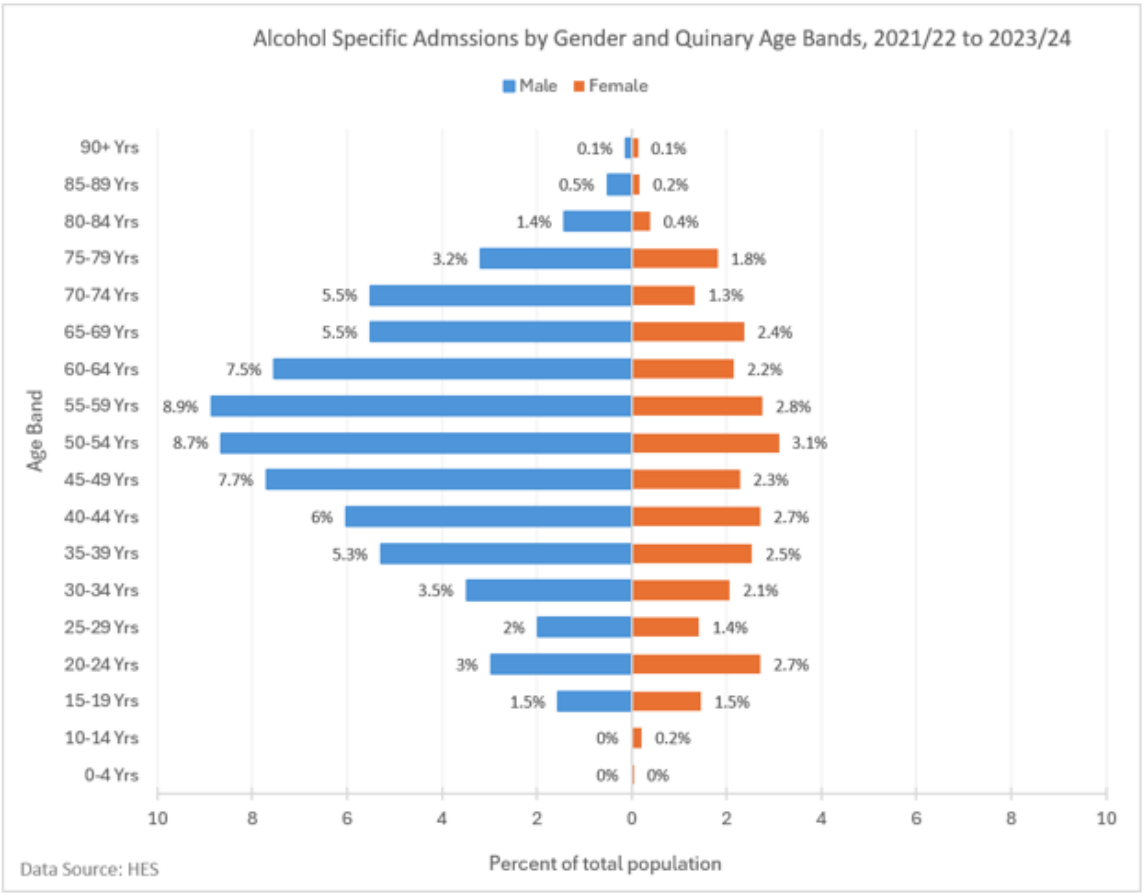
- Between 2017-18 and 2023-24, alcohol-specific admission rates in Nottingham have remained significantly higher than the England average with a persistent and sustained gap and an overall upward trend in both areas.[7]
- In 2023-24, the rate of alcohol-specific admissions in Nottingham was 872.4 per 100,000 people, significantly higher than the national rate of 611.7 per 100,000 people.[7]
- Males have a higher rate of admissions than females, and reflecting national trends, the trend for males is upwards whereas the trend for females is downward.[7]

The rest of this section explores the demographic profile and diagnoses of Nottingham city residents admitted to hospital for alcohol-specific conditions, using Hospital Episode Statistics (HES) data extracted for the three financial years 2021-22 to 2023-24.

Age and gender

Figure 12 shows the percentage of admissions by gender and age bands, identifying the groups that account for the greatest share of admissions.

Figure 12: alcohol specific admissions by gender and age in Nottingham, 2021-22 to 2023-24, HES data



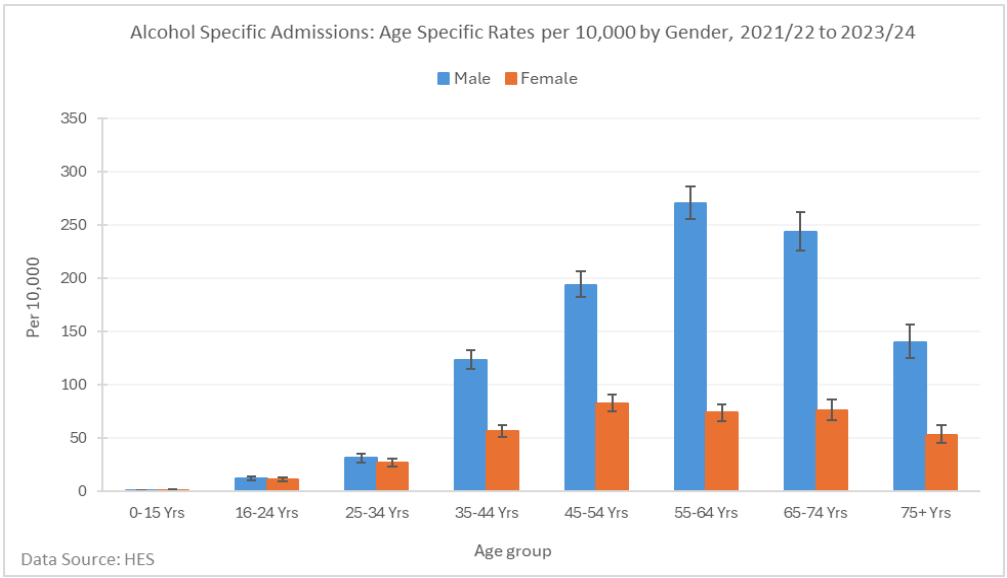
- Males have consistently higher proportions of alcohol-specific admissions than females across nearly all age groups.

- This is more pronounced in the middle and older ages where proportions are 2-3 times as high in males.
- Among males, alcohol-specific admissions increase with age, peaking at 55-59 years before gradually declining.
- Female admissions are more evenly distributed across adult age groups, with a peak at 50–54 years.
- In the younger age groups (24 years and under), proportions are similar in both males and females.

As the above proportions are influenced by the size of the underlying population in each age group, Figure 13 uses broader age groups and considers admissions relative to the population of each of these age groups. These age-specific rates for both genders show a slightly different pattern.

- Males have higher rates than females across all age groups except 0-15 years, with the difference becoming statistically significant from 35 years onwards.
- From 25-34 onwards, rates rise steeply particularly among males, peaking in middle age.
- The highest rate in males occurs at 55-64 years (270.5 admissions per 10,000 male population). This is approximately four times the rate for females in the same age group (73.7 admissions per 10,000 female population).
- Rates in females peak around 45-54 years with a rate of 82.5 admissions per 10,000 female population, after which they remain relatively stable into the older ages.
- After 65 years, rates for males gradually decline but remain approximately three times higher than rates in females.

Figure 13: alcohol specific admission rates per 10,000 in Nottingham, by age and gender, 2021-22 and 2023-24, HES data



The data therefore suggest that **alcohol-specific admissions disproportionately affect males, particularly in the mid-to-late working ages**. While the burden among females is lower and relatively evenly distributed across age groups, rates among males increase with age, peak in late working life, and then gradually decline in older age.

Ethnicity

Of the 81% of people admitted with a valid ethnic group recorded (1,884 people), 89.1% were of White ethnic origin (1,676.8 people), 3.1% Black, 2.9% Asian, and 4.9% were of Mixed, Multiple or 'Other' ethnic background.

Figure 14 compares the ethnic profile of admissions with synthetic estimates of harmful and dependent drinkers in Nottingham, which represent the level of alcohol-related need within each ethnic group. People of **White ethnic background and Mixed/Multiple or Other background are over-represented** among those admitted, while the other two ethnic groups are under-represented.

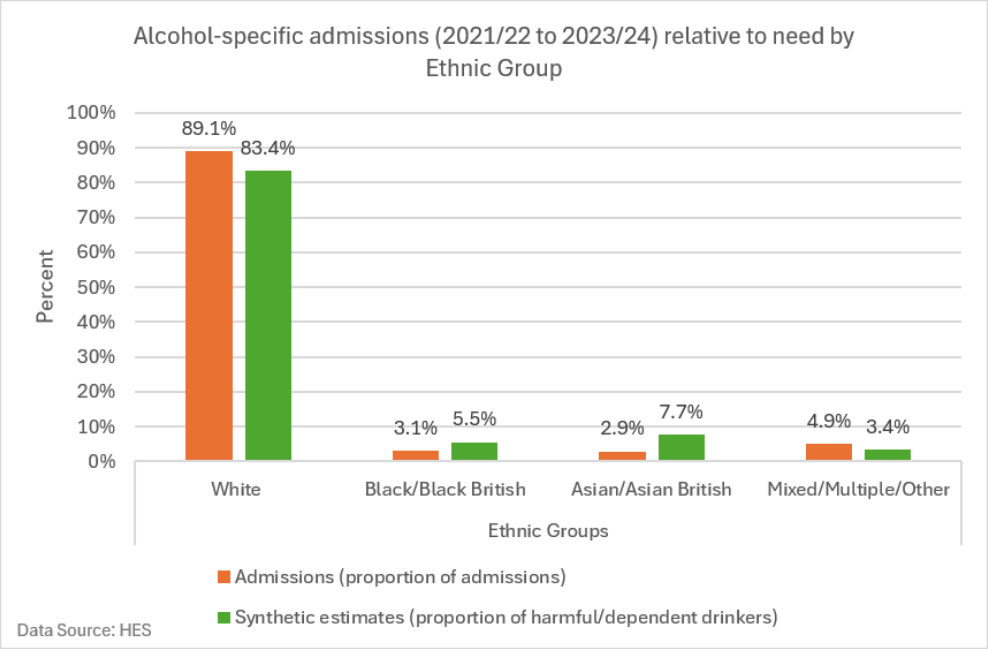


Figure 14: alcohol-specific admissions 2021-22 to 2023-24 in Nottingham, by ethnicity, comparing raw data with synthetic estimates of need

Deprivation

Approximately two thirds (65.7%) of those admitted for alcohol-specific conditions reside in the 20% most deprived areas of the city and less than 1% in the most affluent areas of the city. When comparing persons admitted and the city's population by deprivation decile, there is a substantial over-representation of individuals from the 10% most deprived area, accompanied by a slight over representation in the 2nd and 3rd deciles.

Figure 15 shows age-standardised rates by deprivation decile. A clear and consistent social gradient is evident, with rates significantly higher in the most deprived decile compared to rates in the other deciles. The rate in the most deprived decile (1053.8 per 100,000 population) is twice as high as the rate in the most affluent part of the city (506.7 per 100,000 population) and approximately six times as high as the rate in the 2nd least deprived decile (183.7 per 100,000 population).

The data highlight a pronounced inequality, with **individuals in the most deprived areas experiencing significantly higher alcohol-specific admission rates**.

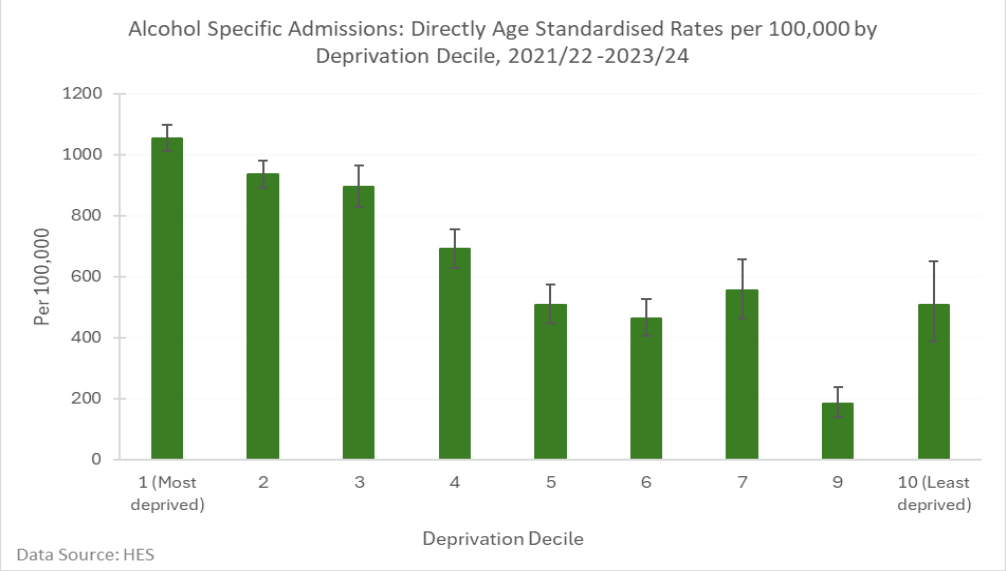


Figure 15: directly standardised rates of alcohol-specific admissions per 100,000 in Nottingham by deprivation decile, 2021/22-2023/24, HES data

Most common alcohol-specific conditions

Figure 16 presents the top 10 alcohol-specific conditions for which Nottingham city residents were admitted during the three-year period, accounting for 93.6% of alcohol-specific admission episodes. More than half of admissions (56.8%) were due to '**mental and behavioural disorders related to alcohol use**', and nearly one-third (30.9%) were due to 'alcohol-related liver disease'. Within mental and behavioural disorders, 'dependence syndrome' was the most common diagnosis (19.6%), followed by 'harmful use' (15.9%) and 'withdrawal state' (13.3%).

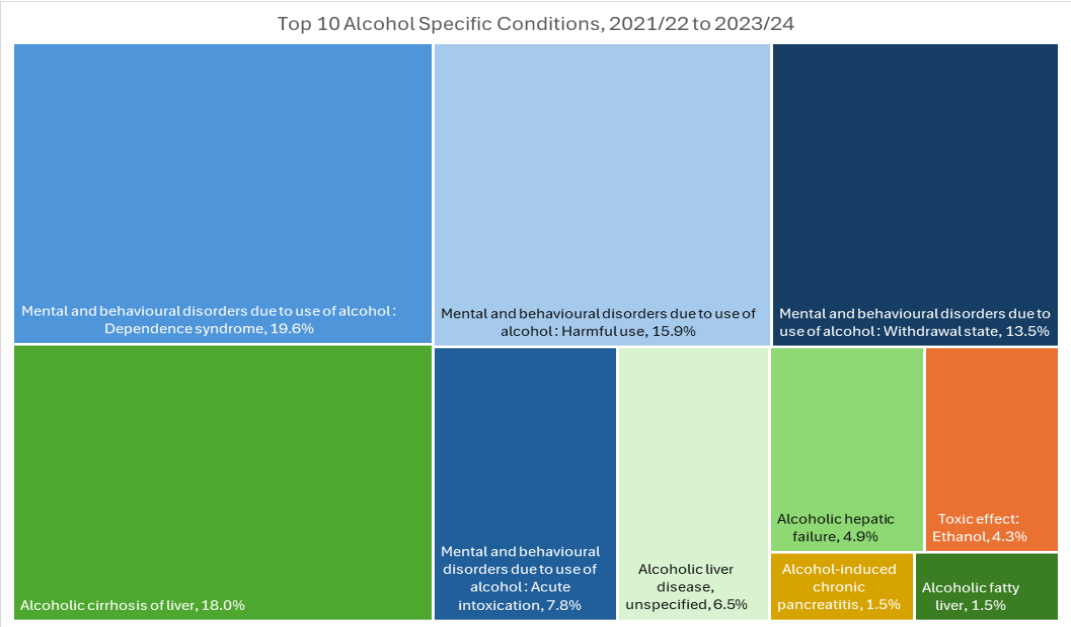


Figure 16: the top 10 alcohol-specific conditions for admission in Nottingham, 2021/22-2-23/24

Table 11 shows the top 5 alcohol-specific conditions for each broad age group apart from 0-15 years which has been excluded due to extremely low numbers.

Table 11: top 5 alcohol-specific conditions leading to admission 2021/22-2-23/24 in Nottingham by age group

Age group	Top 5 alcohol-specific conditions, 2021/22 to 2023/24				
	1	2	3	4	5
16-24 years	Acute intoxication (35.5%)	Toxic effect: ethanol (28.6%)	Harmful use (20.0%)	Dependence syndrome (5.7%)	Alcoholic gastritis (5.3%)
25-34 years	Harmful use (17.5%)	Toxic effect: ethanol (14.1%)	Withdrawal state (12.9%)	Acute intoxication (12.5%)	Alcoholic liver cirrhosis (11.5%)
35-44 years	Withdrawal state (22.9%)	Dependence syndrome (21.6%)	Harmful use (15.8%)	Alcoholic liver cirrhosis (8.2%)	Acute intoxication (7.7%)
45-54 years	Dependence syndrome (23.2%)	Alcoholic liver cirrhosis (17.8%)	Withdrawal state (17.2%)	Harmful use (13.5%)	Unspecified alcoholic liver disease 6.4%
55-64 years	Alcoholic liver cirrhosis (25.6%)	Dependence syndrome (17.4%)	Harmful use (14.2%)	Withdrawal state (9.3%)	Unspecified alcoholic liver disease 8.9%
65-74 years	Alcoholic liver cirrhosis (25.1%)	Dependence syndrome (23.6%)	Harmful use (15.8%)	Withdrawal state (10.7%)	Unspecified alcoholic liver disease 8.6%
75+ years	Harmful use (26.3%)	Dependence syndrome (18.9%)	Alcoholic liver cirrhosis (16.0%)	Acute intoxication (8.4%)	Withdrawal state (7.4%)

- Across the seven age bands, the top 5 conditions account for more than two-thirds admissions.
- Among younger adults (16-24 years), alcohol-specific admissions are dominated by acute alcohol-related conditions, with acute intoxication resulting in mental and behavioural disorders due to use of alcohol and the toxic effects of ethanol accounting for the largest proportions of admissions.
- By ages 35-54 years, conditions associated with alcohol dependence are the most common reasons for admission.
- In older age groups (45-74 years), chronic alcohol-related liver disease becomes increasingly prominent, with alcoholic liver cirrhosis accounting for a large proportion of alcohol-specific admissions.

Length of stay and repeat admissions

Over the three-year period, the average number of bed days per admission episode (the total number of days hospital beds are occupied by patients) was 3. There were nine episodes where the number of bed days was more than 100, and these were mostly associated with mental and behavioural disorders due to alcohol use.

The top 5 alcohol-specific conditions with the highest number of bed days were:

- 'Dependence syndrome' (5,374 bed days)
- 'Harmful use' (4,200 bed days)
- 'Alcoholic cirrhosis of the liver' (2,712 bed days)
- 'Withdrawal state' (2,630 bed days)
- 'Acute intoxication' (1,891 bed days).

There were 3,945 repeat admission episodes involving 1,154 individuals:

- Males accounted for more than two thirds of repeat admissions (70.5%, 814 people).
- The highest proportion of repeat admissions occurred among those aged 55–64 years (28.3%), followed by 45–54 years (23.9%) and 35–44 years (17.6%).
- Over two thirds (68.9%) of repeat admissions were primarily due to the following four diagnoses:
    - 'Alcoholic cirrhosis of the liver' (24.2%)
    - 'Dependence syndrome' (18.3%)
    - 'Withdrawal state' (14.2%)
    - 'Harmful use' (11.6%).

6.3 Alcohol-related hospital admissions

The following section uses the narrow measure of alcohol-related admissions.

- Since 2017-18, Nottingham's alcohol-related admission rates have remained significantly higher than the England average.[7]
- In 2023-24, the age-standardised rate reached 730.5 admissions per 100,000 population, the highest level recorded across the seven financial years and significantly higher than the England average of 504 per 100,000 population.[7]
- When broken down by gender, both male and female rates in Nottingham exceed the national average, with a more pronounced gap in males.[7]
- From 2020–21 onwards, male admission rates in Nottingham show a clear upward trend.[7]

The remainder of this section explores the demographic profile and diagnoses of Nottingham city residents admitted to hospital for alcohol-related conditions, using HES data extracted for financial years 2021-22 to 2023-24, and applying published alcohol attributable fractions.[65]

During the three-year period, there were 5052.17 admission episodes for alcohol-related conditions.

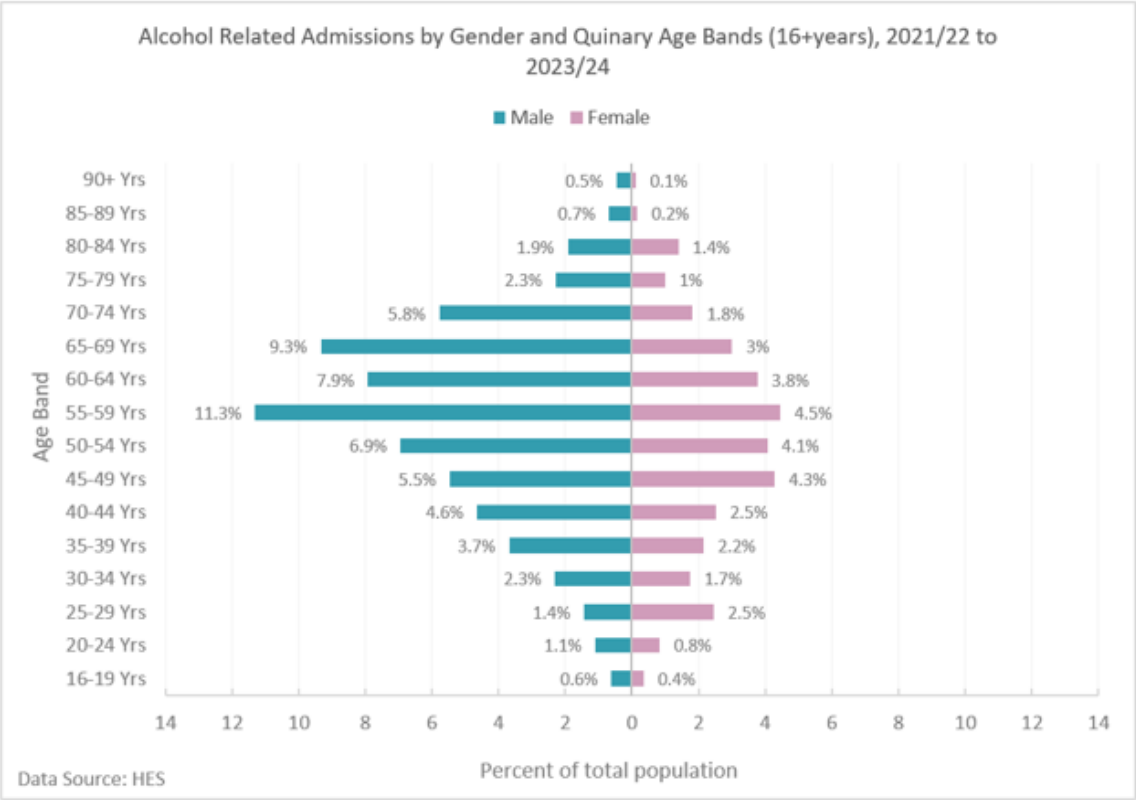
Age and gender

Figure 17 shows the percentage of alcohol-related admissions by gender and age bands, identifying the groups that account for the greatest number of admissions.

- There is a clear pattern of higher admission proportions among males compared to females across all age groups bar 25–29-year-olds.
- The gender disparity is most pronounced in the middle-aged and older populations.

- In males, admissions rise steadily from 30 years onwards, peaking at 55-59 years, then decreasing with age from 70 years.
- Female admissions also increase through middle age and peak at 55-59 years, before gradually declining with age from 60 years.

Figure 17: alcohol-related admissions by gender and age in Nottingham, 2021/22-2023/24, HES data



To account for the influence of the size of the population within each age group, Figure 18 presents age-specific admission rates for both genders.

- From 35 years onwards, **rates in males are consistently and significantly higher** than rates in females.
- Both genders show a clear and pronounced **age gradient** with rates increasing steadily from early adulthood to older age before declining in the oldest group.
- For males, the highest admission rates are observed in the **65-74 age group** with 251 admissions per 10,000 population.
- For females, the highest rate is observed slightly earlier in the **55-64 age band** (87.2 admissions per 10,000 population).

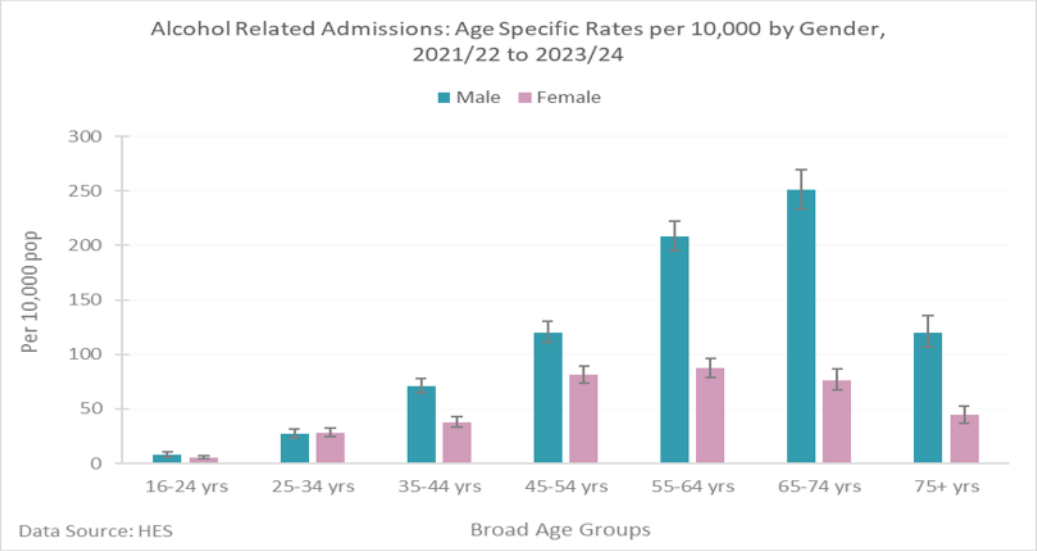


Figure 18: alcohol-related admission rates per 10,000 by gender and age in Nottingham, 2021/22-2023/24, HES data

Overall, these findings demonstrate a marked gender inequality in alcohol-related admissions, with males disproportionately affected. For both genders, admission rates increase steadily across adulthood, with the burden greatest in later working age and early older age.

Ethnicity

A valid ethnic group was recorded for 4,097 alcohol-related episodes (81.1%).

Figure 19 compares the ethnic composition of admissions with synthetic estimates of harmful and dependent drinkers in Nottingham, which serve as an indicator of alcohol-related need within each ethnic group.

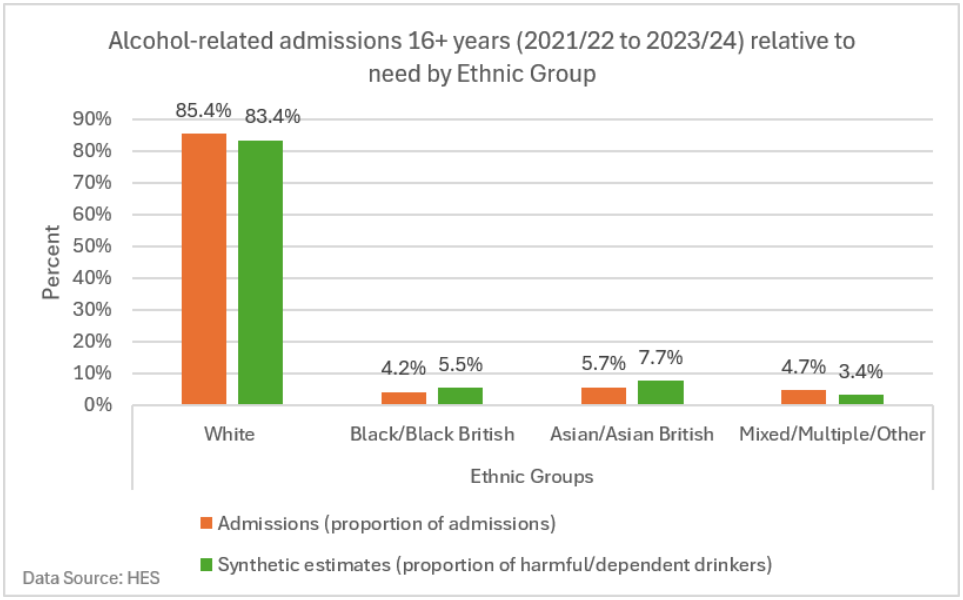


Figure 19: alcohol-related admissions 2021/22-2023/24 relative to estimated need by ethnic group in Nottingham, HES data

Consistent with the pattern observed for alcohol-specific admissions, people from **White and Mixed/Multiple or Other backgrounds are slightly over-represented** among admissions, while the remaining two ethnic groups are slightly under-represented.

Deprivation

Figure 20 compares those admitted and the city's population (16 years and above) by deprivation decile.

- The distribution of the proportion of alcohol-related admissions demonstrates a **pronounced socio-economic gradient**, with the proportion of admissions decreasing with decreasing deprivation, mirroring the population distribution of residents.
- Residents living in the 20% most deprived areas account for nearly two thirds (65.7%) of alcohol-related admissions, demonstrating a clear over-representation given that 53.1% of residents live in these areas.
- In contrast, residents living in the 20% most affluent areas in the city account for only 3.5% of alcohol-related admissions, slightly lower than their population share (4.2%).

This highlights a **substantial burden of alcohol-related harm among the most disadvantaged populations**.

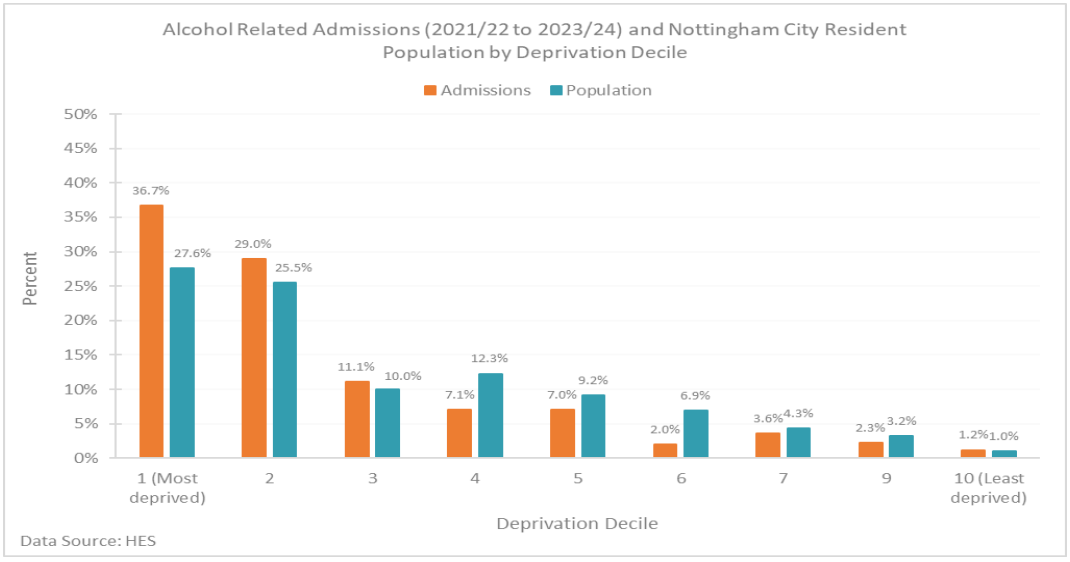


Figure 20: alcohol related admissions in Nottingham 2021/22-2023/24 by deprivation, HES data

Differences in the number of admissions between deprivation groups are partly influenced by the size and age profile of the population living in each area. Adjusting for population size and age structure removes this influence to provide a fairer comparison of alcohol-related admission risk between deprivation deciles. After adjustment, a perfect socio-economic gradient is no longer seen:

- Deciles 1 and 2 still experience the highest admission rates (952 and 948 per 100,000 population respectively).
- These rates are statistically significantly higher than those in deciles 9 and 10 (459.9 and 462.8 per 100,000 population, respectively).
- The lowest rate is observed in decile 6 with 232.1 admissions per 100,000 population.

This suggests some of the variation initially observed is explained by differences in age and population size in the deciles, although the persistently high rates in the most deprived areas indicate that deprivation remains strongly associated with alcohol-related admissions independent of these factors.

Gender-specific analyses provide insight into whether socio-economic inequalities in alcohol-related admissions are experienced similarly by males and females in Nottingham. Figure 21 shows directly age-standardised alcohol-related admission rates by gender across the deciles.

- The disparity between genders is clear, with male admission rates approximately twice as high as female rates in every decile except deciles 6 and 10.
- Notably, **rates in females residing in the most affluent decile are approximately three times higher than in males in the same decile**.
- Among males, the highest admission rate is observed in decile 2, and those in the most deprived decile experience rates over five times higher than those in the least deprived decile.
- Among females, rates do not differ significantly with the exception of decile 6 which shows a significantly lower rate.

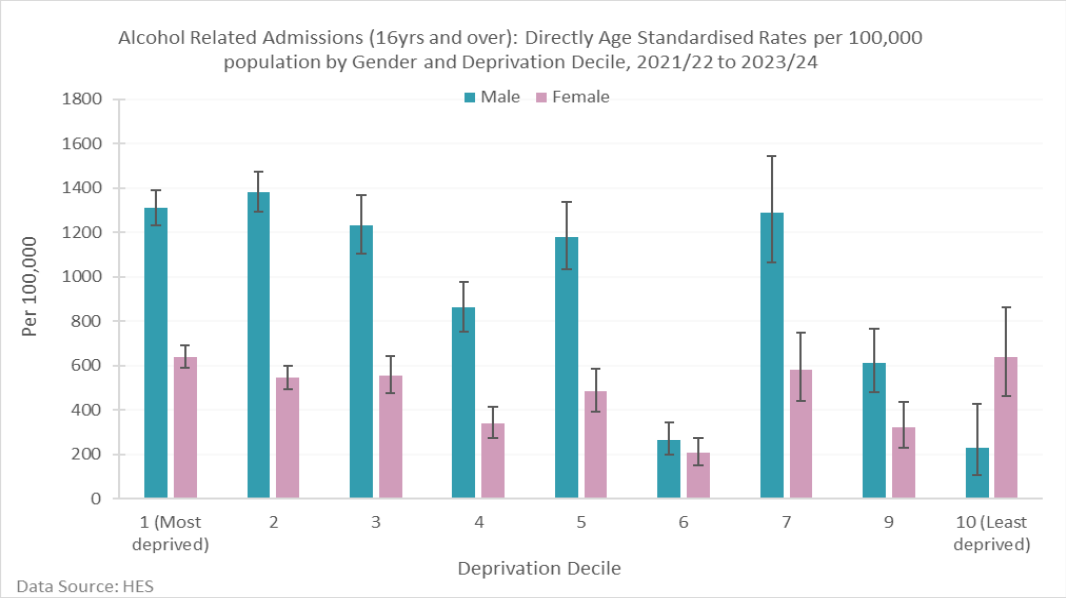


Figure 21: directly age-standardised rates of alcohol-related admissions per 100,000 by gender and deprivation in Nottingham, 2021/22-2023/24, HES data

Overall, alcohol-related admissions show a strong association with deprivation in Nottingham. Residents living in the most deprived areas experience a disproportionate burden of admissions, and this inequality persists even after accounting for differences in population size and age structure. Admission rates are generally higher among males than females across deprivation deciles, although this pattern is reversed in the most affluent areas of the city.

Most common alcohol-related conditions

Figure 22 presents the top 10 alcohol-related conditions for which Nottingham city residents were admitted during the three-year period, accounting for 77.7% of all alcohol-related admission episodes. The top 3 alcohol-related conditions overall were:

- **Malignant neoplasms** at 30.8% of alcohol-related admission episodes
- **Liver disease** - 19.8% of alcohol-related admission episodes
- **Mental and behavioural disorders** associated with alcohol use -13.7% of alcohol-related admission episodes.

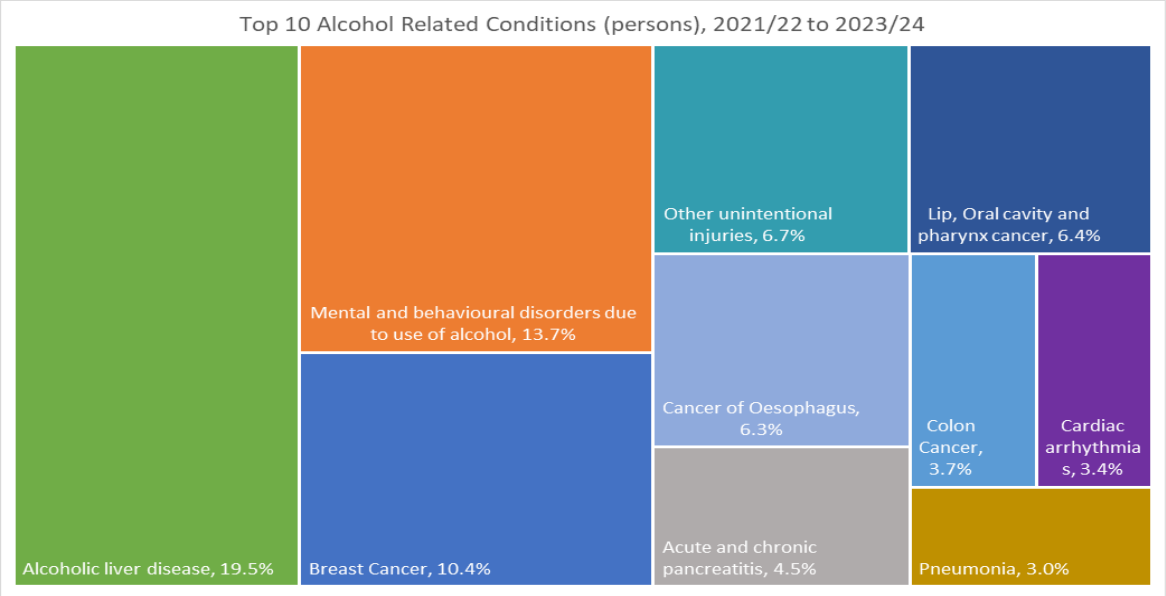


Figure 22: top 10 reasons for admission (alcohol-related condition), 2021/22-2023/24, Nottingham, HES data

The most common cancers were:

- Breast cancer (10.4%)
- Cancer of lip, oral cavity and pharynx (6.4%)
- Oesophageal cancer (6.3%)
- Colon cancer (3.7%).

The top 3 conditions among females were:

- Breast cancer at 30.5% of alcohol-related admission episodes
- Alcoholic liver disease - 17.5% of alcohol-related admission episodes
- Mental and behavioural disorders due to use of alcohol - 12.5% of alcohol-related admission episodes.

The top 3 conditions among males were:

- Alcoholic liver disease at 20.5% of alcohol-related admission episodes
- Mental and behavioural disorders due to alcohol use - 14.2% of alcohol-related admission episodes
- Other unintentional injuries - 8.5% of alcohol-related admission episodes.

6.4 Alcohol-related A&E attendances

This section examines the demographic profile and presenting conditions of Nottingham city residents attending A&E for alcohol-related events, based on HES data for the financial years 2021–22 to 2023–24. National comparison data are not available for this indicator.

- The age standardised rate of alcohol-related A&E attendances was 273.1 per 100,000 population.
- A total of 1,865 individuals accounted for the 2,566 attendances, with between 1 and 15 attendances per person.
- 62% of the individuals attending A&E for alcohol-related events were males.
- The vast majority (89.1%) were of working age (16-64 years), with smaller proportions aged 65+ years (7.9%) and under 16 (3.0%).

Age and gender

Figure 23 shows the proportion of A & E attendances split by gender and age bands, identifying which groups contribute to the largest share of alcohol-related A&E activity in the city.

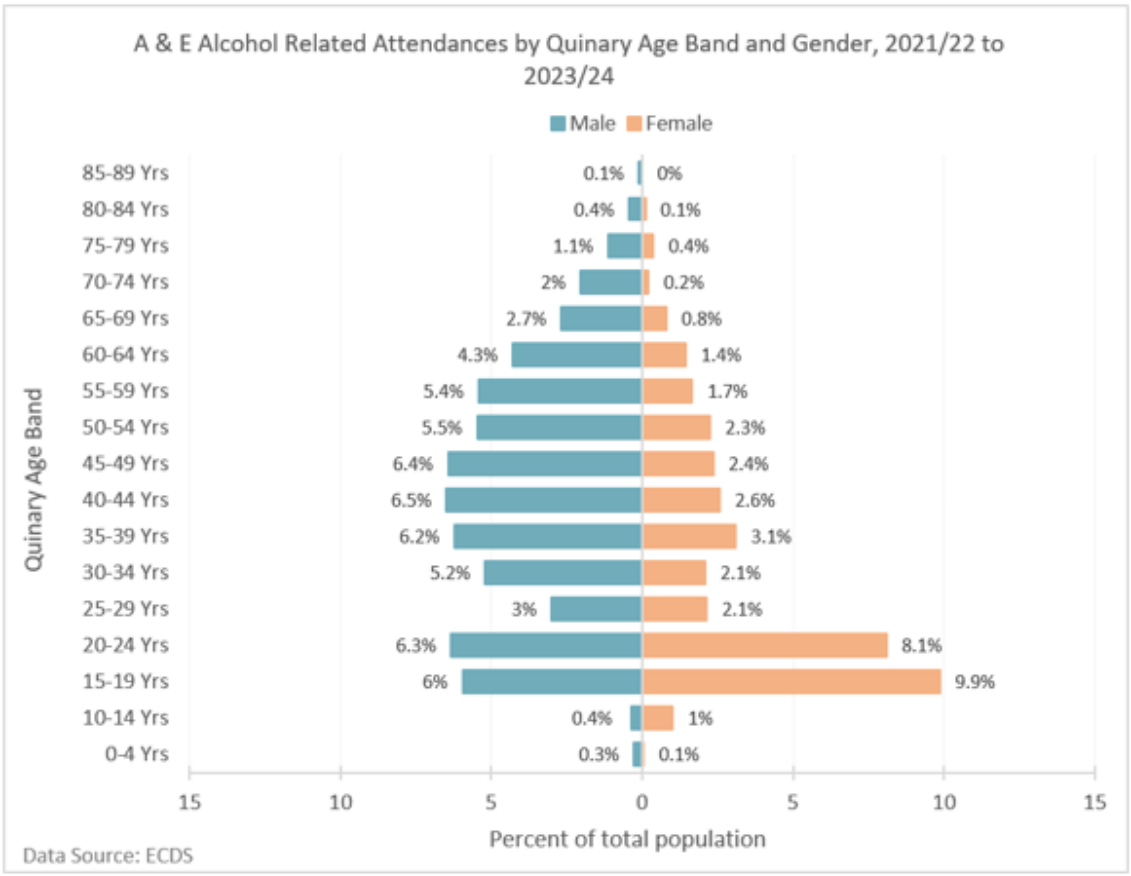


Figure 23: A&E alcohol-related attendances by age and gender in Nottingham, 2021/22-2023/24, ECDS data

This data shows:

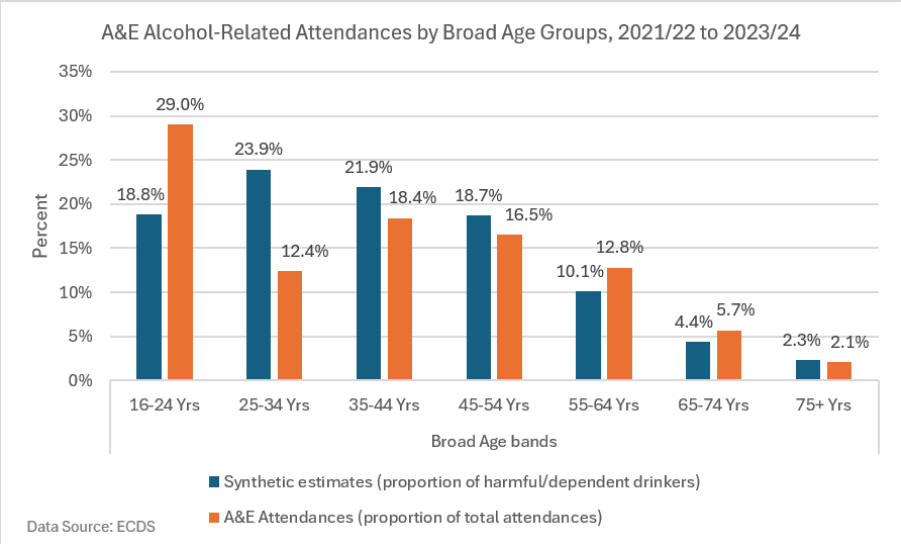
- **Males have higher proportions than females** across all age bands except the 15-19 and 20-24 age groups.

- In both genders, attendances rise sharply with age in the younger age groups (15-24 years) and then drop in the 25-29 age group.
- Attendances increase again in the middle age groups, before gradually decreasing with age in the older age groups.

The distribution of alcohol-related A&E attendances by broad age bands were compared to the synthetic estimates of harmful and dependent drinkers in Nottingham, which represent the level of alcohol-related need within each age group (Figure 24). This enables assessment of whether some age groups account for a greater or smaller share of attendances than would be expected given their estimated level of need.

Young adults (16-24 years), and to a lesser extent 55–74-year-olds, are notably over-represented relative to the estimates of need. Conversely, **working-age adults, particularly 25–34-year-olds accounted for a smaller proportion of alcohol-related A&E attendances** than would be expected based on their estimated level of alcohol-related need. Note, 3.0% of the alcohol related A&E attendances relate to 0–15-year-olds, but this is excluded from the graph as a comparator was not available.

Figure 24: A&E alcohol-related attendances by age group, 2021/22-2023/24 in Nottingham, ECDS data



To remove the influence of the size of the population in each age group, Figure 25 shows age-specific rates by gender and broad age groups. This reveals a different distribution pattern:

- **The highest attendance rate is seen in the 45–54 age group** (154.0 per 10,000 population).
- This is more than double the rate in the 16–24 age group (67.2 per 10,000 population), despite the latter having the highest proportion of attendances. This can be attributed to the demographic composition of Nottingham, where 16–24-year-olds represent a substantial proportion of the total population (22.3%).
- **Male attendance rates are consistently higher** than female rates across most age groups, but particularly from 35 years and older where male rates are two to three times higher.
- Male rates rise steadily with age, peaking at 45–54 years before gradually declining in the older age groups.

- Female rates show a less pronounced pattern, with a rise into early adulthood, a dip at 25–34 years, and relative stability through middle age before declining.
- For both genders, **45–54 years** is the age group with the highest rate.

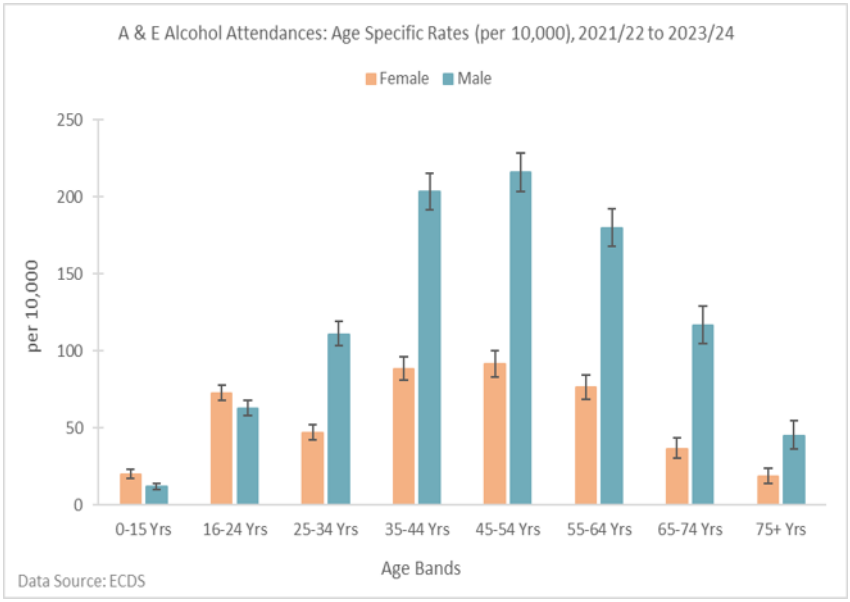


Figure 25: age specific rates of A&E alcohol attendances per 10,000 in Nottingham, 2021/22-2023/24, ECDS data

Overall, alcohol-related A&E attendances show clear variation by age and gender. While young adults account for a disproportionately large share of attendances relative to estimated alcohol-related need, age-specific rates indicate that the greatest risk of attendance occurs among middle-aged adults, particularly those aged 45-54 years. Males generally experience higher attendance rates than females, with the gender gap becoming most pronounced from mid-adulthood onwards.

Ethnicity

Ethnicity was recorded for 1,472 A&E attendees (78.8%). Figure 26 compares the ethnic distribution of attendees with synthetic estimates of harmful and dependent drinkers in Nottingham, which provide an indication of alcohol-related need within each ethnic group.

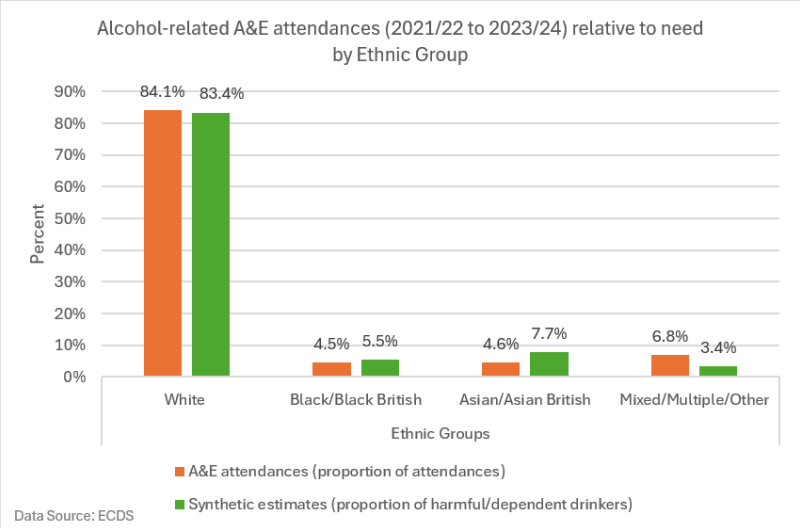


Figure 26: alcohol-related A&E attendances in Nottingham 2021/22-2023/24 by ethnicity

Individuals from **Mixed/Multiple or Other ethnic backgrounds, and to a lesser extent those from White ethnic backgrounds, are over-represented** among attendees relative to estimated need. In contrast, the remaining two ethnic groups are under-represented, most notably Asian/Asian British individuals.

Deprivation

Analysis by deprivation decile demonstrates **a strong socio-economic gradient in A&E attendance**. 63.7% of attendees resided in the 20% most deprived areas and 1.4% in the 20% most affluent areas of the city.

Figure 27 shows the proportion of alcohol-related attendances alongside proportions of the resident population by deprivation decile. There is a clear over-representation of individuals in the 1st and 2nd most deprived deciles and a less pronounced under-representation of individuals in the 3rd to 10th deciles**.**

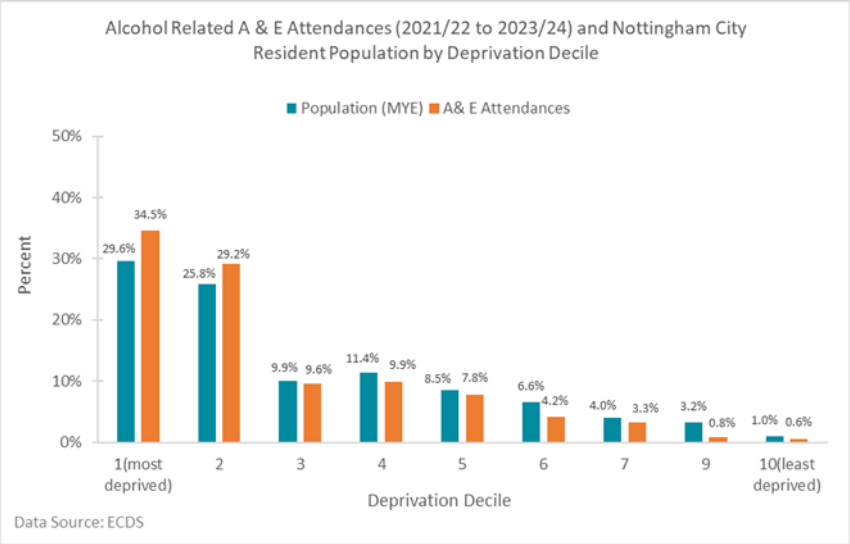


Figure 27: alcohol-related A&E attendances 2021/22-2023/24 in Nottingham by deprivation

Directly age-standardised rates were produced to determine whether differences in attendance reflect underlying deprivation-related inequalities rather than demographic differences alone:

- The rate of A&E attendance remained highest in the first and second most deprived deciles.
- The rate of A&E attendance was lowest in the ninth decile.
- Rates in the first and second most deprived deciles were statistically significantly higher than those in deciles 6, 7 and 9, but not decile 10, likely due to the small population size and low number of attendances from this decile.

Overall, alcohol-related A&E attendances show a clear socio-economic gradient in Nottingham, with residents living in the most deprived areas experiencing a disproportionately high burden of attendances. Higher attendance rates remain evident after adjusting for age structure, indicating that this pattern is not simply the result of differences in the age profiles of deprivation groups.

Reasons for alcohol-related A&E attendances

The most common reasons for alcohol-related A&E attendance were:

1. Alcohol intoxication – accounting for more than half of all alcohol related attendances (56.8%)
2. Uncomplicated alcohol withdrawal (16.3% of attendances)
3. Alcohol withdrawal-induced convulsion (13.1% of attendances)
4. Alcohol dependence (12.1% of attendances).

Table 12 summarises the leading reasons for alcohol-related A&E attendances by age group. Alcohol intoxication remained the most common reason across all age groups, although other alcohol-related conditions became more common in the middle-aged groups.

Table 12: top 5 reasons for alcohol-related A&E attendances in Nottingham 2021/22-2023/24 by age

Age group	Reasons for alcohol-related A&E attendances, 2021/22 to 2023/24				
	1	2	3	4	5
0-15 years	Alcohol intoxication (91.2%)	Toxic effect of alcohol (8.8%)	-	-	-
16-24 years	Alcohol intoxication (91.7%)	Alcohol dependence 2.7%	Toxic effect of alcohol 2.2%	Uncomplicated alcohol withdrawal 1.9%	Alcohol withdrawal-induced convulsion 1.5%
25-34 years	Alcohol intoxication (61.1%)	Uncomplicated alcohol withdrawal (16.0%)	Alcohol withdrawal-induced convulsion (12.2%)	Alcohol dependence (9.7%)	Toxic effect of alcohol (1.0%)
35-44 years	Alcohol intoxication (38.3%)	Uncomplicated alcohol withdrawal (22.7%)	Alcohol withdrawal-induced convulsion (20.6%)	Alcohol dependence (17.2%)	Toxic effect of alcohol (1.2%)
45-54 years	Alcohol intoxication (36.5%)	Uncomplicated alcohol withdrawal (25.0%)	Alcohol withdrawal-induced convulsion (20.2%)	Alcohol dependence (16.5%)	Toxic effect of alcohol (1.8%)
55-64 years	Alcohol intoxication (46.2%)	Uncomplicated alcohol withdrawal (22.0%)	Alcohol dependence (15.3%)	Alcohol withdrawal-induced convulsion (14.7%)	Toxic effect of alcohol (1.8%)
65-74 years	Alcohol intoxication (59.9%)	Alcohol dependence (15.5%)	Uncomplicated alcohol withdrawal (14.1%)	Alcohol withdrawal-induced convulsion (9.9%)	Toxic effect of alcohol (0.6%)
75+ years	Alcohol intoxication (53.3%)	Alcohol dependence (20.0%)	Uncomplicated alcohol withdrawal (15.6%)	Alcohol withdrawal-induced convulsion (8.9%)	Toxic effect of alcohol (2.2%)

Multiple attendances

14% of people attending A&E for alcohol-related events attended more than once during the three-year period. Among these 267 repeat attendees:

- Almost three quarters (74.1%, 198 people) were **male**
- Over half (52%, 139 people) were **middle aged** (35-54 years)
- Almost two thirds (66.1%, 176 people) lived in the **20% most deprived areas** of the city.

The top three reasons for multiple attendances were:

1. Alcohol intoxication (38.2%)
2. Uncomplicated alcohol withdrawal (23.6%)
3. Alcohol withdrawal-induced convulsion (19.9%).

6.5 Alcohol-related crime and anti-social behaviour

Nationally, alcohol is recognised as a significant driver of crime and disorder across England and Wales, although it is not routinely recorded for every offence or by every Police force, so accurate national level data on alcohol-related crime are not available.

Responses to the Crime Survey for England and Wales indicate that around 39% of violent incidents involve an offender perceived to be under the influence of alcohol, equivalent to hundreds of thousands of incidents each year.

More broadly, alcohol is estimated to be linked to millions of crimes annually across the UK, and is widely associated with public disorder and anti-social behaviour (ASB), particularly in the night-time economy. While there is no single robust national measure for alcohol-related ASB, available evidence indicates that a substantial proportion of disorder incidents—such as drunk and disorderly conduct—are alcohol-related, meaning alcohol remains a key contributing factor to community safety issues and demand on policing and other services.

Locally, Nottinghamshire Police have an alcohol qualifier that can be recorded against crimes and ASB incidents to indicate they were associated with alcohol. Table 13 shows the total number of crimes and ASB incidents recorded in Nottingham between 2021 and 2025, alongside the proportion tagged as alcohol related.

Table 13: proportion of crimes that are tagged as alcohol related 2021-2025, Nottingham

Year	Total crime	Alcohol-related crime (%)	Total ASB	Alcohol-related ASB (%)
2021	33,494	11.5	15,491	12.7
2022	36,881	12.1	12,234	13.6
2023	37,284	11.0	11,408	13.1
2024	35,405	11.5	9,735	12.3
2025	36,365	11.6	7,355	14.2

In 2025, 11.6% of all recorded crime was tagged as alcohol related, a level that is broadly consistent with the previous four years. Alcohol-related ASB accounted for 14.2% of all ASB incidents in 2025, the highest proportion across the five-year period. The highest proportion coincided with the lowest annual ASB count, indicating that alcohol-related ASB formed a larger share of a shrinking overall total.

During the 2025–2026 financial year, alcohol-related serious violence accounted for 3.4% of total crime and 8.5% of Violence Against the Person offences in Nottingham. These proportions were broadly in line with the previous year but 2.7% lower than in 2023–2024.

7. Policy guidance and evidence of what works

7.1 Clinical guidelines for alcohol treatment

UK clinical guidelines for alcohol treatment set out a comprehensive, evidence-based framework for identifying and supporting people with harmful drinking and alcohol dependence across health and social care.[66] The guidance emphasises person-centred, non-judgemental and recovery-oriented care, with services designed to reduce stigma and address wider health and social needs.

Early identification is a key priority, with routine screening using validated tools and delivery of brief interventions to help individuals reduce their alcohol consumption or access further support where needed. For individuals with more complex needs, the guidelines recommend comprehensive assessment and personalised care planning, including risk assessment and regular review.

A range of evidence-based interventions should be available, including psychosocial therapies (such as cognitive behavioural approaches), medically assisted withdrawal (detoxification) and pharmacological treatments for alcohol dependence. Recovery is supported through ongoing services such as peer support, family involvement and wider social support (e.g. housing and employment), recognising that long term recovery extends beyond reducing alcohol use alone.

The guidelines also highlight the importance of harm reduction approaches, integrated care across services (including primary care, hospitals, and community services), and targeted support for vulnerable groups, with the overall aim of reducing alcohol-related harm and health inequalities.

7.2 Evidence-based approaches to preventing alcohol-related harm

The WHO has produced a comprehensive list of 'best buys' and other recommended interventions for the prevention and control of non-communicable diseases, where best buys are interventions that are the most effective, cost-effective and feasible to implement.[67] The three best buys for reducing the harmful use of alcohol are:

1. Increase excise taxes on alcoholic drinks
2. Implement bans or comprehensive restrictions on exposure to alcohol advertising
3. Implement restrictions on the physical availability of alcohol.[67]

A review of recent academic literature was undertaken to provide further evidence for interventions to prevent alcohol-related harm. The included studies were predominantly of high quality, providing robust evidence to support decision-making, although the observational nature of some primary studies limits conclusions about causality. Individual study quality assessments are presented in Appendix 1.

Limited evidence was identified on the cost-effectiveness of most population-level policies to reduce alcohol use, but this could be due to the relatively low cost of implementation and enforcement of these policies.[68]

Reducing alcohol availability

The availability of alcohol can be limited through reducing physical availability (the number and proximity of alcohol outlets), restricting temporal availability (hours and days of sale), and enforcing purchasing age restrictions.

- Reduced alcohol availability is associated with lower alcohol consumption.[68]
- Increased density of alcohol outlets is associated with increased alcohol consumption.[68]
- Restrictions in temporal availability are associated with a statistically significant decrease in alcohol consumption[68]
- Restrictions in temporal availability are likely to be associated with a subsequent reduction in injuries, alcohol-related hospitalisations and emergency department visits, and some alcohol-related crime.[69]
- Introducing or increasing minimum purchasing age is associated with reduced consumption, although the magnitude of the effect is unclear.[68]

There are potential challenges in translating these research findings into practice in the UK, which may be due to limitations in local licensing powers[70,71], as Licensing Authorities are not currently able to determine applications solely on public health grounds:

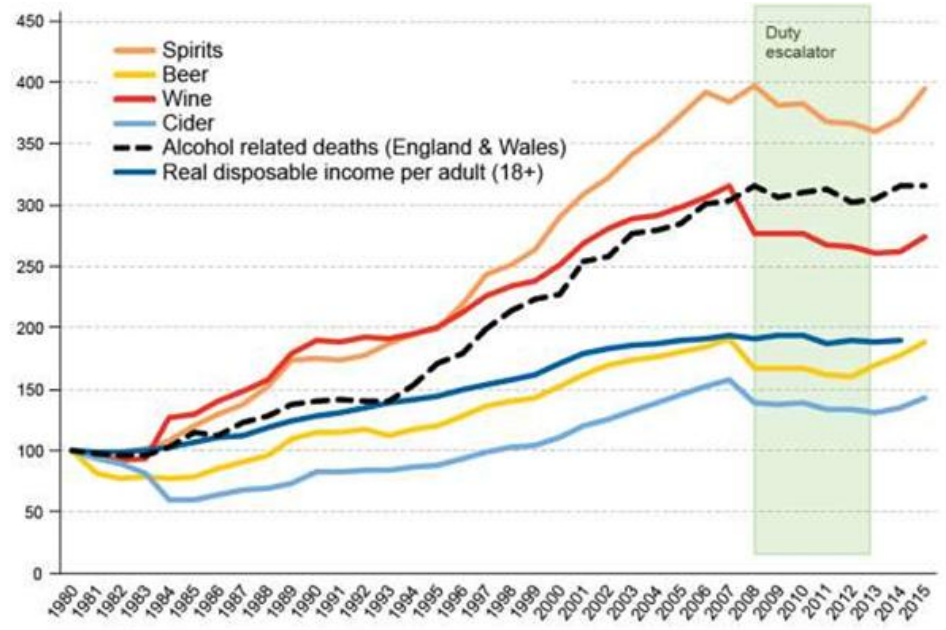
- There is little evidence to link local decisions in alcohol licensing to consistent health or crime benefits.[70]
- Increased engagement of local government public health teams in the licensing system has not been associated with measurable reductions in alcohol-related health harms or crimes in the medium term.[71]
- Qualitative feedback does however suggest that public health team involvement is valued and appears to be gradually reorientating the licensing system to better take account of health in decision-making, although the impact will take time to emerge.[71]

Pricing policies

Taxation

- Higher alcohol taxes are consistently associated with reduced consumption and related harms.[72]
- The UK's 2023 alcohol duty reforms, which introduced taxation based on alcohol content, are expected to deliver modest health benefits when compared with no policy change.[73]
- Greater health benefits could be achieved through further reforms, including introducing a cider escalator (increasing cider duty annually by 2% above inflation), and equalising tax rates for all products between 3.5% and 8.4% ABV.[73]

Figure 28 displays a Public Health England graph depicting trends in alcohol affordability and alcohol-related deaths over time. It highlights the introduction of an alcohol duty escalator in 2008, and its subsequent repeal for beer in 2013 followed by cider and spirits in 2014.[74]



Source: Public Health England, licensed under the Open Government License v3.0

Figure 28: trends in alcohol affordability and alcohol-related deaths over time in England and Wales

Minimum Unit Pricing (MUP)

- Data from Scotland [75] as well as several other high-income countries [76] show that MUP is associated with reduced alcohol consumption[75], reductions in alcohol-related admissions of between 2-10%[76], and a 13.4% reduction in alcohol-attributable deaths from chronic causes.[75]
- The greatest health benefits of MUP are seen among groups experiencing the highest level of harm (including men, heavy drinkers, and people living in the most deprived areas) indicating it could contribute to addressing alcohol-related health inequalities.[75,76]
- MUP could more effectively reduce alcohol-related admissions than general alcohol taxation, bans on below-cost sales, and restrictions on price-based promotions.[76]
- There is no clear evidence that MUP results in major negative impacts on the alcohol industry, or of population-level social harms.[75]
- The benefits of MUP will only be sustained if the price per unit is uprated with inflation. Increasing MUP from £0.50 to £0.65 is estimated to further decrease alcohol consumption, prevent 902 deaths from all causes and 628 alcohol-specific deaths over 20 years, and lead to greater reductions in hospital admissions and years of life lost to premature deaths, with the largest benefits in the most deprived groups.[77]
- Significant duty increases would be required to achieve the same health benefits as raising MUP to £0.65.[77]

Advertising, Marketing, and Consumer Information

Advertising and marketing

- Exposure to alcohol marketing and advertising is likely to be associated with increased consumption.[78]
- There is limited evidence for the benefits of industry self-regulation of alcohol marketing, preventing firm conclusions on its effectiveness.[68]
- Restrictions on alcohol advertising and marketing could potentially produce small reductions in consumption and alcohol-related harm, although evidence is inconsistent.[68,78] The strongest evidence supports comprehensive measures focusing on children and young people.[78]

Consumer information

- There is limited research on the impact of government counter-advertising mass media campaigns, preventing firm conclusions.[68]
- Alcohol labels with health warnings are likely to decrease selection of alcoholic beverages and alcohol consumption before driving.[79]
- Labelling with multiple rotating messages is particularly effective, although the impacts vary depending on individuals' health literacy and drinking behaviour.[79]
- There is less certain evidence suggesting alcohol container labels might reduce the amount drank per occasion, speed of consumption, and consumption during pregnancy.[79]

Community-based interventions

- There is mixed evidence regarding the effectiveness of comprehensive community initiatives (CCIs)—multi-component programmes delivered at a community level—at reducing alcohol-related harm.[80]
- School-based activities, parenting-focused interventions, police-led enforcement initiatives, and media campaigns may contribute to alcohol harm reduction.[80]
- An asset-based community development approach in which lay volunteers were trained as alcohol health champions was not effective at reducing alcohol-related harm or crime, and was not cost-beneficial, although the null findings are likely associated with intervention implementation.[81]

Alcohol screening and brief intervention

- Hazardous or harmful drinkers who receive screening and brief interventions in primary or emergency care settings consume around 2.5 alcohol units less per week than those receiving minimal or no intervention after one year.[82]
- The positive impact of brief interventions on number of drinking days per week, drinking intensity and frequency of binges is small.[82]
- Brief interventions are as effective at reducing alcohol consumption in hazardous or harmful drinkers as longer or more intensive interventions.[82]

- Digital brief interventions lead to the consumption of around three fewer units per week, one unit less per occasion, slightly fewer drinking days, and one fewer binge drinking episode per month.[83]
- Digital brief interventions may have broadly similar positive effects on alcohol consumption as face-to-face interventions, and have the potential to reach those experiencing barriers to accessing health services.[83]
- Digital interventions may be cost-effective relative to no intervention.[83]
- Delivering digital interventions through an evidence-based smartphone app (Drink Less) could be more effective at reducing alcohol consumption in the short term than using the NHS alcohol advice webpage.[84]
- Implementing an app could be cost-effective when considering annual costs, or when used by enough people to offset development costs.[84]
- Neither face-to-face nor electronic brief interventions delivered to adolescents in emergency departments offer additional benefit over screening alone, with low engagement with the digital intervention after discharge limiting effectiveness.[85,86]

8. What are we doing: Assets and services in place

8.1 Current commissioned services and support for alcohol harm in Nottingham

Overview of the local system

Support for people at risk of, and experiencing, alcohol-related harm in Nottingham is delivered across a multi-agency system, spanning prevention, early identification, treatment, and recovery. Services are provided through primary care, secondary care, specialist treatment providers, and the wider voluntary and community sector.

8.1.1. Primary Care and Prevention

Primary care plays a key role in early identification and prevention of alcohol harm.

The NHS Health Check

The NHS Health Check is offered every five years to adults aged 40-74 without certain pre-existing health conditions, aiming to identify individuals at higher risk of cardiovascular disease (and other conditions with shared risk factors), provide tailored advice on reducing risk, and offer referrals to support services where indicated.

Serious Mental Illness (SMI) Health Check

The annual physical health check available for adults with SMI includes use of the AUDIT-C questionnaire to ask about alcohol consumption. Patients with identified need should be signposted to support, and referred to specialist alcohol services where indicated.

Thriving Nottingham

All Thriving Nottingham clients receive a health assessment, which includes the AUDIT questionnaire to assess alcohol consumption. Where a need for further support is identified, clients are offered a referral to specialist alcohol services.

Alcohol Identification and Brief Advice Training

Nottingham City Council commissions the delivery of Alcohol IBA training to support professionals working within organisations identified in NICE guidance. This training aims to increase the routine identification of individuals drinking at increasing or higher risk levels and to equip staff with the skills to deliver effective brief interventions.

Communication Work

Research activity has provided insight to develop a behaviour change campaign to increase the numbers of women accessing treatment services.

Schools Work

Nottingham City Council have developed an Impact Award for drugs and alcohol in schools as part of the Achieve Well Awards.

Licensing

The Alcohol Licensing Matrix is a local data-driven tool that combines a range of alcohol-related harm indicators to identify areas experiencing higher levels of alcohol-related health, social and community harm. The matrix supports an evidence-based approach to licensing by helping responsible authorities assess the potential impact of new or varied alcohol licence applications and consider appropriate mitigation measures.
However, it is important to recognise its limitations: health is not currently one of the four statutory licensing objectives under the Licensing Act 2003, meaning public health bodies cannot make representations solely on the grounds of health impact. Consequently, the matrix is primarily used to strengthen evidence relating to the existing licensing objectives, such as the prevention of crime and disorder, public safety, prevention of public nuisance, and protection of children from harm, rather than as a direct mechanism for reducing alcohol-related health harms.

8.1.2 Specialist Community and Inpatient Treatment Services

Community alcohol treatment services in Nottingham are commissioned by Nottingham City Council Public Health and delivered by two main providers:

- **Nottingham Recovery Network (NRN)**, led by Framework Housing Association – a Care Quality Commission (CQC)-registered provider delivering adult drug and alcohol treatment services.
- **Change Grow Live (CGL) – The Place** – a specialist drug and alcohol service for children, young people and young adults up to the age of 25.

Both services offer flexible and low-threshold access through self-referral, professional referral, telephone contact, and walk-in appointments (where applicable).

NRN

NRN provides community-based drug and alcohol treatment and recovery services for adults living in Nottingham City. The service is delivered through a consortium led by Framework Housing Association, in partnership with Al-Hurraya, Nottinghamshire Healthcare NHS Foundation Trust, and Double Impact.

NRN is based at the Wellbeing Hub in Nottingham city centre, which is easily accessible by public transport. The building is fully wheelchair accessible and includes a lift and accessible toilet facilities. Additional accessibility support includes translation services, a hearing loop, and inclusive communication resources. Service information and signage are reviewed by an on-site Speech and Language Therapist to ensure accessibility for people with communication needs.

For individuals who are unable to travel to the Wellbeing Hub, the Digital Doorway to Change pathway may provide an alternative route into treatment, subject to eligibility criteria.

NRN Alcohol and Drug Services

NRN delivers a range of specialist treatment and recovery services, including:

- **Primary Care Team** – short-term psychosocial interventions.
- **Digital Doorway to Change** – a structured online recovery-focused treatment programme.
- **Psychosocial Interventions Team** – structured interventions and peer-based recovery support.
- **Recovery Case Management Alcohol Team** – specialist treatment for individuals whose primary substance of concern is alcohol.
- **Community Outreach Alcohol Treatment Team** – treatment and support delivered within community settings for individuals unable to attend the Wellbeing Hub.
- **Clean Slate** – substance use services for individuals involved with the criminal justice system.

CGL – The Place

The Place provides specialist drug and alcohol support for children and young people under 18, alongside tailored support for young adults aged 18–25. Located in Nottingham city centre and close to public transport links, the service is accessible to young people across the city.

Hospital Drug and Alcohol Liaison Team (DALT)

Based within NUH, the DALT provides:

- Specialist assessment and intervention within the hospital setting.
- Support for patients admitted with alcohol-related conditions.
- Referral and care coordination into community treatment services following discharge.

8.1.3 Inpatient Rehabilitation and Residential Services

The Level

The Level is a CQC-registered inpatient detoxification service providing medically supervised withdrawal for individuals requiring intensive clinical support. Referrals are accepted from both professionals and self-funding individuals.

Edwin House

Edwin House is a CQC-registered care home providing accommodation, nursing, and personal care for people with substance use support needs. The service also includes four beds commissioned by Nottingham University Hospitals and utilised as a virtual hepatology ward.

Michael Varnam House (MVH)

Michael Varnam House provides abstinence-based supported accommodation for people experiencing homelessness alongside substance use needs.

Residential Rehabilitation

Residential rehabilitation is available dependent on need for up to a 6 month stay for substance use support. This is accessed through Nottingham Recovery Network providing accommodation and recovery support in a CQC registered setting.

8.1.4 National Organisations and Recovery Support

Recovery is defined as voluntary control over alcohol and/or drug use, promoting positive health and wellbeing, and giving people the opportunity to find purpose, understanding and meaningful involvement in their relationships, communities and society.

National organisations complement local provision by offering information, self-help tools and recovery resources:

- **Alcohol Change UK** – national campaigns, digital resources and information to support behaviour change.
- **Drinkaware** – online advice, alcohol self-assessment tools and practical support to reduce alcohol-related harm.
- **Alcoholics Anonymous (AA)** – free mutual support groups across the UK
- **Drinkline** – free and confidential national alcohol helpline

In addition to commissioned and national services, many people benefit from engaging with community-based peer support and mutual aid networks, which provide ongoing encouragement, social connection, and recovery-focused support.

8.2 Service utilisation and unmet need

Access to treatment for adults with alcohol dependence

Treatment need has been assessed by comparing the University of Sheffield's 2019-20 estimates of alcohol dependence[49] with the number of adults who accessed structured treatment (for alcohol only or for alcohol and non-opiates) during the 2025-26 financial year. As the two sets of figures are drawn from different time periods, the analysis provides an estimate of whether current treatment provision is meeting the needs of the local adult population with alcohol dependence.

Of note, this methodology does not incorporate data for people previously in treatment or those in unstructured treatment who are potentially receiving a brief intervention, meaning the true level of engagement may be higher. Additionally, individuals in treatment for opiates who also report alcohol as a problematic substance are not counted in the unmet need estimate as they are excluded from the in-treatment figures, even though around 25% identify alcohol as a problematic substance.

Unmet need refers to alcohol-dependant adults who would benefit from treatment but are not currently receiving it. The figure includes individuals who have never accessed treatment as well as those who have previously been in treatment but are not engaged currently.

As seen in Table 14, there is an unmet need of 76% in Nottingham (95% CI 69%-83%). This is similar to the national estimate of 75%.

Area	Alcohol prevalence estimate (denominator)	Alcohol numbers in treatment *(numerator)*	Unmet Need	*Lower bound*	*Upper bound*
Nottingham	5,047	1,199	76%	*69%*	*83%*
England	608,431	149,791	75%	*70%*	*80%*

Table 14: estimate of unmet need for alcohol treatment services in Nottingham and England

The NHS Health Check

In 2025-2026:

- Less than two thirds of the 3,990 Nottingham city patients attending the NHS Health Check had an assessment of alcohol consumption (AUDIT) recorded (62.5%)
- Only 1.4% had a brief intervention and/or referral to an alcohol service either offered or completed (54 people).

This suggests missed opportunities for early identification of harmful drinking and provision of advice and referral.

SMI Health Check

Table 15 displays SMI health check data for Nottingham and for the Nottingham and Nottinghamshire ICB. In 2025-2026, 78.9% of Nottingham patients with SMI were asked about their alcohol consumption (a total of 2909 people), indicating high coverage overall. Although this represents a marked improvement since 2022-2023, it is a slight decrease from the 2024-2025 level, and marginally lower than the ICB average.

There appears to be an unmet treatment need: in 2025-2026, 78 Nottingham city patients with identified need were referred onto alcohol interventions, less than a third of those with an identified need. This is lower than in previous years, and below the ICB average of 36.7%.

Table 15: unmet alcohol treatment need for individuals receiving an SMI health check, Nottingham

		2022-2023	2023-2024	2024-2025	2025-2026
Nottingham City (%)	**Assessment of alcohol consumption**	71.2	73.4	81.1	78.9
	Alcohol Intervention Need	10.3	8.5	8.2	8.7
	Alcohol Intervention Referral	42.2	32.5	33.2	30.8
ICB (%)	**Assessment of alcohol consumption**	74.8	78.3	83.5	80.7
	Alcohol Intervention Need	9.2	8.8	8.3	8.5
	Alcohol Intervention Referral	39.3	35.2	33.7	36.7

Thriving Nottingham

Thriving Nottingham plays an important role in identifying alcohol-related risk and facilitating access to support. Data from 2025 demonstrate the contribution of Thriving Nottingham to the local alcohol support pathway:

- Of the 3,775 clients who had a health assessment completed, just over half (52.1%, 1,968 people) were asked about their alcohol consumption.
- Based on AUDIT results, 460 people were identified as potentially benefiting from further support and were offered onward referral.

Around two in five of those offered support (38.9%; 179 people) accepted a referral into relevant services.

8.2.2 Alcohol treatment service utilisation by population group

A Health Equity Audit was completed in Nottingham in 2026 to examine access to, engagement with, and outcomes from community alcohol treatment services. It aimed to identify inequalities and inform action to improve equity across population groups. Table 16 summarises the findings.

Table 16: summary of the Health Equity Audit for community alcohol treatment services in Nottingham, 2026

Theme	Key Findings
Overall access	1,227 adults accessed alcohol treatment between July 2023 and November 2024.
Sex	Males accounted for 73% of clients and females 27%. Females are under-represented compared with estimated alcohol-treatment need.
Age	Service use is concentrated among people aged 35-54 years. Younger adults (18-24 years) and older adults (65+ years) are under-represented relative to estimated need.
Ethnicity	Overall utilisation broadly reflects estimated need across broad ethnic groups.
Religion or belief	Utilisation cannot be reliably assessed because 41% of clients did not disclose religious belief.
Disability	Disabled adults are well represented in treatment compared with the local population.
Sexual orientation	LGBTQ+ people are under-represented relative to likely alcohol-related harm.
Gender identity	Utilisation cannot be assessed because gender identity is not routinely recorded.
Geography	Lower referral levels were identified in Aspley, Basford, Sherwood, Clifton East and Bulwell Forest despite high alcohol-related harm.

Socioeconomic factors	Treatment services are predominantly used by people experiencing socio-economic disadvantage, including renters, unemployed people and those without stable accommodation.
Adults with children living with them	Adults with children living with them are under-represented within treatment services.
Domestic abuse	A substantial proportion of clients, particularly females, report experiencing domestic abuse, although recording is incomplete.
Migrant groups	Utilisation cannot be assessed because migrant status data are incomplete.
Sex workers	Utilisation cannot be assessed because recording is insufficient.

It is evident that service utilisation is not evenly distributed across population groups:

- Utilisation is highest among males and adults aged 35-54 years.
- Females and younger adults (18-24 years) are under-represented relative to estimated alcohol-related need.
- Services are predominantly utilised by people experiencing socio-economic disadvantage, suggesting services are reaching groups known to experience a higher burden of alcohol-related harm.
- Geographical variation is utilisation is evident. Lower treatment referral rates were identified in several wards despite relatively high levels of alcohol-related harm, indicating potential unmet need or barriers to access.

Analysis for some protected characteristics and inclusion health groups was limited by data completeness and quality. In particular, substantial gaps remain in the recording of religion, gender identity, migrant status and sex work involvement, restricting the ability to fully understand inequalities in service utilisation for these populations.

Overall, the pattern of utilisation suggests that while alcohol treatment services are reaching many residents experiencing the highest levels of disadvantage, there remain opportunities to improve access among under-represented groups and strengthen understanding of unmet need through improved data collection.

8.3 Community and service user views on current support

Insight from recent engagement activities

A small Nottingham-based survey exploring local alcohol culture in 2026 was sent to local services and suggested a general awareness of services that provide support related to alcohol use. Respondents most often referred to the two local specialist treatment providers, particularly NRN; as well as the AA. There was also evidence of awareness of the Nottingham-based charity Double Impact, and support available through primary care.

A comprehensive engagement exercise was undertaken in 2022 to inform the recommissioning of local alcohol and drug treatment services. This involved consulting existing and former service users, service providers, members of the public, and key stakeholders through surveys, face-to-face focus groups, and interviews. Insights from this process led to the development of a set of engagement themes describing what participants felt effective treatment services should include. Service features which were considered ideal included:

- Recovery at the heart – taking a holistic, person-centred approach
- Culturally appropriate and representative
- Recognising and responding to local diversity
- Accessible and visible
- Provision of support and skills for the workforce
- Improved service integration
- Provision of support for families and carers
- Proportionate data collection and reporting that does not hinder access.

In 2025, a strategic commissioning review of local residential rehabilitation and inpatient detoxification, was undertaken. As part of this review, service users and staff were engaged and consulted with using surveys to better understand experiences of accessing these services, identify strengths, and highlight potential opportunities for improvement. Overall, participants spoke highly of the current services and the pathways for accessing support. Suggestions for improvements covering both services included:

- Improved preparation before entering a service, including around setting expectations
- Stronger post-discharge pathways to ensure continuity of support
- Wider travel options to make services more accessible
- More opportunities for feedback at all stages of the service journey.

Participants also made service-specific suggestions. For inpatient detoxification, these included reducing waiting times and improving communication between the facility and referrers. For residential rehabilitation, suggestions included revising communication materials for service users and strengthening staff training to ensure the service offer is clearly understood.

Positive feedback regarding the alcohol detoxification provision at MVH was reported across a range of engagement activities, including the Tier 4 review and work relating to the provision of safe accommodation for people who have experienced domestic abuse. Participants highlighted the quality of support provided, ease of access to the service, and the safe environment it offered.

9. Recommendations and future development

Theme	Findings	Recommendations & areas for future development
1. Data collection	There is a lack of comprehensive, up-to-date data on alcohol consumption in the city, making it challenging to understand need and identify populations at heightened risk of alcohol harm. There is limited data on alcohol harm in certain population groups, such as inclusion health groups, individuals from certain minority ethnic backgrounds, and people identifying as LGBTQ+. Only a small proportion of people drinking in pregnancy are identified by current processes, resulting in missed opportunities for early provision of support. FASD is likely under-recognised although no reliable prevalence estimates are available.	1.1. Commission a public health survey to generate robust and up-to-date intelligence on health behaviours, including alcohol consumption, to improve understanding of local need and identify groups at increased risk of alcohol-related harm. 1.2. Work with local services to enhance demographic data collection to strengthen understanding of who is accessing support and where gaps may exist. 1.3. Work with healthcare services to understand and reduce barriers to identifying alcohol use in pregnancy, and to strengthen awareness of FASD, supporting improved diagnosis for both new cases and those already living with the condition.
2. Community insight and co-production	There is a particular lack of alcohol consumption data for population groups not adequately captured by surveys, such as people experiencing homelessness and young people who are Not in Employment, Education or Training. There is a local intelligence gap relating to the context and underlying reasons for harmful drinking. Community feedback indicates that experiences of local alcohol services are generally positive, but there is a need for greater engagement to capture a wider range of views.	2.1. Actively engage with the local community to better understand the level of alcohol consumption and harm in under-represented groups. 2.2. Consider local qualitative data collection to develop a clearer picture of the drivers of hazardous and harmful drinking, and inform effective interventions for at-risk groups. 2.3. Continue to engage with the local community, including individuals with lived and living experience, and embed community insight into service design to ensure services reflect local needs and preferences.
3. Advocate for	Nationally, alcohol-related harm has worsened in recent years, and the level of harm in Nottingham is	3.1. Advocate for stronger restrictions in alcohol advertising and marketing, particularly formats

population-level action	consistently higher than the national average. Alcohol-related harm contributes to preventable illness, premature mortality, and widening health inequalities. Reducing alcohol availability, introducing MUP, increasing alcohol taxes, and comprehensive restrictions on advertising and marketing targeting children and young people can all reduce alcohol consumption. The current licensing system limits local authorities' ability to reduce alcohol availability. Measures intended to prevent home delivery of alcohol to underage or intoxicated individuals appear to be inconsistently applied.	that are highly visible to children and young people. 3.2. Advocate for national action that strengthens local authorities' ability to limit the availability of alcohol through licensing, such as via the introduction of a public health licensing objective. 3.3. Advocate for other national policy reforms such as MUP and mandatory, comprehensive alcohol labelling. 3.4. Advocate for strengthened safeguards relating to online alcohol sales, age verification processes and the prevention of sales to people who are intoxicated.
4. Targeted approaches, including early intervention	A substantial number of children in Nottingham are affected by parental alcohol use. Groups that appear to be drinking alcohol at increasing or higher risk levels locally include males, White British residents, people living in the city centre, and young and middle-aged adults. Groups experiencing disproportionately higher levels of alcohol harm locally include males, people from White and Mixed/Multiple or Other ethnic backgrounds, people living in the most deprived areas of the city, and young and mid-to-late working age adults. In addition to this, literature suggests that harm may be amplified in LGBTQ+ communities. Data suggest that acute intoxication contributes significantly to alcohol harm locally, particularly among younger people; and places substantial pressure on A&E departments.	4.1. Work with Children's Social Care services to ensure early intervention and support is provided to families where alcohol has been identified as a risk factor of concern. 4.2. Ensure consistent delivery of high quality, evidence-based alcohol education and resources in schools. 4.3. Deliver targeted, community-based behaviour change campaigns to raise awareness of alcohol-related harm and promote healthier choices, including tailored messaging for at-risk groups. 4.4. Promote and support the widespread delivery of Alcohol IBA across local health and community settings to increase early identification of people for a brief intervention or referral into treatment.

	Evidence indicates that school-based programmes and community-based media campaigns may contribute to alcohol harm reduction.	
5. Workforce development: IBA	Both face-to-face IBA and digital IBA are effective at reducing alcohol consumption, particularly in adults. There were missed opportunities for early identification of harmful drinking and provision of advice and referral at NHS Health Checks. A substantial proportion of individuals supervised by probation services are affected by substance use.	5.1. Prioritise IBA training for staff working with those experiencing more harm, or where the risk of harm is high, for example midwives, Children's Social Care staff, probation workers, those working in mental health services, and those working with inclusion health groups. 5.2. Consider implementation of digital IBA alongside face-to-face delivery.
6. Service accessibility	There are high levels of unmet need in Nottingham (and nationally). Unmet need is greatest among younger adults. There is a significant level of alcohol dependence amongst adults living with children, and a substantial unmet treatment need within this group. There were missed opportunities to refer individuals needing alcohol support, including people drinking during pregnancy and people with SMI identified during health checks. There are a substantial number of people on probation with identified needs for whom it is unclear whether they are receiving any alcohol-related support. There is evidence of good awareness of the local alcohol treatment providers, particularly NRN.	6.1. Explore avenues to increase access (and address barriers) to alcohol support, treatment and recovery services, with a particular focus on groups with high levels of unmet need to tackle inequalities in access and outcomes. 6.2. Increase the visibility of local services and awareness of the service offers. 6.3. Strengthen referral pathways into relevant alcohol services for people drinking during pregnancy, patients with SMI, and children and young people who are either using alcohol or affected by another person's use. 6.4. Improve understanding of the support pathways for people on probation with identified needs who are not subject to a formal ATR/DRR.
7. Holistic care and partnership working	Literature suggests alcohol-related harm may be amplified in people with existing mental health or long-term physical health conditions, people who are overweight or obese, and in people who smoke.	7.1. Strengthen integrated pathways so services can identify and manage co-occurring alcohol use and health conditions that increase harm, ensuring coordinated support

	Data suggest that the main health conditions driving alcohol harm in Nottingham are liver diseases, mental and behavioural disorders, and cancers of the aerodigestive tract and breast. Alcohol is a key contributor to local community safety issues, where crime and disorder account for most alcohol-related harm costs and a greater share of these costs than seen nationally or regionally.	across alcohol services and mental and physical healthcare. 7.2. Collaborate with local health and public health services to optimise prevention and management of health conditions and risk factors identified as key drivers of alcohol harm. 7.3. Support partnership initiatives between Licensing, Police, Trading Standards, Public Health and Community Protection teams to reduce alcohol-related crime, disorder and anti-social behaviour.

Appendix 1

The tables present a summary of critical appraisals of individual studies included in the literature reviews. Study quality was assessed using recognised critical appraisal checklists and assigned an overall RAG rating, where red indicates low-quality evidence, amber indicates moderate-quality evidence, and green indicates high-quality evidence.

Modes of access and alcohol-related harm	
Reference	**Overall quality assessment**
Alcohol Change UK (2022)[86]	Moderate-to-high quality grey literature
Coomber (2026)[87]	Moderate-quality cross-sectional study
Drinkaware (2026)[56]	Moderate-to-high quality grey literature
Grossman (2022)[88]	Moderate-to-low quality cross-sectional study
Hobday (2015)[59]	Moderate-quality ecological study
Holmes (2024)[89]	High-quality cross-sectional study
Lightowlers (2023)[90]	High-quality grey literature
Torney (2024)[91]	Moderate-quality cross-sectional study

Preventing alcohol-related harm literature review	
Reference	**Overall quality assessment**
Blank (2024)[69]	High-quality systematic review of a small and limited evidence base
Burns (2024)[80]	High-quality mixed-methods study
Deluca (2021)[85]	High-quality randomised-controlled trial
Deluca (2022)[84]	High-quality randomised-controlled trial
Elder (2010)[71]	High quality systematic review of moderate-quality observational studies
Fitzgerald (2024)[70]	High-quality mixed-methods study
Garnett (2025)[83]	Moderate-to-high quality randomised-controlled trial
Gates (2025)[79]	Moderate-quality umbrella review of mixed but generally low-to-moderate quality reviews
Guindon (2025)[67]	High-quality umbrella review of limited quality reviews
Kaner (2017)[82]	High-quality systematic review of moderate quality randomised-controlled trials
Kaner (2018)[81]	High-quality systematic review of moderate quality randomised-controlled trials
Maharaj (2023)[75]	High-quality systematic review of moderate-quality modelling and observational studies

Morris (2024)[72]	High-quality modelling study
Morris (2025)[76]	High-quality modelling study
Public Health Scotland (2023)[74]	High-quality evidence synthesis of moderate-to-high quality observational studies
Public Health Scotland (2025)[77]	Moderate-to-high quality rapid review of moderate quality observational studies
Sanchez-Ramirez (2018)[68]	Moderate-quality systematic review of observational studies
Zuckermann (2024)[78]	High-quality systematic review of mixed but generally moderate quality primary studies

Glossary and abbreviations

Glossary	
Alcohol dependence	A strong and often overwhelming desire to drink alcohol, difficulties controlling consumption, and continued drinking despite negative consequences.[1]
Alcohol-related harm	Harm where alcohol is a contributing factor but not always the only cause of the harm. This includes alcohol-specific harm, plus conditions partly caused by alcohol, such as some cancers and cardiovascular disease. This broader measure helps capture the full extent of alcohol's impact.[2] The following definitions are used in analyses in this JSNA: • **Alcohol-related admissions:** hospital admission episodes for conditions where alcohol is either a contributing factor (partial cause) or the sole cause (main cause). • **Alcohol-related deaths:** deaths from conditions that are either partially caused by alcohol or wholly caused by alcohol. The list of conditions where alcohol is a contributing factor and sole cause can be found here (page 29 to 35). These conditions are based on ICD-10 codes which are used in both HES and PCMD. • **Alcohol-related A&E attendances:** attendances where SNOMED codes with a mention of alcohol are recorded in the first diagnosis field (as a final primary diagnosis is not reached and ICD-10 codes aren't used).
Alcohol-specific harm	Harm that is directly caused by alcohol. For example, alcohol-specific mortality refers to deaths from conditions caused exclusively by alcohol consumption, such as alcohol-related liver disease and alcohol poisoning. This is a consistently defined measure so it should be used for geographical and time comparisons.[2]
AUDIT	Alcohol Use Disorders Identification Test. A screening tool used to categorise respondents according to their level of alcohol-related risk. AUDIT-C is a brief 3 question version, whilst the 10 question AUDIT is completed when the AUDIT-C score is 5 or above. An AUDIT score of 0-7 indicates low risk drinking, and 8-15 indicates increasing risk drinking. Individuals who score above this may benefit from specialist interventions and treatment support: a score of 16–19 is classified as harmful drinking, while a score of 20 or above indicates probable alcohol dependence.
DALY	Disability-Adjusted Life Year. A measure of disease burden that sums the years of life lost due to premature death and the years lived with disability. One DALY represents one lost year of healthy life.[3]

Harmful drinking (higher risk)	A pattern of alcohol consumption that causes health problems. It can be defined as the regular weekly consumption of 35 or more units for females, or 50 or more units for males.[1]
Hazardous drinking (increasing risk)	A pattern of alcohol consumption that increases risk of harm. It can be defined as drinking 15-34 units per week for females, or 15-49 units per week for males.[1]
Measures of hospital admissions	• **Narrow measure:** counts hospital admissions where the main reason for admission is an alcohol-related condition.[2] • **Broad measure**: Counts hospital admissions where the main reason for admission is an alcohol-related condition, and additionally includes admissions where alcohol is a contributory factor in order to comprehensively reflect the burden of alcohol on the NHS.[2]
Problem alcohol use	Drinking that exceeds the CMOs' guidance. This includes hazardous drinking, harmful drinking, and dependent drinking - sometimes collectively described by the umbrella term AUD, which covers a wide range of mental health problems associated with alcohol.[1]
UK CMOs' Low Risk Drinking Guidelines	The guidelines state the following: Men and women should not regularly drink more than 14 units of alcohol per week. If 14 units are consumed, drinking should be spread evenly over at least three days to avoid heavy drinking episodes which are known to increase the risk of harm. The safest approach for people who are pregnant or trying to conceive is to not drink any alcohol.[4] It is important to note that no form of alcohol use is entirely risk free, and although the likelihood of alcohol harm increases the more someone drinks on a regular basis, some conditions (including certain cancers) can occur even when drinking within these guidelines.[1]

Abbreviations	
APMS	Adult Psychiatric Morbidity Survey
ASB	Antisocial Behaviour
ATR	Alcohol Treatment Requirement
AUD	Alcohol Use Disorder
CGL	Change Grow Live
CI	Confidence Interval
CMO	Chief Medical Officer
DALT	Drug and Alcohol Liaison Team
DRR	Drug Rehabilitation Requirement
DSVA	Domestic and Sexual Violence and Abuse
FASD	Fetal Alcohol Spectrum Disorder
HED	Heavy Episodic Drinking
HES	Hospital Episode Statistics
HR	Hazard Ratio
HSE	Health Survey for England
IAS	Institute of Alcohol Studies

IBA	Identification and Brief Advice
MUP	Minimum Unit Pricing
MVH	Michael Varnam House
NDTMS	National Drug Treatment Monitoring System
NRN	Nottingham Recovery Network
NTU	Nottingham Trent University
NUH	Nottingham University Hospitals
ONS	Office for National Statistics
OR	Odds Ratio
PCMD	Primary Care Mortality Dataset
RAG	Red, Amber, Green traffic light rating system
RR	Relative Risk
SMI	Severe Mental Illness
STI	Sexually Transmitted Infection
UON	University of Nottingham
WHO	World Health Organisation

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