Item 31 Appendix 3

Alcohol Related Hospital Admissions (ARHA): scoping note

ARHA is a serious problem, nationally and locally, with increasing numbers of people admitted to hospital with alcohol-related conditions – both in terms of emergency admissions following falls, fights, RTAs etc. and in terms of emergency/elective admissions for people with long term alcohol related health problems (liver disease etc).

There are several ways of reducing the number of ARHAs.

1 **Reducing the amount that the general population drinks and encouraging people to drink in less hazardous ways.** This can potentially be achieved by:

- increasing the price of alcohol (higher duty or a minimum price per unit)
- employing differential duty rates (making it more attractive to drink certain types of drink than others – e.g. making it relatively cheaper to drink weak beer than alcopops, spirits etc.)
- limiting the availability of alcohol by restricting where or when alcohol can be sold (e.g. by restricting licensing hours; by reducing the number of alcohol licenses granted; by making supermarkets etc sell alcohol separately from other goods)
- increasing the age at which it is legal to purchase alcohol (e.g. from 18 to 21)
- limiting or banning alcohol-related advertising, branding and sponsorship
- stronger enforcement of existing laws (i.e. it is already an offence to sell alcohol to people who are visibly inebriated, but one which is rarely enforced)
- more public health information on the dangers of excessive drinking
- reducing the legal limit for driving after drinking to near zero and/or more zealous enforcement of current drink-driving laws

2 **Providing better support, advice and treatment for people drinking hazardously.** This mainly involves identifying people who may be hazardous drinkers and offering them 'Brief Interventions' – a short session with a counsellor who explains the risks of drinking excessively. Brief Interventions (BI) have a high success rate for this type of treatment, with 1 in 8 people drinking less following their BI.

3 **Providing better support for dependent drinkers.** This includes having readily accessible detox programmes.

4 **Mitigating the immediate dangers of hazardous drinking.** If people are determined to binge drink there is little that can be done to stop them. However, it may be possible to reduce the immediate risk of ARHA by measures which include:

- requiring bars to use only plastic glasses/bottles
- discouraging licensees from selling products particularly linked to hazardous drinking ('shots', double measures as standard etc)
- discouraging organised binge drinking events (Freshers' Week pub crawls etc.)
- better policing of areas typically used for binge drinking (e.g. parks)
- 'taxi marshals' (minimising violent flashpoints around taxi ranks)

5 **Diverting injured drinkers away from acute hospital services.** This can include initiatives to provide first aid stations in town centres, so that people with minor injuries need to attend A&E; encouraging city centre GP clinics (esp. 'walk-in' clinics) to stay open late at night; using non-ambulance transport to get distressed city centre drinkers to hospital (i.e. using a minibus to transport several people rather than individual ambulances – such schemes reduce inappropriate ambulance use, particularly as drinkers who are sick in an ambulance may take that ambulance out of commission for well over an hour).

It would seem therefore that there is plenty for a Scrutiny Select Committee to investigate here. However, this may not necessarily be the case.

In the first place, many of the above suggestions for reducing ARHA would require national legislation – there is no local ability to vary alcohol duty, to ban advertising, to vary drink-driving limits etc. Even where there is, in theory, some local power to act (for instance in terms of applying conditions to Licensees), it may be practically almost impossible to act in ways contrary to national Government policy. It is not necessarily the case that local Scrutiny should not look at nationally determined matters – there may well be considerable value in local lobbying for legislative changes etc. However, this is most likely to be effective in instances where there is relatively little national awareness of issues. This is not the case with alcohol-related harm (and ARHA) – the issue receives a great deal of publicity, and there is a considerable amount of lobbying going on (for instance, recent reports from the Parliamentary Select Committee for Health and from the British Medical Association). Given this, it is not clear what more local lobbying could add.

Secondly, it is not currently clear what the Coalition Government intends to do about alcohol-related harm, but there have been suggestions that ideas such

as minimum pricing per unit and tightening the 2003 Licensing Act are being actively considered. There is questionable value in conducting a scrutiny review in advance of (relatively) imminent Government policy announcements which may well change the licensing regime etc.

Thirdly, whilst there is considerable scope for mitigatory actions to reduce ARHA (as noted in point 4 above), Brighton & Hove has achieved Beacon status for our management of the city's night time economy. There is generally limited value in scrutinising areas of high performance.

Fourthly, there is already a good deal of ongoing work looking at the issue of ARHA. There are currently around 30 different pilot projects running across England, looking at offering Brief Interventions, improving A&E data recording, offering enhanced detox services etc. The evaluation of these pilots has not yet been completed, but when it has been it is likely to provide a very useful tool in terms of determining what really works to reduce ARHA and what doesn't.

For these reasons, we do not consider the time to be right for a Select Committee on ARHA. OSC would be better advised to delay this piece of work for several months until we have a clearer idea of the new Government's policy with regard to licensing and alcohol-related harm, and until we can begin to get information from the ongoing ARHA reduction pilots.