Written response from NHS Lothian

Thank you for the opportunity to contribute to the Committee's deliberations. I am replying on behalf of NHS Lothian. I note that you are interested in the extent of the Board's relationship with their local licensing boards, how much information they provide license boards and the extent to which local health concerns linked to alcohol are brought to the attention of the licensing board.

NHS Lothian has four licensing boards in its area – City of Edinburgh, East Lothian, Midlothian and West Lothian. NHS Lothian has had extensive and sustained input into the Edinburgh Licensing Board and at times extensive input into the other three boards

While we welcomed becoming a statutory consultee, this was a new area for detailed public health involvement and it has taken a little while to understand the way the licensing system operates and how best to contribute. The five licensing principles remain a very strong statement of the public interest. However there has been a significant learning curve to be able to contribute to this work and it is to some extent unsurprising if progress has been patchy. Licensing is its own, very legalistic world and health considerations have not previously been so prominent in the consideration of boards.

Licensing Forums

We have also tried to cover the four licensing forums and support their work with inputs and suggestions for other presentations to assist their deliberations. Tthe best Forums engage the community councils who can be powerful advocates for the public interest. For instance, the Edinburgh Licensing Forum has a good mix of diverse trade, community reps and statutory representatives.

However, it is difficult for a Forum to scrutinise the work of its Licensing Board when there is such a dearth of data. It is very hard to extract meaningful statistics and trends from licensing boards. Evaluating changes in licensing policy is very difficult. The proposal for an annual report may help to overcome this issue, particularly if the Scottish Government put a minimum dataset into guidance for Boards. Currently, for instance it's not easy for a Forum to tell if the number of offsales in their board area has increased or decreased or stayed the same. Boards and Forums are further hampered by not having access to aggregate sales data for their area. It is essential that Boards and Forums have a clear idea of the amount of consumption of alcohol in their area. The Health Baord cant supply this data. Rather than relying on estimates which do not go down to even local authority level, a Board could receive on a confidential basis annual sales data from each licensed premises and therefore have a reasonable proxy for the amount being consumed in their area, perhaps broken down by locality. No indicator will be perfect but this will be closer than using self reported surveys of alcohol use. Otherwise all attempts to control the effects of alcohol are hampered by a lack of specific, local information on consumption.

Local Alcohol and Drug Partnerships have also had a very helpful input, particularly in the coordination of evidence from the various partners and also in Edinburgh around engaging with other interested parties such as economic development.

City of Edinburgh.

I routinely attend the City of Edinburgh Board on behalf of NHS Lothian and we have objected to 39 applications in the three years from December 2011 to December 2014, mainly focusing on new off-sales applications on the basis that 70% of alcohol sales are through off sales in Scotland. NHS Lothian has contributed significantly to the last two Licensing Board policies and in particular to the debates about overprovision. Four years ago NHS Lothian contributed substantially to the statistical and evidential input into assessment of areas of overprovision including an analysis of the licensing board's data geographically to help inform the debate. At that time the Edinburgh Licensing Board was interested in declaring the whole of Edinburgh as overprovided for off-sales. This led to the Licensing Board at that time to turndown three applications for off sales (see case study). However, the policy was a somewhat equivocal about the position and did not formally declare the overprovision, merely that it was minded to but recongised that the Act did not give a specific power to declare a whole area as overprovided for, only a locality or localities.

Case Study

On the 19th March 2012, Edinburgh Licensing Board adopted a revised statement of licensing Policy incorporating a new policy on the overprovision of off-sales licenses. At their following meeting on the 23rd April 2012 three applications for off-sales licenses in the City were turned down with reference to this policy. One of these applications was from one of the big four supermarkets for a provisional license for a new 'convenience' supermarket in the city centre in an area where there is a comparatively high density of off sales outlets and where residents are affected by alcohol related harm (as evidenced by the rate of alcohol related hospital admissions).

This decision was taken to appeal in the Sherriff Court by the applicant. Legal opinion was sought by the Licensing Board which cast doubt on the legal strength of the wording of the Board's Policy and its reasons for refusal (The statement of reasons). Subsequently, all parties agreed to the decision being 'remitted' (sent) back by the Sheriff Court to the Licensing Board for re-consideration. The Court did not provide a judgment on the Policy or the decision.

Meanwhile in May 2012 local government elections took place and this led to a change in Convenor and in the membership of the Board. The remitted decision was inherited by this newly constituted Licensing Board and, at their first meeting, after hearing representations from all parties involved, the license was granted, reversing the decision of the previous Licensing Board. At subsequent meetings the other two licenses that had been refused were also granted.

East Lothian

NHS Lothian has had input into both the Licensing Board when considering its policy and also in the Licensing Forum. The Alcohol and Drugs Partnership that covers East Lothian led on a report of statistics and evidence to which NHS Lothian contributed. This assisted the licensing board in declaring the whole of East Lothian

overprovided for. At the moment NHS Lothian is looking to provide more permanent input since a key staff member moved on.

Midlothian

NHS Lothian contributed to the development of a report on overprovision which has led to the licensing board declaring Dalkeith Town Centre as overprovided for. NHS Lothian has submitted its first objection to an application in January 2015. We also attend and contribute to the Licensing Forum in Midlothian.

West Lothian

Public Health have presented to the Licensing Board on two occasions in the last 4 years around the issue of availability and health harms in West Lothian. The Alcohol and Drug Partnership coordinated a very detailed consideration of the overprovision issue under the previous board but this did not lead to any change in the policy locally. NHS Lothian has not objected to any specific applications yet in West Lothian. The Forum has been active in West Lothian and NHS Lothian colleagues have been contributing to its deliberatios, including chairing the Forum latterly.

Overprovision

I would like to end with a consideration of the assessment of overprovision as this has dominated much of our interactions with licensing boards. At the heart of this debate has been a consideration of what board members, Clerks, legal representatives and objectors consider as evidence.

The *Licensing (Scotland) Act 2005 – Section 142: guidance for licensing boards and local authorities* was published by the Scottish Government in April 2007. Section 3 covers overprovision. Since the guidance was published Boards have grappled with the issue of overprovision and found it quite difficult to come to a satisfactory conclusion, although a number of Boards have come to a variety of conclusions, including locally in Midlothian and East Lothian.

One of the reasons for the difficulties that some boards have experienced in this area is that the wording of the guidance is problematic and to some extent contradictory in relation to the burden of proof that it suggests is required to make a declaration of overprovision in a locality or localities in a Board area.

The burden of proof is defined as the obligation to prove one's assertion. There are two standards in legal cases, one for civil cases and one for criminal cases. At paragraph 47 it states that a "dependable causal link" needs to be "forged between the evidence and the operation of licensed premises in a locality". This wording appears to confer a high burden of proof on the objector, perhaps as high as 'beyond reasonable doubt' which is the standard in criminal cases.

Paragraph 48 states that "consideration should be given as to whether aggregated information and evidence from a number of sources points compellingly towards a particular conclusion". It might be argued that "compellingly" is closer to a notion of the civil burden of proof – on the balance of probabilities.

Epidemiology has been defined as the science and practice which describes and explains disease patterns in populations. It is very much concerned with analysing patterns scientifically and understanding the causes of disease and ill health. Establishing causation is a central concern, not for its own sake but so that action can be taken to protect and promote health and prevent harm. Epidemiology provides information for action.

The notion of the balance of probabilities sits well with public health notions of causality and the levels of evidence on which to base action to promote and protect health. In public health we aspire to ascribe causality on the basis of a careful judgment against a framework of guiding questions. Over the years helpful criteria have been put together to aid the judgment as to whether an observed association is most likely to be based on cause and effect. What is the strength and consistency of the association? How specific is it? Are we sure which comes first? Is there a dose-response curve? Is there a biologically plausible explanation? Do experiments such as ending the exposure result in a change in the situation. Are there similar situations that provide an analogy?

It cannot be emphasised enough however that these helpful questions are just that and cannot remove the element of judgment from a decision. Proof is defined as the evidence establishing a fact or the truth of a statement.[1] But in all areas of policy making we hardly ever have overwhelming evidence of the effectiveness of interventions. Correlation is not causation but it is important to investigate a correlation and look to evidence from other areas and countries to come to a judgment.

There has clearly been a variation in the degree to which some Licensing Boards are prepared to come to a judgment and this has coloured the success and to some extent the level of engagement of health in licensing. Given how long effective tobacco control has taken, it would be unreasonable perhaps to expect overnight success in a relatively new area such as licensing. But it is also clear that licensing has a very important part to play in promoting and improving public health.

[1] Concise Oxford English Dictionary, Oxford: Oxford University Press, Eleventh edition (revised) 2006