OFFICIAL REPORT
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Local Government and Communities Committee

Wednesday 18 September 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 18 September 2019

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LOCAL GOVERNMENT AND COMMUNITIES COMMITTEE

22nd Meeting 2019, Session 5

CONVENER

*James Dornan (Glasgow Cathcart) (SNP)

DEPUTY CONVENER

*Sarah Boyack (Lothian) (Lab)

COMMITTEE MEMBERS

*Annabelle Ewing (Cowdenbeath) (SNP)
*Kenneth Gibson (Cunninghame North) (SNP)
*Tom Mason (North East Scotland) (Con)
Graham Simpson (Central Scotland) (Con)
*Alexander Stewart (Mid Scotland and Fife) (Con)
*Andy Wightman (Lothian) (Green)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Margaret Mary Cairns (South Lanarkshire Council)
Aidan Collins (Alcohol Focus Scotland)
James Douglas (Inverclyde Council)
Mairi Millar (Glasgow City Council)
Maria Reid (NHS Lanarkshire)
Elaina Smith (Glasgow City Health and Social Care Partnership)
Norman Work (City of Edinburgh Council)

CLERK TO THE COMMITTEE

Peter McGrath

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Local Government and Communities Committee

Wednesday 18 September 2019

[The Convener opened the meeting at 09:45]

Interests

The Convener (James Dornan): Good morning, and welcome to the 22nd meeting in 2019 of the Local Government and Communities Committee. I remind everyone present to turn off their mobile phones.

We have received apologies from Graham Simpson. Tom Simpson—I mean Tom Mason is in attendance as Graham Simpson's substitute. You have had a hard time of it with names recently, Tom. Welcome. Do you have any relevant interests to declare?

Tom Mason (North East Scotland) (Con): Yes, convener. I draw the committee's attention to my entry in the register of members' interests. In particular, I am an Aberdeen City Council councillor and a council tax payer in Aberdeen city, the Highlands and Islands and, of course, Edinburgh as a member of the Scottish Parliament.

The Convener: Thank you very much.

Decision on Taking Business in Private

09:45

The Convener: Agenda item 2 is to consider whether to take in private agenda item 6, under which the committee will consider key themes arising from today's evidence on alcohol licensing in communities. Do members agree to take agenda item 6 in private?

Members *indicated agreement.*

Alcohol Licensing

09:46

The Convener: Under agenda item 3, the committee will hold a round-table evidence session. In our previous sessions, we have explored the ability of communities to engage with and influence alcohol licensing decisions in their areas. Today, our focus will be on alcohol licensing and public health.

I will have to absent myself at about 10.50 for other committee-related business. If the meeting is still under way at that point, Sarah Boyack will take over in the chair.

Welcome, everyone, and thank you for your written submissions, which were very useful in preparing for the meeting. We will all introduce ourselves. I am the MSP for Glasgow Cathcart and the convener of the committee.

Sarah Boyack (Lothian) (Lab): I am the deputy convener and an MSP for Lothian.

Elaina Smith (Glasgow City Health and Social Care Partnership): I am health improvement lead for alcohol licensing for the Glasgow city health and social care partnership and the Renfrewshire health and social care partnership.

Norman Work (City of Edinburgh Council): I am Councillor Norman Work, and I am the convener of the Edinburgh licensing board.

Alexander Stewart (Mid Scotland and Fife) (Con): I am a Mid Scotland and Fife MSP.

Maria Reid (NHS Lanarkshire): Good morning. I am interim head of health improvement for NHS Lanarkshire. I am representing the director of public health and the two health and social care partnerships.

Annabelle Ewing (Cowdenbeath) (SNP): I am the MSP for the Cowdenbeath constituency.

Mairi Millar (Glasgow City Council): Good morning. I am clerk to the city of Glasgow's licensing board.

Andy Wightman (Lothian) (Green): I am a Lothian MSP.

Tom Mason: I am a North East Scotland MSP.

James Douglas (Inverclyde Council): Good morning. I am legal services manager at Inverclyde Council and clerk to the Inverclyde licensing board.

Kenneth Gibson (Cunninghame North) (SNP): I am the MSP for the Cunninghame North constituency.

Margaret Mary Cairns (South Lanarkshire Council): I am legal services manager with South Lanarkshire Council. I am responsible for litigation, licensing and registration.

Aidan Collins (Alcohol Focus Scotland): I am senior co-ordinator for Alcohol Focus Scotland.

The Convener: Thank you very much. Official reporters, a Scottish Parliament information centre researcher and the committee clerks, who provide the committee with support and will not be taking part in the discussion, are to my left. To be fair, the discussion would not be happening at all if it was not for all the hard work that the committee clerks have already done in advance.

We move straight to questions. The city of Glasgow licensing board has highlighted an innovation in its area whereby the local health and social care partnership has a member of staff with specific responsibility for alcohol licensing. The postholder—who is present today—considers every licence application and makes submissions where necessary. How does that work? Could that approach be replicated elsewhere?

As this is a round-table discussion, people should try to catch my eye when they want to participate and I will call them to speak.

Elaina Smith: My post is unique. Glasgow city and Renfrewshire alcohol and drug partnerships identified the post as a priority and permanent funding for it. It is hosted in the health and social care partnership health improvement teams, so it has a level of autonomy. That allows me to work with all our ADP partners, including our public health director, to look at the impacts of alcohol for the communities of both areas.

I take a very broad population-based approach to what evidence is required for the licensing policy statement, but the outcome of an individual application comes down to the information that we have on alcohol-related harm. I go through a triage process of assessing whether we have concerns about alcohol-related harm in an area. If the answer to that question is yes, further investigation is done into whether the harm is at a level sufficient to warrant the submission of a response to the licensing board.

I must thank my colleague Sarah Graham, who pioneered this post in Glasgow before I came into post just over a year ago. We have established a good level of evidence that the board can understand, which allows it to decide whether we have reached the threshold for it to apply the public health objective in rejecting any application. I ask Mairi Millar to comment, because she can speak for the board about that.

Mairi Millar: Elaina Smith's role in providing the evidential basis that is needed to deal with

individual applications in such a way that the public health licensing objective can properly be promoted cannot be overestimated. It is necessary to have local information to be able to show what the likely impact of adding another alcohol licence in a particular area would be. That information needs to be focused on the specific application. It is right that the triage process that Elaina described is carried out. In a situation in which there is no objection from public health, it is difficult to articulate a ground for refusal that could be justified and could stand up against an appeal, if it was challenged. Therefore, I think that the role that Elaina Smith plays is role is crucial.

The Convener: You mentioned a situation in which there was no objection from public health. Is it the case that whereas, previously, public health would not have objected because it could see no point in doing so, it is now objecting more often, or has the situation not changed in any way?

Mairi Millar: At one point in the past, we had a scattergun approach, whereby the national health service put in an objection to every application. That meant that it was difficult to attach weight to such objections, because they were generic in nature and did not relate to the specifics of the application. Agents representing clients will be able to get that generic approach quickly dismissed, because little weight can be attached to it. The availability of targeted, direct and localised information is the key to making use of the public health licensing objective. Where such information is not available, basing the refusal of an application on that objective is much more challenging and very difficult to justify.

The Convener: Before we move on, could one of you give us some idea of the triage work that gets done before a decision is made? What do you mean by that?

Elaina Smith: When an application comes in to me, I look at the information that has been provided. Initially—this demonstrates the process that I and the board have been through—I just used to get a standard letter, which contained very little information. That meant that I was not able to fully establish what the premises was planning to do with its alcohol licence, and I would have to go back to the licensing team to ask it to give me more information. I would also go to the licensing standards officer to get an understanding of what was going on in that area.

We have now moved to a position in which I get the operating plan and the application, so I can see exactly what the licensing team sees. I can properly assess if the information that is available in the application and the operating plan allows me to get a sense of whether there is an issue with the application. There are occasions on which very little information is available, and we can come a cropper on the day of the licensing board hearing, when the agent will come in with lots of additional information that we have not been privy to beforehand.

If I establish that there is something in the application that might give me cause for concern, I look at the area where the premises is located and at the statistics on alcohol-related harm. We look at four measures: alcohol-related hospital stays; alcohol-related deaths; alcohol-related brain damage admissions; and mental health discharges related to alcohol. For us, the figures on alcohol-related hospital stays have more weight, as that measure is a barometer of the more immediate situation as regards harm in the community. We do not want to see the number of alcohol-related deaths rising. If it is already at a high level, that will be a concern.

The data on mental health is giving me more cause for concern, which has made me look at it more, because we cannot understand why our figures for some areas are rising at such a rate. Our mental health alcohol-related figures are for in-patient services. The fact that we are moving away from in-patient support gives me cause for concern about what is going on.

If all the indicators are above a certain statistical level—that is, they are in the top 25 per cent of worst areas—that would make me go away to investigate further. I do due diligence and go out to visit the area where the premises is located and try to touch base with the services that are in the area, to get a sense of what is happening with regard to local availability of alcohol and the impact of alcohol-related harm on that community.

It is not always easy, because we do not always know what is going on. When communities are very closed to engaging with formal services, we do not get the full picture. I try my best to link up with local services through our health improvement teams, which have good relationships in the communities. Once I establish what is happening, I draw up my response letter and submit it to the board.

Norman Work: It is interesting to hear how the city of Glasgow's licensing board operates with its dedicated officer. Maybe other licensing boards can take good practice from that.

Lothian NHS Board reports on applications to the City of Edinburgh Council's licensing board. I was interested to hear what Mairi Millar said, because Lothian NHS Board does not report on every application—if it did so, it would just be reporting on the same issues. Rather, it will mention areas where there is overprovision or where it has other concerns, and it will ask if the licensing board wants a report in order to study all the statistics about health-related matters, crimes

and so on. How we operate is slightly different in some ways, but it is the same in others.

Annabelle Ewing: This discussion is very interesting. I was interested to read about Glasgow City Council's approach to overprovision in its submission, which seems to work alongside the position relating to licensed premises in other localities, and which I assume the council considers to be entirely in the parameters of the applicable legislation.

That seems to be a really good and innovative approach to catching as many potential problems as possible. I may be wrong, but other local authorities do not appear to be doing that. Why not? Is there not a case for sharing Glasgow's approach as best practice? If it works in Glasgow, would it not be appropriate for other local authorities to consider proceeding with such a regime?

The Convener: When other panellists answer that question, I ask them to say how their licensing system works.

James Douglas: In Inverclyde, we had an overprovision policy in place for five years. The basis for that policy was primarily a result of the crime and alcohol-related illness figures. After those five years, the figures showed no discernible decrease—in fact, there was next to no change in crime figures or alcohol-related illnesses in the area. We decided to keep the matter under review and to delete the overprovision policy, which was in central Greenock, because the figures did not support it.

We must always keep in mind that any licensing board's policy is capable of being judicially reviewed at any time. Given that, we thought that it would be dangerous to keep the overprovision policy in place, as we simply did not have the evidence to support it. Many local authorities had such policies at the same time. Now that I have read Mairi Millar's submission about the city of Glasgow's licensing board, I will bring the matter back to my board to see what we can do.

10:00

We must also remember that this is all set against a background of drastic cuts to local government funding. I simply cannot magic people out of thin air and employ them on behalf of the licensing board. However, I accept what has been said about sharing good practice, which we will certainly look at doing.

Mairi Millar: I make it clear that our alcohol licensing post is not funded through the licensing board. It is entirely separate from the board. The role is more like that of a consultee through the community health and care partnership; it is not directly connected with the licensing board.

The Convener: So it has no impact on local government finance.

Mairi Millar: Other than the arrangements. Perhaps Elaina Smith would be better placed to speak to that point.

Elaina Smith: My post is directly funded through the alcohol and drug partnership. NHS Greater Glasgow and Clyde looks at the issue from a board-wide perspective. It has been devolved to the local partnership level, which is where there is an implication for finance. The health and social care partnership has not been able to establish finance to have a dedicated post in the other areas that are covered by the health board. I am fortunate in that Glasgow city health and social care partnership and Renfrewshire health and social care partnership identified funds from the ADP. However, I know that it has not been able to do so in the other areas.

The role is carried out in addition to other posts. For example, in East Renfrewshire, it is carried out by the alcohol and drug partnership co-ordinator. I believe that a postholder for Inverclyde has been identified just recently. I am not yet sure who that person is, but I hope to establish a meeting with them next week. In East Dunbartonshire, another health improvement worker carries out those aspects as part of their wider role, and the position is the same in West Dunbartonshire.

The Convener: Thank you. Annabelle Ewing wants to come in.

Annabelle Ewing: Yes, I will come in just briefly. James Douglas has explained the approach that Inverclyde has taken to the overprovision regime. When did it decide to remove that? Was it quite recently?

James Douglas: It was in November 2018.

Annabelle Ewing: Nonetheless, I guess that, over the next few years, there will need to be some reflection on whether there might be an increase in the stats further to that removal.

James Douglas: Absolutely. We asked the forum, which includes the ADP member and Police Scotland, to keep an eye on the issue and to bring it back to us if there was any discernible increase in the crime or alcohol-related illness figures.

I make it clear that my board would love to support what it sees as a very laudable principle. However, the problem is what Mairi Millar has alluded to: how do we show a causal link under questioning in a courtroom a few months later? That is especially true for new premises. If a business in new premises has never operated and

has never sold a single can of lager, how can it be refused a licence when there is a presumption in favour of grant—that is the starting position—and there is no evidence to support the suggestion that it has in any way contributed to alcohol-related illness? I stress that one of the worst areas in Inverclyde for such illness has no alcohol outlets.

The Convener: Kenny Gibson indicated that he wanted to come in briefly, so I will let him in now.

Kenneth Gibson: My point is about Inverclyde. I found its licensing board's submission very interesting.

Edinburgh licensing board's submission said that

"there remains an ongoing challenge with regard to the public health licensing objective when determining individual applications and linking health data provided for larger localities, in order to demonstrate causation when considering such individual applications",

which goes back to what James Douglas from Inverclyde has just said. People are now very mobile, which makes provision difficult to monitor. In Inverclyde there are areas with large shopping centres and stores such as Tesco, where people no doubt buy alcohol and then take it home.

Perhaps the issue of overprovision should be extended across local authority areas, where practical. Of course, local authority areas are different sizes, but perhaps a whole town, such as Greenock or Port Glasgow, could be considered if the matter was to be revisited.

In the second-last paragraph of your submission, Mr Douglas, you say:

"Inverclyde Licensing Board are of the view that the current law does not empower Boards to deliver public health objectives."

However, your submission does not go on to say how the law could possibly be changed to empower them. Could you enlighten us to help us take the matter forward?

James Douglas: That is the one question I was dreading getting asked the whole way here.

The Convener: Thank you, Kenny.

James Douglas: I regard the principle as laudable, but I am not sure how boards could be asked to promote the public health objective unless there were strong statutory grounds that would back the members of a licensing board and pretty much safeguard them from challenge in the courts if they were to draw a line in the sand and say, as locally elected members, what the situation should be.

When we are appealed on matters where it is believed that we have erred in law, for example, it is the council—not the NHS or Police Scotland—that pays out the money. Board members receive legal advice that, if there is next to no evidence to show how they can come to a particular decision, it would be very dangerous for them to make that decision.

The Convener: I will let Aidan Collins come in, followed by Maria Reid; we will then move on to other aspects. Surely the work in Glasgow might provide one route into obtaining the evidence that you are talking about.

Aidan Collins: I can provide some national perspective. You will probably be aware that in November 2018 the licensing boards had to publish their new licensing policy statements, which AFS reviewed to see whether there are any emerging national trends, examples of good practice or areas of continuing challenge.

There is some good news. We can see measures to promote the health objective in every policy statement, to varying extents—we can identify that with different levels of ease. However, dealing with overprovision remains one of the main ways in which boards seek to promote public health. Of the 38 published policies, 15 boards found some extent of overprovision, 20 boards found no overprovision, and a couple were still consulting on that aspect of the policy. On the changes from the previous statements, there were a handful of areas where overprovision had increased and a handful where it had decreased, but the vast majority of boards have retained their existing policies.

What really stands out is that boards are approaching their assessments of overprovision very differently, and they are applying very different standards of proof. This is where the situation gets a bit abstract and hard to explain. In some areas, boards almost interpret the need to demonstrate a causal link as meaning that they have to prove definitively that X equals or will cause Y. In other areas, boards believe that they need to show that it is more likely than not that X causes Y, so they go more by the balance of probabilities.

I can give you some examples of what boards have said. In a couple of areas, they reported that they could not establish a causal link because the harm that they had identified as resulting from alcohol was not the direct and sole consequence of the number of premises. In the real world, it would be impossible to prove that the harm identified was the direct and sole consequence of the number of premises. There are so many compounding factors in real life that we could never control.

In other areas, boards have said that they can see evidence of a correlation between harm and the number of premises, but that evidence falls short of meeting the causal test required by law.

The question remains: what level of evidence is required to justify a finding of overprovision? When does the balance of probabilities tip in favour of something being causal as opposed to correlational?

It is really hard to link harm to specific premises, because people travel to purchase alcohol. We have seen a rise in online sales, which can be really challenging. Also in the mix is the fact that we do not have sales data—we do not know where people are buying their alcohol, or how much they are buying. However, having highlighted those challenges, I note that a large number of boards are very confident. They have looked at the evidence and have created robust policy based on the balance of probabilities.

The review of policy shows that there is real inconsistency. I go back to Annabelle Ewing's comments about promoting the good practice and providing boards with a bit more guidance and support. I will bring up Glasgow again—I am sorry; this keeps coming back to Mairi Millar—where a really promising new approach was adopted. The board there said that in areas that experience really high levels of harm, it will still reserve the right to refuse additional off-licences, because the evidence that it has gathered identified that if an area was already experiencing harm, throwing extra off-sales availability into the mix was likely to make the problem worse. That is a promising bit of good practice, because, to an extent, it detaches the health objective from overprovision and shifts the focus from the number of premises to the question of the harm that communities experience. We should be supporting and strengthening boards and getting them to share that practice, which might counter a lot of the problems that are being experienced.

Maria Reid: I want to follow up on Elaina Smith's comments about Glasgow's capacity and her dedicated post. Unfortunately, NHS Lanarkshire's director of public health has not had the capacity to service the two licensing boards. That is regrettable, because we recognise that the issue is important.

One of my priorities this year is to consider how, from a health improvement perspective, I can put some dedicated capacity into that area, so that we can have a post that is similar to the post that Elaina Smith described. That is partly an observation based on the very good practice that she outlined.

Aiden Collins' comments assured me and made me more convinced that such an approach would be very beneficial. We need to have a conversation about that with the ADPs so that we are clear about their functions in supporting the wider public health agenda—within the context of reform around public health and the future role of public health Scotland—and how we see that interconnection within a whole-systems approach.

We have seen varying levels of practice, including the good model that was described by Aidan Collins. I have to admit that, from a health improvement and public health perspective, we are not satisfied with the extent to which we fall short. We can say that the problem is capacity, but there are other problems, such as skills and expert knowledge, and feeling comfortable that the licensing board is going to be receptive to our giving our time and energy to the situation.

Sarah Boyack: A few people have said that there is a need for guidance and for a mix of learning from best practice and being clear about what is going to work. When the committee took evidence from the minister, it was told that draft guidance that specifically mentions public health issues is being introduced. Could the draft guidance be helpful in enabling people to establish the causal link between health and the evidence, and then reaching a decision? My question is both for those of you who are on the ground and for those who have the national perspective. Is the guidance in the right place, and will it help?

Aidan Collins: The guidance update is very well intentioned. I appreciate that a significant amount of effort went into updating aspects of the guidance to support boards when they were developing new policy statements. However, to be honest, that process was extremely rushed, and the consultation was not wide enough. That resulted in a product that is inconsistent on overprovision. We can see that aspects of the guidance are attempting to help; similarly, other areas confuse the issue of overprovision even further.

We were delighted that the Scottish Government decided to have an open consultation on the guidance, to which it got about 40 responses. When I looked through them, I saw common themes, and we are hopeful that the Government will take time to consider the range of evidence and to adapt the guidance as appropriate. However, as it stands, I would not say that the guidance is fit for purpose.

10:15

Sarah Boyack: I am interested in what you think the inconsistencies are. The key paragraph says:

> "In considering whether there is a 'causal link' the Licensing Board should assess whether, on a balance of probabilities, the harm identified is caused by the sale of alcohol in the locality."

Is that statement all right, whereas the rest of the document gets muddled?

Aidan Collins: That is how licensing is. When you first read that, it seems quite reasonable, but in practice, people would say, "That's about the sale of alcohol and we don't have sales data, so we don't know." The guidance needs to move towards the issue being about the availability of alcohol.

We have heard about the problems of people travelling from a particular locality and online sales. The guidance update needs to factor in such things, look at where the challenges are and where good practice is happening, and come up with something that helps us all to find a better way forward.

Sarah Boyack: What do other witnesses think?

Mairi Millar: I take a different view. I tend to think that the legislation gives boards enough power around overprovision and public health. It comes down to the evidence that is made available to the boards when setting out policy when it comes to an overprovision assessment and, more important, when dealing with individual applications.

I stress that it is not a matter of refusing an application automatically because of a health board's objection; it is about testing the information that is given in that objection and looking at what the applicant says to mitigate the situation or challenge that information.

The legislation gives appropriate powers; it is about how the boards use the available powers. The importance of guidance can be overstated. It comes down to policy statements and the information that is available around an individual application rather than what the statutory guidance says.

Elaina Smith: I would like to pick up on several things that have been said. The policy is key. If a board sets out a policy that says what its understanding of public health is, that is clear to everybody and it allows us to continue to reinforce that message.

Availability and accessibility are key components of the public health objective. Accessibility is a key challenge for me, especially in relation to home delivery of alcohol and the immediacy of that in certain areas, especially given the huge growth in the use of delivery companies. Whether alcohol is being delivered with food or without, that is a growing area. The crux of my role is to understand the impact that that has on a particular community and what an additional licence or a variation to a licence will mean.

Ultimately, this comes down to whether there would be a legal challenge in court, as has been mentioned in the case of Inverclyde. I certainly see that fear in Renfrewshire because I also cover that board area.

I have shown boards significant harms within their areas but a licence has been granted because the board does not have confidence in the evidence presented as it does not sit robustly within the public health policy, unlike what happens in Glasgow.

The Convener: Are you saying that, if a board or local authority changed its policy direction, as Glasgow has done, that would cover them if it came to a legal challenge?

Elaina Smith: I hope so, although we can never know what will happen with a legal challenge.

The Convener: No, but Glasgow is confident that it is covered to a great extent.

Elaina Smith: Yes.

Mairi Millar: I hope so.

The Convener: I suppose that that is as good as I am going to get.

Elaina Smith: It would also be great from the national perspective. That might be where the guidance can come in. I judge harm that is being experienced in an area and how far that is above the Scottish rate. The Scottish rate is bad, as we all know, and if an area is significantly above the Scottish rate a lot of harm is going on there. That could potentially be inferred in the public health objective guidance, and it is certainly a stance that I take when I assess an individual application.

However, I also look at it from the broader perspective of what the policy for that board area can back me up on. What does it say will be enforced, from a public health perspective? It is not just about overprovision. We are totally entangled in the overprovision issue relating to the number of premises, but that is not the issue; it is about ease of access to alcohol in that community.

The Convener: Because the method of access has changed.

Elaina Smith: Yes.

Sarah Boyack: This might be a daft lassie question, but you said that, in terms of overprovision, the issue of numbers is not critical. To what extent does community health sit alongside that? Access to alcohol is an issue, but how do you factor in the public health problems that are caused by the number of licensed premises, in terms of community health?

Elaina Smith: We have to recognise that deprivation and poverty, and their impacts in communities, also play a significant part. The Scottish public health observatory report looked at the overall burden of alcohol in the disease

process, going beyond the measures that we already look at. It demonstrated that deprivation increases the harm of alcohol by a significant amount. I cannot remember the figure offhand, but harm from alcohol is in the region of 8.4 times more likely if someone lives in a deprived area. Deprivation plays a part, but so do access to services and knowing what help is available. If someone lives in a community where all they see is convenience stores and fast-food outlets selling alcohol and where they might not have access to good food and good examples of sensible drinking, that has an impact on how alcohol is consumed.

Here is where I want to say a bit about normalisation. The fact that alcohol is seen as an everyday commodity is used as an argument for every licensing application that comes forward, especially in relation to off-sales. Alcohol is seen as part of a basket shop and we need to change that whole ethos in society. We are now also seeing an insidious leak into other areas, with hairdressers now providing alcohol. One in Renfrewshire is licensed to provide up to three alcoholic drinks in a very small salon, where children will be sitting among other users of the service. When I asked about the impact on the recovery community, I did not really get a positive response. There are very few safe, alcohol-free areas where people can go now.

Andy Wightman: I want to clarify a few points about the city of Glasgow's licensing board's policy statement. In relation to off-sales, outwith the statutory overprovision bit of the law, it states that judicial review is a mechanism whereby people can challenge decisions made by policy makers, not on their merit but in terms of whether the policy makers had the power to take the decision, followed the appropriate process in terms of consultation and all the rest of it. Glasgow's is just one example of a policy that has been adopted to advance one of the objectives of licensing regulation. The policy is not being challenged, perhaps because people think that it cannot be challenged or because not many cases are being rejected on the basis of that policy. If that policy is not being challenged, it seems clear that no local authority should be reluctant to innovate in the area, as long as the policy is clear—like chapter 9 of Glasgow's policy, which I have just read—and well associated with the law so that what it is says is beyond doubt, and so long as it has been introduced following an appropriate process of consultation, adoption by the council and all the rest of it.

James Douglas talked about resources, which are critical, but this is fundamentally a matter of policy. Resources need to be put in place to implement policy, but the policy is the most important thing. Is that a fair characterisation of some of the issues?

Mairi Millar: I do not agree with everything that you said, because it is also about gathering evidence. We can have the best policy in the world, but if we do not have the evidence, we will not have a basis on which to refuse an individual application.

The policy on off-sales that we have developed in Glasgow sets apart the public health objective from the overprovision issue. An area might have a relatively low number of alcohol premises—or no such premises—but it might also have an obvious problem of people suffering from alcohol-related ill health. The licensing board has taken the general view that granting an application in such an area might make it easier for people there to buy alcohol, which could exacerbate the existing issues. The board looks to establish whether that is the case and whether there could be a causal link. For example, a convenience store, by its very nature, targets people who live locally, and granting an application to sell alcohol will make it easier for local people to purchase alcohol. That is where the concern arises.

On whether the policy is challenged, I think that a policy is probably more successful when people can take informed decisions about whether to lodge applications. It is difficult to measure the policy's success, because the policy might be deterring people from applying for an off-sale in an overprovisioned area or an area where there is evidence of alcohol-related harm. Our policy focuses on enabling people to make informed decisions about that. It might be that clients are going to agents to explore the possibility of making an application in a particular area and are being advised that an application is unlikely to be successful; the client might then not make the application. I have heard of that happening.

The Convener: Does anyone from another council want to speak about the reasoning behind the approach that Andy Wightman and Mairi Millar talked about? If the approach works for Glasgow, why cannot it be taken in other local authorities? Do you disagree with what Andy Wightman said?

James Douglas: I do not disagree at all with what Mairi Millar said. However, there could be practical issues for my area. We have an area where there are no alcohol outlets at all, but it is one of the worst areas for alcohol-related illness—Mairi touched on that. How is it possible for me to say to a sheriff that an application to open a convenience store, for example, should be refused because it might make matters worse? The proposed new premises would clearly have had no input into the existing alcohol-related illness in the area. I hear what Mairi Millar said, and I would proffer the same argument if I was before the

sheriff arguing the point. However, you can bet your bottom dollar that the solicitors acting on behalf of the applicant would say, "There's no causal link here whatever."

I, too, have read Glasgow's policy statement, and I am putting it on the agenda for the next meeting of our licensing board, to see whether there are things in it that we can consider.

I was heartened to hear that Inverclyde might get a dedicated ADP person, just as Glasgow has. I want to make it clear that Inverclyde licensing board thinks that the objective is laudable, especially given that our area has really quite bad statistics—I think that Glasgow, Renfrewshire and Inverclyde are the worst in Scotland. We would love to achieve the objective.

We introduced into our policy statement measures to protect children from harm. Children are simply not allowed to sit at a bar. I heard what was said about normalisation; it is not normal for an eight-year-old to sit at a bar, even if they are taking a meal. We have banned that type of thing.

We have also stopped granting extended hours to football prize-giving events where alcohol is being sold and so on. However, we do not want to get challenged on the type of policy that we are discussing today.

10:30

The difficulty is that refusing a licence is a quasi-judicial decision and, accordingly, has to be mired in evidence. That is what Mairi Millar is saying. We can have the best policy in the world—there will be things that we can pick up from Glasgow's excellent work—but there is a big difference between theory and practice. If we were standing before a sheriff and the Queen's counsel acting on behalf of Better Buy Ltd asked why on earth we had refused the company a premises licence when there are no shops at all in the area that sell alcohol, that would be a very difficult hurdle to get over.

The Convener: I accept that, but I wonder why Glasgow can take a chance and do it while other cities cannot.

Mairi Millar: We have not been challenged on that particular policy as yet.

The Convener: But you have taken a chance that you will be challenged.

Alexander Stewart: That is the point—Glasgow has not been challenged.

The Convener: No—the point is that Glasgow has taken a chance that it may be challenged, while other local authorities have not. That is the point that I am making.

Elaina Smith: I cover two areas. I was very fortunate in that, when I came into post, the groundwork in Glasgow had already been established. The licensing board was already working towards addressing the dilemmas that it had experienced over the years in relation to how it could improve its relationship with the public health objective, hence the policy that has been formulated. That was done in partnership with a lot of people, including people in the trade. We should remember that, much of the time, a decision is not purely about health. I work closely with my police colleagues, licensing standards and the licensing team, and I also listen to what the traders and the community are saying to get a balanced picture.

My post also covers Renfrewshire, which has not had the benefit of a dedicated person, so its understanding of the health data is not so good. Much of my role is about how I articulate the evidence to a licensing board. On Monday, I managed to achieve my first real success with Renfrewshire's board, when a newsagent's shop was refused a licence on the ground of overprovision. That was in an area in which there was only one other relevant premises.

The board listened to what I said about the health evidence and the worsening trend in the area, and recognised that it did not want to add to the burden, so it took the decision to refuse the application. That is the first time during the period in which I have been in post—just over 14 months—that I have managed to achieve something like that. It is about taking the time to enable the board to understand the evidence that I am presenting. A lot of my groundwork with the Renfrewshire board was about how it wanted to hear the information and how a decision would stand up in court. It was important that I was able to be consistent in my approach and in the evidence that I provided.

The Convener: Andy Wightman, do you want to come back in?

Andy Wightman: I want to move the discussion on a little.

The Convener: Yes—me too.

Andy Wightman: The committee has been looking at the issue of community participation in the whole system. If we had stayed on the previous topic, I was going to ask whether there was an argument for reforming the law to include the presumption that there shall be fewer alcohol outlets rather than more. There seem to be fundamental assumptions built into a lot of the legislation that would make that difficult, but I will park that issue to one side.

One of the responses in the Licensing (Scotland) Act 2005 was to attempt to get local communities more involved in the broad policies

around alcohol licensing. We have heard very mixed evidence on the efficacy of those policies—indeed, on whether they are worth it at all, and whether folk are even interested in engaging in an area of policy that is quite straightforward on the face of it but which involves a level of detail that is really quite difficult for the public to engage with. Do people here have any thoughts about the process for local licensing forums, and whether the policy could be made better or whether it is worth having at all?

Norman Work: In Edinburgh, there are several community councils, in particular in the city centre—in the old town, the new town, Tollcross and Stockbridge—that have dedicated licensing conveners, in a sense. They are quite active in presenting their case to the Edinburgh licensing board. The level of participation depends on the individual community council, but when a community council submits an objection—as it normally is—we will invite its representatives up to see us. We listen, and we encourage them to participate. That tends to apply to community councils from the city centre, rather than those outside—and, as I say, they have dedicated licensing conveners.

Andy Wightman: I am aware of the role of the community councils, which is a historic one. The issue that I am raising particularly concerns the section 10 provisions under the Licensing (Scotland) Act 2005, whereby

"Each council must establish a Local Licensing Forum".

Norman Work: Yes.

Andy Wightman: Those forums are separate from community councils. How effective are they? From what you are suggesting, they may not be terribly effective at all. They are designed to influence policy, as opposed to performing the role that community councils have, which is to keep an eye on each application and to make any representations that they wish to make.

Norman Work: Under the legislation, licensing forums have to meet, and there are places for community representatives on the forum. There is a problem with forums—this is where I will be controversial—in that the Edinburgh licensing forum could not come to an agreed position on overprovision. The forums are made up of all different types of people, and the Edinburgh forum was unable to determine its position on overprovision. The forums play their part but, because they encompass everyone, from the trade to communities, their views are varied—as they should be.

Tom Mason: I endorse the comment that has just been made. The attitude of community councils and forums is always split between those who want to prevent further social disruption in an area and those who want to import a vibrant new business opportunity. In my area of Aberdeen we have that continual conflict. We end up with a situation of "He says that, but they say that," and we do not get any definite conclusion, regrettably. Life would be very simple if we did.

Alexander Stewart: We have discussed many things this morning, and much of the conversation has been positive regarding the policies and the direction that we are trying to take. However, our whole culture around alcohol remains a major issue for us as a nation. We have discussed accessibility and the processes. There is also the matter of communication with organisations and individuals across council areas.

We have already heard this morning that some councils are fearful about progressing. I do not know of any supermarket that does not have a large chunk of its floor space given over to alcohol. Have we ever challenged any of those supermarkets in any council area about their size or about how they manage the direction in which they are going? Do the councillors who sit on boards feel confident enough in trying to challenge overprovision from the point of view of health? They are the ones who make the decisions, and they do so on the advice that they are given by the professionals who support them. A decision may relate to health, and it could involve the licensing forum or the Scottish Licensed Trade Association. They all have a role to play. However, I am not convinced that councillors themselves feel confident enough. What if the council does not feel confident enough to challenge and to make progress? Does anyone have any views on that?

Mairi Millar: We have been challenged only once since the 2005 act came in on a decision to refuse an application based on overprovision. That involved one of the largest national supermarkets. At that stage, there was not an awful lot of case law, and nobody knew how it was going to go. The presumption probably was that the supermarket would win, but the licensing board was successful in that case.

Licensing boards should not be concerned about who the potential appellant is; it is a matter of whether they have the evidence to support their decision. That should be the factor in making a decision on whether or not to refuse an application. The issue is whether a board thinks that it can stand up to a challenge, regardless of the likelihood of a challenge or of who may make one.

Aidan Collins: That goes back to the point about having a policy. The benefit of doing so is that it lets us look at the evidence over a wider area and then seek to promote our objectives on the basis of the bigger picture that emerges. We keep coming back to the view that applying the

evidence on an ad hoc, case-by-case basis is much more difficult. When we look at applications and drill down to the local level, we often find that some health information is unreliable. We might be looking at a data zone that consists of 500 households—or even below that, at postcode level—where it is quite hard to get the necessary evidence.

The other point is that health harms occur over quite a long period of time and cannot be linked to specific premises or a specific area. The issue is more about the sum of individual boards' decisions having an aggregate effect on availability, consumption and harm. That has implications for boards as regards their level of understanding about the bigger picture and the links between availability and harm. There are also implications for health stakeholders, which are about the type of evidence that is needed and how it should be gathered and presented to a board in a meaningful way.

We often hear boards saying that they get health data but that it is just irrelevant, while health stakeholders say that they put a lot of work into submitting evidence that is then ignored or unjustifiably dismissed. Some people say that boards focus too much on statistics and do not care about communities, case studies and community experiences, while others say that boards care only about their own experience and do not focus enough on statistics. Looking at the national picture, there is a lot of uncertainty about what boards want and need and how they can use different types of information in relation to health. The area is quite complex when we get down to the level of individual applications. That goes back to the importance of having a good evidence-based policy from which all decision making flows—it helps people navigate some of those complexities.

Alexander Stewart: As you have identified, if you do not have the right information, navigation just does not take place. People put time and effort into submitting reports that are just removed, disregarded or not given the credence that they deserve. That is happening across the country: we seem to have 32 local authorities that are all doing slightly different things to one another. Even neighbouring councils do not seem to do the same things and do not collaborate as much as they should or could to invest in the issue and make the right things happen. I maintain that we still have an issue at board level, which we must try to manage.

The Convener: I like the idea that 32 local authorities are doing things to one another, as you have just suggested, Alexander.

I will have to leave shortly, but first I want to pick up on Elaina Smith's earlier comment about evidence suddenly being produced by lawyers at an appeal against a licensing decision. You said that they might come in with swathes of evidence that you had never seen before. Do they not have a responsibility to make such evidence available to the licensing board at the initial stage?

Elaina Smith: Some of the difficulty comes down to how an agent submits an application and provides background to the vision for the premises. Applicants' operating plans are not always clear about what is likely to be done at the premises. For example, an application might come in for a cafe that is looking to make both on-sales and off-sales, but there is no mention of whether it plans to offer delivery with off-sales. In Glasgow, we are desperately trying to ensure that conditions are applied to anything that has an off-sales capacity. At the moment, operating plans do not have to stipulate whether applicants intend to deliver alcohol as part of their off-sales provision. Therefore we have no idea where their area of operation is, which areas it is likely to impact and how we might establish any impact on areas that are already experiencing harm.

The Convener: Can you deal with that at local level or does it have to be done at national level?

Elaina Smith: We cannot deal with it at local level, because application forms and operating plans are set in stone. Fife Council received a legal challenge because questions had been added to an operating plan in an attempt to clarify matters. Such information might subsequently come through to the board, but, once a licence is granted, the licensee goes off and does what they want.

10:45

There is not necessarily a level playing field. The information that a statutory consultee receives on matters to which they can respond is not always the full picture. Consequently, I go away and ask a lot of additional questions. If we are expecting communities to do the same level of due diligence, we are asking an awful lot of them. It is really hard even for statutory consultees such as community councils to advise fully on whether they have an objection to an application.

The Convener: But the full information should really be available at the very first stage.

Elaina Smith: Yes.

Sarah Boyack: Listening to the evidence on Glasgow and Edinburgh has made me think about overprovision in a city centre and a wider community context. Do you take a different policy approach in either city to those distinct geographical areas, given the wider public health issues and the different community public health issues?

Mairi Millar: In the Glasgow policy statement, we say that we do not consider there to be overprovision in the city centre area. Again, every case is looked at individually, but as a matter of policy, the board generally would not consider there to be overprovision. The statement recognises that licensed premises play an important part in the city centre's appeal and its ability to attract people into that area. A lot of the policy on overprovision is focused on concerns about off-sales and the fact that the consumption of such alcohol is not regulated. A distinction is made between the regulated consumption of alcohol in a pub or club, where there is oversight, and the provision of alcohol where it is sold to be taken away, where there is not. The policy on overprovision and public health focuses more on the concerns associated with off-sales.

Norman Work: In Edinburgh, we have increased our overprovision area—it used to be just the old town basically, but now it includes the new town. It is interesting that you are talking about tourism. With Edinburgh being the tourist city that it is, most of the applications are from new restaurants and hotels. There are also applications to vary licences, with restaurants wanting to extend hours for children—obviously, that is to allow them to have a meal while accompanied by an adult. In some ways that is a good thing, as it is changing the ambience of the premises.

Those are the challenges that we have had, which relate to an overprovision policy. I argue that the policy in Edinburgh has changed many of the premises into more food-orientated establishments, with fewer of the so-called vertical drinking establishments. I do not know whether that makes sense.

The Convener: I take my leave, and hand over the convening of the rest of the meeting to Sarah Boyack.

The Deputy Convener (Sarah Boyack): Thank you, convener.

The convener has gently pointed me to a couple of questions that we have not yet asked on health data. It would be useful to have a snapshot of what information comes from health boards to licensing boards to aid their policy development and decision making. Do health boards provide the same data? Do they have different approaches? Perhaps Aidan Collins has a national perspective.

Aidan Collins: AFS has been trying for several years to support stakeholders to develop and gather evidence, particularly to support the policy statement. We have developed a licensing toolkit, which outlines all the different sources of health evidence that can be accessed. We have also heavily promoted research by the University of Edinburgh and the University of Glasgow, which looked at health data at the data-zone level and linked that to outlet availability. Again, we supported local areas to use that data.

When it comes to what we see boards reporting on, there are similarities—they tend to report on things such as alcohol-related death rates and alcohol-related hospitalisation rates. When the local partners work together to collate evidence from multiple agencies, the process seems to work very well. In quite a few areas, the forum or the alcohol and drug partnership will submit a profile, which will include health data and information about addictions and referrals. That will be combined with fire service and police data, which covers things such as alcohol-related crime. Social work statistics on, for example, children living with a parent who is a drinker might be included. All that information gets collated. There are different approaches, but the process seems to work best when collated data is provided and when boards speak to the stakeholders beforehand to explore what levels of data are available and to agree what might be most useful for the board. From looking at the policy statements, that is the national overview.

The Deputy Convener: Is there a different view on the issue at a more local level? Is the data disaggregated sufficiently to enable you to operate with it?

Elaina Smith: From the perspective of NHS Greater Glasgow and Clyde, we provide all six of our local authority areas with what we call our overprovision data, which covers alcohol-related hospital stays, alcohol-related deaths, alcohol-related brain damage admissions and mental health discharges related to alcohol. At Glasgow city and Renfrewshire level, I try to collate as much information as I can in order to provide a bigger picture. In fact, at Renfrewshire's board on Monday, I was asked for any gender-based violence data that could be provided. That is the first time that I have been asked for that by a board. I will go away and look into that. It is recognised that alcohol permeates into lots of different areas.

We must exercise caution when it comes to the level at which that data can be made available. Data on addiction, child protection and gender-based violence might well have to be reported only at local authority level to prevent identification of individuals. I am very cautious about that, especially in relation to child protection. The numbers are small, but the impact can be quite substantial. In the context of child protection, the child could be experiencing a life of on-going problems.

From a board perspective, we try to ensure that the rest of our local authority areas are provided

with the same information. It is up to each of the individual health and social care partnerships in the NHS Greater Glasgow and Clyde area how they use that data.

The Scottish public health observatory—ScotPHO—also has profiles. That information is taken from the information services department. Licensing boards can access those profiles, which contain additional information such as crime stats, as well as the information on deaths and hospital admissions.

Norman Work: I am in danger of repeating myself, but NHS Lothian reports to the licensing board. All the statistics that we have heard about are available to board members. We can also ask for a report, including on the crime statistics, if we are concerned about a certain area.

However, as I think I mentioned, NHS Lothian reports only on areas of overprovision. It does not report every time, but the information—which I think involves the use of intermediate data zones—is available. NHS Lothian will make the information available if it is requested, or if it relates to an area that it wants to highlight to the board.

James Douglas: The intermediate data sets that the NHS provided were extremely helpful to Inverclyde Council in preparing our policies, both in introducing an overprovision policy five or six years ago and then deciding to do away with it last year. However, we have not received anything like an intermediate data set for any individual application.

The Deputy Convener: I have one final question about health data. As a result of the concerns around the availability of health data, it is now possible for licensing boards to designate their whole area as overprovided for. Has that been a helpful move in policy terms?

I see one nodding head and one person is not so sure—the witnesses from Glasgow City Council and Alcohol Focus Scotland. Do you both want to comment?

Aidan Collins: Whatever approach to overprovision boards take, the most important thing is that it is based on the evidence. Some boards will decide to have an overprovision area for their whole area, for on and off-sales, because all the evidence—the data that they have gathered and what communities are telling them—points to that being the right approach. Having a wider area helps if, for example, people are travelling to buy alcohol. It is now easier to determine the overprovision area.

However, it is sometimes appropriate for boards to take a targeted approach to tackle particular problems in certain areas. A board might have areas in which there are no issues to be concerned about and there might be no evidence that it would be appropriate to designate them as overprovision areas. Rather than saying that whole-area overprovision is necessarily better than a localised approach, the important thing is that boards have the option.

Mairi Millar: On using the health data, I do not think that the change in the legislation was absolutely necessary. If a board wants to take a whole-area approach, it still needs to demonstrate why each individual area within the entire area—at least to small enough localities—has to be defined as an overprovision area.

I have one final point on the use of health data. We should not focus on the use of public health statistics as being of assistance only in deciding whether to grant or refuse individual licensing applications. The data should also be used in the regulation of licensed premises. If premises are identified as being in an area where there is a higher risk, can we attach conditions to applications from those areas to mitigate the risk? We should also perhaps put a responsibility on licence holders in areas in which there is a higher risk from alcohol to put in place measures through their risk assessment and operation of their premises. Health data could be used in that wider sense rather than focusing only on whether it can be used to refuse an application.

The Deputy Convener: I see nodding heads round the table—thank you for that point.

Andy Wightman was interested in the community issues. Have you asked all the questions that you wanted to ask, Andy?

Andy Wightman: I was interested in the local licensing forums. I will leave it at that.

The Deputy Convener: You have got that on the record.

Norman Work: Convener, may I just add one wee thing that Andy Wightman might be interested in? When we were consulting on overprovision policy and deciding which areas were overprovided for, the Leith neighbourhood partnership used the statistics and data to ask the licensing board to include Leith as an overprovision area. We did not do that, and the partnership was very angry, but it used the data that was available. Communities were involved and used the data that was available from the intermediate data zones and so on. I thought that I had better mention the Leith partnership, because it is still annoyed with the licensing board.

The Deputy Convener: I suppose that that makes the point that community involvement in the process does not necessarily mean that the community will be happy with the end result.

Annabelle Ewing: On community engagement, I want to pick up a point that it would be remiss of us not to flag up. On the issue of licensing boards having greater involvement with community planning partnerships, we received a submission from the Law Society of Scotland—I should probably say that I am a member of the Law Society but I am not a practising solicitor—that raises concerns about how that would work, given that licensing boards are meant to be independent. I know that we do not have much time left, convener, but that is an important issue.

Mairi Millar: I tend to agree with that point. I am a member of the Law Society sub-committee on licensing, so there is a potential conflict of interests there.

I would be concerned about any changes that create a greater link with community planning partnerships. Community councils, elected members and individual local residents already have the ability to input into the licensing process. It is about better enabling people to make representations or objections and getting across information about how they engage with the licensing process. We tried to do that more in the most recent development of the policy statement by holding community-based meetings and getting community councils in for focus group sessions. We should focus more on increasing understanding of the licensing process than on changes to legislation.

The Deputy Convener: As we have no more questions, I thank all the witnesses not just for being interrogated and for being prepared to engage with us, but for the written submissions that you sent us in advance. I thank all those who provided written submissions, which have been extremely helpful. The committee will consider in private how we want to take forward the evidence that you have given us. Thank you all for coming.

I suspend the meeting briefly to enable the witnesses to leave.

11:01

Meeting suspended.

11:04

On resuming—

European Union (Withdrawal) Act 2018

Management of Extractive Waste (EU Exit) (Scotland) (Miscellaneous Amendments) Regulations 2019 (SSI 2019/273)

Town and Country Planning and Electricity Works (EU Exit) (Scotland) (Miscellaneous Amendments) Amendment Regulations 2019 (SSI 2019/274)

The Deputy Convener: The fourth item on our agenda is consideration of whether the regulations have been laid under the appropriate procedure. The regulations have been laid under the negative procedure. The Delegated Powers and Law Reform Committee considered the instruments at its meeting on 10 September and agreed that it was appropriate for the instruments to be considered under the negative procedure. We have received advice to the same effect from the Scottish Parliament information centre.

As there are no comments from members, is the committee content for the instruments to be considered under the negative procedure?

Members *indicated agreement.*

Subordinate Legislation

Management of Extractive Waste (EU Exit) (Scotland) (Miscellaneous Amendments) Regulations 2019 (SSI 2019/273)

Town and Country Planning and Electricity Works (EU Exit) (Scotland) (Miscellaneous Amendments) Amendment Regulations 2019 (SSI 2019/274)

11:05

The Deputy Convener: Agenda item 5 is consideration of the negative instruments. This is the standard consideration of the policy of the instruments, now that we have decided that the procedure is appropriate. I refer members to paper 3, which contains further detail.

As the instruments are laid under the negative procedure, the provisions will come into force unless the Parliament agrees to motions to annul them. No motions to annul have been lodged. The Delegated Powers and Law Reform Committee considered both instruments at its meeting on 10 September and determined that it did not need to draw the Parliament's attention to them.

As no member wishes to comment, does the committee agree that it does not wish to make any recommendations in relation to the instruments?

Members *indicated agreement.*

The Deputy Convener: That is the end of the public part of the meeting.

11:06

Meeting continued in private until 11:29.

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