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Health as a Licensing Objective

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Report of: Chief Officer Elections and Regulatory and Director of Public Health

Report to: Licensing Committee

Will the decision be open for call in? ☐ Yes ☒ No

Does the report contain confidential or exempt information? ☐ Yes ☒ No

Brief summary

Local health bodies have been a responsible authority under the Licensing Act since 2012, however, without a health specific licensing objective, their ability to reduce the harm alcohol has on individuals and communities is limited. Without a Public Health Licensing Objective, health evidence must be linked to the protection of children from harm. This fails to capture the significant health harms of alcohol and restricts the ability of Local Authority Public Health to make meaningful representations to protect the people of Leeds from such harms.

A health licensing objective would allow Public Health to a broad spectrum of health data such as that provided by hospitals, ambulance services and GPs to show how a proliferation of licensed premises in an area is having an impact on health. This data can be provided on an MSOA basis, and so is relevant to a locality but not at a street level as this would identify patients. This allows Leeds to protect patient confidentiality whilst having a good understanding of the harms that different neighbourhoods experience. This is already successfully used for the Alcohol Licensing Data Matrix.

Alcohol is a complex issue and regulating the alcohol environment through Licensing is an important measure. However, this alone will not address broader cultural and social norms around drinking in the UK, particularly the social acceptability of drinking at levels of increasing risk which have a serious impact on the health of people in Leeds.

Recommendations

a) To receive this report regarding health as a licensing objective

b) To consider any action that may be appropriate

What is this report about?

Background

1 Local health bodies – usually local Directors of Public Health – became a Responsible Authority for Licensing through the Police Reform and Social Responsibility Act 2011 which was implemented in 2012. However, health was not made a licensing objective at that time. Any health representation must be made under other licensing objectives, for example public safety or protection of children from harm.

2 In Scotland, public health boards have been responsible authorities and protecting and improving public health has been a licensing objective since 2009. There is a natural experiment in Scotland where there is a health licensing objective and where attempts are being made to evaluate the impact on population health and these findings are helpful in understanding the case for a public health licensing objective in England. Minimum Unit Price was introduced in Scotland in May 2018.

3 In April 2013 Public Health teams moved from the NHS to the Local Authority as a result of the Health and Social Care Act 2012 which strengthened the relationship between public health and local government.

4 The Local Government Association (2020) issued advice to public health on how to intervene on licensing issues stating that "whilst public health can contribute against any of the four existing licensing objectives, in practice it can be difficult for them to be heard". In 2014, and again in 2021, the Local Government Association called for a public health licensing objective and an LGA survey (2016) found widespread support amongst Directors of Public Health for a new public health licensing objective. The Association of Directors of Public Health (2023) advocate for a new public health licensing objective as part of the Licensing Act to ensure that public health is placed at the centre of licensing policies.

5 The Home Office (2023) in their Revised Guidance issued under section 182 of the Licensing Act 2003 (2.8) specifically state that public health should not be considered under the "public safety" licensing objective because "this concerns the safety of people using the relevant premises rather than public health which is addressed in other legislation", although Directors of Public Health are allowed to contribute to the protection of children from harm licensing objective with data on harms to underage drinkers (2.35). The Home Office (2012) dismissed introducing health as a fifth licensing objective "as being disproportionate given the evidence base and anticipated larger costs to business".

6 Alcohol-related health data from 2022 (OHID,2024) shows that deaths wholly due to alcohol in England continue to rise and those partly due to alcohol follow a similar trend but at this time in 2024 health is still not a licensing objective.

Health As A Licensing Objective

7 Health as a licensing objective has been something that Licensing Authorities and the LGA have been lobbying for since around 2012.

8 There was a commitment to investigate this as part of the government's alcohol strategy published in March 2012. Home Office Alcohol Strategy (publishing.service.gov.uk) and the government consulted on the issue in 2012: Impact Assessment - health as a licensing objective (publishing.service.gov.uk). The response states:

9 "During the recent consultation, the Government sought views on how to introduce health as a licensing objective linked specifically to cumulative impact. This would allow licensing authorities to take wider alcohol-related health harm into account when developing cumulative impact policies. A clear theme from respondents was that, at present, local processes and data collection are insufficient, meaning that it is unclear how this proposal could be implemented in practice. The Government remains interested in this policy in principle, as there is good international evidence that controls on premises density reduce a range of harms from alcohol, including crime and health harms. However more work is required at a local level to put in place processes to underpin it. This will form a key part of work in local alcohol action areas. The Government will ask Public Health England to support local areas in England interested in this work."

10 This was looked at again in 2017 as part of a House of Lords Select Committee on the Licensing Act. House of Lords - The Licensing Act 2003: post-legislative scrutiny - Select Committee on the Licensing Act 2003 (parliament.uk). The conclusion the Select Committee came to then was:

"All Governments should adopt policies attempting to reduce the harmful consumption of alcohol. The Government has done so for England and Wales, the Scottish Government for Scotland, and in later chapters we note steps which could be taken within the licensing system to take forward this policy. But putting ourselves in the position of a licensing authority having to decide whether to refuse an application, or to impose conditions, we do not believe that the promotion of public health is capable of relating to specific premises and particular licensing applications. Promotion of health and well-being is a necessary and desirable objective for an alcohol strategy, but we accept that it is not appropriate as a licensing objective."

11 Again it's the same argument that health data is too broad to be used in licensing applications.

12 However the LGA continues to lobby Government:
Public health and the Licensing Act 2003 | Local Government Association
Microsoft Word - br032016.3 - Licensing and Public Health.doc (ias.org.uk)
Public health should be a factor in licensing decisions, says LGA | Local Government Chronicle (LGC) (lgcplus.com)

Is Health Data Specific Enough?

13 In Leeds we understand the value of health data in licensing decisions. We have worked together with Public Health to develop a tool which provides data on an MSOA level.

Leeds Alcohol Licensing Data Matrix

14 Middle layer Super Output Areas (MSOAs) are geographical areas designated by the Office for National Statistics. Each MSOA comprise between 2,000 and 6,000 households and have a usually resident population between 5,000 and 15,000 persons. For the vulnerable areas in Leeds, MSOA level data is specific enough, due to the density of housing in these areas. For example there are 3 MSOAs that cover the area of Harehills.

15 We take a range of data sources and rank MSOAs against these data sources. We also have an overall ranking. The sources we use are specifically chosen as they either directly relate to one of the four licensing objectives – crime, and disorder, public safety, nuisance, or protection of children, or they provide an overall flavour of the area, for example deprivation.

16 As an example, in the table above there are several data sources that relate to children – NEETs, Not achieving English and Maths strong pass, looked after children, population aged 16 and under. The high ranking of these data sets indicates this is an area where there are vulnerable children who may be impacted by the number of alcohol licensed premises. The data relating to stroke emergency admissions, alcohol related harm hospital stays, alcohol use disorders identification test (where a patient advises their GP, they drink more than 30 units a week), and alcohol treatment shows this is an area which has significant problems relating to the abuse of alcohol. This directly impacts on the protection of children. You can see there is a very high level of violent crime where alcohol is flagged, antisocial behaviour – alcohol related and drunk and disorderly crime. This shows that alcohol has an impact on crime and disorder in the area. Add to this the very high density of off licensed premises, and the very high level of licensing risk scores (the scores enforcement officers give when they inspect premises in this area), this shows that it is off licences, where there is little confidence in the management, that are adding to this problem.

17 This information is used, along with Police crime statistics, to identify areas that may be suffering from the cumulative impact of licensed premises. In Leeds we have identified 6 such areas. Three of these have issues directly related to the density of off licences. There is a seventh area being investigated at this time.

18 Both the Licensing Authority and Public Health use this data use this tool when we look at licence applications. We are aware of the areas in Leeds where there is significant health harm due to alcohol, and these are the same areas which the council has identified as a priority. Agencies are already working in these areas to reduce health inequalities, to reduce crime and the fear of crime. We use the cumulative impact assessment, and the data from this Matrix to raise objections to applications for new premises licences as well as variations to existing ones.

19 We find this approach to be very successful. We are often able to secure a refusal for a new application, but where the applicant can demonstrate that they can operate without adding to the issues being experienced in the area, the Licensing Authority is able to impose tighter controls on the licence, through licence conditions to ensure that this is the case. For example, an applicant for a new off licence offered a £10 minimum grocery spend before alcohol could be purchased. This, along with conditions prohibiting the sale of super strength alcohol, has meant that this premises is not attracting custom from alcohol dependent drinkers or from the large family groups who create antisocial behaviour in residential areas.

20 For example, Harehills is an area that has recently been in the news due to disorder. In this area there is a proliferation of premises licensed to sell alcohol for consumption off the premises, which are mostly small independently owned shops. These premises supply cheap high strength alcohol to people who habitually drink in the street, and to family groups who have a culture of drinking in large family groups, socially and outside their homes. This creates community tension with groups who do not have a culture of drinking alcohol.

21 People who drink habitually in the street, either because it is their culture, or because of alcohol dependency display challenging antisocial behaviour and are regularly attended to by the local neighbourhood policing team and the Council's antisocial behaviour team. The council have designated this area as suffering from the cumulative impact of alcohol, due to this disorder and the density of off licences.

22 However, this area also ranks highly for health related data, for example, stroke emergency admissions, alcohol related harm hospital stays, alcohol use disorders identification test (a World Health Organisation screening tool which gives a numerical score to indicate harms and risk from drinking alcohol) and alcohol treatment which shows this is an area which has significant health harms relating to the alcohol use. At the moment Public Health make representations based on the protection of children from harm, but a much stronger case could be made if health was a licensing objective. If crime and disorder were absent from this area, it would not rank so highly on the council's priority list, despite there being a high level of alcohol related harm. The council would be powerless to restrict the number of premises licensed to sell alcohol on the basis of alcohol harm.

23 The health harms data referred to describes some of the longer-term health impacts of alcohol consumption at higher risk levels. It is important that if health is made a licensing objective, that chronic effects of alcohol use - for example liver damage and alcohol related brain damage – are considered as well as acute effects such as injury due to alcohol related violence or accidents captured in ambulance and emergency room data. The use of both chronic and acute health harms data gives a clearer picture of the impacts of alcohol on health. The experience of Public Health teams both in England and Scotland has been that the restriction of Public Health evidence to short-term, premises specific and local evidence fails to capture the extent and severity of alcohol-related harms.

What impact will this proposal have?

24 There are limitations to the action Leeds is currently able to take to address alcohol-related health harms on a local level. Leeds City Council uses its existing powers well for example using Cumulative Impact Assessments and using the Alcohol Licensing Data Matrix to make effective representation on premises licence applications. Cumulative impact assessments help, and are specific to a locality, but to address the alcohol related harm in the longer term, national policies are required, such as minimum unit price, alongside a public health licensing objective.

25 Local public health teams are given the responsibility to address alcohol-related health harms and have been specified as a responsible authority to do so but without the tools or legitimacy to make meaningful representations. This makes it hard to justify the expenditure of public health resources in making representations to licensing applications and attending the subsequent hearings where the outcome is uncertain and potentially limited to the application of conditions. In Leeds, Public Health work closely with the licensing authority despite the limitations of the regulation but this is not the case in all Local Authorities.

26 Public Health as a Licensing Objective and Minimum Unit Price are important cogs within a complex machine. Health as a licensing objective is not a panacea for all alcohol-related harms and in Scotland it has been hard to quantitatively show impact, in part because of other factors which licensing is less able to influence such as social norms around alcohol and home deliveries of alcohol which licensing is less able to influence but which impact availability and affordability of alcohol. Therefore, it is important to be realistic about the impact of Public Health as a Licensing Objective and to continue to address the wider alcohol environment, and cultural and social norms around drinking alcohol.

27 A fifth licensing objective of health and wellbeing would allow us to use other health data without being restricted to the four licensing objectives. For example, we have liver testing programme data which we do not reference. We could identify areas through the Health Needs Assessment process which would benefit from a cumulative impact policy. We are aware in some part of South Leeds, the mortality rate is ten years lower than in other more affluent areas. This information is not used in licensing decisions as it does not relate to one of the licensing objectives, however we know that one of the causative factors of a reduced life expectancy is alcohol use. However, in the main a fifth licensing objective would strengthen the representations from Public Health.

How does this proposal impact the three pillars of the Best City Ambition?

☒ Health and Wellbeing ☐ Inclusive Growth ☐ Zero Carbon

28 The proposal to make health a fifth licensing objective would directly impact on health and wellbeing. It would provide Public Health with a stronger voice when objecting to licence applications and would allow health data to be used to directly address health harms in the Council's Statement of Licensing Policy.

What consultation and engagement has taken place?

Wards affected:
Have ward members been consulted? ☐ Yes ☐ No

29 This report is for information and consideration only. At this point a formal consultation is not required, however the matter has been discussed at length with partner agencies and has been a national conversation since 2012.

What are the resource implications?

30 There are no resource implications associated with the report recommendations and it is unlikely there to be any significant resource implications for the subsequent actions Licensing Committee may wish to undertake.

What are the key risks and how are they being managed?

31 There are no key risks associated with the report recommendations.

What are the legal implications?

32 There are no legal implications associated with the report recommendations.

Options, timescales and measuring success

What other options were considered?

33 The report recommendations ask that Members consider the information provided in this report and consider any action that may be appropriate.

34 The Local Government Association has lobbied Government on health as a licensing objective several times over the last ten years. Similarly this matter has been addressed when the Local Government Association has responded to Government consultations on this matter. Licensing Committee could choose to support the Local Government Association in their efforts.

35 Should a more direct action be considered appropriate a joint letter from Licensing Committee and the Director of Public Health could be sent to the Minister for Policing, Fire and Crime Prevention who ultimately has responsibility for the Licensing Act 2003 to request that this matter is investigated again.

36 There may be other options Licensing Committee consider appropriate.

How will success be measured?

37 The successful implementation of health, or health and wellbeing, as a licensing objective.

What is the timetable and who will be responsible for implementation?

38 There is no set timetable for the report recommendations.

Appendices

- Appendix 1 – Timeline – Alcohol Licensing and Public Health
- Appendix 2 – References

Background papers

- None

Appendix 1

Timeline – Alcohol Licensing and Public Health

2003	Local Authorities (the licensing authority) have responsibility for the issue of licenses for the sale or supply of alcohol
2009 (Scotland)	The Licensing (Scotland) Act 2005 (implemented in 2009) makes public health boards responsible authorities includes “protecting and improving public health” as a fifth licensing objective.
2011 (2012)	Local health bodies become Responsible Authorities for licensing but there is no health licensing objective
2012 (2013)	Local public health teams move from the NHS into the local authority
2014	Local Government Association (LGA) calls for a public health licensing objective
2021	Local Government Association (LGA) calls for a public health licensing objective
2022	Deaths wholly due to alcohol in England continue to rise. There are 7,912 alcohol-specific deaths (wholly due to alcohol) in England, an increase of 56.7% from 5,050 deaths in 2006 and a 4.7% increase since 2021. The trends in alcohol-related deaths (deaths wholly or partly due to alcohol) and deaths from chronic liver disease are similar (OHID, 2024)
2023	Association of Directors of Public Health advocate for a new public health licensing objective as part of the Licensing Act to ensure that public health is placed at the centre of licensing policies.
2024	Health is still not a licensing objective in England

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