NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Alcohol: preventing harmful alcohol use in the community

Date of Quality Standards Advisory Committee post-consultation meeting:
22 September 2014

2 Introduction

The draft quality standard for Alcohol: preventing harmful alcohol use in the community was made available on the NICE website for a 4-week public consultation period between 1 July and 29 July 2014. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 31 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- General support for the draft quality statements on alcohol.
- Equality and diversity considerations were raised (LGB&T issues, homeless people, engagement with local faith leaders).
- Comments were made about the introductory sections, in particular the statistics and the ‘training and competencies’ section.
- Concern about excluding national policy issues, such as advertising and minimum unit price.
- Comments on the outcomes frameworks.
- Examples were given of initiatives and good practice being used.

- Suggestions for inclusions of other policy context references.
- Suggestions were made on groups to specifically address (looked after and adopted children, young people not in education, employment or training (NEET), older people).

Consultation comments on data collection

- Concerns over data collection issues due to diagnostic coding and the financial resource needed for it.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Local crime and related trauma data are used to map the extent of alcohol-related problems before developing or reviewing a licensing policy.

Consultation comments

The full set of comments received from stakeholders about this draft statement is presented in appendix 1. Committee members are invited to review all comments to ensure that important issues are discussed at the committee meeting. The following comments on draft statement 1 may be discussed:

- The statement assumes that licensing policies are regularly and meaningfully reviewed.
- It sounds like the focus is on crime when health should be the focus.
- Protection of public health is not a licensing objective. Health data can be used to 'set the scene'.
- Include the entire licensing process, including responsible authorities making representations during the licensing process.
- The principles and values that are written into the Licensing Policy Statement are more effective than this limited approach.

- Licences should be granted and reviewed on a case by case basis: mapping data to specific premises should be done with caution. Attributing this type of data to sales from off-licences is difficult.
- There is too much focus on Cumulative Impact Policies (CIPs).
- Terminology issues were raised:
  - ‘local licensing agencies and partners’ should be replaced with ‘Local Licensing Authority’ and ‘Responsible Authorities’
  - ‘Statement of Licensing Policy’ should be used instead of ‘licensing policies’
  - Quotas of licences are not allowed, so on p.10 write ‘individual licence applications can be refused’ instead of ‘the number of new licences may be limited’
  - CIPs are not a mechanism under the 2003 Act, it is set out in 182 guidance not the legislation.
- Data issues were identified: collection, accuracy, quality, systems and protocols for effective sharing.
- Suggestions for additional data to consider were made: concerns from residents, building capacity, support to enable community involvement, GP data, alcohol-related deaths and disease, housing provider data on antisocial behaviour, domestic violence, alcohol consumption and sales.
- Mention not having off-licenses next to schools.
- The number of promotional offers in supermarkets and in licensed premises need to be restricted.
- The definition of alcohol-related problems is too broad and contravenes what is permissible as evidence as per the Licensing Act 2003.
- Individual premises and licensees should be considered as relevant partners.
- Measure the number of representations made by responsible authorities with respect to the grant and review of premises’ licences.
- Equality and diversity issue: off-licence outlets are more numerous in deprived areas rather than on-licence premises.
- Local areas need the skills and capacity to interpret the information.
- Links to guidance documents for health teams engaging in the licensing process should be included.

5.2 Draft statement 2

The appropriate authorities work in partnership to identify and take action against premises that regularly sell alcohol to people who are under age.

Consultation comments

The full set of comments received from stakeholders about this draft statement is presented in appendix 1. Committee members are invited to review all comments to ensure that important issues are discussed at the committee meeting. The following comments on draft statement 2 may be discussed:

- Some stakeholders felt that this statement is already being achieved.
- Proxy sales of alcohol and sales to people who are intoxicated are also an issue.
- The statement is too focused on the process (partnership working) rather than the outcome.
- Legislation is making it harder for local authorities to carry out test purchases.
- Health teams are not responsible for taking action to reduce underage sales and do not have regulatory powers. The district council licensing teams are the licensing authority.
- Page 13: 'licensed premises are reviewed' is technically inaccurate. Replace with 'examined'.
- Mention local businesses and the industry as a partner in tackling underage drinking e.g. through Community Alcohol Partnerships.
- What does 'regularly' mean?
- Home delivery services for alcohol should be included in test purchasing.
- Authorisation for test purchasing is needed, which requires intelligence on problem traders. Test purchasing should be evidence led.
- Funds should be shared to finance legal challenge rather than test purchasing as this is core business for the police/trading standards.
- Reference the Better Regulation Delivery Office's test purchasing code of practice more extensively in the definition.
- What data would provide evidence of partnership working?
- The measures should focus on an outcome that shows a reduction in alcohol consumption amongst young people.

- Prevention and best practice schemes should be highlighted: measures can be put in place to prevent underage sales happening e.g. Challenge 25, conditions of licence relating to staff training, effective ID schemes.
- Child protection issues and services should be highlighted.

5.3 Draft statement 3

Schools have a 'whole school' approach to alcohol that involves staff, parents, carers and pupils.

Consultation comments

The full set of comments received from stakeholders about this draft statement is presented in appendix 1. Committee members are invited to review all comments to ensure that important issues are discussed at the committee meeting. The following comments on draft statement 3 may be discussed:

- The focus of the statement is unclear: add more detail.
- Schools are limited in how much they can do to address this issue amidst other competing priorities.
- Add the significance of training and ongoing professional development for staff to the rationale.
- What school phase does this apply to? It should be aimed specifically at secondary schools.
- Comments on the definition of 'whole school approach' were:
  - Add that alcohol should not be allowed on the school premises
  - The term is tired and inappropriate in some contexts
  - Working with outside agencies (e.g. alcohol misuse services, community groups, the alcohol industry) should be included
  - There should be ready access to assistance if a problem is disclosed
  - Include advice and support for staff and parents/carers around dealing with alcohol-related issues and how to access supporting services
  - Suggestions for further detail that could be added
- School absence is not an appropriate measure.
- Ofsted are not a suitable data source for the measures.

- Including alcohol on the curriculum is not an adequate measure of quality.
- Suggested amendments to the measures were made.
- There should be specific recommendations for how young people who are NEET are targeted.
- Mention that schools should be engaged with local licensing and action on alcohol.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Alcohol and hepatitis
- Alcohol and binge medicating
- Alcohol and obesity.
- Increasing strength of alcoholic drinks.
- Prevention of fetal alcohol spectrum disorder through educating young women.

Appendix 1: Quality standard consultation comments table

ID	Stakeholder	Statement No	Comments[1]
1	Alcohol Health Alliance	General	The Alcohol Health Alliance welcomes the quality standard's recognition that alcohol-related harm has a wider social impact that extends beyond the individual drinker and affects families, the wider economy, health services, crime and policing, and beyond.
2	Alcohol Research UK	General	The data at the top of p. 2 is unclear. The estimated number of hazardous drinkers (24%) is originally taken from APMS 2007, so is somewhat out of date and not *additional* to the 24% of men and 18% of women reporting drinking over the guidelines as reported in HSE 2012 and HSCIC 2014.
3	Alcohol Research UK	General	When giving the broad figure for hospital admissions it should be clear that this is an estimate based on aggregated Alcohol Attributable Fractions (as is standard practice in HSCIC reporting). The current phrasing gives the impression there were 1,008,850 separate specific admissions – which is not precisely what the figure represents.
4	Alcohol Research UK	General	The figure of 15,000+ hospital admissions for under 18's is also an estimate based on the broader AAF figures (the link doesn't go to the data, just to the LAPE home page). Again, for accuracy this shouldn't be described as 15,000 separate hospitalisations. HSCIC Statistics on Alcohol 2014 (Table 4.2) provides a figure of 9,070 alcohol-related admissions for under-16s in 2012-3 (5,730 wholly attributable and 3,340 partially attributable). This could provide an additional / alternative figure (link here: http://www.hscic.gov.uk/catalogue/PUB14184) for underage admissions.
5	The Association of Convenience Stores	General	ACS (the Association of Convenience Stores) welcomes the intervention of the National Institute of Clinical Excellence in this emerging area of local public health policy. We acknowledge the important and positive role that health professionals can provide to the development of local licensing policy. We believe this should be done in a way that is based on the effective and consistent use of data; and in a way that helps local licensing authorities target the right interventions at the right places in the local area.

[1] PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

			We also hope that the use of Quality Standard will help to avoid situations where interventions by public health professionals in local licensing system are based on inadequate or misapplied data, and especially to prevent local health groups using their position as responsible authorities under the licensing act to advocate unilateral policy interventions. ACS (the Association of Convenience Stores) ACS represents 33,500 local shops across the UK; our members include some large national chains, but the significant majority are independent retailers. Almost all of our members' stores hold an alcohol licence ACS supports the Government's aims to tackle alcohol-related crime and disorder and to reduce alcohol-related health harms. ACS has led change in retail practices like Challenge 25, which builds on the mandatory alcohol licensing for premises to have an age verification policy, by requiring staff to check the age and identity of all customers who look less than 25 years of age. This has been very successful, with a recent report by the Retail of Alcohol Standards group showing that 11 million people have been challenged through Challenge 25 since its launch in 2005, with 67% of the public, including 86% of 18-24 year olds, are aware of Challenge 25. In addition, young people drinking in the last week has fallen 18% since Challenge 25's introduction, while consumption by 16-24 year olds has dropped by 24%. We are also actively involved in a number of other responsible retailing schemes, including being founding members of Community Alcohol Partnerships, an initiative which encourages partnership working between retailers, local enforcement authorities and communities to address alcohol-related issues. There are currently 46 CAP schemes in 17 counties in England, Scotland & Northern Ireland, with the first scheme in Wales is planned for later this year .
6	The Association of Convenience Stores	General	<u>Why This Quality Standard is needed:</u> We are concerned that the reference to general data about per-capita alcohol consumption and binge drinking suggests that the outcomes in the first two Quality Statements can be related back to population-wide behaviour change. Allowing any local stakeholders to make this type of generalised assumption about the impact of these specific interventions would not be based on robust evidence. It would be more helpful if this Quality Standard was placed in a more specific and appropriate context. We are also concerned about the use of general hospital admission data in this section. As is made clear in the quality statement, public health data has to be deployed in a way that is directly related to licensing considerations of that particular local licensing authority, or area within it. For example: - Trauma data that provides insight into places where people are frequently victim of violence or extreme drunkenness is highly relevant to the development of cumulative impact zones in local licensing policy.

			- Data on admissions of children linked to harms associated with alcohol consumption is relevant to understanding the extent to which an area has a particular underage drinking problem - Data on chronic health illnesses (outside of children) is unlikely to have a direct relevance to considerations related to local licensing policy. It is important that the Quality Standard does not set the example of viewing aggregate hospital admission data as relevant in the specific areas that are the subject of the three quality statements. In reality it is only specific data that will be relevant and helpful. The claims in this section about the contribution of the outcomes that are expected from this Quality Standard are broadly drawn and significantly lacking in detail. The outcomes are defined as: quality of life; hospital admissions; alcohol related deaths; anti-social behaviour and crime; prevalence of harmful drinking; and rates of underage drinking These are merely listed and as such are poorly explained and there is no corroboration for the claimed outcomes. This is important because local agencies need to know how to set local expectations and measurable outcomes that are directly linked to the interventions described in the quality statements.
7	The Association of Convenience Stores	General	The training and competencies suggestion suggest that 'all people' involved in preventing harmful alcohol use should have sufficient and appropriate training to deliver the actions described in this quality standard. There is a risk that this section, read in the context of the whole document, could contribute to an emerging confusion of roles between agencies, especially with regard to functions carried out under the Licensing Act 2003. Under this Act licensing officers, trading standards officers and local authority staff (employed in licensing) have very specific roles that relate to upholding the licensing objectives set out in the Act and **these are not the same as the public health outcomes** set out in the Quality Standard. The licensing objectives are in Section 4 of the Act, the licensing objectives are: - The prevention of crime and disorder - Public safety - The prevention of public nuisance - The protection This section could be improved by setting out more clearly the different functions local agencies have and specifically setting out the role that commissioners and providers of health and social care can make to development of local licensing policy.

8	The Association of Convenience Stores	General	How this Quality Standard supports the delivery of outcome frameworks: This section fails to explain how the specific statements that follow can be related back to the outcomes in these frameworks. It is therefore potentially confusing for local stakeholders especially those outside the public health community to understand how these should be interpreted and applied.
9	Association of Directors of Public Health	General	The standards generally look fine to me
10	Association of School and College Leaders	General	In our earlier response we also pointed to the pressure of advertising and the cheapness of alcohol as significant factors in establishing and maintaining unhealthy habits of drinking. Perhaps these are not issues that NICE can address in the context of a document such as this, but it is to be hoped that it can draw the attention of government to these factors which work against anything that schools, colleges, licensing authorities and other agencies do to address the problems associated with under-age drinking and the drink culture in general.
11	British Association for Adoption & Fostering	General	This response is being submitted on behalf of the BAAF Health Group, which is also a special interest group of the Royal College of Paediatrics and Child Health (RCPCH). The Health Group was formed to support health professionals working with children in the care system, through training, the provision of practice guidance and lobbying to promote the health of these children. With over 500 members UK-wide, an elected Health Group Advisory Committee with representation from community paediatricians working as medical advisers for looked after children and adoption panels, specialist nurses for looked after children, psychologists and psychiatrists, the Health Group has considerable expertise and a wide sphere of influence. Our area of concern is the particularly vulnerable group comprised of looked after and adopted children and young people.
12	British Association for Adoption & Fostering	General	It is disappointing that the QS does not address national policy, as our members would like to see robust measures such as introduction of minimum pricing units and reduced licensing hours, which would help to address the serious problem of binge drinking, and significantly reduce alcohol consumption by young people.
13	British Association for Adoption & Fostering	General	Training and competencies p7: We suggest that a wider group of health professionals should be included here. Those working with young people and in particular providing sexual health services have a key role to play in educating young people about the risks of alcohol use and especially during pregnancy, given that FASD is both entirely preventable and causes permanent damage.
14	British Association for Adoption & Fostering	General	The QS should specifically address children and young people in high risk groups, such as looked after children and particularly those that go missing from care, those not in education or training, etc.

15	British Beer & Pub Association	General	With regard to the figure of 1,008,850 alcohol related hospital admissions quoted for 2012/13 we would suggest that it is inaccurate to state that 'in 2012/13, there were 1,008,850 hospital admissions for which an alcohol-related disease, injury or condition was the reason for admission'. The broad measure used in this document includes both primary and secondary diagnoses if attributable to alcohol and therefore will include factors highlighted when a person is admitted even if not the reason for their admission. The narrow measure uses primary diagnoses if alcohol related or a secondary diagnoses if there is an alcohol related external cause therefore is likely to be a more accurate representation of the direct reasons that people are admitted to hospital. We would therefore suggest that either the wording is altered to ensure that it is clear that this number of 1,008,850 includes admissions for which an alcohol related disease, injury or condition may not have been the direct reason for the admission or that the NICE quality standard used the figure from the narrow measure instead which is currently 325,870.
16	British Beer & Pub Association	General	We would suggest that the statistics used on the cost of alcohol to society are now somewhat out of date as originally quoted from data releases from 2009-2011, based on 2003 estimates. In addition whilst the costs of alcohol related crime has been widely used it is likely to be somewhat speculative given that there is currently no nationally accepted definition of alcohol crime. Furthermore, these figures do not take into account tax paid by and revenue generated by the industry; the beer and pub industry pays over £11 billion in taxes annually and contributes around £20 billion to the UK economy.
17	The College of Emergency Medicine	General	Why is this quality standard needed: This section mentions the effect of alcohol on hospital admissions but Emergency Department alcohol related attendances (and re-attendances) should be specifically mentioned.
18	The College of Emergency Medicine	General	Table 3: Re: indicator 1.11 Domestic abuse – include Domestic abuse Intimate Partner Violence (partners who do not live together)?
19	The College of Emergency Medicine	General	Older people (over 65's) have not been explicitly covered in this standard. There is no advice as to what their drinking limits should be – they should be lower/different in the over 65s as they can be deemed Frail (Using an ISAR scoring system) if on 3 medications. Alcohol can interact with the meds and increase falls etc. One of the outcome measures should be ED attendances/admissions of the elderly who drink.
20	The College of Emergency Medicine	General	Equality and diversity: If we are serious of reducing harm in the community, then there needs to be some engagement with local churches, Gurdwaras and faith leaders etc. as some minorities are more susceptible to alcohol but go to these places for solace.

21	The College of Emergency Medicine	General	Table 3 - Sexual assault and violence: Though the paper deals with sexual assault and violence, there should be specific mention of sexually transmitted diseases - more likely when drunk! Therefore liaising with STI clinics in the community.
22	Department of Health	General	Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation. However, I have received some comments from colleagues at the Home office, and I attach these for your consideration
23	Dietitians in Obesity Management UK	General	We welcome this quality standard and agree in principle with the standards particularly the emphasis on the additional risk faced by those in socially deprived areas.
24	Dietitians in Obesity Management UK	General	However given the importance of the environment in contextualising and shaping behavioural choices, we are disappointed that the promotion of alcohol particularly at low cost, has not been addressed in these standards. We feel that with the move of Public Health into Local Authorities and the additional powers that are now available to help shape public health, this is a missed opportunity. In particular we feel it may limit the impact of QS3, since no matter how much work is carried out in schools and by parents, low cost availability of alcohol may override this.
25	Dietitians in Obesity Management UK	General	We are also disappointed that the promotion of alcohol to young people, especially related to sporting activity or personalities has not been addressed, and feel this may adversely impact on QS3.
26	Dietitians in Obesity Management UK	General	We welcome the emphasis on training and acquisition of competencies by all people involved in preventing harmful alcohol use in the community. However we would welcome clarification of what such training would include, and what competencies should be acquired.
27	Durham County Council	General	We welcome the draft quality standards on preventing harmful alcohol use in the community and agree with the necessity of such a standard. The quality standard will help organisations understand the role that they play in reducing alcohol related harm and why this is important in terms of their own service outcomes.
28	Hampshire County Council	General	Strongly support this general statement ‘All people who are involved in preventing harmful alcohol use in the community should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality statement’. This should be a requirement of e.g. police service when working in local communities and schools to ensure that this work is effective.
29	Hepatitis B Trust	General	***Why this quality standard is needed***

			In the UK the annual amount of alcohol sold per person (aged 16 years and over) rose from 9.53 litres of pure alcohol in 1986/87 to a peak of 11.73 litres in 2004/05, before dropping to 9.65 litres in 2012/13 (Tax and Duty Bulletins: alcohol factsheet HM Revenue and Customs 2013). For 2012/13, this is approximately 18 units per week for each person. In England, the NHS guidelines on alcohol recommend that men should not regularly drink more than 3 to 4 units of alcohol per day and women should not regularly drink more than 2 to 3 units per day ('regularly' means most days or every day).
30	Hepatitis B Trust	General	***Why is Alcohol far more dangerous than ever?*** I feel the relationship between our unprecedented boom in viral hepatitis and increasing liver harm has not been noticed, far less addressed with in depth studies. The million almost completely undiagnosed viral hepatitis patients develop cirrhosis when given 18 units of alcohol over a 5 year period more often than not needs some consideration. Further the 14% drop over the last decade in alcohol use and harm has happened and is in your lead paragraph, whilst during the same period a 500% increase in Viral Hepatitis and Obesity driven cirrhosis has happened and this also does not seem to have registered. If 18 units can kill a million people should anyone be recommending it without a liver test to see if it is safe??????????? The guideline can easily make cirrhotic 330,000 people as it is! (Assuming a half of our hep population follow it and have 21 units over a 5 year period.) Further many many patients, perhaps most complain that units in general have left them unaware of what is safe drinking since their invention. If you drink every day you are an alcoholic, just is not clear with "units". If you drink every morning you are dying of alcoholism even this is also often blurred by "units". Further if one double shot of spirits is 3 units and drinkers since Roman times have known one is never enough, the whole notion that everyone can stop after 3 units has actually been more or less impossible for most humans for thousands of years. Also the invention of "binge drinking" as a concept. Drinking patterns have been governed by human nature since recorded history, they are fairly changeless, it is as if a new more dangerous form of alcoholism is being invented to explain the growth of liver disease. Obviously it is the same awful and very substantial problem but merely 13% less over the last

decade.

Something that is 13% less of a problem during our 500% boom in cirrhosis from 2002 is also patently not the underlying cause. This 500% boom in cirrhosis is very much caused by something new and something else from alcohol, or something contributing to alcohol, this also seems to not have been made clear here. The predictions of morbidity and death from hepatitis 1999 to 2014 need to be included perhaps. See below. The boom mirrors the tripling of our undiagnosed viral hepatitis and doubling of obesity and ever more aggressive binge medicating very closely however.

The fact that over the last four years of helpline calls far more patients reported needing A n E due to medications than alcohol or drugs combined, is not on the documents radar at all. How many drinkers are on long term prescriptions that are destroying their livers? A “These plus alcoholism (daily drinking) will damage your liver.” Warning with every packet could be very good mandatory at GP level. There are 12 genres of long term medications in mind, starting with certain pain killers. There is a scale to debate on this with for instance 2 million having the hbv antibody 1 in 30 of us will be in danger of coma and death with leukaemia treatment. Whilst other drugs need study for their far milder liver effects.

For our million hepatitis patients, the fact that every pint does the damage of 4 needs to be made clear with much more force.
The message to them has to be total abstinence, we know that 1 in 5 drinkers fail to control themselves and become addicted, hepatitis patients tend to die rapidly if they are the 1 in 5.

We are also concerned that if a hepatitis patient mentions they have ever drunk alcohol their liver status and morbidities are commonly related to that. At GP level they are able to commission services and budgets for alcohol care whilst to date I have never found a GP prepared to spend a penny on Hepatitis Diagnostic Care or a CCG for that matter, neither have any access or budget for diagnostic tools to date.

Of the 400 practices that have them, all were financed by patients, often dying patients have paid to put a warning up that would have saved them. “The alcohol plus undiagnosed hepatitis equals death” was designed by a patient recommended 21 units by his GP, after 4 years he had 90% liver fibrosis. His hepatitis was on his med file at the time.

So please can there be a section on alcohol and hepatitis and alcohol and binge medicating and while we at being alcoholic, alcohol and obesity. Could be called why alcohol is causing more harm than ever

1. and lead with why alcohol is 400% more deadly to a 1,000,000 hepatitis patients,

			2. I believe approximately twice as deadly to certain obese and diabetic cohorts 3. The figures become many and varied with prescriptions yet some dangerous ones with alcohol are remorselessly booming in use. Hopefully the topic and title can appease the alcohol lobby, while honouring our vastly changed and changing UK liver landscape. Public bewilderment with Units and What is safe drinking is detailed in our helpline 1000 caller audit. There were visible regrets about needing terms like “angry drunk” “can’t hold his drink” “ daily alcoholic” “on it for how many years” ”drinks during work” to help define dangerous drinking better. Callers expressed wishing they had been given those definitions or asked those questions to define the scale of the problem rather than 21 units. We hope via PHE and Ministers and Press to obtain a up to date 2014 Prevalencing for HBV (0.8%) including the figures for the 3% of migrants cHBV positive arriving since 1993 to replace the 1993 blood bank guesstimate (0.3%) soon.
31	Hepatitis B Trust	General	Onward to using liver tests and scan results to remove alcohol addiction, over 95% of patients trained in the HBV positive programme removed alcohol completely from their diet or reduced it to less than 30 units a year. We found educating patients to understand liver damage, to be able to see ALTs improve with abstaining, to see immunity strengthen with platelets. The very diagnosis of cirrhosis should slam the wine cabinet door for good here. Severe fatty liver needs the same. The liver is fairly symptomless, so these investigations can also plot impending death, actually show the numbers walking that way. The power of this is well 95% success and my concern is GP tend to know less than their wives about diet and many waffle a competitive clutter of platitudes, “everything in moderation, less fats and more exercise, try 5 a day and yes 21 units is acceptable, stop smoking and take these prescriptions forever.” If the figures say developing cirrhosis we need to tell people Drink will kill you and only teetotal will save you and show them exactly test by test the range and meaning of the results. This firm ban certainly never happened to many hbv patients on diagnosis and I feel we need to make GP’s know the line on liver damage and a firm ban, or many will resort to moderation waffle. We found it very valuable to explain clearly that liver failure just like heart failure is invariably fatal. And then point out to drinkers that alcoholic jaundice is on a par with a heart attack in terms of deaths door approaching. An indispensable organ is threatening to fail. Then as with HBV patients we build the understandings e.g. a patient on leukaemia treatment went from normal to 2500 alts and millions load over 1 week and back again with Tenofovir over 3 months. He was able to see and feel his liver shrink, he was aware the bilirubin is going back into the gut not the blood stream etc. week by week fascinated and compliant.

			We usually recommend alcohol users do liver tests after a night out to get a baseline on how bad it is. We have often done this with other patients also for instance paracetemol addiction showed alts lowering from 900 to near normal. A McDonald s manageress hooked on her own junk food went from 500 alts to under 100. The effect of seeing the liver score improvement and knowing what it means is definitely the motor to complete lifestyle change here. So is alcohol far more dangerous than ever before, of course, but the millions affected by this with obesity, hepatitis and on prescriptions do not know and are not being warned properly or behaviour modified expertly. The last undertaker on the national HBV helpline noted of 50 plus virally infected cadavers just 2 had it on their death certificates, many have reported on the helpline, web forum and at hundreds of day long awareness events deaths from undiagnosed hepatitis and alcohol use. And for 20 years we expect this group to double again the death and morbidity tolls because patently we need to notice who is dying from liver disease and how, far, far more often. It is rather like over the last four years we have had far more calls from nhs infections of hbv than idu infections but there is a desire not to notice some things and this Denialism can be more fatal than the actual epidemics.
32	Hepatitis B Trust	General	http://www.hepctrust.org.uk/NR/rdonlyres/D4F37988-2F64-4456-B72D-700663E2B98F/0/163_APPGHReport.pdf About 15 years ago WHO and the CDC explained projections for cirrhosis growth if a nation like ours failed to diagnose 80% of its hepatitis patients. These projections included in a report by the Commons APPG on Heptology noted that liver transplants and other liver ailments could rise without serious testing and awareness campaigns by a figure of up to 528%. Imagine we were discussing for months in the Commons in 2004 the exact figure that has arisen, see below..... "The harsh reality is that HCV infection is a serious public health problem that the UK is not equipped to address. US projections suggest that by 2008, for example, the number of **patients requiring liver transplants because of HCV will increase by 528%.** The number of cases of hepatocellular carcinoma and cirrhosis will also increase and it is unlikely that the UK will be far behind. The costs of liver transplants alone would be £123 million in the UK based on these projections. So unless the Government begins planning for this increase now by commissioning services and increasing funding, our existing services will be overwhelmed and many more people will progress to end stage liver disease and die." Quote The Liver Trust in the 2004 Hepatitis Scandal Report.

			I conclude an enormous number of people must have developed cirrhosis or died from innocently drinking and harming 4 times more quickly than they should over the last two decades. In Canada they had hepatitis crosses in the pubs for such accidents back in the Nineties. The projection above was done for us by Everett Koop in 1999. To date no endemic HBV or HCV nationals have been offered hepatitis tests on admitting drinking. 200,000 extra cases of cirrhosis were always guaranteed among the 20% who drink from our million strong hepatitis cohort. At the time of vanishing the borders to a world 1 in 12 positive for hepatitis we arranged alcohol cheaper than water, 24 hour licensing, quadrupling our junk food outlets in inner cities and made long term prescribing very lucrative for GP's. Is it any wonder we have fulfilled WHO's direst prediction? For 20 years liver specialists in our cities are meeting hep patients diagnosed with end stage cirrhosis rather than a £5 swab, many, many have drunk alcohol to get to this state. We need to thoroughly test anybody from endemic areas if they socially drink, need a long term contraindicated for those with hepatitis medication or are morbidly obese as quickly as possible. Especially in UK communities and their UK areas that are super endemic, all citizens originating from sub Saharan nations and all from Pacific Rim Nations especially, as the death rates in these communities are very high and so often innocent alcohol and medicine use is to blame. We have gone from always meeting someone bereaved to now meeting people with multiple family deaths or even dying, this is the norm when we do a Supermarket stand anywhere in London for instance. These huge communities numbering 2 to 2.5 million always had a right and an urgent need to see the WHO HBV n HCV Atlases and know they are more likely to have had hepatitis than not and are urgently indicated for safety hbv n hcv testing as common household products, especially alcohol and its recommended use can easily kill them. Every year since we began recording, the huge bulk of fatalities (90%) are from long term non diagnosis and recommended uses. Ultimately people in their tens of thousands are getting cirrhosis, not from alcohol or hepatitis, but actually from simple ignorance of their liver status and the fact that for millions with hepatitis, fatty hepatitis and on liver wearing medications alcohol is far more deadly than ever. This is what is booming, not alcohol abuse, alcohol use thank goodness is actually having its biggest decade long drop since records began in the 1950's.
33	Institute of Alcohol Studies	General	The Institute of Alcohol Studies (IAS) welcomes the opportunity to comment on the NICE quality standard on preventing harmful use of alcohol in the community. We applaud the quality standard's recognition that alcohol-related harm has a wider social impact that extends beyond the individual drinker and affects families, the wider economy, the health services, crime and policing, and beyond.
34	The Lesbian & Gay Foundation	General	The Quality Standard should recognise inequalities in alcohol use and dependence experienced by different population groups. For example, research shows a higher prevalence of alcohol use among lesbian, gay, bisexual and trans (LGB&T) communities, including higher levels of binge drinking.

			Binge drinking is high across all genders, sexual orientations and age groups in the LGB community, with 34% of males and 29% of females reporting binge drinking at least once or twice a week. Available comparable data (from the ONS General Lifestyle Survey 2010) suggests that binge drinking is around twice as common in gay and bisexual males, and almost twice as common in lesbian, gay and bisexual females, when compared to males and females in the wider population (Buffin, J et al. 'Part of the Picture: lesbian, gay and bisexual people's alcohol and drug use in England [2009-2011], Manchester, LGF, 2012.) 41% of lesbian and bisexual women drink on three or more days in a week compared to 36% of women in general (Hunt, R and Fish, J. (2008) 'Prescription for Change: Lesbian and Bisexual Women's Health Survey 2008 (London: Stonewall). 42% of gay and bisexual men drink alcohol on three or more days a week compared to 35% of men in general (Guasp, A. [2012] 'The Gay and Bisexual Men's Health Survey 2012'. London: Stonewall). LGB people report high levels of potentially problematic substance use, with between a quarter and a fifth scoring as substance dependent. Available comparable data indicate that LGB people seem more likely to be substance dependent than the general population (Buffin, J et al. 'Part of the Picture: lesbian, gay and bisexual people's alcohol and drug use in England - Briefing Sheets', Manchester, LGF, 2014) 62% of trans people may be dependent on alcohol or engaging in alcohol abuse (Scottish Transgender Alliance "Trans Mental Health Study 2012" STA, Edinburgh, 2012)
35	The Lesbian & Gay Foundation	General	The voluntary and community sector (VCS) has a clear and critical role to play in the design and delivery of integrated services which target the specific needs of minority communities. The Quality Standard should recommend a whole-system approach to commissioning and service delivery which includes collaboration with the VCS. VCS organisations can deliver healthcare services in community settings, direct to higher-risk individuals, such as alcohol interventions to LGB&T people. The VCS has a strong connection with communities, expertise and the ability to reach people who may be less likely to access traditional healthcare settings. Through targeted communications using imagery which LGB&T people can identify and connect with, the VCS can also support and encourage communities to access healthcare settings. VCS partnerships can also provide a range of broader health and social care interventions (e.g. drugs and alcohol, counselling, advocacy, housing etc.). Coordinated services also need to include other agencies as well as health and schools (e.g. social services, housing services and youth groups). To tackle harmful alcohol use, every contact will count.
36	The Lesbian & Gay Foundation	General	Introduction: LGB&T and equality issues should be included in the sub-section *Why this quality standard is needed* (see first point above re. recognition of inequalities in alcohol use and dependence).
37	The Lesbian & Gay Foundation	General	Equality Assessments: We are concerned that LGB&T issues are not mentioned in the Equality Assessments for the Quality Standard.

38	The Lesbian & Gay Foundation	General	The Equality Assessments mention that homeless people are one of the target groups but the Quality Standard itself does not mention homeless people, neither in relation to evidence nor approach. Homeless agencies, day centres, advice centres need to be involved in work to prevent harmful alcohol use in the community and they need to know how to refer to LGB&T support services.
39	Lundbeck	General	Lundbeck is an ethical research-based pharmaceutical company specialising in central nervous system (CNS) disorders, such as depression and anxiety, bipolar disorder, schizophrenia, Alzheimer's, Parkinson's disease and alcohol dependence.
40	Lundbeck	General	Lundbeck welcomes this draft NICE Quality Statement on *'Alcohol: preventing harmful alcohol use in the community.'* While Lundbeck acknowledges that alcohol screening and brief interventions are outside the scope of this Quality Standard, we would recommend that the final document includes clear signposting to existing NICE guidance, in particular around the provision of screening and brief interventions, such as that found within NICE Quality Standard 11, *'Alcohol dependence and harmful alcohol use'.* It is important that commissioning efforts are joined-up between the organisations now responsible for the delivery of public health services within the new public health environment, including those for managing alcohol misuse. Therefore ensuring that alcohol-related guidelines are aligned across the treatment pathway will help to underpin the delivery of improved outcomes for patients and a reduction in the health burden attributed to harmful alcohol consumption.
41	National LGB&T Partnership	General	The Quality Standard should recognise inequalities in alcohol use and dependence experienced by different population groups. For example, research shows a higher prevalence of alcohol use among lesbian, gay, bisexual and trans (LGB&T) communities, including higher levels of binge drinking. Binge drinking is high across all genders, sexual orientations and age groups in the LGB community, with 34% of males and 29% of females reporting binge drinking at least once or twice a week. Available comparable data (from the ONS General Lifestyle Survey 2010) suggests that binge drinking is around twice as common in gay and bisexual males, and almost twice as common in lesbian, gay and bisexual females, when compared to males and females in the wider population (Buffin, J et al. 'Part of the Picture: lesbian, gay and bisexual people's alcohol and drug use in England [2009-2011], Manchester, LGF, 2012.) 41% of lesbian and bisexual women drink on three or more days in a week compared to 36% of women in general (Hunt, R and Fish, J. (2008) 'Prescription for Change: Lesbian and Bisexual Women's Health Survey 2008 (London: Stonewall). 42% of gay and bisexual men drink alcohol on three or more days a week compared to 35% of men in general (Guasp, A. [2012] 'The Gay and Bisexual Men's Health Survey 2012'. London: Stonewall).

			LGB people report high levels of potentially problematic substance use, with between a quarter and a fifth scoring as substance dependent. Available comparable data indicate that LGB people seem more likely to be substance dependent than the general population (Buffin, J et al. 'Part of the Picture: lesbian, gay and bisexual people's alcohol and drug use in England - Briefing Sheets', Manchester, LGF, 2014) 62% of trans people may be dependent on alcohol or engaging in alcohol abuse (Scottish Transgender Alliance "Trans Mental Health Study 2012" STA, Edinburgh, 2012)
42	National LGB&T Partnership	General	The voluntary and community sector (VCS) has a clear and critical role to play in the design and delivery of integrated services which target the specific needs of minority communities. The Quality Standard should recommend a whole-system approach to commissioning and service delivery which includes collaboration with the VCS. VCS organisations can deliver healthcare services in community settings, direct to higher-risk individuals, such as alcohol interventions to LGB&T people. The VCS has a strong connection with communities, expertise and the ability to reach people who may be less likely to access traditional healthcare settings. Through targeted communications using imagery which LGB&T people can identify and connect with, the VCS can also support and encourage communities to access healthcare settings. VCS partnerships can also provide a range of broader health and social care interventions (e.g. drugs and alcohol, counselling, advocacy, housing etc.). Coordinated services also need to include other agencies as well as health and schools (e.g. social services, housing services and youth groups). To tackle harmful alcohol use, every contact will count.
43	National LGB&T Partnership	General	Introduction: LGB&T and equality issues should be included in the sub-section *Why this quality standard is needed* (see first point above re. recognition of inequalities in alcohol use and dependence).
44	National LGB&T Partnership	General	Equality Assessments: We are concerned that LGB&T issues are not mentioned in the Equality Assessments for the Quality Standard.
45	National LGB&T Partnership	General	Equality Assessments: The Equality Assessments mention that homeless people are one of the target groups but the Quality Standard itself does not mention homeless people, neither in relation to evidence nor approach. Homeless agencies, day centres, advice centres need to be involved in work to prevent harmful alcohol use in the community and they need to know how to refer to LGB&T support services.
46	NHS England	General	Thank you for the opportunity to comment on the draft scope for the above Quality Standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation
47	Public Health England	General	'Co-ordinated services' on page 7: There does not seem to be any mention of community engagement/advocacy.
48	Public Health England	General	'Training and Competencies' on page 8: There is a point needed here about understanding public health (prevention and treatment) amongst licensing colleagues and the development of core competencies around public health and licensing.

49	Public Health England	General	'Role of families and carers' on page 8: This should also cover other members of the community which will be affected by the misuse of alcohol.
50	Royal College of General Practitioners	General	This draft quality document essentially seeks to correlate information on alcohol abuse (health, health care, social, police data-crimes, RTA's) with geography, social deprivation and ethnicity. The aim is to make better decisions about licensing applications, and the selling and distribution of alcohol. It also seeks to develop health promotion/health education models to enable young men and women in particular to use alcohol responsibly and safely. At local level this is essential, for care and services are best tailored to the needs of a particular population and an agreed and local strategy.
51	Royal College of General Practitioners	General	While appreciating that wider policies concerning pricing, age restraints are not part of the remit one factor which is of importance is the increasing strength of alcoholic drinks over the last 30 years (PS)
52	Royal College of Nursing	General	Nurses caring for people with Alcohol: preventing harmful alcohol use in the community were invited to review the draft quality standard. There are no further comments to make on this document on behalf of the Royal College of Nursing. Thank you for the opportunity to participate.
53	Royal College of Paediatrics and Child Health	General	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Alcohol: preventing harmful alcohol use in the community draft standard. We have not received any responses for this consultation.
54	Scottish Health Action on Alcohol Problems	General	Introduction page 2: SHAAP suggests that, along with the mention of children and young people, groups in whom awareness of alcohol related harm is high, mention should be made of older people, where awareness is less.
55	Scottish Health Action on Alcohol Problems	General	It is clear that there is a strong relationship between alcohol related harm and many of the Department of Health's outcomes and improvement areas. This emphasises the importance of alcohol to the health of the population and shows the importance of this and other NICE alcohol guidelines.
56	Scottish Health Action on Alcohol Problems	General	Effective service co-ordination is crucial in this area of work. Effective joint work requires the establishment of working relationships, and stability in service provision helps these relationships considerably. A commissioning system where service providers change frequently is not conducive to good joint working.
57	Trading Standards Institute	General	Although this Quality Standard relates to the harmful use of alcohol, the measures in place to restrict the availability of alcohol to children such as ID checks and enforcement action against traders who sell alcohol to children are also applicable to the sale of other age restricted products. Most shops that sell alcohol will sell tobacco and may also sell fireworks or butane gas.

			The impact of the measures put forward in the standard, may, therefore, be of wider benefit in improving public health within communities.
58	Wine and Spirit Trade Association	General	The Wine and Spirit Trade Association (WSTA) is the UK organisation for the wine and spirit industry representing over 340 companies producing, importing, transporting and selling wines and spirits. We work with our members to promote the responsible production, marketing and sale of alcohol and these include retailers who between them are responsible for thousands of licences. We work with our members and other partners to reduce anti-social behaviour related to alcohol through initiatives such as Challenge 25, which was developed by the Retail of Alcohol Standards Group; Community Alcohol Partnerships which have proven successful in reducing alcohol related crime and anti-social behaviour and with the Government through the Public Health Responsibility Deal. In 2012 the industry also provided £5.2m of funding to Drinkaware to develop social marketing campaigns and education programmes to encourage responsibility among young adults and change attitudes about drunkenness. We believe that initiatives that seek to engage with business, rather than restrict, are those which result in the most positive outputs. The WSTA fully supports the NICE's overall aim of trying to reduce alcohol misuse and harm and believe that the partnership approach is the best model when looking to tackle alcohol related. However we believe that all initiatives should be targeted, evidence based and focused on constructive partnership working between the trade, government and other stakeholders. We are responding to this consultation as the Draft Quality Standard makes a number of recommendations that impact on alcohol licensing and therefore on our members.
59	Wine and Spirit Trade Association	General	Community Alcohol Partnerships bring together local retailers, trading standards, schools and police to tackle the problem of underage drinking and associated anti-social behaviour in communities. They link alcohol education, enforce measures and partnership working to tackle the demand and supply side of underage drinking. There are now over 60 operational CAP schemes across the UK, with plans in place to expand their role and scope. The schemes reduced alcohol related ASB in Barnsley by 30% and in Durham by 37%. Further information is available at www.communityalcoholpartnerships.com **Challenge 25** builds on the highly successful Challenge 21 campaign developed by the Retail of Alcohol Standards Group in 2005. Challenge 21 proved an effective tool to tackle underage purchase, and research has demonstrated that 90% of 18-24 years olds are aware of the Challenge 21 scheme. However, with levels of sales to minors still not low enough and the personal consequences of illegal sales for the member of shop staff more severe, retailer employees requested a program which gives them a greater backing and a higher margin of error in challenging customers for proof of age.

			The Retail of Alcohol Standards Group has developed a suite of designs, from posters to shelf barkers to badges, to reinforce the message throughout the store. The signage in red and black adds a fresh and striking look and makes it clear that under 25s must now expect to be challenged to prove their age. It also spells out the heavy fines which could follow for those caught breaking the law. The signage rolled out in Retail of Alcohol Standards Group member stores across the UK in 2009 and since then the uniform look has ensured recognition and awareness by consumers up and down the country. A guide on how to adopt Challenge 25 can be downloaded here. A model refusal log can be downloaded here. "Rising to the Challenge": A report into the application and impact of Challenge 25 can be viewed here. For further information please contact.
60	Wine and Spirit Trade Association	General	There are a number of further evidence sources that the quality standards should consider adding to improve the policy context, these include: **Home Office (2013)** Next steps following the consultation on delivering the Government's Alcohol Strategy. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223773/Alcohol_consultation_response_report_v3.pdf **The Health and Social Care Information Centre (2014)** Smoking, drinking and drug use among young people. **ADD link after publication on Thursday**
61	Wine and Spirit Trade Association	General	The WSTA fully supports the Quality Standard approach of wanting to promote the use of existing measures to help tackle alcohol related harm. Additionally we believe that there can be much value in partners sharing information and in order to build the most detailed analysis of the impact of alcohol related harm and its impact on the licensing objectives. However, there are some areas of in which we believe the Quality Statements could be enhanced.
62	British Association for Adoption & Fostering	Question 1	There is growing recognition among health professionals that significant numbers of children are affected by foetal alcohol spectrum disorder (FASD). Given this is an entirely preventable condition, with lifelong adverse effects for individuals, families and society in general, it deserves more recognition and resources directed to prevention, including education of young women of reproductive age, and should be addressed in the quality standard. NICE should also consider developing guidance specifically to address recognition and management of FASD.
63	The College of Emergency Medicine	Question 1	Yes

64	The College of Emergency Medicine	Question 2	Collecting data- Data capture is incredibly important but this is totally dependent on diagnostic coding, which is highly variable between Trusts. Some of the measures would be difficult to monitor particularly those around mental health This has to be looked at in more detail. Often patients come in with multiple problems and alcohol is missed in the coding process, so under-estimating its effect. It needs to be remembered that the 'alcohol' patients do not necessarily have a mental health condition and that they are thought of as a separate cohort of patients. SOME will have dual pathology i.e. with a mental health issue. Often patients are drinking excessively but are also depressed and suicidal. Funding is crucial to all this data collection – where is it going to come from? Separate budget? More ED specific data is needed. There has been a lot of controversy around alcohol being the primary reason for attendance as opposed to secondary. Most of us believe that capturing both sets of patients will give a more accurate picture but there is some are reluctance from certain bodies as this entails more work and cost. Evidence suggests that 1 in 3 house fires is related to alcohol- ? Liaising with the Fire Service since data is being gathered for RTAs
65	Hampshire County Council	Question 2	Data collection for alcohol related assaults is not systematically collected and recorded by NHS acute hospitals except where specific local arrangements and protocols are in place and may incur a cost to the public health/NHS commissioners and/or partner agencies. Assault data and trends should be systematically collected, analysed and reported through Public Health England as a mandated requirement on NHS Acute Trusts to reduce variation in reporting across the country. This would support the local authorities as statutory consultees in the licensing of premises and work around cumulative impact assessment; and polices to manage saturation in areas where there is a density of premises selling alcohol and related high incidence of assaults. (see also Quality Statement 1; local licensing policy

66	The Lesbian & Gay Foundation	Question 2	In order to achieve comprehensive data collection for the proposed quality measures, it is essential that services implement sexual orientation and gender identity monitoring of their service users. Currently, LGB&T people's needs are not recognised in alcohol use services, despite evidence of greater risk of binge drinking and alcohol dependency, because their access and experience of services is not monitored. The Quality Standard should highlight the importance of service providers monitoring the sexual orientation and gender identity of service users in order to better understand and meet their needs. Commissioners have an opportunity to make service user monitoring a requirement of contracts, which would be key driver in meeting the needs of LGB&T communities and result in reduced health equalities as well as cost-efficiencies.
67	National LGB&T Partnership	Question 2	In order to achieve comprehensive data collection for the proposed quality measures, it is essential that services implement sexual orientation and gender identity monitoring of their service users. Currently, LGB&T people's needs are not recognised in alcohol use services, despite evidence of greater risk of binge drinking and alcohol dependency, because their access and experience of services is not monitored. The Quality Standard should highlight the importance of service providers monitoring the sexual orientation and gender identity of service users in order to better understand and meet their needs. Commissioners have an opportunity to make service user monitoring a requirement of contracts, which would be key driver in meeting the needs of LGB&T communities and result in reduced health equalities as well as cost-efficiencies.
68	Trading Standards Institute	Question 2	Question 2 of the consultation asks: If the systems and structures were available, do you think that it would be possible to collect the data for the proposed quality measures? The TSI response would be "yes" - one measure could be the number of representations made by responsible authorities with respect to the grant and review of premises licences.
69	Alcohol Concern	Statement 1	The use of local crime and related trauma data to map alcohol harms when formulating or reviewing a statement of licensing policy should be a matter of routine good practice. In order to develop an effective policy, the local authority must seek to capture an accurate picture of alcohol-related harms in its area. This extends to the use of alcohol-related hospital admissions data captured and made available by health bodies, which will have relevance to the crime and disorder licensing objective. The capturing and sharing of good quality crime and health data, however, remains patchy: police crime data often lacks detail, and heath bodies encounter difficulties and expense in accurately collecting alcohol-related accident and emergency data. Nevertheless, guidance has now been made available by the Department of Health on 'Information sharing to Tackle Violence' to improve this position.

			Moreover, there are also examples of good practice dotted around the country that can be followed by others, such as the Cardiff model, which utilises anonymised information obtained from accident and emergency patients about the precise location of violence, weapon use, assailants and day/time of violence, and digital mapping work undertaken by Camden and Islington councils to assess levels of crime, ambulance call-outs and alcohol-specific hospital admissions in their locality. As highlighted by NICE, greater co-operation between the relevant agencies and practitioners will be key to ensure that such data can be used as an accurate and accessible resource to inform local alcohol licensing decisions.
70	Alcohol Health Alliance	Statement 1	We welcome that the quality statement promotes joined-up use of local crime and trauma data to map the extent of alcohol-related problems. However, to allow this to happen it is essential that there are systems and protocols in place for effective information-sharing to take place. There are a number of data sources in addition to local crime and related trauma data that should be taken into consideration and would provide valuable data in relation to alcohol-related problems (eg police National Intelligence Model). First-hand concerns from residents are also a vital and valuable source of local intelligence which must be used meaningfully to inform licensing policy and practice locally. Building capacity and support to enable strong safe community involvement to happen is important. Further, whilst data is important in informing any decision-making process, equally important are the necessary skills and capacity required to use and interpret the data to provide timely, relevant information that can inform licensing policy development. Local areas must be supported to secure and prioritise these skills and approaches. It must also be recognised that the implementation of quality statement 1 will require changes to current practice. Local areas should be supported to draw on exemplar practice from elsewhere (eg the 'Cardiff model'). Finally, the success of this quality statement is predicated on an assumption that licensing policies are regularly and meaningfully reviewed, with input from local stakeholders who understand the role that licensing can play in reducing alcohol-related harm. We would be interested to understand how realistic an assessment this is, and what approaches are recommended to enable this meaningful review process to take place.
71	Alcohol Research UK	Statement 1	The phrase 'local licensing agencies and partners' should be replaced with 'Local Licensing Authority' and 'Responsible Authorities' as these are specific roles under the Licensing Act 2003.
72	Alcohol Research UK	Statement 1	The phrase 'Statement of Licensing Policy' should be used rather than 'licensing policies'. It is important that those applying this framework know exactly which policy instrument they should be seeking to influence. It might be useful to recommend readers familiarise themselves with Chapter 13 of the Home Office Guidance on S.182 of the 2003 Licensing Act (Statements of Licensing Policy).
73	Alcohol Research UK	Statement 1	It should be made clear that according to the Home Office Guidance for s.182 of the 2003 Licensing Act, health considerations can be taken into account in the development of cumulative impact policies (HO Guidance s13.23).

			However, it is also important to note that the protection of public health is currently not a licensing objective, so health teams need to be realistic about what they can achieve in this process.
74	Alcohol Research UK	Statement 1	Support and guidance for health teams engaging in the licensing process has been developed by Alcohol Research UK / Local Government Association and further support is being developed by Public Health England. Links to these documents could be included here.
75	Alcohol Research UK	Statement 1	The phrase "crime and trauma data" is unclear: it could be interpreted as encouraging local health teams to be involved in the collection of crime data as well as trauma data. As crime data collection falls to the police, it may be advisable instead to use the phrase "crime-related trauma data", or, since evidence of criminality may be hard for A&E staff to ascertain, "violence-related trauma data". The 'Cardiff Model' provides an evaluated framework for this, so it might be helpful to include a link. Other sources of data could be specified more explicitly: e.g. ambulance call-out data; local alcohol profiles. Non-crime / trauma related health data can be used to 'set the scene ' in the development of Statements of Licensing Policy. This separate function for health data could be mentioned as well. PHE are developing an available data resource which could be linked to, if it is available in time for publication of this QS.
76	Alcohol Research UK	Statement 1	Because health is not a licensing objective, local licensing teams are unlikely to use general crime data as a proxy measure for health outcomes. It is, perhaps, more important that health teams establish clear working relationships with other Responsible Authorities, develop trauma data using the 'Cardiff Model' as a framework and gather data on chronic health harms that can inform SLPs. Many local health teams have found engagement with licensing time consuming so the effective allocation of resources is a key consideration.
77	Alcohol Research UK	Statement 1	For accuracy, on p.10 'The number of new licenses may be limited..' should be replaced with 'individual licence applications can be refused…'. Quotas are not allowed under current HO Guidance (s13.38).
78	Alcohol Research UK	Statement 1	Equality and diversity considerations: This section will need to be revised. Alcohol outlets are not universally more numerous in socially deprived areas. Areas of highest density are often town and city centres, and many deprived areas have very few outlets (especially on-trade). However, off-licence density can be high in some deprived areas, and alcohol-related health harms are very significantly skewed towards areas of deprivation.
79	The Association of Convenience Stores	Statement 1	Local crime and related trauma data are used to map the extent of alcohol related problems before developing or reviewing a licensing policy. ACS agrees that the statement accurately reflects the main area where quality improvement is required. It is vitally important that all agencies understand that it is trauma data that is most relevant to the development of licensing policy and identification of areas of cumulative impact.

			We are concerned about the following reference 'local licensing agencies and partners (such as directors of public health and public health teams, health and wellbeing boards, the police and the licensing authority)' mapping 'the extent or alcohol related problems before developing or reviewing a licensing policy or cumulative impact policy.' In this context the definition of alcohol related problems is too broad and should not extend to 'absence from work, financial costs, children growing up in families in which there is parental abuse, chronic health problems and death'. We do not believe that these factors would be easy to map accurately and we believe that it would be impossible to prove a causal link between these factors and concentrations of licensed premises – and the Government's response to the Alcohol Strategy consultation acknowledged this. Any attempt to do so is likely to contravene the scope of what is permissible under the Licensing Act 2003. In the Secretary of State Section 182 guidance it clearly stipulates "The authority's determination should be evidence-based, justified as being appropriate for the promotion of the licensing objectives and proportionate to what it is intended to achieve". Moreover, it clearly lists the evidence that can be considered by local authorities in relation to in section 13.23 of the Guidance.
80	Association of Directors of Public Health	Statement 1	This quality standard accurately reflects the key areas for quality improvement and I'm sure it is possible to collect the data. Systems need to be in place for A&E to collect information on alcohol related violence.
81	Balance The North East Alcohol Office	Statement 1	Developing or reviewing a licensing policy is an important step - as it as opportunity to set out a clear vision or an ambition around tackling alcohol-related harms within a particular area and as such Balance would agree that local crime and related trauma data should be used to map the extent of alcohol-related problems. However, to allow this to happen it is essential that there are systems/protocols in place for effective information sharing to take place. In addition to local crime and related trauma data – there are a number of information and intelligence sources available from the police and local authorities that would provide an enhanced assessment via the National Intelligence Model; therefore building capacity and support to enable strong safe community involvement to happen is important. Further, whilst data is important in informing any decision making process, it is having the necessary skills and capacity available to use and interpret the data - that will provide timely, relevant information to inform a developmental or review process.
82	British Association for Adoption & Fostering	Statement 1	We would argue that QS 1 should be more robust and state explicitly that the number of licensed premises should be reduced, but given the statement 'Alcohol outlets are more numerous in socially deprived areas', then this should at least be done in these areas.

83	British Beer & Pub Association	Statement 1	The link between density of licensed premises to alcohol harms is not a straightforward one and in our view licensing policies and approach to licence applications should be focussed on the granting and review of licences on a case by case basis and all action taken should be fully evidence based. Local authorities have powers to ensure compliance with the licensing objectives and now have responsibility for public health as part of their remit. However, it is worth noting that health is not a licensing objective and although the Government previously consulted on the introduction of health as a licensing objective in relation to Cumulative Impact Zones, it was made clear in their response to the alcohol strategy consultation that the evidence on the link between health and licensed premises was insufficient and therefore this was currently not a practical change. In addition, although local partners will naturally seek to use evidence on crime and alcohol related disorder to feed into the licensing process, we would suggest that caution should be used when attempting to map data on crime and alcohol related incidents to specific premises. Regardless of location many premises are well run and do not significantly contribute to local problems. With regard to the implementation of Cumulative Impact Policies, again we would suggest that limiting the number of licensed premises in areas should only ever be a last resort and should be fully evidence based and that generally licences should be granted on an individual case by case basis. With reference to the potential for partnership working to tackle local issues, we would suggest that individual premises and licensees must also be considered relevant partners in such discussions as there are many industry supported schemes such as Pubwatch and Best Bar None which have been extremely successful in tackling local issues, improving and expanding responsible retailing practices and reducing alcohol related crime and anti-social behaviour.
84	The College of Emergency Medicine	Statement 1	There should be some mention of looking at not having off licences next to schools. Rest of document good on this.
85	Dietitians in Obesity Management UK	Statement 1	We agree that local crime and related trauma data should be used and shared to map the extent of alcohol related problems in an area. We would like this to specifically include health-related harm e.g. incidence of alcohol-related disease, and alcohol-related deaths. We wonder if local general practitioner data may also be a useful source of information on the wider impact of alcohol-related harm, rather than solely relying on hospital and ambulance data.
86	Durham County Council	Statement 1	We agree identifying problems caused by the presence of a high number of licensed premises selling alcohol in a specific area is important. More still needs to be done with Foundation Trusts to ensure the correct information in relation to crime/trauma related data is readily collected, available to share and of sufficient quality to enrich the picture in relation to alcohol related harms in relation to on-licensed premises. Many of the issues facing emergency services locally currently arise from violent incidents which take place at home/in a house where individuals are consuming alcohol. It is exceptionally difficult to attribute much of this violence to the sale of alcohol from supermarkets or off-licenses.

87	Hampshire County Council	Statement 1	Agree
88	Hampshire County Council	Statement 1	This rather misses the point. Individual staff are not responsible for this. It should be a mandated requirement nationally for common data sets to be used to inform e.g. licensing decisions and cumulative impact policies. The data collection, analysis and reporting from NHS Acute hospitals is very variable when it should be standard and reported as part of e.g. PHE substance misuse reporting on alcohol harm (see also introduction).
89	Home Office	Statement 1	We consider that statement 1 focuses too heavily on the licensing policy statement (and CIPs in particular) and whilst amendments to the LPS are helpful, introducing CIPs will not be appropriate in all areas. The section overlooks the fact that as responsible authorities health bodies can have a powerful impact by using health data to make representations on individual licence applications and variations and are also able to request reviews of existing licensed premises where they have evidence to support this. I am also not sure that the specific reference to 'crime and related trauma data' are helpful, as there is likely to be wider sources of data such as data on cases of alcohol poisoning which will also be of value to feed into the licensing process. I think that statement 1 could be made much more effective if, like you say, this better reflected the wider range of data sources that could feed into the licensing process and removing reference to the LPS specifically. I also think there is a little confusion in the document about what the local licensing policy is- a CIP is part of the area's statement of licensing policy rather than being a separate local policy. This distinction is important to make because of how the CIP mechanism works. A CIP is not a specific mechanism under the 2003 Act as suggested on p10 as the process is set out in the 182 guidance and not the legislation.
90	Institute of Alcohol Studies	Statement 1	We welcome that the quality statement promotes joined-up use of local crime and trauma data to map the extent of alcohol-related problems. However, to allow this to happen it is essential that there are systems/protocols in place for effective information sharing to take place. There are a number of data sources in addition to local crime and related trauma data that should be taken into consideration and would provide valuable data in relation to alcohol-related problems (e.g. police National Intelligence Model). First-hand concerns from residents are also a vital and valuable source of local intelligence which must be used meaningfully to inform licensing policy and practice locally. Building capacity and support to enable strong safe community involvement to happen is important. Further, whilst data is important in informing any decision making process, equally important are the necessary skills and capacity required to use and interpret the data to provide timely, relevant information that can inform licensing policy development. Local areas must be supported to secure and prioritise these skills and approaches. It must also be recognised that the implementation of quality statement 1 will require changes to current practice. Local areas should be supported to draw on exemplar practice from elsewhere (e.g. the 'Cardiff model').

			Finally, the success of this quality statement is predicated on an assumption that licensing policies are regularly and meaningfully reviewed, with input from local stakeholders who understand the role that licensing can play in reducing alcohol-related harm. We would be interested to understand how realistic an assessment this is, and what approaches are recommended to enable this meaningful review process to take place.
91	The Lesbian & Gay Foundation	Statement 1	LGB&T issues need to be included in each Quality Standard's Equality Statement.
92	London Borough of Barking and Dagenham	Statement 1	Mapping of alcohol crime and trauma is a helpful contributor to the understanding of local alcohol-related problems, but this is a process measure and it is the principles and values that a council writes into its Licensing Policy which has the major impact on effectiveness. Focusing on mapping with a view to introducing saturation policies seems a limited approach to demonstrating the effectiveness of a local licensing policy.
93	National LGB&T Partnership	Statement 1	LGB&T issues need to be included in each Quality Standard's Equality Statement.
94	Northern Ireland Association for the Care and Resettlement of Offenders	Statement 1	We know that people buy alcohol in local supermarkets because of promotional offers and cheap ‘own brands’, and drink it at home (pre-drinking) before going out for the night. Therefore, they are already intoxicated before entering licensed premises. We believe that there may not be a direct correlation between a concentrated number of licenced premises in a specific area and anti-social behaviour, hospital incidents, and crime.
95	Northern Ireland Association for the Care and Resettlement of Offenders	Statement 1	We recommend that the number of promotional offers, in supermarkets and in licensed premises, needs to be restricted as these offers encourage binge drinking.
96	Public Health England	Statement 1	The wording of the statement makes it feel like the focus is on crime and not health. It needs to be rephrased to make health the focus. Also, alcohol-related data that is broader than trauma should be included as it is not clear whether trauma data will accurately map all alcohol-related problems. This statement does not address issues with off-licences as crime and trauma data tends to focus on on-licences and the night-time economy (NTE).
97	Royal College of General Practitioners	Statement 1	In agreement with this statement missed opportunity to consider accessing information collated by housing providers where there is a concentration of data on antisocial or problematic behaviours linked to local tenancies

98	Royal College of General Practitioners	Statement 1	There is probably value ins specifically pulling out domestic violence data (LH)
99	Scottish Health Action on Alcohol Problems	Statement 1	Measures of long-term health harm such as liver disease rates and alcohol related mortality rates should be used in addition to local crime and trauma related data. Local alcohol consumption and sales data should also be used to inform licensing policy. In addition to numbers of licences, authorities should monitor the sales capacity of each licensed premises, both on sales and off sales, in order to effectively measure cumulative impact. Health harm and mortality data will be available from standard NHS recording systems. Local consumption data should be monitored by regular surveys. Alcohol retailers will have considerable data on levels and distribution of alcohol sales. Local agencies should engage with retailers to establish what data is available, and retailers should develop system to share non-market sensitive data in the interests of public health.
100	Trading Standards Institute	Statement 1	This statement is concerned with the development or review of a local authority's licensing policy. It does not reflect the fact that Responsible Authorities can make representations during the licensing process itself.
101	Trading Standards Institute	Statement 1	All Responsible Authorities, which now include Public Health, should be encouraged to become actively involved in this process to put forward conditions that are **appropriate, proportionate and enforceable** before a premises licence is granted or when it is subject to review.
102	Trading Standards Institute	Statement 1	It is acknowledged that this can present challenges, particularly in two-tier authorities. However, the recent changes in the delivery of Public Health provide a very real opportunity for new ways of working, strengthening the links between Public Health and regulatory services such as Trading Standards and Licensing which can have a major impact on Public Health outcomes.
103	Trading Standards Institute	Statement 1	The Trading Standards Institute feels therefore that this statement should be widened to encompass the entire licensing process, not just the development or review of a licensing policy.
104	Wine and Spirit Trade Association	Statement 1	**Definition of alcohol related problems –** The statement outlines that alcohol-related problems should be mapped ahead of the development of a local licensing police. However, there is concern regarding the definition of alcohol-related problems and how this interacts with the licensing objectives. The definition includes "Problems resulting from alcohol that may be indicated (perhaps by proxy) by local crime and related trauma data, such as crime and disorder, social issues and health harms. These include drunkenness and rowdy behaviour, assault, accidents and injuries."

			As this is can be related to the Licensing Objective of Crime and Anti-social behaviour, it is clear why this is included as part of the definition. However the definition continues and includes "use of absence from work, financial costs, children growing up in families in which there is parental alcohol misuse, chronic health problems (mental and physical) and, in extreme circumstances, death." The main concern with this is that the use of this data goes far beyond what is acceptable in terms of evidence the licensing act as it is difficult to relate this information to any of the licensing objectives. Additionally, it is difficult to see how this information would support the evidence base against a particular venue. Therefore it calls into question why an authority would look to ensure that this information is analysed before a licensing policy statement is agreed.
105	Wine and Spirit Trade Association	Statement 1	Quality of Health Data – It is important to highlight that there is no current health objective in relation to licensing and therefore the data produce by health stakeholders has not been refined to fit within the current framework. This was referenced by the Government in its alcohol strategy consultation response when it stated in relation to adding a health objective to cumulative impact policies "local processes and data collection were insufficient, meaning that it is unclear how this proposal could be implemented in practice"[2]. Therefore there should it is recommended that the measures are taken to ensure that the data used is robust and relevant for this purpose.
106	Wine and Spirit Trade Association	Statement 1	**Focus on Cumulative Impact Policies -** There is a concern that the statement seeks to highlight Cumulative Impact Policies as a potential an area in which the sharing of health data could be beneficial. There are a number of concerns with this approach. CIPs are a blanket measures which do not take into account the extent to which operators are responsible and there is limited evidence that the restriction of licenses will impact on the alcohol related harm in a particular area. For example over the past 7 years the number of licensed premises has increased at the same time there has been a marked decline in alcohol consumption. Further to this, there is also a concern that the use of CIPs protect irresponsible businesses as it helps to protect them from competition.
107	Wine and Spirit Trade Association	Statement 1	**More effective alternatives -** Further to this, the standard discusses the use of the Licensing policy and the policy of Cumulative Impact Policies in particular. However does not outline further measures that are already within the power of police and local authorities that could be used to support the development of the licensing policy and which the collection of health data could equally support. For example **Alcohol Control Zones -** under the Criminal Justice and Police Act 2001 local authorities have the power to introduce Designated Public Place Orders, which give police the power to confiscate alcohol in a designated zone. The collection and dissemination of data that provided evidence as to where drinkers engaged in either underage drinking or alcohol relate harm could help agencies with the development of this policy to restrict that behaviour. The same would be true for the use of dispersal notices, which are available under the Violent Crime Reduction Act 2006.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223773/Alcohol_consultation_response_report_v3.pdf

			Serving drunks: Under section 141 of the Licensing Act 2003 it is illegal to serve drunks. However, this law is hardly ever enforced with just five convictions for this in 2013 and just one conviction for the offence of buying for someone that is intoxicated[3]; The collection of data outlining where people suffering from acute alcohol harm had been consuming alcohol could help to ensure that enforcement agencies are ensuring this this law was being properly enforced. **Education Courses:** The Criminal Justice and Police Act 2001 contains provisions that permit a chief officer of police to establish a PND educational course scheme in relation to one or more penalty offences, if they wish. It also permits constables to give a person a penalty notice with an education option where appropriate. These provisions were introduced by section 132 of, and Schedule 23 to, the Legal Aid, Sentencing and Punishment of Offenders Act 2012. The use of data to show particular demographic groups in local areas that are engaged in harmful drinking could help the targeting of these courses. **Clamping down on alcohol fraud and theft:** Existing powers are available for both police and local authorities to tackle alcohol related duty fraud and theft. This particularly is relevant from a health perspective given the concerns over the illegal manufacture or faking of alcohol. This can often include the use of chemicals and other materials that are damaging to health as well as contributing to public safety concerns. The NICE Quality Standard should recommend that any data available that records this should be shared with the relevant authorities, so that the police and trading standards can respond accordingly. This could be through the Licensing policy statement as well as a local drug and alcohol strategy or crime strategy.
108	Alcohol Concern	Statement 2	Alcohol Concern agrees that ongoing work is required to minimise the sale of alcohol to minors. Historically, the policing of under-age alcohol sales has been uncoordinated, but improvements in the last decade has seen an increase in age-checking practices and awareness-raising aimed at ensuring retail staff are adhering to the necessary regulations and processes. Research from Serve Legal and Plymouth University suggests that under-age checks now take place around three out of every four times a young person attempts to buy alcohol. Voluntary schemes like Challenge 21 and 25 have been helpful; however they would be more effective if a mandatory requirement for all retailers of alcohol were introduced. Recognition must also be made to how young people access alcohol. Research by Alcohol Concern in Wales (On Your Doorstep) has shown that home delivery services provide a source of alcohol for underage drinkers, which are perceived as offering less robust age verification practices, especially for younger teenagers who would have greater difficulties in buying alcohol in person from in-store at a supermarket or pub. More test purchasing of such home deliveries, as recently undertaken by South Wales Police, should be incorporated into checking whether, and how, businesses are selling alcohol to under 18s.

[3] Hansard [201058], Response to Parliamentary Question by Justice Minister Jeremy Wright

			The majority of alcohol sourced by minors is through proxy sales, that is, via their parents and, especially in the case of older teens, from their older siblings or asking another adult to buy it from them. Therefore, stricter enforcement of the Licensing Act in terms of under-age sales will likely only have a limited impact on the availability of alcohol to minors, and measures that include restricting the density of alcohol outlets, which has been linked to the quantities of alcohol consumed by young people, and targeted interventions (see quality statement 3) are equally important.
109	Alcohol Health Alliance	Statement 2	Whilst the quality statement correctly states that reviewing licenses is a key part of the Licensing Act 2003, government data suggests that only 0.1% of licensed are reviewed each year and less than a third of these reviews result in licenses being revoked or suspended (Department of Health. Alcohol and late night refreshment licensing England and Wales 31 March 2013. London: DH, 2013.). We welcome that the quality statement encourages local partners to work together to tackle underage alcohol sales, but we are concerned that the quality statement is focused on the process (working in partnership) rather than the outcome (reduction in alcohol sales to children, and a corresponding reduction in harm caused by underage drinking). Moreover, whilst underage sales are an important source of alcohol consumed by children, a substantial proportion of alcohol consumed by children is provided by friends and family. This quality statement will not address this source. Finally, local intelligence suggests that the legislation contained within the Regulation of Investigatory Powers Act 2000 (RIPA) has made test purchases increasingly more difficult for local authorities to carry out, thereby making it more challenging to identify and take subsequent action against licensed premises that are selling alcohol to people who are under the age of 18.
110	Alcohol Research UK	Statement 2	This may not be an appropriate QS. Responsibility for enforcement of the law on underage sales falls to Trading Standards and the police; procedures for action against offenders are well-established (though often inconsistently applied); data on prosecutions is kept by the police and courts; and underage sales are not treated as a health issue under current legislation. While health teams should encourage responsible partners to carry out their duties effectively, *taking action* to reduce underage sales (e.g. identifying outlets or test purchasing) is not obviously a role for health - especially given the importance of appropriate resource allocation.
111	Alcohol Research UK	Statement 2	It is important that the key authorities responsible for enforcement are highlighted here: i.e. Trading Standards and the police. Effective partnership with these bodies is important; however, it isn't clear why underage sales are singled out (above, say, sales to drunk customers) as an area of enforcement that needs to be supported.
112	Alcohol Research UK	Statement 2	On p. 13 the phrase ‘licensed premises are reviewed..’ is technically inaccurate. A ‘licence review’ is a procedure that would (possibly) follow persistent evidence of underage sales. The process for identifying such practices is test purchasing.
113	Alcohol Research UK	Statement 2	Again, the diversity statement needs to be revised here for accuracy regarding outlet density.

114	The Association of Convenience Stores	Statement 2	ACS does not agree that this quality statement accurately reflects the main area of quality improvement. The outcome for any meaningful action has to be ‘to reduce incidents of underage drinking’ NOT to ‘reduce the number of underage sales.’ All independent evidence shows that young people buying alcohol for themselves makes up a small percentage of the access to alcohol by young people. Health and Social Care Information Centre data shows that only 2% of young people are likely to buy alcohol from a shop or supermarket. Also strategies that focus solely on taking action against licensed premises invariably fail to have a significant impact on youth drinking behaviour or attitudes among young people. There is a significant evidence base on alternative measures and actions that local authorities can take to tackle underage drink for example the Demos report Sobering Up. We strongly object that the outcome of the quality statement is to identify the 'incidence of licensed premises being found to sell alcohol to people who are under age'. Increases or decreases in the number of licensed premises subject to enforcement do not necessarily correlate with prevalence of underage drinking in the community. It would be far more valuable for the quality statement to be targeted at an outcome that saw a reduction in alcohol consumption amongst young people. We welcome that the quality standards references central guidance on the use of test purchasing to tackle underage drinking. We understand that test purchasing is an important tool for assessing due diligence in the prevention of underage sales in the on trade and off trade and can be effective when intelligence led. It is unacceptable that this quality statement does not reference the role of local business as a partner in tackling underage drinking. The most successful interventions that bear down on drinking behaviours involve marrying effective enforcement with partnership initiatives that prevent young people getting hold of alcohol in the first place and provide adequate education and diversionary activities (for example the Community Alcohol Partnerships Initiative). Without significant amendment this quality statement would represent a retrograde step in successful interventions to drive down access to alcohol for young people.
115	Association of Directors of Public Health	Statement 2	As an area that has done a lot of ‘test purchasing’ – I believe that the standard captures the issue well. The data is available and can be captured.
116	Association of School and College Leaders	Statement 2	ASCL welcomes the presence of this quality statement. In an earlier response we identified the ready availability of alcohol to children as a problem. ASCL is not competent to judge the appropriateness of the approach adopted.

117	Balance The North East Alcohol Office	Statement 2	Balance would agree that it is important where evidence is secured that action should be taken against premises that sell alcohol are identified as selling alcohol to people who are under age, however, the following points would be made – Friends and parents are the most common means by which young people obtain alcohol i.e. proxy provision (NHS Information Centre, 2010; Institute of Alcohol Studies). As the point made in the previous 'Standard' - it is important for police and Local Authority to work together and to share relevant data through developed mechanisms of community engagement e.g. the Police and Community Together (PACT) Forums. Further, it is suggested that the legislation contained within the Regulation of Investigatory Powers Act 2000 (RIPA) has made action such as "Test Purchases" increasingly more difficult for Local Authorities to carry out. Balance believes that Government should be doing something, not just to restrict the supply of alcohol to young people, but also to reduce the demand by protecting them from aggressive alcohol marketing
118	British Beer & Pub Association	Statement 2	The statement makes a great deal of reference to the powers that exist for local authorities and individuals to penalise businesses which are found to be selling alcohol to those that are underage. Whilst our members are committed to preventing underage selling wherever it occurs, and they would accept that penalties need to be in place as a disincentive to ensure that premises have the correct procedures in place to prevent this happening, we would suggest that there are a great many steps to take before this stage to ensure that premises are fully engaged and working with local authorities to prevent this happening. Working with local premises to prevent underage sales would be an effective starting point. It would be good to see further reference to working with industry and utilising industry supported schemes which have a proven track record of success in tackling underage sales and consumption. For example, Community Alcohol Partnerships bring together retailers, police, trading standards, schools and alcohol services, working in partnership to tackle very specific indicators of underage drinking in a clearly defined area using a mix of education and enforcement. To date over 50 CAPs have been set up across the UK and have been extremely successful in reducing under 18 purchase of alcohol, instances of youth related alcohol incidents and a number have had independent evaluations by academic partners and been found to have had a significant positive impact on local communities. We would therefore like to see further reference to work with industry where there are clearly shared objectives in tackling such issues and where real results can be achieved.
119	Dietitians in Obesity Management UK	Statement 2	We strongly welcome this quality standard but would like clarification of what 'regularly' means in this context. On how many occasions and within what timeframe must under-age sales of alcohol occur in order for action to be taken?

120	Durham County Council	Statement 2	Under-age sales - locally we feel that we already meet this proposed quality standard as tackling under age sales is part of our alcohol harm reduction strategy. Our local police and trading standards department work very closely to identify and review premises that sell directly to under-18s within the constraints of current guidance around the issue. This has been heavily influenced by the alcohol industry to increase constraints on regulatory authorities.
121	Durham County Council	Statement 2	Second paragraph refers to Licensed premises being “reviewed”. We feel that this terminology needs to be clarified as “reviewed” in licensing terms has a different meaning. We suggest “reviewed” is replaced with “examined”.
122	Durham County Council	Statement 2	Public health teams do not have the regulatory powers to undertake test purchasing or to issue fines or close premises. There needs to be some clarification within the standard about the strategic assurances that test purchases will be undertaken and the operational responsibility for this.
123	Durham County Council	Statement 2	Paragraph 4 states “sharing funds to finance operations”. We do not think this adequately reflects what should happen as part of a quality standard. We feel that a sharing of funds to finance legal challenge of such operations would be more beneficial as test purchase operations are undertaken as core business of police and trading standards.
124	Hampshire County Council	Statement 2	Agree.
125	Hampshire County Council	Statement 2	This paragraph indicates that local licensing agencies should be working in partnership to reduce the sale of alcohol to underage persons at individual premises. It is our view that this paragraph would benefit from clarification. It does not include reference to district council licensing teams when the district council is the licensing authority. It appears to suggest that Public Health teams should be working in partnerships with other agencies in respect of individual premises. In practice, public health teams will provide public health advice and leadership and set the strategic direction of the work with partner agencies, and through organisations such as Community Alcohol Partnerships. Trading Standards teams, will work in partnership with both the Police and district council licensing teams in respect of individual premises. Outcomes from this work is fed into the Public Health Department and is used at a strategic level to assist in setting overarching policy direction and for responding as e.g. a statutory authority consulted on licencing premises.
126	Home Office	Statement 2	Statement 2 focuses specifically on persistent underage sales but again I think there is scope to encourage areas here to think about protection of children from harm more generally in the context of their role as responsible authorities.
127	Institute of Alcohol Studies	Statement 2	Whilst the quality statement correctly states that reviewing licenses is a key part of the Licensing Act 2003, government data suggests that only 0.1% of licensed are reviewed each year and less than a third of these reviews result in licenses being revoked or suspended (Department of Health. Alcohol and late night refreshment licensing England and Wales 31 March 2013. London: DH, 2013.) We welcome that the quality statement encourages local partners to work together to tackle underage alcohol sales, but we are concerned that the quality statement is focused on the process (working in partnership) rather than the outcome (reduction in alcohol sales to children, and a corresponding reduction in harm caused by underage drinking).

			Moreover, whilst underage sales are an important source of alcohol consumed by children, a substantial proportion of alcohol consumed by children is provided by friends and family. This quality statement will not address this source. Finally, local intelligence suggests that the legislation contained within the Regulation of Investigatory Powers Act 2000 (RIPA) has made test purchases increasingly more difficult for local authorities to carry out, thereby making it more challenging to identify and take subsequent action against licensed premises that are selling alcohol to people who are under the age of 18.
128	The Lesbian & Gay Foundation	Statement 2	The role of the VCS could be recognised in Quality Statement 2 (Under Age Sales) as premises could advertise preventative and support services for young LGB&T people.
129	The Lesbian & Gay Foundation	Statement 2	LGB&T issues need to be included in each Quality Standard's Equality Statement.
130	London Borough of Barking and Dagenham	Statement 2	While doubtless the director of public health would support trading standards and the police to identify and address alcohol sales to those who are under age, it is not entirely clear what directors of public health would be expected to do in a practical sense, nor is it clear what data would provide evidence of partnership working. Locally trading standards work in partnership with the police both within the borough and across London to participate in initiatives that clampdown on unlicensed activities. The main concern is that reductions in council budgets do not limit this important work.
131	National LGB&T Partnership	Statement 2	LGB&T issues need to be included in each Quality Standard's Equality Statement.
132	National LGB&T Partnership	Statement 2	The role of the VCS could be recognised in Quality Statement 2 (Under Age Sales) as premises could advertise preventative and support services for young LGB&T people.
133	Public Health England	Statement 2	Along with identifying and taking action against premises that sell alcohol, there should be a mention of the data/information on the harms to children that public health has and its usage. For example, being able to use the effect of alcohol on a young person as evidence in a case? Within the rationale, you could mention the objective of the act is focused on the moral, psychological and physical harms to children. The role of children protection services should be mentioned more in this Quality Standard.
134	Royal College of General Practitioners	Statement 2	No further comments – in broad agreement (LH)
135	Scottish Health Action on Alcohol	Statement 2	Effective action against premises that sell directly to underage customers is important. Establishment of effective ID schemes, server training and test purchase programmes are a key element of this action.

	Problems		Much of the alcohol consumed by under-age consumers is now purchased by people of legal drinking age and passed onto children and young people. This pattern of “proxy purchase”, often strongly influenced by the availability of low cost alcohol in stores and supermarkets, must be considered in any action on underage drinking. Trends in direct and proxy purchase can be measure by sequential population surveys. The Scottish SALSUS surveys, now running for almost 20 years, are an example of this.
136	Trading Standards Institute	Statement 2	The identification of non-compliant premises is important.
137	Trading Standards Institute	Statement 2	Trading Standards departments may have to obtain the appropriate authorisations before embarking on a test purchasing exercise using under-age volunteers and this cannot be done without intelligence regarding problem traders.
138	Trading Standards Institute	Statement 2	Partnership working can mean that information is shared and resources used effectively.
139	Trading Standards Institute	Statement 2	The focus of this statement is on enforcement after an under-age sale has occurred.
140	Trading Standards Institute	Statement 2	The statement does not reflect the fact that traders and local authorities can put measures into place which prevent under-age sales from happening in the first place.
141	Trading Standards Institute	Statement 2	Recent evidence that young people are drinking and smoking less may reflect the success of measures such as “Challenge 25” whereby anyone who appears to be under 25 is asked to provide valid proof of age before being sold age-restricted products.
142	Trading Standards Institute	Statement 2	A measure such as "Challenge 25" is a frequent condition on premises licences for the sale of alcohol. It is often accompanied by conditions relating to staff training and the recording of refused sales.
143	Trading Standards Institute	Statement 2	The Trading Standards Institute feels that prevention of the under-age sale of alcohol should be emphasised in the quality statement, as well as taking appropriate action once a sale has occurred.
144	Trading Standards Institute	Statement 2	As with the previous quality statement we believe that the licensing process provides a good opportunity for all responsible authorities to put forward **appropriate, proportionate and enforceable** conditions.

145	Wine and Spirit Trade Association	Statement 2	The WSTA believes that the most effective way for local authorities and others to tackle underage sales is to tackle both the supply and the demand side of alcohol by working in close partnership with retailers. Through the Retail of Alcohol Standards Group the WSTA have developed Challenge 25 and Community Alcohol Partnerships, both of which have proved to be effective in tackling underage sales. On this basis there are a number of areas where we believe the statement could be enhanced.
146	Wine and Spirit Trade Association	Statement 2	**Broaden the focus -** This statement focuses solely on the penalties to deal with persistent sales of alcohol to people underage. While the WSTA agree that all powers should be used to deal with those that persistently sell to underage customers, this approach fails to take into account a number of important issues such as the importance of due diligence, the inclusion of the trade in local partnerships and the rise of proxy purchasing.
147	Wine and Spirit Trade Association	Statement 2	**Due diligence -** In the definitions of "identifying premises regularly selling alcohol to people who are underage" the guidance simply outlines test purchasing as the way to reduce the persistent sale of alcohol to people underage. However, test purchasing should only be carried out on an evidence led basis and not simply used as a blanket measure, which is inefficient and ineffective and this is not included in the definition. The definition should, in our view, look to reference the Better Regulation Delivery Office's test purchasing code of practice more extensively. Further to this, the statement should seek to highlight the benefits of the Primary Authority scheme which includes provision for the sale of age restricted products. Further consideration should also be put into the promotion of best practice scheme such as Challenge 25, which can be included in a licensing policy statement.
148	Wine and Spirit Trade Association	Statement 2	**Including retailers in partnerships -** While the statement mentions partnership working, it is important to note that there is no mention of partnership working with the retailers themselves. Through schemes such as Community Alcohol Partnerships, where retailers are seen as part of the solution, effective partnerships have been developed that have l shown measurable reductions in sales to and purchase by under 18s as well as reduced health and social harms associated with underage drinking in local communities. This has been achieved by a range of agencies working with retailers to share data and information, working together towards common objectives and ensuring that due diligence has been carried out. We believe therefore that the statement should encourage local authorities to develop partnerships that include retailers.
149	Wine and Spirit Trade Association	Statement 2	Focus on proxy purchasing - The draft statement focuses solely on the retailing of alcohol and makes no mention of the issue of proxy purchasing. This is important because the majority of alcohol that underage people drink is not obtained directly but through either a parent or family member, therefore the focus solely on direct sales on this is likely to be ineffective. A report by test purchasing experts Serve Legal found only 4% of under-age consumers would attempt to obtain alcohol from a large supermarket main till and 13% from a high street chain pub. Yet 74% of under-age consumers would attempt to obtain alcohol from their parents and 86% from older siblings or friends[4]. This is why effective schemes such as Community Alcohol Partnerships focus on both the supply and demand side of alcohol, as a focus solely on restricting underage sales will never be sufficient to entirely deal with the issue of underage drinking.

[4] Checked Out, report by Serve Legal, 2012

150	Alcohol Concern	Statement 3	Alcohol Concern welcomes recommendations for a ‘whole school’ approach to reducing the harms from alcohol. Damage from heavy drinking during adolescence can be serious and long term. Alcohol use, especially binge drinking which is most common amongst younger people, can adversely affect development of brain regions associated with learning, memory, and decision-making and is associated with increased risk to physical health through accidents, sexual assault etc. Messages from schools around risky behaviours need to be joined up between teaching and pastoral staff, and include parents whenever possible. Overall, the evidence is strongest for the development of life skills interventions, based on psychosocial or developmental, over alcohol-specific ‘education’ programmes. Bolstering young people's resilience, supported by promoting positive parental/family influences and healthy school environments which foster positive social and emotional development, is shown to be the most effective approach. As NICE recommends, it is vital that parents are involved in initiatives so that they can support learning at home, thereby reinforcing what is learnt in school. Timing is also likely to be very important, particularly in relation to periods of transition in young people's lives. Programmes need to be commonly implemented at ages 11–12, during transition into adolescence, rather than solely at ages 13–14, when risk behaviours, or experimentation with them, may already have started. The ‘whole school’ approach would have the advantage of including pupils of all ages in interventions and is therefore welcomed. Alcohol Concern welcomes NICE’s recommendation around targeted interventions for children and young people in a school setting. It is vital that young people drinking in ‘risky’ way are offered one-to-one advice, either delivered by trained professionals in the school, such as a school nurse or counsellor, or by an external service. All staff working alongside young people need to feel comfortable challenging and addressing alcohol given the prevalence of misuse and potential risk of harms. The evidence supporting such brief interventions in adults is strong, and whilst the evidence base is less developed with younger people it is likely to also be affective at reducing harms.
151	Alcohol Health Alliance	Statement 3	Childhood – and adolescence and young adulthood in particular – are key stages in the development of lifestyle habits, risk behaviours and social norms. School therefore can be an important lever in supporting healthy attitudes and behaviours around alcohol consumption. However, this quality statement offers a loosely-framed measure of success, and would (like quality statement 2) benefit from a clearer focus. Moreover, we are not confident that school absence related to alcohol is a commonly-recorded measure.
152	Alcohol Research UK	Statement 3	A ‘whole school’ approach to alcohol education is to be welcomed. However, it is important that schools base any alcohol interventions on the existing evidence base. The evidence on the efficacy of schools interventions is very mixed, and there is a known risk that programmes can have an iatrogenic effect (i.e. leading to higher use) if not implemented carefully and

			with high levels of fidelity to well-evaluated programmes. The statement here suggests that engagement and community consultation should drive intervention design, but effective interventions are often counter-intuitive. For instance, simply increasing knowledge about alcohol has not been shown to change behaviour significantly. Inclusion and buy-in is critical, but the need to implement evaluated and evidence-based programmes needs to be emphasised more clearly here. See recent evidence reviews by Cairns et al. and Martin et al.
153	Alcohol Research UK	Statement 3	The inclusion of alcohol in the curriculum alone (p. 15) will not be a sufficient quality measure if the programme being included is ineffective or has iatrogenic effects.
154	Alcohol Research UK	Statement 3	Rates of absence from school are only a limited measure of efficacy in schools education programmes. The known effects of alcohol education programmes are generally small and incremental at an individual level: they are not generally held to significantly reduce absences due to alcohol, which are more likely to be caused by other social and familial problems. Equally, a reduction of absences due to alcohol is likely to be related to other factors (such as better pastoral care and general inclusion), so the proposed outcome measure may not be well-aligned to the intervention.
155	The Association of Convenience Stores	Statement 3	ACS does not have any comment on this statement as it is an area in which we do not have expertise.
156	Association of Directors of Public Health	Statement 3	In this standard it states that there has to be a 'whole school' approach to alcohol. I've read the definition on this but want to make sure that we include in this the issue of alcohol not being allowed on the school premises e.g. at summer fairs, Christmas fairs. It also needs to address the fact that often the children are asked to bring alcohol in to contribute to events for fund raising.
157	Association of School and College Leaders	Statement 3	ASCL would not disagree with the aim of this section, but there are a number of concerns about how it is stated. The general point is that schools have a great many other issues to deal with in educating their students, and there is a presumption in the way this is expressed that it can be a significant feature of school life. In general that will not be possible. It would be helpful if there was a recognition that while schools can and should address this important issue there is a limit on how much they can be expected to do, and on the impact that can be expected from what is only one element of a child's life. There was such recognition in the earlier document. Some more specific points follow.
158	Association of School and College Leaders	Statement 3	"Whole-school approach" is a rather tired term, and presupposes a particular approach that may not be the most appropriate in some contexts. Apart from that (and the point above), the rationale is reasonable.
159	Association of School and College Leaders	Statement 3	Quality measures: the first four of these rely on "Ofsted reports". It is doubtful that Ofsted reports, which have become focussed on teaching and learning of 'academic' subjects, will in future supply much meaningful information in this regard. ASCL would oppose any suggestion that Ofsted should be asked to routinely report on this or any other specific topic, not least because the list of such topics would quickly grow to an unreasonable length.

160	Association of School and College Leaders	Statement 3	Outcomes measure: Rates of absence from school related to alcohol, though of importance, are not perhaps a measure the most important outcomes of schools' work in this area, which should be to do with the attitudes and habits that young people adopt with respect to alcohol, rather than the immediate consequences of their drinking. It is hard to see how to measure the behaviour of young people outside the school day and term time. And it is still harder to measure the habits and attitudes they take with them into adult life, but the proposed measure is of little value in this respect. Further this is expected to be collected by 'local data collection', which in practice may prove unreliable, intrusive, and burdensome on schools.
161	Association of School and College Leaders	Statement 3	The section 'what this means to schools' again presupposes a particular approach that may not be appropriate in all contexts.
162	Balance The North East Alcohol Office	Statement 3	Whilst Balance would agree that education and awareness can form an important components of a comprehensive approach to reducing alcohol-related harm, however the evidence-base in relation to school- educational approaches is fairly weak - Whilst it is suggested that there may be some slight positive effects of life-skills training; good behaviour contracts and reward-based programmes, a systematic review of 53 studies found that many of the preventative programmes showed no or little effects (www.parliament.uk - The evidence base for alcohol guidelines (2011)) . Further, Balance would add that the Alcohol Industry should be kept away from educating our children.
163	British Association for Adoption & Fostering	Statement 3	While it is useful to address schools, there is no mention of the high risk group of young people who are not in education or training, and the QS should make recommendations about targeting this group with special interventions.
164	British Association for Adoption & Fostering	Statement 3	Schools have an important role to play in educating children and young people about FASD and this should be explicitly stated.
165	The College of Emergency Medicine	Statement 3	Though education here is important and should be encouraged – evidence suggests that this is of limited benefit. There should therefore be some mention of students more likely to engage if someone they look up to (e.g. David Beckham) were to extoll the virtues of not drinking alcohol excessively and highlighting its dangers…. In fact the AHA have written to him. 20% of children calling Child line are worried about a parent drinking too much – data from them too would be helpful in getting a more accurate picture and reducing harm in the community.
166	Drinksense	Statement 3	The 'Whole School' approach mentions work and consultation with the wider community but does not seem to include specialist alcohol misuse services. Local providers would be best placed to offer advice and support to schools, parents and pupils on every issue surrounding alcohol misuse.
167	Drinksense	Statement 3	Rates of absence from school related to alcohol: unsure how this can be an accurate measure

			does this take into account absence linked to parental alcohol misuse or is it purely based on the young person's alcohol misuse?
168	Durham County Council	Statement 3	We believe that the whole school approach to alcohol which includes staff, parents, carers and pupils is imperative for culture change around alcohol. It would be helpful if a comprehensive policy for schools considers issues such as working with the alcohol industry/using alcohol industry funded resources for education and using ex-dependent drinkers in education – advice from NICE, based on evidence around these issues would be helpful.
169	Durham County Council	Statement 3	Quality measure: Structure a) we feel should read "Evidence that schools have **effective/comprehensive** policies for staff and pupils relating to alcohol
170	Durham County Council	Statement 3	Page 16 Rates of absence from school related to alcohol. We are unsure how easy this information would be for schools to collect. It is unlikely that a pupil, parent or member of staff would admit their absence was due to alcohol. Schools could be encouraged to look for patterns of absenteeism, linked with other indicators, to determine if alcohol is a factor (this would apply to all – pupils / staff / etc.).
171	Hampshire County Council	Statement 3	Agree. 'Whole school' approach fundamental, as are the links to Healthy Schools, PHSE and Ofsted reports. NICE PH Guidance 7 School-based interventions on alcohol provide the basis for what is, or is not effective; and the need for all those working in schools and external agencies to have the appropriate training. (See also introduction).
172	Institute of Alcohol Studies	Statement 3	Childhood – and adolescence and young adulthood in particular – are key stages in the development of lifestyle habits, risk behaviours and social norms. School therefore can be an important lever in supporting healthy attitudes and behaviours around alcohol consumption. However, this quality statement offers a loosely-framed measure of success, and would (like quality statement 2) benefit from a clearer focus. Moreover, we are not confident that school absence related to alcohol is a commonly-recorded measure.
173	The Lesbian & Gay Foundation	Statement 3	LGB&T issues need to be included in each Quality Standard's Equality Statement.
174	The Lesbian & Gay Foundation	Statement 3	We are concerned that there is no *Equality and diversity considerations* section for Quality statement 3: School approach to alcohol. This statement must recognise that LGB&T young people may be at greater risk of under-age drinking and alcohol abuse due to experiencing homophobic, biphobic and transphobic bullying and/or accessing the commercial LGB&T scene, which is dominated by bars and clubs, as a way of meeting other LGB&T people. Specific support could be offered by schools around tackling bullying in schools and providing safe spaces for young LGB&T people to socialise.
175	The Lesbian & Gay Foundation	Statement 3	This statement could recommend that schools engage with community groups to offer better information and access to support for LGB&T young people at risk of under-age drinking.

176	London Borough of Barking and Dagenham	Statement 3	This statement would potentially engage schools and families in the issues around under-age and binge drinking which should be helpful, and mean that alcohol policies would be more likely to be stand-alone and recognise the different issues between alcohol and drugs. Currently schools are more likely to have drugs policies that mention alcohol rather than separate alcohol policies. Data to demonstrate the existence of school alcohol policies is proposed to be based on Ofsted. This would depend on Ofsted considering the existence and impact of such policies and reporting on them. At secondary school level, and for a relatively small geography such as a London borough, trawling the school websites for alcohol policies would not be difficult, although would not address effect implementation in the way that Ofsted could do. It would be helpful to have clarity about age-appropriateness and whether this statement is directed at all schools – it is probably more realistic to focus on secondary schools in the first instance.
177	National LGB&T Partnership	Statement 3	LGB&T issues need to be included in each Quality Standard's Equality Statement.
178	National LGB&T Partnership	Statement 3	We are concerned that there is no *Equality and diversity considerations* section for Quality statement 3: School approach to alcohol. This statement must recognise that LGB&T young people may be at greater risk of under-age drinking and alcohol abuse due to experiencing homophobic, biphobic and transphobic bullying and/or accessing the commercial LGB&T scene, which is dominated by bars and clubs, as a way of meeting other LGB&T people. Specific support could be offered by schools around tackling bullying in schools and providing safe spaces for young LGB&T people to socialise.
179	National LGB&T Partnership	Statement 3	This statement could recommend that schools engage with community groups to offer better information and access to support for LGB&T young people at risk of under-age drinking.
180	Northern Ireland Association for the Care and Resettlement of Offenders	Statement 3	We welcome that the 'whole school approach' is being encouraged. However, we believe that not only should it be in the school curriculum and culture, staff and parents should be made aware of how to access services that can help them to deal with alcohol related issues, both emotionally and practically e.g. school counselling services.
181	Northern Ireland Association for the Care and Resettlement of Offenders	Statement 3	We recommend that there is support for parents and carers, such as advice groups in school, on how to talk to young people about alcohol use so they don't feel like they are doing it on their own. We also believe that doing it in this environment would remove the stigma around discussing the issue.
182	Public Health England	Statement 3	There should be a point added in here about a school's engagement in the Statement of Licensing Policy and sales to children and the impact of premises on the school. Possible intelligence sharing with licensing to be included in here.

183	Public Health England	Statement 3	There is no mention of the school phase that the Quality Statement applies to – primary, secondary, special? What about colleges? Perhaps it needs a statement to qualify and to describe scope – i.e. should apply to a range of education establishments, regardless of whether they are maintained by LA – so would apply to Academies, free schools, independent schools, colleges etc.
184	Public Health England	Statement 3	It currently reads 'Schools have a 'whole school' approach to alcohol that involves staff, parents, carers and pupils.' We appreciate that a definition of 'whole school approach' follows but I think it would be helpful to capture in the overarching statement what is meant by a whole school approach as this is more than 'involving staff, parents, carers and pupils.' Suggest that it would be helpful if the Quality Statement read as follows: 'Schools take a 'whole school' approach to preventing harmful alcohol use, with dedicated time within a taught curriculum, a supportive school culture and environment and effective engagement with families and local communities.' (This statement reflects the findings of the Cochrane Review published earlier this year: Langford R, Bonell CP, Jones HE, Pouliou T, Murphy SM, Waters E, Komro KA, Gibbs LF, Magnus D, Campbell R. The WHO Health Promoting School framework for improving the health and well-being of students and their academic achievement. Cochrane Database of Systematic Reviews 2014, Issue 4. Art. No.: CD008958. DOI: 10.1002/14651858.CD008958.pub2.)
185	Public Health England	Statement 3	The rationale is helpful – particularly the point about learning and teaching about alcohol use and its effects being contextualised as part of the promotion of positive messages and values about keeping healthy and keeping safe – perhaps this sentence should be moved to the beginning of the rationale? There should also be a statement in the rationale about the significance of training and ongoing professional development for staff which reflects quality measure (d) on page 16.
186	Public Health England	Statement 3	In relation to quality measure (a) on page 15 which states 'Evidence that schools have policies for staff and pupils relating to alcohol,' (**Data source: Ofsted Reports),** the perception is that the current Ofsted inspection process does **not** provide the level of scrutiny to warrant it being identified as the data source relating to the measure specified. Whilst appreciating the intention to be 'aspirational,' the usefulness of these quality measures will be enhanced if that wording is moderated to reflect what might be realistically achieved in practice. It is felt that a more realistic aspiration might be reflected in the following wording (changes highlighted in Red): a) Evidence of whole school actions to prevent harmful alcohol use are reflected in the school improvement plan and associated policies. b) Evidence that schools consult with and encourage participation from staff, parents, carers, pupils, governors and the wider community in their approach to preventing harmful alcohol use. c) Evidence that pupils acquire age appropriate knowledge, understanding and skills to prevent harmful alcohol use as an integral part of the PSHE curriculum. d) Evidence that school staff are provided with professional development opportunities to enable them to acquire the knowledge, understanding and skills to embed and deliver effective alcohol education to high, consistent and measurable standards.

187	Public Health England	Statement 3	We strongly recommend that NICE consults with Ofsted in advance of issuing this guidance to agree wording that will accurately reflect Ofsted's capacity and capability to be the identified 'data source' on page 15.
188	Public Health England	Statement 3	In relation to the Outcome Measure (on page 16), it would be helpful to include a positive measure alongside the proposed 'a) Rates of absence from school related to alcohol.' Whilst appreciating there might now be an existing positive outcome measure at a national scale, could NICE provide some indication as to what this might look like for Local Authorities, or schools aspiring to this? Again, a conversation with Ofsted would be helpful here. For example, as part of Ofsted's review of PSHE 2013 children and young people's experiences and opinions of PSHE education, were informed by the **'Your Say' Children and Young People's Panel online survey conducted on behalf of Oftsed by Ipsos Mori.** Is there scope to influence an agreed measure that could be used nationally and locally?
189	Public Health England	Statement 3	In defining a 'whole school approach,' we would want to see reference to the following: A whole school approach requires actions relating to **each** of the following: **1. Formal health curriculum:** specific time allocated within the school curriculum in order to help students develop the knowledge, attitudes and skills needed to support health and wellbeing. **2. Ethos and physical environment:** The health and well-being of students and staff is promoted through the 'hidden' or 'informal' curriculum, which encompasses the leadership practices, values and attitudes promoted within the school, as well as the physical environment and setting of the school. **3. Engagement with families and/or communities:** Schools seek to engage with families, outside agencies, and the wider community in recognition of the importance of these other spheres of influence on children's attitudes and behaviours. **Supported by processes that ensure:** - Commitment to health and well-being is integral to, and not viewed as an 'add on' to school improvement processes that help support learning in a safe and secure environment and promotes the health and well-being of all. - Use of data and intelligence to understand needs of staff and pupils, including universal and targeted need (e.g. because of their own or parental behaviour in relation to alcohol). - Consultation and active participation of the whole school community (staff, parents, carers, pupils, governors and the wider community).

			- Staff health and well-being is valued and this includes opportunities supporting their own professional development.
190	Royal College of General Practitioners	Statement 3	Fully support Not sure if use of Ofsted reports by way of evidence sufficient. Should we expect to see linkages made with sexual health education?
191	Royal College of General Practitioners	Statement 3	Need to ensure the whole school approach is backed up by seamless and ready access to assistance should a problem be disclosed or exposed and this needs to be fast tracked (LH)
192	Scottish Health Action on Alcohol Problems	Statement 3	We support an approach which ensures effective school based action to reduce harm, both for the general school population and for children in high risk situations. Schools have a particular role in countering alcohol marketing to children and this should be a high priority in school programmes.
193	Wine and Spirit Trade Association	Statement 3	Overall the WSTA are supportive of the quality statement on the school approach to alcohol. Through our work on Community Alcohol Partnership we have seen the benefits of the benefits of schools and other educational institutions being part of local partnerships.

Stakeholders who submitted comments at consultation

- Alcohol Concern
- Alcohol Health Alliance
- Alcohol Research UK
- The Association of Convenience Stores
- Association of Directors of Public Health
- Association of School and College Leaders
- Balance The North East Alcohol Office
- British Association for Adoption & Fostering
- British Beer & Pub Association

- The College of Emergency Medicine
- Department of Health
- Dietitians in Obesity Management UK
- Drinksense
- Durham County Council
- Hampshire County Council
- Hepatitis B Trust
- The Home Office
- Institute of Alcohol Studies
- The Lesbian & Gay Foundation
- London Borough of Barking and Dagenham
- Lundbeck
- National LGB&T Partnership
- NHS England
- Northern Ireland Association for the Care and Resettlement of Offenders
- Public Health England
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Scottish Health Action on Alcohol Problems

- Trading Standards Institute
- Wine and Spirit Trade Association