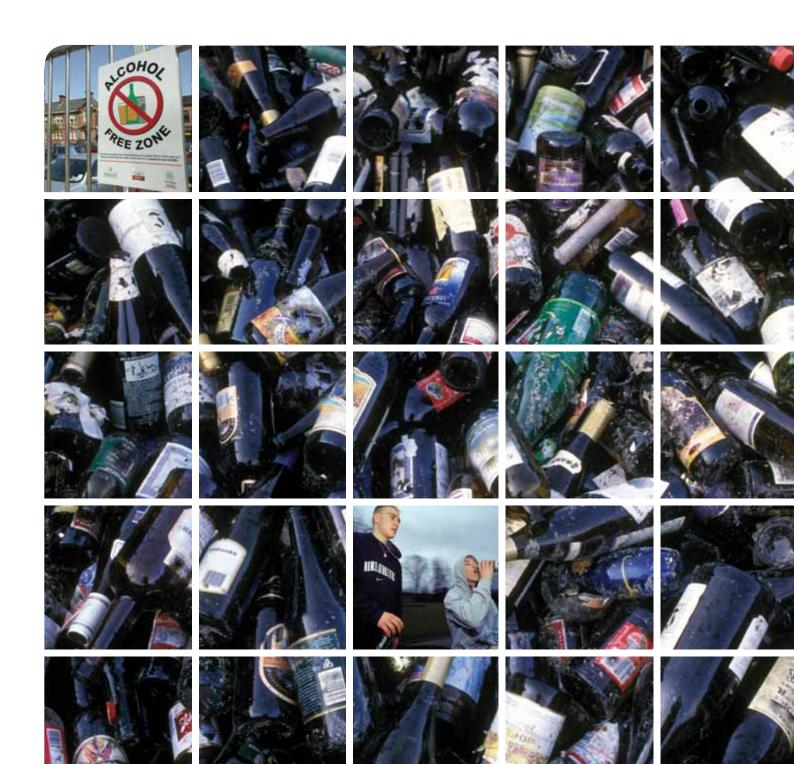




Public health and alcohol licensing in England

LGA and Alcohol Research UK briefing



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Purpose

Public health will become the responsibility of local government when it transfers from the NHS to local authorities in April 2013. This briefing for councillors and officers explains the challenges facing councils and the opportunities they have to tackle alcohol-related harm through the licensing process.

This briefing aims to place health bodies' new role in alcohol licensing in a strategic context, and to provide guidance to those who will be delivering the responsible authority role.

1. Background

Public health has always been a key consideration for alcohol policy. However, until recently health authorities had little or no input into the licensing process. Historically, licensing has been concerned primarily with crime and disorder, trade regulation and public safety; it has also focussed on regulating the on-trade in alcohol, where the prevention of disorder has tended to be a more pressing issue than the protection of public health.

However, alcohol consumption has a clear impact on public health. In 2010-11 there were 198,900 hospital admissions directly attributable to alcohol, an increase of 40 per cent since 2002-3. Furthermore, in 2010 6,669 deaths were directly attributable to alcohol, a rise of 22 per cent on the 2001 figure. The cost of alcohol-related harm to

the NHS is currently estimated at around £2.7 billion per year.1

Patterns of alcohol consumption in the UK have changed dramatically over the last 50 years. These also have public health implications. Some key developments include:

- a rise in home drinking and a decline in the amount of alcohol consumed in pubs and bars
- alcohol is 45 per cent more affordable now than in 1980 and accounts for only 5.2 per cent of household spending
- a significant increase in wine consumption across the population
- the emergence of supermarkets as leading providers of alcohol for home consumption
- the development of new alcohol products and brands, including 'ready to drink' beverages (often known as 'alcopops') and strong white ciders.

Research suggests that increases in consumption across the population are associated with increases in alcohol-related harms, especially long-term diseases.²

Particular patterns of consumption such as binge drinking and drinking above the Government's recommended limits are also linked to poor health outcomes. It is argued that because health impacts are linked to consumption, and consumption is influenced by availability, there is a need for public health bodies to play an active role in licensing activities.³

Under the Police Reform and Social Responsibility Act (2011), the Government amended licensing legislation to give health authorities a statutory role in the licensing process. Under the forthcoming changes to NHS and public health structures, it is envisaged that responsibility for engagement in licensing will fall to the Director of Public Health (DPH) or delegated individuals.4 This topic may also be of interest to health and wellbeing boards, although this will vary from area to area. This briefing document will set out the legislative framework for that relationship, identify some of the challenges that local areas will need to address, and provide guidance for effective engagement.

This new responsibility and opportunity should be seen alongside the transfer of public health from the NHS to local government and Public Health England (PHE). This is one of the most significant extensions of local government powers and duties in a generation and represents a unique opportunity to change the focus from treating sickness to actively promoting health and wellbeing. Alcohol licensing is an area that is worth exploring with these new roles.

2. The Licensing Act 2003

The Licensing Act established four categories of activities that require a licence:

- · the sale by retail of alcohol
- the supply of alcohol by or on behalf of a club to, or to the order of, a member of the club
- the provision of regulated entertainment
- the provision of late night refreshment.

Applications for a licence must be made to the licensing authority, which will be a unitary or district council.

The applicant is required to send all new licence applications and applications to vary a licence to a defined list of responsible authorities (RAs). The role of RAs is to comment on applications and make representations to the licensing authority if they think the application threatens one of the statutory licensing objectives. The licensing objectives under the 2003 Licensing Act are:

- the prevention of crime and disorder
- · public safety
- · the prevention of public nuisance
- · the protection of children from harm.

Since April 2012, local health bodies have been added to the list of responsible authorities, which now includes:

- police
- · fire service
- · health and safety
- · environmental health
- · child protection services
- · trading standards
- planning
- the licensing authority
- · regional health authority.

3. Role of health authorities in alcohol licensing

Currently, the health authority identified as the responsible authority is the relevant PCT. In most cases, this role has been delegated to an individual lead. In future, it is expected that responsibility will fall to the relevant Director of Public Health who will delegate the role as necessary.

As a responsible authority, the DPH can make representations in response to either a full licence application or an application for a variation in the conditions of an existing licence. They can also call for the review of a licence if they feel it breaches a licensing objective. Any representation must be specific to the premises and cannot be a general objection.

Representations should be evidence-based and should demonstrably refer to one or more of the licensing objectives. As there is currently no licensing objective directly relating to public health (see section on 'policy context' below), health authorities must ensure their representations are relevant to one of the four existing objectives.

In many cases, this will involve the presentation of evidence based on data from accident and emergency departments. Recent guidance on data sharing to tackle violence encourages accident and emergency departments and ambulance services to gather anonymised data for sharing with the police and other relevant authorities.⁵

The sharing of A&E data to tackle alcoholrelated violence has been trialled extensively in Cardiff, and the 'Cardiff Model' is the most developed model of practice in this area.⁶ If such data is available, it may be used in representations addressing both crime and disorder and the protection of public safety.

In Leeds the NHS is working with Yorkshire Ambulance Service to include a question in the proforma used by ambulance crews, asking where the patient last purchased or obtained their alcoholic drink. It is hoped that this data, while not perfect, would complement A&E data, which can then be used to better effect in alcohol and violent crime analysis reports like the one prepared for the Leeds partnership groups.

Health leads may also consider using evidence from:

- 'local alcohol profiles' (produced by the North West Public Health Observatory)
- · locally commissioned research
- · local NHS data
- ONS 'Statistics on Alcohol' and 'Drinking and Smoking in England' reports
- research literature on relationships between alcohol-related harm and availability, outlet density or pricing.

It is advisable to establish a bank of relevant data that can be used across representations rather than seeking to source data on a case-by-case basis. Health teams may also wish to establish guidelines to support decision-making. It is unlikely that all applications will require representations from health authorities so working with the health and wellbeing board to identify 'red flag' issues may be advisable in order to filter incoming documents. These may include:

- Is the premise in an existing area of cumulative impact?
- Is the premise in an area associated with alcohol-related crime?
- Is the premise in an area with high levels of alcohol-related hospital admissions?
- Is the premise of a type associated with high-volume drinking?
- If an off-trade outlet, does it seem likely that it will increase levels of hazardous or harmful drinking in the area?

Representations need to be made in writing, within 28 days of an application being received by the licensing authority. Protocols for written representations differ, and you should ensure that your local authority has clarified the process with you. Representations can suggest an application is rejected or propose conditions that should be attached to the licence. Representations can also support an application where there is good reason to do so. Proposed conditions could include:

- · require the use of safety glass for drinks
- · require limits on operating hours
- require limits on floor space allocated to alcohol
- · signage restrictions

- requirement for calming measures, such as provision of free food or soft drinks, or provision of a 'wind down' period
- alteration of layout to increase seating or avoid 'pinch points'
- restrictions on the type or strength of alcohol sold, such as no alcohol above 6.5 per cent ABV or no single bottles of spirits may be sold.

Some local authorities provide a 'pool of licensing conditions' on their websites which applicants are invited to consider. You may wish to look at these documents to inform your understanding of what licensing conditions may be available for you to propose.

4. What happens next?

Representations will be received and considered by the licensing authority, and adjudicated on at a meeting of the licensing sub-committee. All representations are sent to the applicant, and they are given the opportunity to respond. If you have submitted a representation, you will be able to speak at the relevant licensing sub-committee meeting should you wish, and you are encouraged to attend to gain an understanding of how representations are considered.

Applicants can voluntarily accept the addition of further conditions to their licence, or the licensing committee may decide to impose conditions after considering all the evidence, and the application proceeds.⁷ Any party involved in the process has 21 days to appeal to the magistrates' court if an application is rejected, or not granted as applied for.

5. Policy context – public health licensing objective

The Government has launched a consultation on the 2012 Alcohol Strategy, including an invitation to comment on the proposal to introduce a public health licensing objective in areas of cumulative impact.

What would this mean?

It would mean that the protection of public health would be added to the existing licensing objectives, but only in areas designated as 'stress areas' or areas of 'cumulative impact'. If adopted, you would be able to make representations on applications for premises in these areas on the grounds that they threatened the protection of public health.

The introduction of a public health objective could allow more scope for the use of health data in licensing decision-making. It could, for instance, allow health authorities to argue that A&E admissions are a prima facie public health issue, as well as a proxy indicator of crime and disorder.

It could also allow representations to make greater use of indicators of long-term health harms. Evidence that an area has higher than average rates of alcohol-related mortality or disease could be used to argue for the establishment of new cumulative impact areas or against applications for new premises within existing cumulative impact areas. The local alcohol profiles produced by the North West Public Health Observatory may be particularly useful providing a benchmark of regionally-specific health indicators.

The Scottish experience

In Scotland, the 'protection and promotion of public health' is a fifth licensing objective. Initially, licensing boards and health authorities had difficulty in applying this objective effectively. Recently, however, Alcohol Focus Scotland has sought to clarify the legal and practical grounds for involving health in the licensing process in its report 'Re-thinking Alcohol Licensing'. While many recommendations are specific to Scotland, wider headline findings of the report include:

- the importance of acknowledging the role of the off-trade in increasing availability
- the central role of 'statements of licensing policy' in establishing grounds for healthrelated licensing decisions
- the legitimacy of using wider research evidence on the relationship between availability and harm in developing a local evidence base.

The key challenge regarding the application of a public health objective is the danger of applying general principles or indicators to individual premises. Licensing teams have to take account of possible legal challenges, so health authorities should be realistic about what their involvement can achieve. However, active engagement is critical if the role of health in licensing is to be established in the longer term.

6. Partnerships and support

Many councils will provide training for health leads on their role as a responsible authority. In London, the Health Improvement Board is actively engaged in developing capacity among health leads. In other areas regional alcohol agencies support partnership and capacity building (eg DrinkWise North West and Balance North East). In most areas, regional groups of licensing authorities will meet regularly to discuss issues and you may wish to attend these meetings.

The main partnership groups established in most areas are Community Safety Partnerships (CSPs), Drug and Alcohol Action Teams (DAAT) and, where they are established, Community Alcohol Partnerships (CAPs). These bring together a range of local partners to tackle alcohol harm and active engagement is recommended where possible. The newly elected Police and Crime Commissioners will also be looking closely at this issue from a community safety perspective.

The LGA has established a dedicated Alcohol, Entertainment and Events Licensing Knowledge Hub which provides a closed environment for elected members and officers to receive the latest updates on managing alcohol consumption, and to discuss specific enforcement issues in a safe environment. www.knowledgehub.local.gov.uk

Information on a range local alcohol initiatives, alcohol policy developments and recent research data are also available at:

Alcohol Policy UK http://www.alcoholpolicy.net

The Alcohol Learning Centre http://www.alcohollearningcentre.org.uk

Drug and Alcohol Findings http://www.findings.org.uk

Alcohol Research UK http://alcoholresearchuk.org

7. Suggested documents to read

'Alcohol Strategy 2012': This outlines the Government's approach to tackle the 'binge drinking' culture, cut alcohol-fuelled violence and disorder, and reduce the number of people drinking to damaging levels. http://tinyurl.com/6qog75m

'Licensing Act 2003': The main piece of legislation, establishing licensing controls for alcohol, regulated entertainment and associated activities. http://tinyurl.com/2uho62t

'Additional Guidance for Health Authorities Under the Licensing Act 2003': Brief guidance outlining the statutory role of health authorities in their new role as responsible authorities. http://tinyurl.com/ayrpouu

'Police Reform and Social Responsibility
Act 2011': Introduces amendments to the
Licensing Act, including new locally flexible
tools to raise finance and restrict the sale of
alcohol during specific hours.
http://tinyurl.com/2ufywel

'Section 182 Guidance': This guidance helps authorities to interpret the legislation in the Licensing and Police Reform and Social Responsibility Acts.

http://tinyurl.com/bnmkwwh

'Research into minimum pricing levels': Sheffield University research has led the way in analysing the impact of minimum pricing levels on alcohol consumption. http://tinyurl.com/bythruw

'Rethinking Alcohol Licensing': Report by Alcohol Focus Scotland on the operation of the public health licensing objective. http://tinyurl.com/avd4uk7

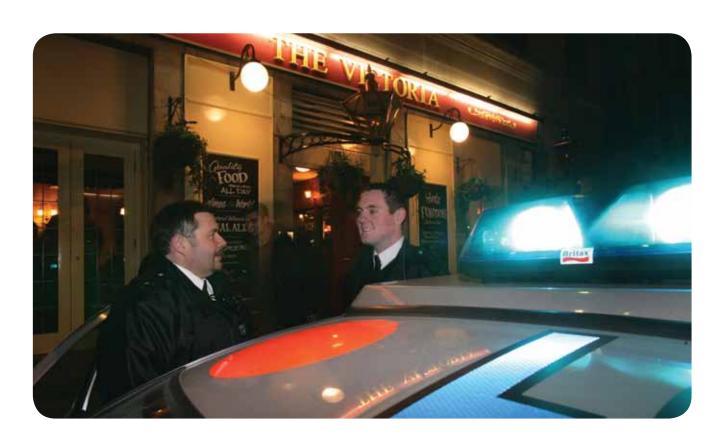
'Alcohol and public health: culture, policy and delivery': Report from the Alcohol Culture Exchange project (2011), looking at the relationship between public health and licensing. http://tinyurl.com/a8sejv5

'Information Sharing to Tackle Violence -Guidance for Community Safety Partnerships on Engaging with the NHS': Department of Health guidance on the use of anonymised data gathering in A&E departments. http://tinyurl.com/8jhag87

'The Cardiff Model – Effective NHS Contributions to Violence Prevention': Report outlining the methods and outcomes of the 'Cardiff Model'.

http://tinyurl.com/65uvl4





Endnotes

- 1 All figures taken from Office of National Statistics, Statistics on Alcohol, 2012 http://tinyurl.com/crjqouk
- 2 See Babor, T. et al. Alcohol: No Ordinary Commodity 2nd Ed (Oxford: Oxford University Press, 2010)
- 3 Alcohol Focus Scotland, Re-thinking Alcohol Licensing http://tinyurl.com/avd4uk7
- 4 See Home Office, 'Additional guidance for health bodies on exercising new functions under the Licensing Act, 2003' http://tinyurl.com/ayrpouu
- 5 See, for example, Department of Health, Information Sharing to tackle Violence: Guidance for Community Safety Partnerships on Engaging with the NHS http://tinyurl.com/8jhag87
- 6 A full description of the Cardiff Model is available here: http://tinyurl.com/65uvl4
- 7 The most recent figures on the proportion of applications accepted, modified and rejected are available here: http://tinyurl.com/an3ps9h





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