THE STRATEGIC ALCOHOL PLAN

PLYMOUTH
CITY COUNCIL

A report of the Health and Adult Social Care Overview and Scrutiny Panel – Task and Finish Group following a review of the Strategic Alcohol Plan

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1 SUMMARY

1.1 Alcohol plays a significant role in the city of Plymouth and over the last decade Plymouth has seen an expansion of the night-time economy across centralised areas of the city. This growth of the night-time economy has been beneficial for Plymouth in many ways; it brings money into the city, provides jobs, attracts visitors and brings people together to socialise and have fun.

1.2 At the same time, we cannot avoid the status of alcohol as a controlled substance and the impact of alcohol related crime, disorder and the serious health impacts experienced by people when alcohol is abused.

1.3 In July 2012 the Health and Adult Social Care Overview and Scrutiny Panel considered the draft Plymouth Strategic Alcohol Plan "Promote Responsibility, Minimise Harm". Subsequent to this meeting the panel submitted a request to establish a Task and Finish Group to focus on assisting the further development of the strategic and operational plan. The task and finish group would focus on balancing the impact of alcohol on health and maintaining a vibrant night time economy.

1.4 In conducting this inquiry members of the task and finish group received evidence from a wide variety of sources, conducted desk top research and examined good practice from elsewhere. We found that proactive management, driving up quality and the diversity of Plymouth's night time economy could help to improve customer experience, draw in a wider range of people and ultimately reduce the negative impact of alcohol whilst supporting the city vision to be "one of Europe's finest, most vibrant waterfront cities, where an outstanding quality of life is enjoyed by everyone".

1.5 The panel in analysing all the information agreed to make a number of recommendations, which will be submitted to Cabinet, via the Overview and Scrutiny Management Board. The recommendations are aimed at providing shared ownership of both the benefits and negative impact of alcohol across the city's partnerships.

2. INTRODUCTION

2.1 This report gives the findings from the Health and Adult Social Care Overview and Scrutiny Panel's Task and Finish Group which will support a strategic approach to managing the supply of alcohol in the city that will in turn maximise the impact of the City's investment in services that respond to alcohol related harm. The Task and Finish Group's review took place over five sessions between November 2012 and March 2013.

2.2 Members appointed to the group were as follows:

- Councillor Mrs Mary Aspinall (Chair of the group)
- Councillor Grant Monahan (Vice-Chair of the group)
- Councillor Mrs Lynda Bowyer
- Councillor Jon Taylor
- Councillor Lorraine Parker
- Councillor Ian Tuffin
- Councillor Dr John Mahony

Officers supporting the group were as follows:

- Professor Rod Sheaff (Plymouth University)
- Ross Jago, Democratic Support Officer

This report summarises the findings of the Task and Finish Group review and makes recommendations for the strategic management of alcohol in Plymouth.

3 BACKGROUND – The Strategic Alcohol Plan

3.1 Alcohol was identified as a priority by the Plymouth 2020 Partnership in 2011. In response Chief Superintendent Andy Bickley took on the role of Alcohol Champion and convened an Alcohol Champions Group which met until mid-2012. This group oversaw the initial work on the development of the Alcohol Strategy and helped instigate an Alcohol Joint Commissioning Group Chaired by the Public Health Unit which would support development of the strategy and identify key commissioning intentions that would support the emerging strategic direction of travel.

3.2 The ambition

3.2.1 The overall ambition of the Alcohol Strategy is to reduce alcohol related harm in Plymouth, specifically the strategy aims to -

- Change attitudes towards alcohol;
- Provide support for children, young people and parents in need;
- Support individual need;
- Create safer drinking environments.

3.2.2 The Strategy's objectives are to -

- Reduce the rate of alcohol attributable hospital admissions
- Reduce levels of harmful drinking by adults and young people
- Reduce alcohol related violence
- Reduce anti-social behaviour
- Reduce the number of children affected by parental alcohol misuse
- Increase the number of visitors to the city

3.2.3 The Strategy seeks to support the city's strategic vision to '*be one of Europe's finest most vibrant waterfront cities where an excellent quality of life is enjoyed by everyone.*'

3.2.4 Success in delivery of this strategy would mean -

- the supply of alcohol is strategically planned and well managed;
- alcohol plays a proportionate role in Plymouth's cultural, sporting and hospitality offer;
- people socialise and relax in environments that feel safe and are family friendly;
- visitors to the city feel safe in the evening and night time economy and feel motivated to return;
- more people drinking responsibly and within lower risk limits;
- fewer people being admitted to hospital;
- less alcohol fuelled crime;

- fewer children affected by parental alcohol misuse;
- people in need of help can access the information, advice and support that they need.

4 BACKGROUND – Evening and Night Time Economy

4.1 Most UK cities have developed a lively night-time economy which can be beneficial to the city's economic and reputational status. Plymouth has a large number of licensed premises and our night-time economy focuses on the use of these premises in areas such as Mutley Plain, North Hill, the Barbican and Union Street. As a result, the level of alcohol related problem incidents in these areas is significantly higher than elsewhere in the city.

4.2 Plymouth boasts a selection of restaurants, theatres, cinemas, bars and night clubs, but the night time economy can also be the cause of nuisance. Many residents are confronted with anti-social behaviour, litter, noise, disturbance and other individual and cumulative impacts of the night time economy which will need to be addressed in an integrated way.

4.3 The value of the UK Evening and Night-time Economy (ENTE) was estimated at £66bn in 2009, accounting for 27% of town and city centre turnover and between 5-10% of employment.[1]

4.4 Businesses operating in the ENTE derive a large proportion of their income between 6pm – 6am and employ staff, invest and offer services to meet the demands of customers. The economic benefits associated with an effective ENTE could include meeting latent demand for consumption, employment and attracting talent, creativity, entrepreneurship and wealth.

4.5 In 2011, Plymouth's ENTE supported over 6,000 employees (6,400 including working proprietors) and was worth around £93.2 million in terms of Gross Value Added (GVA). This equated to 6% of city employment and 2.3% of GVA.

Table 1: Estimated Value of Plymouth's ENTE (employment and GVA), 2011

	Standard Industrial Classification of Economic Activities (SIC 2007)	**Employment***	**Employees**			**GVA/ FTE (£)**	**GVA (£m)**
			Full-time	Part-time	Total		
Accommodation	Hotels and similar accommodation	800	400	300	800	25,100	15.2
Restaurants	Licensed restaurants	1,400	600	900	1,400	21,600	21.2
	Unlicensed restaurants and cafes	1,100	600	500	1,100	21,600	17.9
	Take away food shops and mobile food stands	800	200	500	700	21,600	10.3
Bars	Licensed clubs	700	200	400	600	21,600	8.3

[1] TBR Ltd & MAKE Associates (2009) Night Mix Index

	Public houses and bars	1,500	500	900	1,400	21,600	20.3
	TOTAL ENTE**	**6,400**	**2,400**	**3,700**	**6,000**	**22,200**	**93.2**

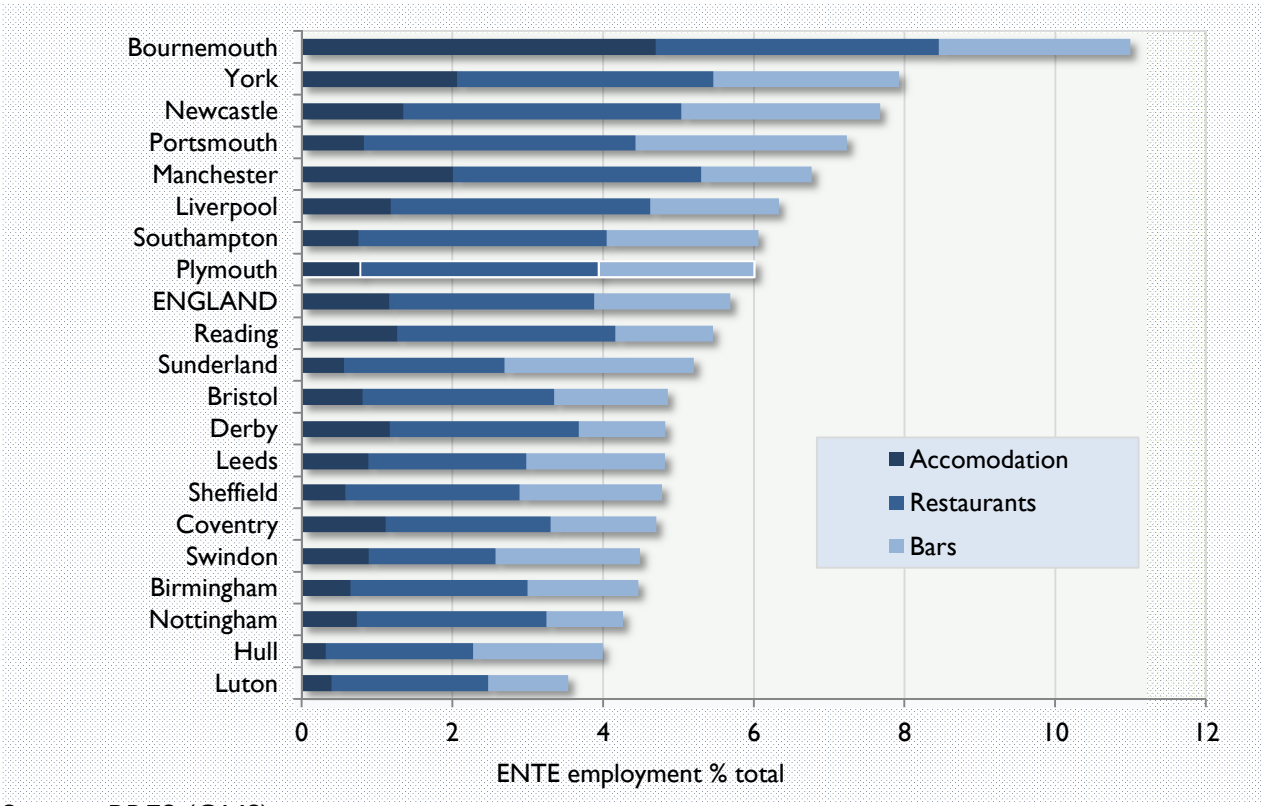
Source: BRES (ONS), Oxford Economics

4.6 Table 1 gives a broad breakdown of the components of the city's ENTE and is grouped into Accommodation, Restaurants and Bars. These definitions can only be considered an estimate of the real value of the ENTE as the figures exclude theatres, cinemas and casinos and includes restaurants and cafes not open past 6pm.

4.7 The UK average employment in the ENTE is 5.7% compared to the 6% of total employment in Plymouth. Of the main components, the city ranked highest (6th out of 20 cities) on the relative proportion of employment in 'Bars' (e.g. licensed clubs, public houses and bars). 'Restaurants' was the largest employer in absolute terms.

4.8 Employment in the ENTE remained relatively stable over the period 2008-2011, while the city's total job stock contracted significantly.

Chart 1: ENTE employment (%) for England cities, 2011



Source: BRES (ONS)

4.9 Around 60% of Plymouth's ENTE is concentrated in the City Centre. Licensed restaurants represented the largest share of the ENTE and licensed clubs, public houses and bars the smallest which reflects the dispersed and localised nature of these businesses. Out of 9,180 UK council wards, St Peter and the Waterfront ranked 14th highest for the number of ENTE businesses.

5. GOVERNMENT LEGISLATION

5.1 The **Licensing Act 2003** established a single integrated scheme for licensing premises that are used for the supply of alcohol. The Act transferred responsibility for licensing of clubs and pubs to local authorities and took account of the impact of licensed premises on the wider community. Local authorities were asked to be mindful of thriving night time local economies which are important for investment and employment. As a result of the Act local decisions about flexible closing times could be made. One of the key objectives of the Act was to balance the needs of businesses with those of residents and local communities.

5.2 The Act provided a framework for local authorities in developing licensing policies and assessing licensing applications. In undertaking these functions the authority must promote the licensing objectives:

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

5.3 Under the **Police Reform and Social Responsibility Act (2011)**, the Government amended licensing legislation in a number of different ways –

- **Persistent underage alcohol sales** - The maximum fine for persistent underage alcohol sales was doubled to £20,000 and businesses found guilty by the courts could be closed;
- **The Licensing Authority (Council) made a Responsible Authority** - Licensing authorities now have greater powers under the Act by becoming a responsible authority. This allows licensing authorities to make representations against applications and call for reviews of licences where appropriate.
- **New Responsible Authorities** – Some health services became responsible authorities and are able to make representations against new and variation applications, as well as calling for a review of licences where appropriate.
- **Reducing the evidence threshold** - Decisions taken by the licensing authority must be **necessary** to promote the licensing objectives. This is being amended to **appropriate** to promote the licensing objectives, therefore allowing greater flexibility at a local level to take action.
- **Giving local residents a greater say in decision-making** - Any person has the right to make a representation about an application irrespective of where they live, providing they can demonstrate how the application would impact on them in relation to the licensing objectives.
- **Non-payment of annual fees** - Licensing authorities will now be able to suspend the licence where the fee is unpaid until such time as the debt is cleared.

- **Personal licences** - Various new offences were added to the list of relevant offences that the licensing authority can consider in granting a licence.

- **Licensing Policy Statements** - Licensing Authorities now have to publish a Policy Statement every five years rather than every three.

- **Early Morning Restriction Orders (EMRO)** - An EMRO can be applied by a licensing authority between the hours of midnight and 6 am to restrict the sale of alcohol. The effect is that the sale or supply of alcohol will be prohibited during the hours determined by the licensing authority, on the days and in the areas to which the EMRO applies. The licensing authority can also decide whether to apply the EMRO to the whole of the district or restrict it to certain parts; and whether it will run for a limited or unlimited period if it is considered that restricting the late night supply of alcohol is appropriate to the promotion of the licensing objectives.

- **Late Night Levy** - A Late Night Levy can be applied by a licensing authority between the hours of midnight and 6 am to all premises whose licence allows them to sell or supply alcohol between the levy hours, irrespective of whether or not they actually trade during those hours. Should it be deemed appropriate to introduce a levy, the licensing authority will have to undertake a local consultation with the police, licence holders and others. The final decision on whether or not to introduce a Late Night Levy and what, if any, reductions or exemptions are to apply rests with the licensing authority.

5.4 The **Health and Social Care Act 2012** made unitary authorities responsible for improving the health of their population and as such the responsibility for public health transferred from the NHS to local authorities in April 2013. In Plymouth the Office of the Director for Public Health has been established within the Local Authority and is backed by a ring-fenced public health grant.

5.5 Drug and Alcohol Action Team will continue to coordinate alcohol treatment services on the ground. This group works closely with wider partnerships, such as community safety partnerships that incorporate the police, probation, local government, education and health.

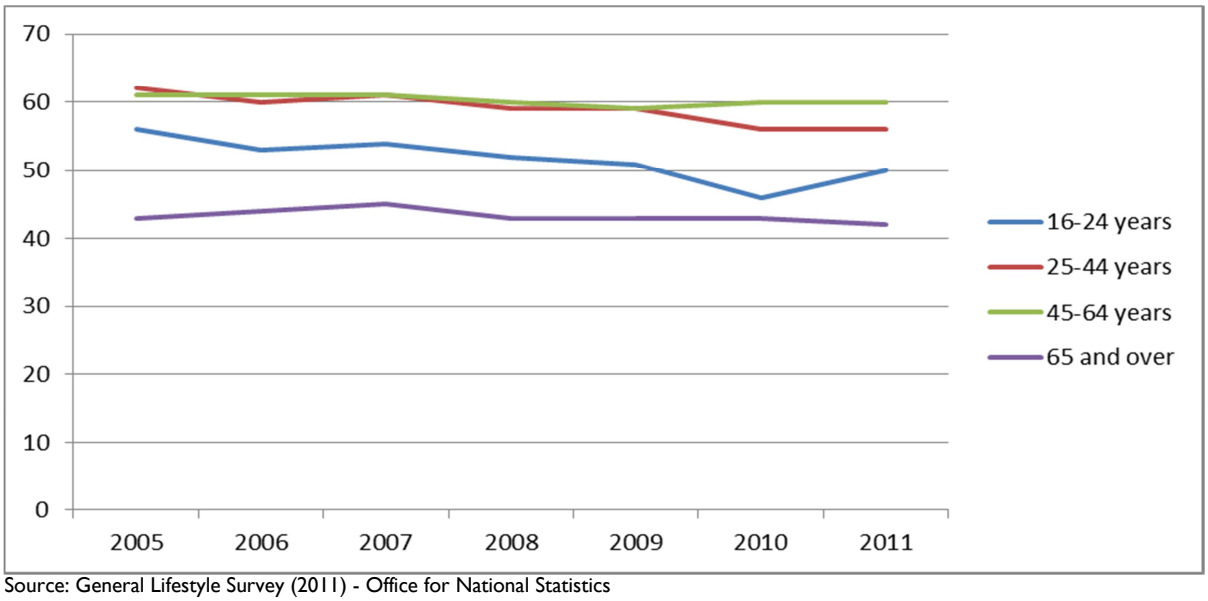
6 RELEVANT NATIONAL STATISTICS AND INFORMATION

6.1 The following findings have been obtained from the Office for National Statistics' General Lifestyle Survey (2012), the Marmot Review "Fair Society, Healthy Lives" (2010) and a report provided by Plymouth City Council's Young Peoples Lead for Drugs and Alcohol. The information provides a brief insight into national drinking patterns and is not in any way comprehensive.

6.2 The 2012 General Household Survey has shown that in England the downward trend in the proportion of adults who reported drinking in the week prior to the survey interview has continued. In 2011 66% of men and 54% of women drank in the week prior to interview compared to 72% of men and 57% of women in 2005. In 2011, 16% of men and 9% of

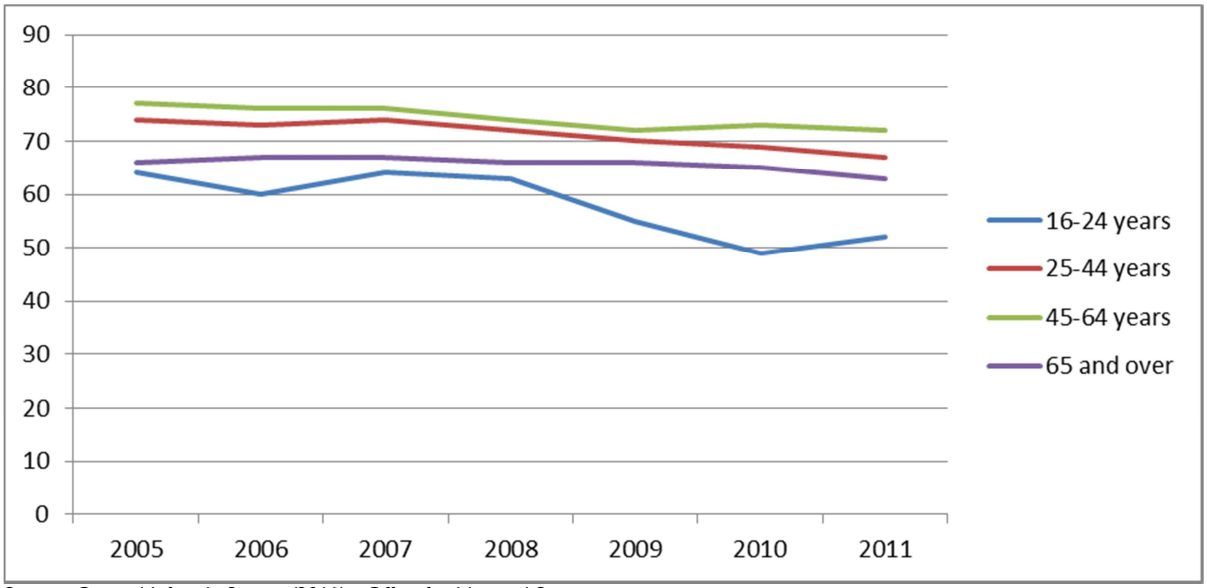
women had drunk on at least five of the preceding seven days.[2]

Women who drank in the week before interview



Source: General Lifestyle Survey (2011) - Office for National Statistics

Men who drank in the week before interview



Source: General Lifestyle Survey (2011) - Office for National Statistics

6.3 The proportion of adults who drank every day in 2011 increased with each age group; just 1% of the 16 to 24 age group drank every day during the previous week. This increased to 4% in the 25 to 44 group and then to 9% in the 45 to 64 age group and 13% in the 65 and over age group.[3]

[2] General Lifestyle Survey Overview - a report on the 2011 General Lifestyle Survey. Office for National Statistics 2012

[3/7] General Lifestyle Survey Overview - a report on the 2011 General Lifestyle Survey. Office for National Statistics 2012

6.4 The proportion of people who drank alcohol in the week before interview increased as household income increased. In 2011, of the households in the lowest 20% quintile of household income, 45% of adults drank alcohol in the previous week and 9% did so on 5 or more days. In the highest income quintile, 77% of adults drank in the previous week and 18% did so on 5 or more days.[4]

6.5 While people with lower socio-economic status are more likely to abstain altogether, if they do consume alcohol, they are more likely to have problematic drinking patterns and dependence than people higher up the scale.[5]

6.6 In England across all regions, hospital admission for alcohol-specific conditions for both males and females is associated with increased levels of deprivation. Rates of admission for the most deprived quintiles are particularly high.[6]

6.7 Links between alcohol consumption patterns and socio-economic status have also been identified; a survey of 15–16 year olds in the North West reported that although binge drinking was found across all socioeconomic groups it was more common among those living in deprived areas.[7]

6.8 Over 11 million people in the UK are dependent on alcohol or drink hazardously, yet treatment for alcohol related programmes is only available to 6% of problem drinkers.[8]

6.9 It is estimated that 30% of children live with an adult binge drinker, 22% with a hazardous drinker and 2.5% with a harmful drinker.[9]

6.10 Research evidence shows that domestic violence is more likely than not to occur within intimate partner relationships where one partner has a problem with alcohol or other drugs.[10]

6.11 The cost of alcohol misuse in the UK is substantial and can be divided into four broad categories:

- Healthcare service costs: including costs to primary care services and hospital services (A&E, medical and surgical inpatient services, paediatric services, psychiatric services, and outpatient departments) of alcohol-related morbidity and mortality.
- Cost of alcohol-related crime, disorder and anti-social behaviour: including costs to the criminal justice system, costs to services (e.g. social work services), costs of drink-driving, and the human cost of alcohol-related harm (e.g. domestic abuse, assault).
- Loss of productivity and profitability in the workplace: including costs to the economy from alcohol-related deaths and alcohol-related lost working days.
- Impact on family and social networks: including human and emotional costs such as

[5/6/8/9/10/]Fair Society, Healthy Lives'- Post-2010 Strategic Review of Health Inequalities (the Marmot Review)

[9] Manning V, Best D, Faulkner N & Titherington E (2009). New estimates of the number of children living with substance misusing parents: results from UK national household surveys. BMC Public Health 9: 377.

[10] Galvani, S. (2010) *Grasping the nettle: alcohol and domestic violence*. 2nd Edition. London: Alcohol Concern

breakdown of marital and family relationships, poverty, loss of employment, domestic and child abuse, homelessness and other drug use.

7 RELEVANT LOCAL STATISTICS AND INFORMATION

Alcohol consumption in Plymouth

The amount of alcohol-related harm likely to be present in a population can be estimated by the proportion of the population engaging in binge, hazardous, harmful and dependent drinking. These groups are defined below.

7.1 Hazardous drinking

Hazardous drinking is currently defined as around 22-50 units per week for men and 15-35 units per week for women. Within Plymouth there are an estimated 25,300 hazardous drinkers.[11]

7.2 Harmful drinking

Harmful drinking is currently defined as more than 50 units of alcohol consumed per week by men and 35 units per week by women. Within Plymouth there are estimated to be 6,360 harmful drinkers. [12]

7.3 Dependent drinking

7.3.1 Dependent means that a person feels that they are unable to function without alcohol and the consumption of alcohol becomes an important factor in their life. Moderately dependent drinkers do not usually experience withdrawal symptoms, or withdrawal symptoms are mild to moderate. However, severely dependent drinkers do experience withdrawal symptoms, which are usually severe.

7.3.2 Most severely dependent drinkers fall into a pattern of 'relief drinking', where they drink to avoid or counter withdrawal symptoms. Severely dependent drinkers usually have an extremely high tolerance to alcohol, and are able to drink amounts that would incapacitate or even kill most other people.

7.4 Alcohol Needs Assessment Research Project (ANARP) 2006

In 2006 the Public Health unit estimated that in Plymouth;

- 26% of the adult population has an alcohol use disorder, representing 38% of all males in the city and 16% of females. This equates to 32,500 men and 13,500 women who have a potential alcohol use disorder.
- 23% of the adult population is hazardous or harmful alcohol users, equating to 39,200 adults who are potential harmful drinkers.
- 3.6% of the adult population is alcohol dependent, equating to 6% among the male population and 2% among female population. These proportions equate to 6,800 dependent drinkers.

[11] 'Models of Care for Alcohol Misusers (MoCAM) drinking behaviour in Plymouth for the 16-65 year population
[12] 'Models of Care for Alcohol Misusers (MoCAM) drinking behaviour in Plymouth for the 16-65 year population

7.5 Local Alcohol Profiles England[13]

Table 1 below shows how Plymouth compares with other local authorities and primary care trusts across England according to the data in the 2011 local alcohol profiles provided by the North West Public Health Observatory. Only those areas where Plymouth is significantly better or worse than the England average are reported.

● = significantly worse than England average □ = significantly better than England average	Compared to Local Authorities	Compared to Primary Care Trusts
Alcohol-specific hospital admission – under 18s	●	●
Alcohol-specific hospital admission – Males	●	●
Alcohol-specific hospital admission – Females	●	●
Alcohol-attributable hospital admission – Males	●	●
Alcohol-attributable hospital admission – Females	●	●
Admission episodes for alcohol-attributable conditions (previously NI39)	●	●
Alcohol-related recorded crimes	●	●
Alcohol-related violent crimes	●	●
Alcohol-related sexual offences	●	●
Claimants of incapacity benefit - working age	●	●
Mortality from land transport accidents	□	□
Employees in bars - % of all	●	●

[13] Plymouth Alcohol needs assessment 2011

employees		

Table 1 – Local Alcohol Profile 2011

8 TASK AND FINISH GROUP PROCESS

The Task and Finish Group was established to review the Strategic Alcohol Plan and focus on the relationship with the Evening and Night-Time Economy. The group's membership was drawn from the Health and Adult Social Care Overview and Scrutiny Panel.

8.1 Task and Finish Group Objectives

To make recommendations that will support a strategic approach to managing the supply of alcohol in the city that will in turn maximise the impact of the City's investment in services that respond to alcohol related harm.

8.2 Task and Finish Group Methodology

The Task and Finish Group convened over five days on the following dates:

- 19 November 2012
- 18 January 2013
- 25 January 2013
- 4 March 2013
- 11 March 2013

At each meeting the group met to consider evidence, review background information and hear from witnesses.

8.3 The witnesses who presented evidence to the group were:

Gary Wallace, Drug and Alcohol Team Manager, NHS Plymouth
Paula McGinnis, Crime Reduction Officer, Plymouth Community Safety Partnership
Dave Schwartz, Young People's Lead, Joint Commissioning and Adult Social Care, Plymouth City Council
Superintendent Brendan Brookshaw, Devon and Cornwall Police
Amanda Clements, Hepatology Nurse Consultant Plymouth NHS Hospitals Trust
John Hamblin, Chief Executive Shekinah Mission
Christine Little, Head of Operations Harbour Drug and Alcohol Services
Dr Hugh Campbell, Primary Care General Practitioner
Mark Bignell, Chief Executive, Hamoaze House
Councillor Eddie Rennie, Chair, Licensing Committee Plymouth City Council
Andy Netherton, Safety, Health & Licensing Manager, Plymouth City Council
Clint Jones, City Centre Manager, City Centre Company
Sarah O'Leary, Waterfront Manager, Plymouth Waterfront Partnership
Stephen Bashford, Economic Research and Monitoring Officer, Plymouth City Council

8.4 Contextual Overview

In order to aid members and officers of the task and finish group Dave Schwarz, Young People's Lead (Joint Commissioning and Adult Social Care) Stephen Bashford, Economic

Research and Monitoring Officer (Economic Development), Clint Jones, City Centre Manager (City Centre Company) and Professor Rod Sheaf (Plymouth University) presented reports which provided members with the required background knowledge to aid their questioning of witnesses.

9 PROCEEDINGS FROM THE TASK AND FINISH GROUP

9.1 The first meeting

The group met on the 19 November 2012 where they received information on the current trend of alcohol consumption in Plymouth and the development of the strategy in response to the issue of alcohol abuse. Gary Wallace, Paula McGinnis, Dave Schwartz and Superintendent Brendan Brookshaw reported that –

- the Joint Strategic Needs Assessment had identified alcohol as a priority area and the Alcohol Joint Commissioning Group was established with Chief Superintendent Andy Bickley as the chair to draft a strategy in response;
- alcohol clearly had an important place in the economy and a joined up approach was sought to balance that economic benefit against harm;
- the risk to children through the hidden harm of parental alcohol abuse was significant;
- improved access to information and advice in a range of venues was required (eg simple screening tools by employers).

The group highlighted key risks for the group to consider which included that –

- between 2002/03 and 2009/10 hospital admissions linked to alcohol consumption increased by 71% in Plymouth;
- it was estimated that 35% of all Emergency Department admissions were alcohol related, this figure rose to 70-80% at weekends;
- it was estimated that between 3,900 and 6,500 children in Plymouth were affected by significant parental alcohol misuse;
- violent crime accounted for 70% of all alcohol related crime recorded;
- domestic violence was estimated to make up 30% of all violent crime in Plymouth;
- there was a complex relationship between alcohol and mental health and as many as 65% of suicides could be linked to excessive drinking;
- alcohol was now 44% more affordable in 2010 than in 1980;
- aggressive price competition had been driven by supermarkets and off sales had steadily increased whilst on-sales had decreased. Between 1992 – 2008 purchases of wine brought into the home increased by 59%;

- there had been an overall trend of increasing strength alcohol marketed towards street drinkers;

- pre-loading was a significant issue and data suggested that this was additional drinking and not an attempt to save money.

From the session a number of key themes emerged and the group would further explore :

- the economic benefit of alcohol to the city and the role and function of alcohol in the city's evening and night time economy;
- treatment and support systems;
- unaddressed drinking problems.

Superintendent Brookshaw highlighted to the group that there were a number of "tools" available to the authority through the licensing process. Partners in the city were in the early stages of reviewing these tools. "Best Bar None" was a responsible retailing policy which could be strengthened if included within an Evening and Night-Time Economy plan.

9.2 **The second meeting**

At the second meeting, the group met with Amanda Clements, John Hamblin, Christine Little, Dr Hugh Campbell and Mark Bignell. The purpose of the meeting was to discuss the supply and abuse of alcohol and the effect on demand for commissioned services. It was reported that -

- alcohol, its availability and abuse should be of the highest priority for the city

- hepatology patients were dying younger;

- services were encountering individuals with increasingly complex needs many of which abused both drugs and alcohol. The individuals with the most complex needs were aged between 30-50 years;

- the supply of super-strength lagers and ciders was highlighted as a key consideration for the group. Witnesses commented that it was immoral that super-strength lagers and ciders were available at lower prices than many soft drinks;

- Shekinah Mission was part of a campaign which challenged the sale of white cider and its direct marketing to individuals who were alcohol dependent. As a result of the campaign some white cider brands had been removed from sale although other brands had quickly filled the vacant shelf space;

- a large number of dependent and abusive alcohol users were seen often seen first in primary care, particularly General Practice and the treatment of issues of Alcohol dependency where ;

- there was not sufficient funding attached to the treatment of alcohol dependency, the process of alcohol detoxification was fraught with risk and primary care clinicians could have contact with patients every other day to deal with issues of withdrawal. Much more specialist provision was required as primary care services

were not able or funded to deal with what was seen as a widespread problem;

- public health media campaigns would have an effect on the levels of dangerous drinking.

In response to questions from the group, witnesses reported that –

- many dependent and abusive drinkers had complex social care needs which, unaddressed, could lead to further risk taking behaviour;
- alcohol was often the secondary reason for entrance to Emergency Departments;
- alcohol services within healthcare settings were poorly resourced;
- alcohol dependency was not seen as a long term condition;
- there needed to be greater honesty about the cost to society of alcohol abuse and dependency;
- most, if not all, alcohol treatment services were currently commissioned through health and social care, there was no criminal justice commissioning for alcohol services;
- Plymouth did not have a large street drinking culture, most street drinkers were known to agencies and were subject to interventions, there was no need for a separate street drinking strategy and the resource could be better applied elsewhere;
- People who consumed alcohol within the home, with levels of consumption that could lead to death were not engaging, in particular people aged over 65 did not engage with services and more intelligence was needed around that demographic;
- there was a requirement to think creatively to address the problem and a need to address why people started drinking and continue drinking alcohol to dangerous levels;
- drinkers who were dependent on alcohol were price sensitive and there was evidence from Australia and America that minimum unit pricing would have an effect;
- social deprivation was a major cause of alcohol abuse;
- there was a generational change required, parents needed to be aware of the effect that their drinking had on their children and if young people wished to use alcohol they needed to be equipped with the knowledge to do so safely;
- the culture of the student life meant that young people were given permission to get very drunk on a regular basis and this could be seen to impact their relationship with alcohol later in adult life;
- there was no easy demographic to target, all people affected by issues of alcohol

abuse needed to be able to access services for help when required;

- there was confusion around 'units of alcohol' it was important that people were equipped with information to assess their own levels of drinking;

- issues of mental health linked to alcohol abuse had not been adequately addressed. The city had a dual diagnosis strategy which had not been implemented.

Witnesses commented that -

- there was a real willingness of providers and the community to address the problems of alcohol abuse;

- serious, robust research and consultation was required to gain a deeper understanding of how alcohol abuse and dependency was effecting different demographics;

- in general there was a lack of understanding about the nature and size of the problem;

- any approach to deal with alcohol related problems needed to be creative, responsive and flexible;

- through partnership working the city needed to make a clear statement about its relationship with alcohol.

9.3 The third meeting

At the third meeting the group met with Councillor Eddie Rennie, Andy Netherton. During the discussion it was reported that -

- the licensing committee played a facilitator role, working together with retailers to ensure that premises worked within regulations;

- current licensing objectives worked well for the city and made sure people felt safe in the night time economy;

- the committee had, in the past, used powers to revoke licences and close premises. It was commented that licensees who were irresponsible and did not work within regulations were bad for the trade;

- licensing policy was approved at meetings of the full council, the policy had to conform to national statutory guidance;

- although there was some discretion at a local level it was limited.

In response to questions from members of the group it was reported that –

- there were conditions available to the licensing authority to prevent the sale of super strength lager and ciders. Such conditions could be targeted to areas with clear evidence of related problems;

- with regard to the granting of off-sale licences in close proximity of recovery services or service for vulnerable people it was commented that the licensing authority needed to identify robust routes for consultation to ensure that all stakeholders were made aware of applications in their local area;
- although health services were a responsible authority that the licensing authority was required to consult, Public Health was not a licensing objective and therefore could not form the basis of any objection;
- cumulative impact areas were reviewed by all partners and set by the council;
- evidence which could be used in support of cumulative impact areas included crime and disorder figures, noise complaints, ambulance statistics and complaints to the police and could further include anything that could demonstrate the negative impact of large number of alcohol retailers on an area;
- off-sales were not included as a consideration for cumulative impact areas.
- the licensing authority was unable to impose blanket conditions across the city. Licenses were tailored for individual premises; therefore they would be unable to impose single sales of super strength drinks across the city

9.4 The fourth meeting

At the fourth meeting the group met with Clint Jones, Sarah O'Leary and Stephen Bashford. During the meeting it was reported that -

- there was a significant proportion of the city's employment in the evening and night-time economy, a large part of the employment was part time;
- Plymouths ENTE was comparatively large with 60% of the ENTE in the city centre;
- the growth of the ENTE was positive and the role of the ENTE in place making should not be underestimated;
- there was scope for more businesses in the ENTE but exactly what kind of business and where they were located needed to be carefully planned;
- diversification of the ENTE would be a slow change which could be achieved through the planning and licensing process. The ENTE would need to be a key strand of the Plymouth Plan;
- there was a role for the service industry as ambassadors for the city, there was a project on-going to improve levels of customer service in premises engaged in the ENTE;
- an ENTE economy coordinator should be appointed. The post would ensure that ENTE was core to the growth of the city and there was a vision to create more jobs;
- a scoping document to consider bidding for the Purple Flag accreditation was being developed. The Purple Flag accreditation focused on five core standards, a clear evidence based strategy, high standards of wellbeing, safe and easy movement, a choice of leisure activities and a use of place throughout the day and evening;
- perceptions of the waterfront, particularly bank holidays on the waterfront, needed to be changed;
- less than 10% of licensed premises were signed up to 'Best Bar None' scheme.

This reflected that publicans across the city were signed up to multiple responsible retailing schemes and there was no single consistent scheme applied across the city;

- in a well-managed ENTE we would see more people drinking less. There was a need to increase the breadth of the ENTE offer.

9.5 The fifth meeting

The group met for a fifth time to consider the information they had reviewed over the preceding months and develop recommendations which are outlined below.

10 CONCLUSIONS

In reviewing all of the evidence and analysing all of the data provided the group identified a number of points of concerns:

10.1 Lack of specialist provision

The lack of specialist provision for dependent and abusive drinkers was of concern to the group. Members were told that dependent alcoholics had been known to die whilst waiting for specialist alcohol treatment. The group felt that this situation was indefensible and urgent consideration needed to be given to the commissioning of specialised treatment services for those who required it.

10.2 Licensing

10.2.1 The licensing authority has an important role to play in supporting the Strategic Alcohol Plan to achieve its objectives. Having taken into consideration the views of invited witnesses the group was of the opinion that there were areas in which the licensing authority could improve communication of relevant licensing applications and improve the routes for those who wish to comment to be able to do so.

10.2.2 It was highlighted to the group that the licensing authority had a number of "tools" available when granting licences. The group have requested that a licensing toolkit is made available to all councillors so they can assist local residents who may wish to support or object to licensing objectives.

10.2.3 In the opinion of the task and finish group the council should consider lobbying government to ensure that the protection of public health is included as a licensing objective and the current government stance on minimum pricing is challenge.

10.4 Safer Alcohol Retailing

The group received information on the Home Office recognised 'Best Bar None' scheme which promotes safer retailing practices within the licensed trade. During the witness sessions the group were informed that although the scheme was good practice it was one of many schemes that publicans had been asked to engage with and was in addition to schemes such as pub and club watch. The group have made recommendations in an attempt to strengthen the promotion of 'Best Bar None'.

10.5 Off-Sales

10.5.1 After meeting with representatives from the Shekinah Mission and Hamoaze House the group highlighted that off-sales of super strength ciders and lagers were a cause for concern.

10.5.2 Often sold cheaper than bottled water, super strength cider and lager (typically at 7.5% ABV or above) has a particularly damaging effect on the health and behaviour of consumers. The affordability and availability of super strength drinks also makes them attractive to under-age drinkers with considerable immediate risks, as they are able to get very drunk, very cheaply and very quickly.

10.5.3 The reducing the strength campaign in Ipswich has now been running for six months and has seen reductions of street drinking related incidents. The campaign asks off-licence owners to voluntarily remove super-strength products from their stores and around 85% of on and off-licence premises in the town have made that commitment. The group will make recommendations to the health and wellbeing board to consider leading a scheme of this nature.

10.6 Diversification of the night time economy

The group heard that the evening and night time economy was becoming centralised in towns and cities across the UK. Members believed that the diversification of Plymouth's night time economy should be identified as a key strand in the Plymouth Plan. Many of Plymouth's citizens are excluded from the night time economy and poorly represented within late night entertainment areas. A more diverse night time economy would assist in reducing these extremes and could attract a wider range of visitors to Plymouth City Centre at night ensuring that the centre of the City is 'alive after five' and includes those who feel excluded from alcohol-driven entertainment activities.

10.7 The Strategic Alcohol Plan

10.7.1 Members were of the opinion that the use of the multi-component model to reduce and prevent harm was appropriate. The plan seeks not only to reduce the alcohol consumption but also alcohol related violence and anti-social behaviour, addresses the hidden harm on young people and expresses the need for an improved local treatment system.

10.7.2 In 2009 the Department of Health identified seven 'High Impact Changes' (HICs) for alcohol which would have the greatest impact on health -

1. Work in partnership
2. Develop activities to control the impact of alcohol misuse in the community
3. Influence through advocacy
4. Effectiveness and capacity of specialist treatment
5. Appointment of alcohol health workers
6. Identification and brief advice (promote more help and encourage people to drink less)
7. Amplify national social marketing priorities

10.7.3 Members believe that the Strategic Alcohol Plan starts to address some of these areas. Specifically the plan –

- had been developed in partnership. However partnership working had focused on the 'violence and the vomit' and to ensure the plan was a success a wider range of stakeholders, particularly those concerned with the growth agenda, needed to be engaged;
- expresses the requirement to develop capacity in the community, particularly community detoxification services;
- highlights that influence through advocacy is key area. However members believed that the plan required the high profile leadership of an established partnership in order to advocate change (for example the supply of cheap strong alcohol);
- makes recommendations to implement a clear pathway of integrated support and specialist treatment, the group heard that specialist alcohol treatment services in the city lacked significant funding and believe that steps needed to be taken to address this;
- identifies key sites where opportunities for early intervention exist to prevent need before it becomes more costly to treat. In particular the plan highlights where investment in identification and advice can lead to significant savings in the health economy. Members highlighted that more work needed to take place to identify where other savings could be made in the wider economy such as sickness absence levels;
- within the plan social and direct marketing are referred to as a high impact change, members believe that through strong local leadership national social marketing priorities could be tailored and amplified for the local population.

11 Scratching the surface

11.1 The focus of this task and finish group was to review the strategic alcohol plan and its role in maintaining a vibrant evening and night time economy. By meeting with witnesses and reviewing information provided, the group found that they had only scratched the surface of an issue which could affect every member of our society, some in severe and life changing ways. The group was of the opinion that further scrutiny work would need to be undertaken in relation to alcohol and would need to focus on -

- Alcohol and mental health, in particular work to implement the Dual Diagnosis Strategy
- Alcohol induced dementia
- Loss of productivity and profitability in the work place due to alcohol
- Further work on the impact of alcohol on children and families
- Education, focusing on clear messages regarding consumption and units
- Alcohol related violence and domestic abuse

Although the group met with representatives from the Police and joined officers on night time patrol, they did not feel that they sufficiently addressed the impact of alcohol abuse on urgent care or 'blue light' services and that further scrutiny of this area would be required in the future.

12 RECOMMENDATIONS

12.1 The below recommendations, were agreed by the group to be submitted to the Overview

and Scrutiny Management Board for referral to Cabinet.

R1	The task and finish group are in agreement with the aims, objectives and recommended actions of the Strategic Alcohol Plan and recommends its adoption and implementation by the city council.
	For the plan to be a success strong multi agency and city wide leadership is required in its implementation, to support this the task and finish group have made the following specific recommendations –
R2	that the Health and Wellbeing Board take ownership of the plan as key to the delivery of their vision of "Happy, Healthy, Aspiring Communities" and the vision for Plymouth to be "One of Europe's finest, most vibrant waterfront cities where an outstanding quality of life if enjoyed by everyone';
R3	a night time economy strategy, as a key strand of the Plymouth Plan, should be developed. The strategy should set out a clear vision for the future, create a firm platform for improved partnership working and secure funding and actions for improvement of the various night time economies across the city. The prevention of alcohol related problems should be a key consideration in the development of the strategy;
R4	an evening and night-time economy (ENTE) manager should be appointed as soon as possible to support the evening and night-time economy and development of the ENTE strategy;
R5	the Plymouth business improvement districts should review and implement good practice from other cities who are effective at working with the private sector to fund improvements to community safety;
R6	specific measures to improve the quality and diversity of the night time economy should be implemented. These should include: • work to obtain a Purple Flag • Enhanced bar staff training • Place marketing activities to attract quality businesses • Improved promotion of the range of activities available at night within the city • Non-alcohol lead events programmes
R7	further promotion is undertaken with regard to the "Best Bar None" to enhance participation in the scheme;
R8	an approach to improving safer retailing practices as to the sale alcohol in off licence premises should be developed and consideration should be given to potential initiatives such as the super-strength free programme in Ipswich;
R9	the licensing authority should draw on good practices from the planning department to ensure that all applications for alcohol licenses are properly advertised to the public and stakeholders;

R10	the licensing authority should review the communication of licence applications to responsible authorities (RAs) and ensure that all RAs are aware of applications and have robust routes to comment on applications;
R11	the licensing authority should develop a licensing "tool kit" for councillors to ensure that all members have a clear understanding of the policy for the granting of applications and conditions and actions available to the licensing authority;
R12	the Health and Wellbeing Board should coordinate the approach to communicating alcohol needs across city partnerships;
R13	the children's partnership should ensure that primary, secondary, further and higher education establishments implement a coordinated approach for targeted alcohol related information and guidance to young people;
R14	all customer facing public services should be equipped to identify alcohol misuse and be able to signpost those identified to appropriate services, a programme of identification and brief advice should be established;
R15	an increase in specialist, structured interventions for dependent drinkers must be commissioned. These interventions must be supported by links to the broader range of services necessary to support recovery such as housing, education and employment services;
R16	that before implementation of the plan a system of indicators to measure the success and evaluate new services is developed.