Drink Aware?
Reducing Alcohol Misuse in Buckinghamshire

A report by the Buckinghamshire County Council Health Scrutiny Committee

Chairman: Jenny Puddefoot
Published: April 2013
Contents

Executive Summary ................................................................................................................3
Recommendations ...................................................................................................................5

Introduction .............................................................................................................................6
Drinking Habits and Impacts ...................................................................................................6
Challenging the Perception of Alcohol Misuse ......................................................................10
Review Scope ........................................................................................................................11
Review Methodology .............................................................................................................12
Local Alcohol Structures and Policy ....................................................................................12

Government Alcohol Strategy March 2012 .........................................................................14
Buckinghamshire Alcohol Strategy .........................................................................................15

Behaviour Change ..................................................................................................................17
Workplace Initiatives .............................................................................................................20
Highlighting the Issue and Supporting Workplace Initiatives .............................................21

The Role of Licensing ............................................................................................................22
Proposed Licensing Legislation Changes ............................................................................23
Licensing Data .......................................................................................................................24
Local Response to Legislation Changes ..............................................................................25

Working with the Off-trade ....................................................................................................26

National Alcohol Strategy Consultation: A missed opportunity? ........................................28

Conclusions ............................................................................................................................29

Acknowledgements ...............................................................................................................30
Glossary and Acronyms .........................................................................................................31

Appendices .............................................................................................................................32
Executive Summary

The alcohol consumption of the UK population is at historically high levels driven in part by the affordability, availability and social acceptance of alcohol. Alcohol is one of the big four lifestyle behaviours that are significant contributory factors to premature death and disability. As well as the costs to personal health, alcohol also generates antisocial behaviour and disorder, impacts on business and the economy, and damages families. The cost of alcohol misuse nationally to public services is in excess of £21 billion per year. Locally there are 90,000 people thought to be drinking in excess of recommended guidelines, increasing the risks to their health and contributing to the short and long term costs of alcohol misuse.

The scale of the problem explains the presence of alcohol strategies at both the national and local level. Our review focussed on reducing the local adult population drinking above recommended levels which would support the local alcohol strategy to reduce the impacts of alcohol, and minimise the potential need for more intensive alcohol dependency treatment services at a later stage. The review explores the role of local behaviour change initiatives and the licensing process to reduce the number of people drinking above recommended levels.

From the evidence gathered as part of this review it is apparent that perceptions of alcohol misuse need to be challenged if the problem is to be tackled. The costs and impacts of misuse are not confined to a small minority of alcoholics or town centres on weekends, but are more widespread yet less visible than this, affecting older age groups and taking place in the home over many years. These are where the real costs to our health and health services lie.

We were encouraged by what we heard about the local alcohol strategy and partnership structures in place. Partnership working is key to the issue given its cross cutting impacts on public services, and the range of responses to these. There are new and emerging opportunities to tackle the issue of alcohol misuse and the structures in place should take advantage of these.

There is good evidence to support the effectiveness of certain behaviour change initiatives and we would like to see these initiatives continue and their reach extended, such as to workplaces, to increase awareness of alcohol misuse locally.

Changes in licensing legislation potentially offer greater control and influence over the availability of alcohol justified by health data. However we feel Government proposals could and should go further in this area, and capitalising on any changes locally will require close working and data sharing.
between the district councils, who are the licensing authorities, and other partners of the Alcohol Strategy.

In addition to using licensing legislation we feel a priority should be to work more closely with the off-trade suppliers of alcohol, and we were encouraged by some of the activities we heard about from two of the national supermarket chains. Partnership working should extend to off-trade suppliers and encourage more responsible retailing.
Recommendations

1. Recommendation: The Cabinet Member for Health & Wellbeing should ensure opportunities to highlight the risks of excessive alcohol consumption in the home are taken, champion new healthy workplace initiatives, and ensure alcohol awareness raising work is included in any existing or new workplace health initiatives. *Paras 43-49*

2. Recommendation: Buckinghamshire County Council’s Employee Wellbeing Strategy should include a comprehensive approach to promoting sensible drinking. *Paras 50-51*

3. Recommendation: That the Alcohol Strategy Group with the strategic support of the Healthy Communities Partnership works with hospital trusts and South Central Ambulance Services to improve the availability of data on alcohol related presentations, and consider the provision of an alcohol liaison nurse at A&E. *Paras 55-58*

4. Recommendation: That the Healthy Communities Partnership collaborates with district councils to identify how collection of licensing data can be improved and how it can be used and shared by partners of the Alcohol Strategy Group. *Paras 65-69*

5. Recommendation: Following any changes to licensing legislation, particularly concerning any public health objectives, the Alcohol Strategy Group should work in partnership with district licensing departments to agree an action plan on how the changes are applied locally. *Paras 70-74*

6. Recommendation: That the Alcohol Strategy Group includes in its action plan for 2013/14 the exploration of options to increase engagement and partnership working with off-trade premises (off licenses and supermarkets), and strengthen their contribution to the local alcohol strategy and campaign work. *Paras 75-81*

7. Recommendation: The County Council and Health and Wellbeing Board should lobby Government to introduce public health as a fifth licensing objective, permitting health to be a consideration in all premises licensing decisions. *Paras 82-86*
Introduction
Drinking Habits and Impacts

“The fact that alcohol has been enjoyed by humans since the dawn of civilization has tended to obscure the fact that it is also a toxic, dependence inducing teratogenic and carcinogenic drug to which more than one million people in the UK are addicted” (House of Commons Health Select Committee, January 2010)

1. The UK population is consuming alcohol at a historically high level. Fig 1.0 below shows consumption has tailed off slightly in the last five years, largely accounted for by a fall in beer/lager consumption. It is also worth noting that alcohol consumption has changed dramatically in the past century, affected by economic prosperity and hence its affordability, its availability and changing lifestyles. The impact of the two world wars on all these factors is clear in the graph. Increased affordability and availability of alcohol were key drivers behind the growth in consumption since 1970, with alcohol 54% more affordable in 2003 than it was in 19801. Not only have the amounts people consume varied, but also what they drink has changed, particularly in the last forty years with increases in wine and spirits consumption.

![Annual Alcohol Consumption per UK Resident 1900-2010](image)

**Fig 1.0: Annual alcohol consumption**


2. The impacts of this growth in alcohol consumption in the last fifty years are stark. There is a wealth of evidence which makes clear links between alcohol consumption and harms to health, its links with antisocial behaviour and disorder, its impact on economic productivity, and its impact on families. These impacts result in significant costs to taxpayers through the resulting pressures on the health service, the police, and social services. A London study\(^3\) by Alcohol Concern found 62% of children subject to care proceedings were from homes with parental alcohol misuse. Alcohol misuse also costs business and the wider economy. Fig 2.0 illustrates how the combined costs of alcohol are thought to exceed those of smoking, obesity and drugs. These costs, in excess of £21 billion per year, are entirely avoidable.

\[\text{Fig 2.0: Estimated alcohol costs, DoH}\]^4\]

3. The health harms of alcohol are many and varied. Drinking above recommended levels increases the risk of high blood pressure, heart disease, strokes, liver disease, and various cancers. It effects sleep, can cause sexual problems, and is related to depression and fatigue. The £3.5 billion to the NHS shown in the graph above is the equivalent to a cost of £120 per year for every tax payer. Given the long term nature of many conditions linked to alcohol misuse, there will be a lag between the recent high levels of consumption, and the full health impacts of this.

4. Fig 3.0 illustrates the recent growth in a number of alcohol related conditions in England. Fig 4.0 shows liver cirrhosis rates for England and Scotland, compared to other European countries. The 2012 Chief Medical Officer’s annual report\(^5\) highlighted how liver disease is the only major cause of mortality and morbidity that is on the increase in England while it is decreasing among our European peers. Between

---


\(^4\) Department of Health slide shown at LGA conference, 17/1/2013.

2000 and 2009, deaths from chronic liver disease and cirrhosis in the under 65s increased by around 20% while they fell by the same amount in most EU countries.

![Graph showing alcohol-related hospital admissions by condition in England](Image)

**Fig 3.0:** Alcohol Related Hospital Admissions by condition in England, *Source: The Alcohol Academy*.

![Graph showing liver cirrhosis death rates 1950-2006](Image)

**Fig 4.0:** Liver Cirrhosis Death Rates 1950-2006. *Lancet* 2006: 367: 52-56.

5. Alcohol is a significant local issue. Although the problem in Bucks is not as serious as other areas, 90,000 people drink at levels which is at

---

risk to their health (increasing risk and higher risk categories\(^7\)), the cost locally to the NHS is estimated at £26m/yr\(^3\), and alcohol related admissions to hospital has shown a steady upward trend in keeping with the national trend (see Fig 5.0). £15.5m of the £26m annual cost is generated by inpatient admissions with the over 55s accounting for 71% of this cost, and 16-24 yr olds accounting for just 4%. Table 1.0 shows how hazardous drinking is spread evenly across the districts.

<table>
<thead>
<tr>
<th></th>
<th>Abstain</th>
<th>Lower risk</th>
<th>Increasing risk</th>
<th>Higher risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aylesbury Vale</td>
<td>17,207</td>
<td>88,152</td>
<td>23,759</td>
<td>9,524</td>
</tr>
<tr>
<td>Chiltern</td>
<td>9,367</td>
<td>45,725</td>
<td>12,040</td>
<td>4,803</td>
</tr>
<tr>
<td>S Bucks</td>
<td>7,287</td>
<td>32,469</td>
<td>8,448</td>
<td>3,363</td>
</tr>
<tr>
<td>Wycombe</td>
<td>21,350</td>
<td>78,743</td>
<td>20,274</td>
<td>7,665</td>
</tr>
<tr>
<td>Bucks</td>
<td>55,211</td>
<td>245,089</td>
<td>64,521</td>
<td>25,355</td>
</tr>
</tbody>
</table>

Table 1.0: Alcohol consumption by local authority (NWPHO Topography of drinking behaviours in England 2012)

6. Department for Health guidelines recommend men should not regularly drink more than 3-4 units of alcohol a day (around 2 pints of 4% strength lager, beer or cider), while women should stick to 2-3 units a day (no more than a standard 175ml of 13% wine). People should have at least two alcohol free days a week, and shouldn’t drink for at least 48 hours after a heavy drinking session.

---

\(^7\) Increasing risk – people drinking above recommended daily guidelines on a regular basis, Higher risk – Men drinking more than 8 units a day or more than 50 units a week, and women drinking more than 6 units a day or more than 36 units a week.

\(^8\) April Brett 15/11/12. These costs comprise admissions which are either wholly attributable (e.g. Liver Disease) to alcohol, or partly attributable (e.g. falls, certain cancers and circulatory diseases). Figures derived from the latter reflect the proportional contribution of alcohol to this condition, with alcohol’s contribution varying by condition and age of patient.
Challenging the Perception of Alcohol Misuse

7. The common perception, and the issue typically highlighted in the media, is that problems with alcohol stem from young people binge drinking in town centres at night. Undoubtedly this is a big issue and puts notable pressure on police resources and health services from accident and injury admissions. It also has social impacts and damages the perception of town centres and the night time economy.

8. However, it is the longer term health issues caused by regular drinking over a number of years that accounts for the biggest burden on health services, and not binge drinking events. Fig 3.0 illustrates this, as it is the longer term conditions such as hypertensive diseases, cardiac arrhythmias, digestive diseases and cancer which account for the greater number of hospital admissions, and dwarf those concerning the more immediate impacts of alcohol such as assaults/injuries/poisoning.

9. 45-65 year olds drink the highest weekly average of alcohol, and managerial and professional households drink more frequently and are more likely to drink above recommended levels. In recent years there has been a reduction in the number of school pupils who report drinking alcohol.

10. Coupled with the facts that alcohol misuse is just as much an issue among middle aged/older groups as young people, and that significant health impacts result more from longer term drinking behaviour rather than just binge drinking episodes, is the evidence on where people

---

*Fig 6.0:* On- and off-trade sales of alcohol units, on average, per person (aged 18+), per week in Scotland, England and Wales.

---

9 Health and Social Care Information Service 2012.
10 April Brett Presentation 15/11/12 – HSCIS 2012.
11 Institute of Alcohol Studies: alcohol consumption in the UK factsheet.
drink. Fig 6.0 shows how two thirds of alcohol consumed is purchased from the off-trade (off-licenses and supermarkets). This would typically then be consumed in the home.

11. The perception that alcohol misuse is an issue restricted to young people drinking in bar/clubs or alcoholics needs to be challenged, and we must be more aware of the larger adult population who are drinking at levels harmful to their health often in the home.

Review Scope

12. With the responsibility for public health transferring to the County Council from the Primary Care Trust in April 2013, the HOSC was keen to look at an area of significant public health concern. Alcohol is one of the ‘big four’ lifestyle behaviours (alongside smoking, physical activity and obesity) that together account for 42% of the leading causes of death and 31% of all years lived in disability (disability adjusted life years)\(^\text{12}\).

13. Given the evidence above, a review on alcohol misuse was agreed, with a focus on the large number of residents drinking above recommended guidelines. The HOSC was keen for the review to focus on prevention of more serious and costly health impacts further down the line and so focussed on those drinking above guidelines, but not those classed as alcoholics / dependent drinkers and on the treatment services available to them. The HOSC was also mindful of the consultation on home office proposals to implement the Governments Alcohol Strategy opening in November 2012.

14. Following further refinement of the scope it was agreed that the review aim should be to support the Buckinghamshire Alcohol Strategy to reduce the number of people drinking above recommended levels, and for the review to look at the role of licensing and behaviour change initiatives in this. For the agreed review scope, please refer to Appendix A.

15. Although our focus was on adults, we were mindful that a comprehensive alcohol strategy aimed at preventing future impacts from misuse must also target children and young people. Encouraging change among adults and parents has a role to play as part of this, given the evidence that parents influence their children’s attitudes to alcohol\(^\text{13}\). Initiatives targeted at children and the role of PSHE (personal, social & health education) in schools to educate on alcohol misuse was however out of the scope of this review.

---

\(^{12}\) April Brett presentation 15/11/2012, original source: DPH Public Health Strategy

Review Methodology

16. Evidence gathering for this review took place between November 2012 and March 2013. The following Councillors were appointed from the Health Overview and Scrutiny Committee to the Task and Finish Group: Jenny Puddefoot (Chairman), Bruce Allen, Lesley Clarke, Lin Hazell, Steve Lacey (Wycombe District Council), Wendy Mallen, Wendy Matthews (South Bucks District Council), Nigel Shepherd (Chiltern District Council). The review was supported by April Brett from the Primary Care Trust (from April 2013 the County Council) Public Health Team, Susie Yapp the Safer Bucks Partnership Manager, Maureen Keyworth from Democratic Services and James Povey from the Policy Team.

17. The review was conducted using the following methods:
   - Initial planning meeting to clarify the scope of the review
   - Evidence sessions on the background of alcohol misuse and current activity and strategies in this area, with evidence from April Brett and Susie Yapp.
   - An evidence session on the role of Alcohol Premises Licensing attended by representatives from Chiltern, South Bucks and Wycombe District Licensing Teams, and with written input received from Aylesbury Vale.
   - An evidence session on alcohol behaviour change initiatives including the role of workplaces and retailers. Evidence was received from James Morris of the Alcohol Academy (www.alcoholacademy.net), Buckinghamshire Business First, Sainsbury’s and Waitrose supermarkets.
   - Attendance at two Local Government Association (LGA) conferences. One on the Council role in tackling drug and alcohol problems attended by representatives from Alcohol Concern, Department of Health, Public Health England and local councils. The second was a licensing conference attended by representatives from Alcohol Focus Scotland, Department of Health, the Police and licensing authorities.

Local Alcohol Structures and Policy

18. The impacts of Alcohol misuse stretch across multiple policy areas and public services, as was explained in paragraph 2. Approaches to manage, mitigate and reduce these impacts similarly cut across multiple public agencies. Hence it is vital that there is strong and effective partnership working. There has been a Buckinghamshire Alcohol Strategy in place since 2007. This was initially coordinated through the Drug and Alcohol Action Team (DAAT) and a multi-agency Alcohol Advisory Group. The strategy is being refreshed in April 2013 by the Alcohol Strategy Group, with the Public Health Team as the lead coordinator.
19. The Alcohol Strategy Group consists of partners from; Buckinghamshire County Council, the District Councils, voluntary sector treatment providers, voluntary sector support services, community safety/licensing officers, Thames Valley Police, Thames Valley Probation Trust, and NHS partners. This group reports progress to the two established multiagency partnership bodies of the Safer and Stronger Bucks Partnership Board, and the Healthy Communities Partnership which coordinates the delivery of the public health priorities for the county and reports to the Health and Wellbeing Board (see Fig 7.0).

20. The DAAT commission alcohol treatment services for people with an alcohol dependency. In 2011/12 490 adults accessed alcohol treatment, with 61% completing treatment which is better than the national average. It is estimated that there are 6,184 dependent drinkers in Buckinghamshire. The DAAT commissioning plans are informed by a needs assessment. This, alongside the broader Joint Strategic Needs Assessment (JSNA), informs the overall Alcohol Strategy.

Fig 7.0: Alcohol strategy accountability

21. Funding for the Community Safety Partnership comes from the Community Safety Fund controlled by the Police and Crime Commissioner (PCC). In his draft Police and Crime Plan the PCC states that the “majority of crime that directly affects the public is caused by excessive consumption of alcohol and the need of drug addicts to fund their addiction. Tackling alcohol misuse is clearly a priority for the Police.

22. The DAAT Partnership Board has been dissolved in response to the creation of the Health and Wellbeing Board and the redefined role of the Healthy Communities Partnership, and following clarification of the

---

14 April Brett presentation 15/11/12, original source: National Treatment Agency 2012.
16 Membership included senior strategic staff from the County Council, representatives from the District Councils, Thames Valley Police, National Probation Service, Bucks Children's and Young Peoples Trust, NHS Buckinghamshire.
above structure overseeing the Alcohol Strategy. With the reorganisation of the NHS in April 2013 there is concern over engagement between the Public Health Team and the Safer and Stronger Bucks Partnership, and this should be addressed to ensure strong links with the Police on the Alcohol agenda.

23. At the conference\textsuperscript{17} we attended we heard how licensing and health sectors have traditionally not linked up. However with recent and possible further legislation changes increasing health considerations in licensing decisions (see paragraphs 59-64), there is now a need for them to link effectively. We feel the partnership structures already in place and the joint strategy will facilitate this, but would urge the Public Health Team and district licensing teams to forge effective and cooperative working links beyond these formal structures.

24. One body we feel should perhaps be better represented or at least involved in the work of the Alcohol Strategy Group and the partnership structures are the magistrates. Licensing appeals following district council decisions are heard by the magistrates. Very low instances of license applications being refused in the county\textsuperscript{18} means it is not an issue currently, however were legislation to change to allow district councils to be more restrictive on license applications, the support of magistrates courts would be crucial so as not to undermine such efforts. Therefore depending on further legislation changes, and how these are adopted locally, there may be an increased need to engage with magistrates over local policy and interpretation.

Government Alcohol Strategy March 2012

25. The government ambition for this strategy is to reshape the approach to alcohol and reduce the number of people drinking to excess. It seeks the following outcomes:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others.
- A reduction in the amount of alcohol fuelled violent crime.
- A reduction in the number of adults drinking above NHS guidelines ; including ‘binge drinking’.
- A reduction in the number of alcohol related deaths.
- A sustainable reduction in both the numbers of 11-15yr olds drinking alcohol and the amounts consumed.

26. Delivery of these outcomes will be supported through the following policy initiatives:

- Reducing availability of cheap alcohol and considering alcohol advertising.

\textsuperscript{17} LGA Licensing Conference.
\textsuperscript{18} In 2011/12 there was one instance in Buckinghamshire of a licence being refused. Home Office: \url{http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/home-office-science/alcohol-lnr-licens-1112-supptab}
- Responsibility Deal with the alcohol industry.
- Changes to licensing legislation.
- Supporting individuals to change via social marketing, alcohol in health checks, improved treatment and recovery services, activity focussed on offenders health, and mental health links.

**Buckinghamshire Alcohol Strategy**

27. The four local Alcohol Strategy themes and associated strategic objectives are:

<table>
<thead>
<tr>
<th>Community safety</th>
<th>Treatment</th>
<th>Prevention</th>
<th>Support for more vulnerable</th>
</tr>
</thead>
</table>
| To reduce alcohol related crime. | To provide effective high quality services that enable people to be free from dependence and sustain recovery. | **To reduce the proportion of adults drinking above NHS guidelines.**  
**To provide widespread, targeted identification and brief advice.**  
**To sustain a reduction in the numbers of 12-15yr olds drinking and the amount they consume**  
**Prevention and early intervention through e-learning** | To ensure care coordinated treatment and integrated pathways to safeguard the needs of children and young people impacted by alcohol misusing parents.  
Provide outreach and support for more vulnerable drinkers such as homeless, street drinkers.  
To support MARAC clients in accessing alcohol treatment to help reduce their assessed risk of harm |
| To reduce violent crime in night time economy  
**To enforce countywide and local policies which impact on the alcohol availability.** | To provide timely access to alcohol treatment | |
| To reduce levels of concern in a geography experiencing alcohol related antisocial behaviour | To provide a range of services to meet local need | |

Those strategic objectives underlined are of greatest interest to this review, given their potential to reduce at risk drinking through either licensing or behaviour change activity.

28. In our evidence sessions on the local alcohol strategy we were reassured that the local approach follows the NICE guidance and is based on a robust needs assessment. There was an emphasis on approaches that are evidence based. The following were identified as key indicators on the effectiveness of the local alcohol strategy:
• Proportion of adults drinking above NHS guidelines
• Numbers of young people (12-15yrs) who drink.
• Numbers of people reached through identification and brief advice
• Numbers of people accessing alcohol treatment services for the first time
• Successful completion of alcohol treatment
• Waiting times for alcohol treatment
• Levels in crime linked to the night time economy including violent crime
• Levels in the concern relating to a geography experiencing alcohol related anti-social behaviour
• Numbers of those killed and seriously injured on our roads where alcohol is identified as a contributory factor

29. We were interested in the intelligence used to inform preventative approaches locally, and were reassured to hear about the application of population segmentation data, and life course considerations in the delivery of the local alcohol strategy.

30. The preventative activity in the alcohol strategy draws on Department of Health population segmentation data which is compiled from various sources\(^\text{19}\) to segment the population into 13 groups reflecting their level of alcohol risk. Using this data not only informs where concentrations of at risk groups live, but also their accompanying pen portraits indicate typical age and employment profiles of these groups, the types of newspaper and media they consume, supermarkets they use and what campaigns and messages they will be more receptive to. The information is only for use in social marketing contexts and not for determining service commissioning. More detail on these population segments, including the identified local risk groups (7, 8 and 9), can be found at the Alcohol Learning Centre website\(^\text{20}\).

31. A life course approach recognises that peoples drinking behaviour and levels do not remain static through their life. Changes in drinking are often a ‘side-effect’ to a change in some other behaviour (e.g. a change in employment) or because drinking interferes with another goal (e.g. increase in caring responsibilities). People can respond differently to similar events. Fig 8.0 provides a useful illustration of this in practice.

32. We were satisfied with what we heard about the approach to the local alcohol strategy, and are confident it reflects good practice and guidance provided by NICE (National Institute of Clinical Excellence). The strategy embraces a systematic and evidence based approach, and deploys a mix of targeted approaches and population wide initiatives. Effective partnership structures are in place and there is senior buy in. The report now looks at some of alcohol strategy activity concerning behaviour change in more detail.

\(^{19}\) Alcohol hospital admission data, population health inequality data (Health ACORN), TGI data on heavy alcohol users, alcohol expenditure from the family expenditure survey, media consumption data.

\(^{20}\) http://www.alcohollearningcentre.org.uk/Topics/Browse/SocialMarketing/SegmentationTool/segments/
Fig 8.0: Illustrative life course scenario across various alcohol intake risk levels. Source: COI, created from Birmingham Untreated Heavy Drinkers study, wave 5 (2007) please note, typical example, does not reflect specific individuals.

**Behaviour change**

33. Encouraging drinking behaviour change is a significant challenge. Health messages that consumers receive from public agencies, the media, parents or other elements of society encouraging them to drink less, are more than outweighed by the £800m spent by the industry on advertising and promotion, the increased availability and affordability of alcohol over recent decades, and a drinking culture ingrained in modern British society. The alcohol industry and tax revenues generated by it are also an important consideration for government.

34. In addition to the above points we have heard evidence that people tend to underreport what they drink and downplay any misuse. This is evident from variations in self reporting lifestyle surveys of drinking behaviour compared to alcohol sales figures.

35. Research by Kings College London suggests people are far more inclined to want to change their behaviour to stop smoking or lose weight than they are to drink less. In our evidence sessions we heard about the customer journey people need to follow to change their behaviour which comprises the four steps of Identify, Displace, Empower and Support, and the support and behaviour change

---


22 [http://www.bbc.co.uk/news/health-21586566](http://www.bbc.co.uk/news/health-21586566) UCL study which showed that 19% more men than previously thought were regularly exceeding their recommend daily limit and 26% more women. Total consumption across the week was also higher than officially thought with 15% more men, and 11% more women drinking above the weekly guidelines.
approaches required to assist this. It is essential in delivering support and encouraging behaviour change that there is an awareness of the messages that do and don't work on certain audiences (see Fig 9.0 below). We heard that frank health messages about the dangers of alcohol don't work and tend to entrench people's position, and that lighter drinkers tend to be more receptive to messages while heavier drinkers see messages as an attack.

<table>
<thead>
<tr>
<th>What works</th>
<th>What doesn't work</th>
</tr>
</thead>
<tbody>
<tr>
<td>References to health, especially cancer and rise of cirrhosis</td>
<td>Freak health messages – e.g. young people dying following heavy drink sessions</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>References to emotional health, especially for heavier drinkers</td>
</tr>
<tr>
<td>Embarrassment</td>
<td>Impact on relationships, especially for heavier drinkers</td>
</tr>
<tr>
<td>Victim of crime</td>
<td>Notion that alcohol is a depressant, refuted especially by bingers and young people</td>
</tr>
<tr>
<td>For older women, references to weight and calories</td>
<td>Social consequences for men</td>
</tr>
<tr>
<td>Loss of productivity for older drinkers</td>
<td>Reminders of the cost of drinking</td>
</tr>
<tr>
<td>Social consequences for women</td>
<td></td>
</tr>
<tr>
<td>Tips for cutting down</td>
<td></td>
</tr>
<tr>
<td>Units information</td>
<td></td>
</tr>
</tbody>
</table>

**Fig 9.0:** Alcohol behaviour change messages which do and don’t work.  
*Source: Presentation by April Brett, 14 December 2012*

36. Preventative activity conducted as part of the alcohol strategy in recent years has included:

- Providing training and information packs to 30 licensees in South Bucks as part of a ‘Chose to Refuse’ project to reduce underage sales.
- Awareness raising campaigns such as ‘Gourmet Dining’\(^{23}\), distribution of alcohol consumption scratch cards, and through various DAAT events including night time economy events.
- Proactive prevention work with Police Road Safety, Licensing and Pubs to reduce drink driving.
- Alcohol Awareness Week, amplifying national messages at health centres, children centres and university.
- Identification and Brief Advice (IBA – see para 39 for what this is) training to primary care staff and front line workers. IBA has been used locally within supported housing and GP practices. EBI (Extended Brief Intervention\(^{24}\)) being used in Probation and Specialist services.

---

\(^{23}\) This included a production of an advert released on YouTube and the DAAT website, directing people to the DAAT website for further information and guidance. It was promoted by posters at train stations on commuter lines directed at the target market.

\(^{24}\) Extended Brief Interventions are similar to IBA but are extended to 20-30 mins to allow for interaction and motivational enhancement. For more information see the Alcohol Academy website [www.alcoholacademy.net](http://www.alcoholacademy.net)
37. In addition there are activities focussed on specific vulnerable groups. There is a joint safeguarding protocol between DAAT and safeguarding adults and children. A parenting assessment is being used as part of a substance misuse assessment process, and young people specialist services have started screening for alcohol. E-learning provision is being developed to be marketed to schools, and domestic violence services and champions are being engaged by treatment services.

38. A particularly innovative campaign was the distribution of scratch cards to assess drinking levels to specific adult customers of pharmacies. These served to raise self-awareness of personal alcohol consumption levels and then directed them to websites for self-help. Effectively a self-help form of IBA. Feedback on the campaign and website hits would suggest it had a positive impact, although there is no way of gauging reductions in alcohol consumption.

39. IBA is an early intervention approach, with a strong evidence base supporting its effectiveness. It consists of using a screening tool (often a short questionnaire) to identify risky drinking, followed by the delivery of short, structured advice aimed at encouraging a risky drinker to reduce their consumption to lower risk levels. IBA often takes only 5-10 minutes, and is intended for increasing or higher risk drinkers. It is not intended for dependent drinkers, who are better referred to specialist services. For more information see www.alcoholiba.com and www.thealcoholacademy.net. DoH recommends this is delivered in primary care to new registrants and to at risk groups, and in hospital settings.

40. At the conference we attended we heard from a representative of Alcohol Concern that anyone could be trained to deliver IBA, and there is literature highlighting how it has been delivered in settings such as workplaces, police arrest or court diversionary schemes, via the internet or by telephone. However, the evidence for its effectiveness is strongest in health settings delivered by a health professional.

41. Evidence on the impact of health campaigns and health education campaigns aimed at the general population is not very strong, although this is partly due to difficulties in evaluating their impact. However it is logical for such initiatives to have a role in any comprehensive alcohol strategy.

42. The pen portraits and population segmentation data highlighted some of the characteristics of the local population who are drinking above recommended guidelines. They include affluent professionals over 45, blue collar workers and parents in their late 20s and early 30’s. Given younger people and males are typically less likely to engage with health services, we feel that IBA activity needs to be extended beyond

---

25 Most notably from the £4m DoH funded study into IBA called SIPS (Screening & Intervention Programme for Sensible drinking).
26 DoH, Signs for Improvement – commissioning interventions to reduce alcohol-related harm, 2009.
27 Achieving positive change in the drinking culture of Wales. Glyndwr University, 2011.
health settings. Housewives and the retired are also groups mentioned in the pen portraits.

**Workplace Initiatives**

43. We were interested in the potential role of alcohol awareness raising activity in workplaces, as a means to reach out to the local at risk population not in regular contact with health services. At our evidence session James Morris (from the Alcohol Academy) explained that an effective approach to addressing alcohol in the workplace would require:

- Effective alcohol policies comprising a clear employer position on alcohol misuse relating to work events/conduct and support, as well as preventative and broader well-being initiatives (healthy workplaces).
- Alcohol training to a range of workplace roles and employers. This would include on alcohol awareness and the delivery of IBA.

44. We heard from Buckinghamshire Business First (BBF) who had recently been commissioned to look at the potential for workplace health initiatives by the Public Health Team. We learnt that whilst businesses feel they have a duty of care around workplace stress, they see alcohol as an outside working hours issue that is someone else’s problem and with little return potential to them. In Buckinghamshire engagement on this subject is particularly difficult given employers are disperse and there are only 60 companies who have more than 250 employees. It is often larger firms who tend to be more paternal and have the resources to invest in such initiatives.

45. Given current economic conditions, staff health and wellbeing is often not a high priority given more pressing concerns and support needs tend to revolve around money and finances, business planning and staff development. Resource requirements, staff workload, staff take up, business reorganisation and culture of the business are all barriers to employers improving staff health and wellbeing. It is clear that encouraging workplace health initiatives, let alone ones featuring alcohol awareness, will be very challenging.

46. The advice from BBF was there was a need to sell the benefits of improved workplace health to businesses, and work with local private health providers in partnership on this, which in turn would develop this sector of the local economy. Selling the initiative to businesses could draw on the fact that alcohol related harm in the workplace costs the UK £6.4 billion per year through accidents, absenteeism, presenteeism (poor productivity in the workplace), low team morale, damaged customer relationships, as well as through unemployment and associated recruitment and training costs. As well as saving in the above areas, business could also potentially save on their insurance.
47. Support to businesses for this could include a workplace wellbeing website portal, a workplace wellbeing supplier directory, awareness raising events, the development of case studies and a public relations campaign to existing business networks. It is important to avoid nanny state perceptions.

48. It would make sense to focus resources initially on the 60 larger businesses located in the county as well as business parks. However there are also possible opportunities to work with national chains that have their own employee health initiatives. For example we heard from Sainsbury’s that they had signed up to two of the Health at Work Network pledges in the Public Health Responsibility Deal, are keen to increase awareness and encourage positive behaviour change in their staff28.

Highlighting the Issue and Supporting Workplace Initiatives

49. Given the need to challenge perceptions on where alcohol misuse takes place and by who, outlined in earlier sections, we feel the cabinet member for Health and Wellbeing should ensure the promotion of alcohol awareness whenever there is opportunity to do so. Given the need to reach out to populations who may not be in contact with health services, and despite the challenges, we think a workplace initiative should be championed with efforts made to engage businesses on the issue of alcohol awareness. New or established workplace health initiatives should highlight alcohol awareness, and go beyond mere promotions and posters, to ensure appropriate workplace policies are in place and routes to IBA and any required counselling or treatment services are signposted. Large employers, including public services such as members of the Health and Wellbeing Board, should be a focus to start with, with business parks and smaller employers given appropriate support thereafter.

Recommendation: The Cabinet Member for Health & Wellbeing should ensure opportunities to highlight the risks of excessive alcohol consumption in the home are taken, champion new healthy workplace initiatives, and ensure alcohol awareness raising work is included in any existing or new workplace health initiatives.

50. The County Council already has in place a company, Health Management Ltd, providing its occupational health service, and there is also an Employee Assistance Programme which provides a counselling and referral service. In terms of awareness raising and preventative activity there is an Employee Wellbeing Strategy which is currently being refreshed for 2013/14.

51. As a significant local employer and given its responsibility for public health the County Council should set an example for other employers on employee health and wellbeing, and be a model of good practice. As such the Council’s Employee Wellbeing Strategy should identify

---

alcohol misuse as one of the key lifestyle issues. In addition to awareness raising of the issue among staff and managers, there should be opportunities for people to access IBA.

**Recommendation:** Buckinghamshire County Council’s Employee Wellbeing Strategy should include a comprehensive approach to promoting sensible drinking.

### The Role of Licensing

52. The Licensing Act 2003 is the primary legislation controlling the sale of alcohol. This Act passed licensing responsibilities to local authorities (district councils in two tier areas such as Buckinghamshire) and in this duty required the promotion of four licensing objectives; the prevention of crime and disorder, public safety, the prevention of public nuisance, the protection of children from harm. There is no objective for public health so this cannot be a consideration in licensing decisions.

53. The Police Reform and Social Responsibility Act 2012 made the Primary Care Trust (PCT) responsible for public health a ‘Responsible Authority’, meaning they had to be sent applications for new, or variations in, licences, and could instigate a review of a license. However any representation had to relate to at least one of the four licensing objectives. PCTs are being dissolved in April 2013 as part of the national NHS restructure, and the County Council will become a responsible authority due to its public health role.

54. At our evidence session on licensing we heard how the PCT to date had been largely inactive in its responsible authority role to date, and this was understandable given the limited scope of for health considerations to inform licensing decisions. Furthermore, issues around premises selling alcohol to children or being a source of violence would generally be picked up much earlier by the police, and the enforcement activity of the district councils.

55. Elsewhere in the country extra information has been recorded on computer systems from people presenting at A&E or ambulances who have been drinking. Not only has this data which has been shared with partners informed licensing policy and enforcement by identifying where people who have been injured have been drinking, but it has also provided the opportunity to deliver IBA to these patients where it has been appropriate to do so.

56. At our evidence session we learnt that such data was not being made available to licensing teams in Buckinghamshire. Given its potential to assist Licensing Authorities in enforcing the licensing objectives and relieving pressure on the health service by reducing instances of people being served alcohol when they are already drunk, as well as

---

29 The Cardiff model is held up as good practice, and has been replicated in the East of England Region (Bedford, Cambridge, Norwich and Peterborough).
assisting partners such as the police in their work, we think this should be addressed.

57. The DoH recommends\(^\text{30}\) that the commissioning of specialist alcohol nurses are considered to link with A&E units where there is an apparent need, citing evidence of a high likelihood of success for interventions (IBA) delivered in A&E to susceptible patients.

58. Given the potential for A&E or ambulance data to inform licensing enforcement and policy in the interests of relieving pressure on the health service and other partners, and the possible extension and enhancement of IBA delivery in hospitals, we recommend that the Alcohol Strategy Group remedy these current gaps in activity.

**Recommendation:** That the Alcohol Strategy Group with the strategic support of the Healthy Communities Partnership works with hospital trusts and South Central Ambulance Services to improve the availability of data on alcohol related presentations, and consider the provision of an alcohol liaison nurse at A&E.

**Proposed Licensing Legislation Changes**

59. The Home Office Consultation on *Delivering the Government’s policies to cut alcohol fuelled crime and anti-social behaviour* in November 2012 outlined a number of proposals to deliver the national Alcohol Strategy (see paras 25-26). Proposals for minimum unit pricing and a ban on multi-buy promotions made the headlines, but alongside this there were proposals for health to be a licensing objective for cumulative impact policies (CIPs).

60. CIPs are permitted under the guidance to the 2003 Act, and allow an authority to take account of the density of premises in one area and where there is evidence this impacts on the promotion of a licensing objective, establish a CIP which creates a presumption against new licence applications in a defined area. This is a discretionary power, and must be considered in the development of the licensing authority’s licensing policy statement.

61. In Buckinghamshire there are three established CIPs; Aylesbury Town Centre, Chalfont St Peter and Amersham Old Town. These have been justified largely by crime and disorder concerns. The new legislation offers the potential to increase the number of CIPs in force and expand their coverage, if local health data supports this. Applications for licenses within the CIP areas would need to demonstrate how they would promote the health objective, and have to offer conditions to ensure they did so on their licence.

62. At our evidence session on licensing, there was scepticism on the need for new CIPs in Buckinghamshire, with a view that it was not the

---

\(^{30}\) DoH, Signs for Improvement – commissioning interventions to reduce alcohol-related harm, 2009.
number or concentrations of premises that was a problem but how well managed they are and their adherence to their conditions. The health evidence that underpins the Home Office proposal\textsuperscript{31} highlights the link between outlet density and harm, both in terms of health through increased consumption, and crime and disorder. Hence if a health objective was introduced this stance may need to be challenged. Although there were few concerns raised by the licensing authorities over the availability of alcohol, some concerns were raised over the growth in small off-licenses and petrol stations selling alcohol.

63. The Scottish Government have gone further than the Home Office proposals and already have health as a fifth licensing objective (introduced under the 2005 Scottish Licensing Act), and so is not restricted in its application to areas with a density of premises. This has changed licensing in Scotland from an application driven process to a policy driven process\textsuperscript{32}, in contrast to England. The Scottish Licensing Boards policies are informed by a statement of overprovision, and so unlike England they are able to refuse an application on the grounds that there would be an overprovision of premises. This can apply to parts of the local authority area or the entire area.

64. Criticisms of the legislation in Scotland, and the CIPs in England is that they stifle competition, and given they don’t apply retrospectively, don’t serve to reduce premises, they just preserve the ones already in existence. In ruling out health as a fifth licensing objective as part of the Home Office 2012 proposals, the Government cited the larger costs to business and it being a disproportionate response (the difference in liver cirrhosis rates between England and Scotland illustrated in Fig 4.0, partly explains this stance).

**Licensing Data**

65. Unfortunately the data available on local licensed premises after the 2003 Act is not directly comparable to data that pre-dates 2003 due to changes in how premises were classified. What we can tell is that alcohol availability in the county (2012) appears in line with what is typical of neighbouring comparable counties and the average for England, both for on and off-sales licenses\textsuperscript{33}. This is similar to the situation a decade ago (2001 data). However this is against a backdrop of increasing alcohol availability since the mid-20th century nationally.

66. One anomaly locally is that South Bucks has more than double the number of on-sale licensed premises per head of population than other districts and the England average. This could be due to the number of restaurants in the area, but data on the number of those in employment in the beverage serving activities industry sector (includes licensed clubs, pubs and bars but excludes restaurants) in the district, is also

\textsuperscript{31} Summarised in the consultation impact assessments.
\textsuperscript{32} Re-thinking alcohol licensing, Alcohol Focus Scotland, 2011.
\textsuperscript{33} Based on data collected for our Licensing Evidence Session on 24 January 2013, which is included in Appendix D.
significantly higher than the national average at 2.4% of all employees\textsuperscript{34}. Such data could point to a heightened level of alcohol availability in this district, or parts of the district, but would need further investigation.

67. The data on premises in South Bucks, as well as the data requested from the district council licensing teams as part of this review highlights shortfalls in the current availability and flexibility of local licensing data. The data available is largely restricted to what the home office requests annually, and the categories in licensing legislation. From a health perspective it would be useful to distinguish between a premises which is largely alcohol led (i.e. a pub/bar) and one where alcohol is ancillary to other activities (i.e. a restaurant).

68. To thoroughly assess alcohol provision it is also essential to measure premises hours of operation and retail capacity (i.e. floor space devoted to alcohol sales). The districts were also unable to provide licensing data to bespoke geographies, which could be needed to match available health data. This has been an issue in Scotland, and license authorities here have been encourage to adapt their data to the available health data when this can only demonstrate issues at certain geographies\textsuperscript{35}.

69. Clearly improvements to data recording and availability could have resource implications, which could be beyond the licensing teams. We would like to see improvements made in this area however, particularly if legislation is introduced increasing the consideration of health in licensing decisions, so this can be capitalised on and in the interests of partnership working and robust local policies. Licensing policy reviews by the district councils would be a good opportunity to examine improvements to data collection and sharing.

**Recommendation:** That the Healthy Communities Partnership collaborates with district councils to identify how collection of licensing data can be improved and how it can be used and shared by partners of the Alcohol Strategy Group.

**Local Response to Legislation Changes**

70. Through health as either a fifth licensing objective, or one limited to CIPs, there would be an opportunity to exert greater control over alcohol availability. Health evidence as well as other evidence in support of the other objectives would be needed, but as was evident from the opening paragraphs, alcohol misuse is a significant problem, and although Buckinghamshire is no worse than other areas alcohol is a source of numerous issues and costs to public services. There would therefore be potential to develop a convincing evidence base.

\textsuperscript{34} Local Alcohol Profiles for England, Public Health England, \url{www.lape.org.uk}

\textsuperscript{35} Rethinking Alcohol Licensing (2011), Alcohol Focus Scotland & Scottish Health Action on Alcohol Problems.
71. CIPs apply to on and off-trade premises, which is vital given the growing trend for consuming alcohol purchased off-trade (see Fig 6.0). It would therefore be equally important that CIPs are not therefore restricted to small clusters of pubs but cover large enough areas to encompass possible off trade premises applications. A CIP would not mean a blanket refusal for any new premises, but instead could be applied to allow certain types or sizes of premises within restricted operating hours and not others.

72. Areas of the city of Brighton are covered by a CIP and the local council have agreed a decision making matrix which allows pubs and restaurants, but not nightclubs, super pubs or off-licenses (including supermarkets) in CIP areas. This gives an opportunity to shape the night time economy, and from a public health perspective the ability to limit off-trade premises, but allow pubs and restaurants where people could consume alcohol in controlled environments. CIPs would also put an onus on applicants to offer conditions in the interests of public health. These could include promoting responsible drinking, and requiring prescribed levels of seating in a pub to reduce vertical drinking which is associated with heightened consumption.

73. Given the potential applications and benefits of a CIP, the ability to shape a night time economy rather than stifle it, and the potential to restrict further increases in off-trade alcohol retail and encourage more responsible retailing, we feel strongly that any new legislation giving health greater influence in licensing, should not be dismissed lightly.

74. Better local data and strong partnership work and engagement called for elsewhere in this report will be essential. Therefore alongside this, we call on the Alcohol Strategy Group to give the opportunities from any new legislation prompt and serious consideration.

Recommendation: Following any changes to licensing legislation, particularly concerning any public health objectives, the Alcohol Strategy Group should work in partnership with district licensing departments to agree an action plan on how the changes are applied locally.

Working with the Off-trade

75. A message we heard at the Licensing Conference we attended was that partnership, not only with other public agencies, but also business is important. Similarly we heard that some of the licensing policy tools that are available such as CIPs and Early Morning Restriction Orders (EMROs) can be blunt and result in unintended consequences. They should therefore be applied carefully and should only follow once solutions in partnership with premises have failed.

---

36 EMRO’s extend the ability of the Licensing Authority to restrict alcohol retail across all of part of its area, for any duration between 12 midnight and 6am.
76. At our evidence session we heard how local licensing authorities work in partnership with on-trade premises, as part of schemes such as Pubwatch and Nightsafe. Across these initiatives however there is little to no engagement with the off-trade and little appreciation of the health impacts on alcohol misuse, and more focus on antisocial behaviour. Wycombe District Council does organise an annual licensees conference to facilitate engagement, and this is attended by some retailers.

77. One example we came across of partnership working with the off-trade, was in High Wycombe where the district council is consulting on a voluntary ban on certain high strength alcoholic drinks in all town-centre off licenses. This was aimed at addressing issues with street drinkers, and young people pre-loading before nights out.

78. As part of our evidence gathering we invited the major supermarkets with a local presence to contribute evidence on how they sell alcohol responsibly and assist in tackling alcohol misuse. We received responses from both Waitrose and Sainsbury’s (see Appendix C). We were encouraged by what we heard, with the supermarkets efforts including:

- Never displaying alcohol in foyers and never selling below cost
- Include DoH guidance on their own brand products
- Selling and promoting low alcohol drink ranges
- Communications to customers on responsible drinking and in-store notices highlighting recommended daily units and promoting the Drinkaware website.

79. Such good practice is not common to all supermarkets, but this does illustrate what engagement with other retailers, large and small, could encourage, and raise the bar with regards to responsible alcohol retailing and promoting public health messages. We were also encouraged to hear that Sainsbury’s participates in a number of Community Alcohol Partnerships which aim to drive down underage drinking through education, enforcement and public perception.

80. Such activity offers the potential to work with the off-trade on local alcohol misuse campaigns. Through the Alcohol Strategy Group offering training and materials to retailers, and perhaps though accreditation schemes similar to those used with the on-trade, engagement could be encouraged. Engagement could also be encouraged if licensing legislation and activity detailed previously in paras 70-74 came forward, and retailers thought greater restrictions on their activity could follow if they failed to engage.

81. Recognising the current gap in activity, the potential it offers, as well as it being a sensible precursor before any potential use of licensing policy tools to effect change, we feel greater partnership working and engagement with the off-trade should be pursued.

---

37 Licensing Evidence Session, 24/01/13.
Recommendation: That the Alcohol Strategy Group includes in its action plan for 2013/14 the exploration of options to increase engagement and partnership working with off-trade premises (off licenses and supermarkets), and strengthen their contribution to the local alcohol strategy and campaign work.

National Alcohol Strategy Consultation: A missed opportunity?

82. The Prime Ministers’ forward to the Governments’ Alcohol Strategy illustrates a preoccupation with binge drinking, and town centre anti-social behaviour. Health considerations do feature in the strategy, but appear secondary. This perception was identified earlier in this report and must be challenged. The House of Commons Health Select Committee concluded in their response to the strategy that it was focussed on public order issues, whilst in their view the health impacts of misuse are more insidious and pervasive\(^\text{38}\).

83. In attempting to tackle this problem partly by targeting cheap alcohol, by introducing minimum unit pricing and bans on multi buy discounts, there will undoubtedly be some impact on overall consumption and public health gains. However the government could have been more bold, and empowered local authorities to address their own alcohol related health impacts.

84. This view was reflected in our response to the Home Office consultation submitted in February 2013 as part of this review, where we focussed on the health related objective proposals (Appendix B).

85. Currently Local Authorities can’t take into account the public health impacts of alcohol in licensing decisions, which would be a means to tackle the problem at source. The recent Home Office proposals will change this but only in areas of high premises density. Mindful of the Government’s localism agenda, we think this falls short of what should be expected and is required to tackle a significant local health issue. Local authorities should be empowered with health made a fifth licensing objective, enabling local policy led control of alcohol availability subject to locally available evidence of alcohol misuse impact.

86. Given the discretionary application of CIP outlined in para 71, which could similarly apply to health as a fifth objective, we feel the Government’s view that such a legislation change would be a disproportionate response and too costly for business is unwarranted, particularly given the costs of alcohol misuse to public services outlined previously. Depending on the outcomes of any new legislation introduced following the recent Home Office consultation, we feel this is

Recommendation: The County Council and Health and Wellbeing Board should lobby Government to introduce public health as a fifth licensing objective, permitting health to be a consideration in all premises licensing decisions.

Conclusions

87. Alcohol misuse is a key public policy issue. It affects peoples’ health, their quality of life and those around them as well as representing significant pressure on public resources. The job of public agencies is however not to tell them to avoid alcohol, but instead ensure people are aware of the potential harms, and are given sufficient encouragement and support to better control their drinking. People should be aware of the impacts, what a unit is, and the recommended consumption guidelines. Cutting through all the media stories on whether certain drinks are good or bad for your health, the simple message is that it is best to drink in moderation and have at least a few alcohol free days each week.

88. That said, alcohol has become increasingly available and affordable over the last twenty years, and there are many factors which encourage consumption, not least the significant marketing budgets of the alcohol industry and retailers. Simply encouraging behaviour change is unlikely to be sufficient to tackle alcohol misuse, and it is important that not only is action taken at a national level as part of the Government’s Alcohol Strategy, but opportunities are taken locally where this would support the objectives of the local alcohol strategy.

89. There needs to be greater awareness that the costs of alcohol misuse are not limited to binge drinking in town centres and a minority of dependent drinkers/alcoholics. The health impacts of alcohol misuse are significant, long term consumption above recommended guidelines are the main contributor to these costs, and alcohol consumption of adults is just as concerning as that of young people. That most people underreport what they consume, and two thirds of alcohol is bought off-trade and typically consumed at home, helps conceals the problem.

90. Partnership working is key to tackling the issue and we have been reassured by what we have heard about the structures in place and the joint alcohol strategy that has just been refreshed. The recommendations in this report seek to further strengthen the delivery of the local alcohol strategy.

91. Local partnerships, data sharing and senior buy-in will all be vital if new opportunities are to be grasped which have the potential to reduce the size of the local population who consume alcohol in excess of recommended guidelines. Such opportunities include the County
Councils new public health role, the Government’s Alcohol Strategy and associated legislation changes, and the new Police and Crime Commissioner who has already attached significant importance to the issue of alcohol misuse.

Acknowledgements
We would like to thank everyone who assisted with and contributed to this review.

Special thanks goes to April Brett in the PCT/BCC Public Health Team who was of great value providing evidence and guiding the review.

We would also like to thank the representatives from the four district council licensing teams who contributed evidence, and spoke very openly with us on the subject of licensing.

Other contributors we would like to thank are James Morris from the Alcohol Academy, Jim Simms and Philippa Batting from Buckinghamshire Business First, Susie Yapp, Joanne Surguy from Sainsbury’s and John Gregson from Waitrose.
## Glossary and Acronyms

<table>
<thead>
<tr>
<th><strong>Alcohol Strategy Group</strong></th>
<th>Multi agency partnership, including local councils, Police and NHS, responsible for the production and delivery of the local Alcohol Strategy.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BBF</strong></td>
<td>Buckinghamshire Business First</td>
</tr>
<tr>
<td><strong>Big four lifestyle behaviours</strong></td>
<td>The four lifestyle behaviours of alcohol, smoking, physical activity and obesity which are a significant factor in a range of death and diseases.</td>
</tr>
<tr>
<td><strong>CIP</strong></td>
<td>Cumulative Impact Policy</td>
</tr>
<tr>
<td><strong>DAAT</strong></td>
<td>Drug and Alcohol Action Team</td>
</tr>
<tr>
<td><strong>DoH</strong></td>
<td>Department of Health</td>
</tr>
<tr>
<td><strong>IBA</strong></td>
<td>Identification and Brief Advice</td>
</tr>
<tr>
<td><strong>JSNA</strong></td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td><strong>Off-Trade</strong></td>
<td>Premises which sell alcohol for consumption of site such as off licenses including shops and supermarkets.</td>
</tr>
<tr>
<td><strong>On-Trade</strong></td>
<td>Premises which sell alcohol for consumption on site such as pubs and restaurants.</td>
</tr>
<tr>
<td><strong>PCC</strong></td>
<td>Police and Crime Commissioner</td>
</tr>
<tr>
<td><strong>PCT</strong></td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td><strong>Pubwatch</strong></td>
<td>A partnership of licensees, typically from the on trade, which aims to maintain a safe and secure local environment and reduce alcohol related crime. They often work closely with local authorities.</td>
</tr>
<tr>
<td><strong>Nightsafe</strong></td>
<td>A multi-agency partnership seeking to support a vibrant night time economy and tackle alcohol related crime and anti-social behaviour through education, communication and partnership activity.</td>
</tr>
</tbody>
</table>
Appendices

A - Review Scope
B - Home Office Consultation Response
C - Supermarket Responses
D - Licensing Data collected
### Appendix A: Reducing Alcohol Misuse Scope

| Membership | Jenny Puddefoot (chairman), Bruce Allen, Lesley Clarke, Lin Hazell, Steve Lacey, Wendy Mallen, Wendy Matthews, Nigel Shepherd |
| Lead Scrutiny Officer | James Povey |
| Lead Cabinet member / Service officer | Patricia Birchley – Cabinet Member for Health and Wellbeing  
Dr Jane O’Grady - Director of Public Health |

#### Background (key facts on why this issue should be reviewed)
Drinking levels in Buckinghamshire are no higher than other parts of the country, however the scale and impact of drinking, as is the case nationally, is significant. In Buckinghamshire there are:
- 76,000 (19%) hazardous / increasing risk drinkers
- 16,000 (4%) high risk drinkers
- 60,000 (15%) binge drinkers
[Data and definitions in 2011 local public health annual report]

Whilst Bucks recorded the third lowest rate of alcohol admissions from 151 PCT areas (NWPHO 2011), locally as was the case nationally there was an increase in alcohol attributable hospital admissions between 2002-2009.

Alcohol misuse increases risk of stroke, depression, cancer, liver diseases, accidental injury and suicide. Significant contributory factor to violent crime. The cost of alcohol misuse overall to society in England is £18-25 billion /yr (taking account of health, crime, loss of productivity in workplace, and cost to families).

Multiagency partnerships are already in place concerned with alcohol misuse: Drug & Alcohol Action Team (DAAT) Partnership Board, Healthy Communities Partnership, Alcohol Strategy Group, Safer & Stronger Partnership Board, Health and Wellbeing Board. There is an established Buckinghamshire Alcohol Strategy (2007-2010), and this is currently being refreshed for 2012-15. DAAT commissions services for alcohol treatment, recovery and rehabilitation and with the wider community on education and prevention matters.

Nationally the Government has unveiled its Alcohol Strategy (2012) with plans for minimum unit pricing, bans on multi-buy discounting and changes to Licensing legislation which include more consideration of local health impacts.

Given the size of the ‘increasing risk’ drinking population (i.e. those drinking above recommended guidelines), the County Councils new public health function, and the national alcohol strategy the HOSC decided to conduct a review to support the delivery of the health objectives of the local alcohol strategy.

#### Purpose of the review
To support the Buckinghamshire Alcohol Strategy to reduce the number of people drinking above recommended levels through:
- a) Local initiatives to encourage changes in peoples drinking behaviour
- b) The new health related objective for licensing

#### Anticipated outcomes
We will work with relevant partners to:
- Identify improvements to local approaches to encourage behaviour
| Key questions / tasks for the review | A1. Identify and understand of the problem and the evidence behind this, and its impact on communities / families / individuals / Health providers / the local authority (in terms of costs, resources, services, wellbeing). |
|                                     | A2. What is the current knowledge base of local ‘at risk’ / increasing risk drinkers |
|                                     | A3. What national guidance and evidence based best practice on targeted behaviour change (population profiling, social marketing) exists |
|                                     | A4. Review current local activity targeted at this group and evidence of efficacy |
|                                     | A5. What are the gaps and barriers, regarding local activity and knowledge? |
|                                     | A6. What activities (data and initiatives) are required and by who to deliver an effective approach and the budget implications of this? Is it more about re-assigning resources more effectively? |
|                                     | A7. Agree the future monitoring of recommended activities |
| B1. Understand current alcohol licensing process and context | |
| B3. Identify local issues and barriers to the effective use of the health related objective for licensing to contribute to the alcohol strategy. | |

| Out of scope | Higher risk drinkers – Although a sub group of the ‘increasing risk’ population, this group, which would include people commonly regarded as alcoholics or those dependent on alcohol, and the treatment services available to them are not a focus for this review, given we are concerned with the proactive public health agenda, and effecting behaviour change before this level of drinking. |

| Key background papers and data | Director of Public Health for Buckinghamshire Annual Report 2011 |
|                               | Buckinghamshire Joint Strategic Needs Assessment 2010 |
|                               | The Government’s Alcohol Strategy 2012 |
|                               | Buckinghamshire DAAT Drug and Alcohol Needs Assessment 2011 - 14 |

| Key stakeholders | Director of Public Health & (PCT/BCC) Public Health team |
|                 | Drug and Alcohol Action Team |
|                 | District Council Licensing Teams |
|                 | BCC Cabinet Member for Health and Wellbeing |
|                 | Clinical Commissioning Groups |
|                 | Buckinghamshire Healthcare Trust |
|                 | Health and Wellbeing Board |

| Timetable | Evidence collection Dec 2012 – Feb 2013 |
|           | Reporting March – April 2013 |
| Reporting mechanism | BCC Cabinet Member for Health and Wellbeing  
Healthy Communities Partnership  
Drug and Alcohol Partnership Board  
Alcohol Strategy Group |
|---------------------|---------------------------------------------------------------------------------------------------------|
| Evidence sources    | Desktop Research  
NHS Buckinghamshire (PCT) public health team  
Drug and Alcohol Action Team  
Frontline staff delivering Intervention and Brief Advice (IBA)  
District Council Licensing Teams  
Magistrates / Legal advice  
Alcohol/health charities/community groups |
Appendix B: BCC Health Overview and Scrutiny Committee response to the Home Office Consultation on delivering the Government’s policies to cut alcohol fuelled crime and anti-social behaviour.

The HOSC submitted its response on the 6 February 2013, informed by the evidence collected as part of this review. In addition to completing relevant questions in the pro forma (below) the HOSC submitted an overall response by email (over the page).

Pro forma Responses

Do you think any aspects of the current cumulative impact policy process would need to be amended to allow consideration of data on alcohol-related health harms?

Please select one option.
YES

If yes, please specify which aspects in the box below (max 200 words)

Data on alcohol health harms do not seem compatible to justify a policy limited in coverage to a very local area, and given the lag time between a history of consumption and that materialising into harm. It sounds good in principle but seems unlikely to stand up to scrutiny. You could be trying to justify decisions concerning a single premises, based on a health issue that could have been in the making for 10-20 years caused by alcohol purchased nowhere near the premises.

It would be far better and more workable, to introduce health as a fifth statutory licensing objective, with policies justified by authority wide population data concerning health and alcohol consumption which is already readily available. Concerns over the costs of this to business do not appear justified, given new premises could still be permitted providing they demonstrated how they would promote the responsible consumption of alcohol, or at least not encourage the irresponsible consumption of alcohol. It could then be determined locally what other conditions, including involvement in any relevant local partnership and accreditation schemes, would be appropriate to assist with tackling local public health issues arising from alcohol consumption.

What impact do you think allowing consideration of data on alcohol-related health harms when introducing a cumulative impact policy would have if it were used in your local area?

Please specify your answer in the box below, providing evidence to support your response (keeping your views to a maximum of 200 words):

Very little, and we suspect that is the intention given the consultation states it is likely to be limited to areas with the highest/fast rising levels of alcohol related harm.
In practice it will be difficult to use population level health harm data as supporting evidence against specific premises and locations.

With uncertainty over the strength of such data in the licensing process and hence the likely outcome, public health teams and local authority licensing teams are unlikely to put the resource into the compilation of the data into a useable format and geography, and the development of the local policies supported by it. Furthermore with health data only being of value in supporting crime and disorder objectives predominantly, given the current four statutory licensing objectives, it is doubtful much resource will be put into this unless the Police push for it.

Overall this is disappointing given locally we have 90,000 people drinking at levels which is at risk to their health and locally this is estimated to cost the NHS £26m per year, not to mention the costs to social services, police, business etc.

----------------------

**Overall Response submitted by email:**

We represent the views of Buckinghamshire County Council Health Scrutiny Committee. Between November 2012 – March 2013 we undertook a review on the subject of Reducing Alcohol Misuse. As part of this we looked at the role of licensing which included these Home Office Alcohol Strategy proposals. To inform our views we held an evidence session with representatives from Chiltern, South Bucks and Wycombe District Council licensing teams, and received a written statement from Aylesbury Vale.

We consider that the proposed health objective for cumulative impact policies represents a missed opportunity, and that the Home Office should reconsider introducing health as new objective alongside the existing four statutory licensing objectives, as is the case in Scotland. The current proposal reflects a preoccupation with on-sale premises and the social disorder some generate in town centres, rather than a genuine effort to improve public health.

90,000 Buckinghamshire residents drink at levels which is at risk to their health and locally this is estimated to cost the NHS £26m per year. Alcohol is freely available and the majority of it is bought at off-sales premises and consumed at home. Minimum unit pricing and (providing retailers don’t find ways to circumvent the rules) the ban on multi-buy promotions will help, but will not influence a significant proportion of the population who can afford to pay more or who’s type of drink will not see much change in cost.

Despite alcohol misuse being a significant local issue, Buckinghamshire is not considered to have many high densities of alcohol premises. We think it is wrong for the licensing process not to take account of the health impacts of alcohol in the absence of a concentration of premises. This is particularly so given the large volumes of alcohol which are sold by supermarkets at very competitive prices.
An out of town supermarket selling large volumes of alcohol at competitive prices, and at prices much lower than on-trade premises, has no less impact on the local population's health than a concentration of town centre pubs and off-licenses. Restricting the public health objective to cumulative impact policies will therefore limit the influence local authorities can have over major retailers of alcohol, and the partnership working that could otherwise be encouraged to improve local public health.

Local licensing authorities should be free to use local health evidence alongside economic and social considerations in setting and enforcing their policies. The current proposals, as is the case with existing policy, will restrict their ability to do so.

Alcohol misuse is a public health issue for most local authorities, and it seems counter intuitive to limit their influence over the source of the problem. In Buckinghamshire it is unlikely a public health objective would be used to reduce the number of premises locally. Instead the aim would most likely be to encourage certain types of premises which would be less likely to encourage irresponsible drinking behaviour, and encourage more responsible retailing and partnership working to address alcohol misuse.

Given the clear links between alcohol consumption and health harms, it does not make sense that those providing the product to the population are not required to take some responsibility and play a role in reducing those health harms caused by excess consumption. By introducing public health as a fifth licensing objective for all premises, they would have to offer conditions and demonstrate how they would promote healthier drinking habits and not encourage excess consumption.

We urge the Home Office, alongside colleagues from the Department of Health, to reconsider their position on health as a fifth statutory licensing objective.
Appendix C: Supermarket responses received from Waitrose and Sainsbury's

WAITROSE:

May I begin by apologising for taking such a long time to reply to your original note regarding your local scrutiny into alcohol misuse.

I’m afraid that we will be unable to send anyone to appear in person for the review but I wanted to take this opportunity to let you know about the Waitrose approach to the sale of alcohol.

The health of our customers is of the utmost importance to Waitrose. We are committed to selling alcohol responsibly and pursue policies which support this objective.

Waitrose does have a wide ranging approach to the issues associated with alcohol which cover how we sell it and the information we give customers.

There are a number of policies which support our position and general stance. In summary we:

- Never display alcohol in foyers
- Never sell below cost
- Always offer a non-alcoholic alternative for Meal Deals (except in the Channel Islands)
- Have never been prosecuted for under age sales
- Never sell spirits at half price
- Only sell beers below 5.5% in our wine bars
- Include the DH guidance on the labels of all of our own label products
- Highlight the ABV on shelf edge tickets for our lower alcohol range
- Have improved customer engagement around responsible drinking, including linking food and wine
- Have improved customer communication at the fixture, online and through print marketing
- Support the pledge to remove 1bn units from the market

Minimum Unit Pricing:
We welcome the Government's proposals as a constructive approach. We fundamentally believe that changes to pricing should be accompanied by a long-term approach to customer education. It is important that we strike a balance between offering consumers who drink sensibly good value for money, at the same time as preventing irresponsible drinking.

Multi-buy discounts:
We also welcome the Government's proposals to promotional changes as a constructive approach. We fundamentally believe that changes to promotions should be accompanied by a long-term approach to customer education. Whilst we currently do offer multivalue promotions on wine we will continue to work with the Government as they develop alcohol legislation and will ensure our business complies with any changes. Already, our meal deals always includes a non-alcoholic alternative and we never run 50% discount offers on spirits.
Labelling
We are committed to providing clear labelling on all of our own label products, so that customers can make informed choices about the products that they buy and how they choose to consume them.

All of our own label beers, wines, spirits and ciders carry clear labelling including:
- Unit information
- NHS drinking guidelines
- Pregnancy warnings
- Energy content
- Link to the drinkaware website

Information
We provide guidance about responsible drinking in our branches, in our print publications and on our website.

The following web links contain further information for our customers

http://www.waitrose.com/content/waitrose/en/home/inspiration/About_our_product_ranges/drink/drinking_and_you/drinking_guidelines.html

http://www.waitrose.com/alcohol

Additionally, in our branches we display Point of Sale notices in our Beers, Wines and Spirits department.
I hope you have found this information helpful. Please do not hesitate to contact me for further information.

Yours sincerely

John Gregson
Senior Manager
Public Affairs

SAINSBURY's:

Please see below the link to our Corporate Responsibility Report. This outlines all our health initiatives including our plans for a “lighter” range of alcohol for our customers. The attachments are copies of new advertising which is being introduced into stores to highlight the lighter range of wines available.

http://www.j-sainsbury.co.uk/media/171822/cr2011_report.pdf

As a major retailer, we recognise our responsibility to ensure we do not sell alcohol to those underage and also to encourage our customers to drink responsibly.

We are committed to playing a constructive role in bringing about real change in this area and as part of this, have signed up to all the alcohol pledges in the Government's Public Health Responsibility Deal, see attached document.

We are an active supporter of Drinkaware and operate a rigorous Think 25 policy to help reduce under-age purchasing of alcohol. We have been a partner in the Community Alcohol Partnership (CAP) scheme since 2007. We are also committed to providing clear labelling to customers and all Sainsbury's own brand alcohol products include Department of Health approved information about units.

I am waiting for information from our Head of Wellbeing and Health regarding the material supplied to staff with regards alcohol and other health related issues, as soon as I receive this I will forward this on to you.

Also with regards the staff training/initiatives we have in place, please see below for your information:

- Substance misuse policy
- Training material for our Line Managers /HR Managers
- Any Occupational Health Referrals are signposted to relevant teams including PCT, colleagues need to show evidence they are attending AA or other support.
- Health and Wellbeing campaign each year, 2013 will be run last qtr of the calendar year and is called “Message in a bottle” where we will try to raise awareness of risk of alcohol and work activities particularly, driving.
Kind regards, Joanne

Joanne Surguy | Licensing Manager
Sainsbury’s Corporate Services Division
Expertise you can trust

Sainsbury’s Supermarkets Ltd | 33 Holborn London | EC1N 2HT
Appendix D: Licensing Data gathered in advance of evidence session on 24 January 2013

Alcohol availability past and present

The number of off licence premises doubled between 1953 and 2010 (from 24,000 to 45,000), and overall in 2010 the number of premises with on-sales alcohol licences and both on and off-sales alcohol licenses was at the highest level in 100 years. The number of on and off licensed premises increased by 20% between 1980-2004 in England and Wales.

2001 comparative data (as at 30/6/2001)

Local licensing data pre 2004 was collated by Petty Sessional Division (now known as Local Justice Areas) reflecting the fact that licensing was the responsibility of the magistrates rather than district councils. Data for Buckinghamshire was compiled from Central Buckinghamshire, Milton Keynes, and Wycombe & Beaconsfield.

In 2001 on licensed premises (pubs, restaurant, residential, clubs) in Buckinghamshire totalled 1,242 (includes MK LJA) equating to 17.9 per 10,000 population. Excluding MK totalled 918.


In 2001 off licenses premises (garages, supermarkets, shops) totalled 482 (includes MK LJA) equating to 7.0 per 10,000 population. Excluding MK total was 337.


2012 Licensing Data, National, Local and Comparative (as at 31/3/2012)

Nationally (England and Wales) licence totals are:

- 202,000 premises licenses, the same as on 31 March 2010;

---


Due to difficulties in classification licensing authorities do not collect details of whether a premises is a pub, bar, club, store etc. The Act defines activities not premises types. Also note that the possession of a particular licence does not mean premises is actually providing such a service. See [http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/home-office-science/alcohol-lnr-licensing-user-guide?view=Binary](http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/home-office-science/alcohol-lnr-licensing-user-guide?view=Binary)
- 15,900 club premises certificates, six per cent fewer than in 2010; and
- 502,400 personal licenses, 16 per cent more than in 2010.

District statistical returns in Buckinghamshire show the following totals for various licence types which permit the sale of alcohol:

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Premises Licenses</th>
<th>Club Licenses</th>
<th>Personal Licenses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>On-sales or supply of alcohol only</td>
<td>Off-sales of alcohol only</td>
<td>Both on and off sales or supply of alcohol</td>
</tr>
<tr>
<td>Aylesbury Vale</td>
<td>279</td>
<td>107</td>
<td>33</td>
</tr>
<tr>
<td>Chiltern</td>
<td>41</td>
<td>61</td>
<td>117</td>
</tr>
<tr>
<td>South Bucks</td>
<td>26</td>
<td>48</td>
<td>228</td>
</tr>
<tr>
<td>Wycombe</td>
<td>58</td>
<td>141</td>
<td>192</td>
</tr>
</tbody>
</table>

The following table combines the above totals to give a comparison of on and off-sale licenses per 10,000 head of population for each district, as well as England and other selected counties:

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Resident population /10,000</th>
<th>Total on-sales Licenses, (Premises and Club Certificate) (including on and off-Sale combined licenses)</th>
<th>On-sales licenses per 10,000 head of pop</th>
<th>Total off-sales licenses</th>
<th>Off-sales licenses per 10,000 head of pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aylesbury Vale</td>
<td>17.4137</td>
<td>371</td>
<td>21.3</td>
<td>107</td>
<td>6.1</td>
</tr>
<tr>
<td>Chiltern</td>
<td>9.2635</td>
<td>198</td>
<td>21.4</td>
<td>61</td>
<td>6.6</td>
</tr>
<tr>
<td>South Bucks</td>
<td>6.6867</td>
<td>289</td>
<td>43.2</td>
<td>48</td>
<td>7.2</td>
</tr>
<tr>
<td>Wycombe</td>
<td>17.1644</td>
<td>298</td>
<td>17.4</td>
<td>141</td>
<td>8.2</td>
</tr>
<tr>
<td>England</td>
<td>5301.2456</td>
<td>109365</td>
<td>20.6</td>
<td>42463</td>
<td>8.0</td>
</tr>
<tr>
<td>Herts</td>
<td>111.6062</td>
<td>1490</td>
<td>13.4</td>
<td>686</td>
<td>6.1</td>
</tr>
<tr>
<td>Northants</td>
<td>69.1952</td>
<td>1641</td>
<td>23.7</td>
<td>759</td>
<td>11.0</td>
</tr>
<tr>
<td>Oxon</td>
<td>65.3798</td>
<td>1796</td>
<td>27.5</td>
<td>483</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Commentary: Alcohol availability in the districts of Buckinghamshire would appear in line with what is typical of neighbouring comparable counties and the average for England, both for on and off-sales licences. This is similar to

the situation ten years ago. However this is against a backdrop of increasing alcohol availability since the mid 20th century nationally. The table above highlights South Bucks has a significantly (more than double) higher number of on-sale licensed premises per head of population than the other districts and the England average.

**Cumulative Impact Areas in the County**:  
A Vale: 1 (Aylesbury Town Centre)  
Chiltern: 2 (Amersham Old Town, Chalfont St Peter)

Cumulative Impact Policy create a rebuttable presumption that applications for new premises licences or club premises certificates or variations that are likely to add to the existing cumulative impact will normally be refused, following relevant representations, unless the applicant can demonstrate in their operating schedule that there will be no negative cumulative impact on one or more of the licensing objectives.

**2011/12 Licensing activity by District**

<table>
<thead>
<tr>
<th></th>
<th>Aylesbury Vale</th>
<th>Chiltern</th>
<th>South Bucks</th>
<th>Wycombe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Premises Licence</td>
<td>Applied 29</td>
<td>13</td>
<td>8</td>
<td>26</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>Granted 25</td>
<td>13</td>
<td>8</td>
<td>25</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>Refused 0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Variation to Premises Licence</td>
<td>Applied 13</td>
<td>15</td>
<td>8</td>
<td>241</td>
<td>277</td>
</tr>
<tr>
<td></td>
<td>Granted 13</td>
<td>15</td>
<td>8</td>
<td>241</td>
<td>277</td>
</tr>
<tr>
<td></td>
<td>Refused 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table shows it is very unusual for a licence application to be refused.