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Enquiries to 01224 557047  
Our Ref 20151115  
Email: [grampian.healthprotection@nhs.net](mailto:grampian.healthprotection@nhs.net)

Eric Anderson  
Solicitor  
Legal and Democratic Services  
Corporate Governance  
Aberdeen City Council  
Business Hub 6, Level 1 South,  
Marischal College, Broad Street  
Aberdeen AB10 1AB

Dear Mr Anderson

**Licensing (Scotland) Act 2005 – Application for a Variation of Premises Licence  
Lidl UK, Inverurie Road, Bucksburn, Aberdeen, AB21 9LZ**

I refer to the above application and in terms of Section 22(1)(a) of the Licensing (Scotland) Act 2005, I make the following objection under the licensing objective:

**Protecting and Improving Public Health.**

The applicant seeks to increase the capacity of the premises off-sales display at Wellington Road, Aberdeen from 28.94m<sup>2</sup> to 35.06m<sup>2</sup> by introducing an end of aisle alcohol display area.

This objection will focus on the following points:

1. Increase in capacity
2. Hospital admission rates for wholly attributable alcohol- related conditions.
3. Comparison of alcohol related death rates.
4. Appendix 2 – major disease and injury categories causally linked to alcohol

There is a strong relationship between the availability of alcohol leading to over consumption resulting in health harm. The World Health Organisation has reported on major disease and injury categories causally impacted by alcohol consumption. These are presented in appendix 2. The World Cancer Report cites alcohol as a considerable contributor in preventable illness and disease<sup>1</sup>.

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<sup>1</sup> <http://www.iarc.fr/en/publications/books/wcr/wcr-order.php>

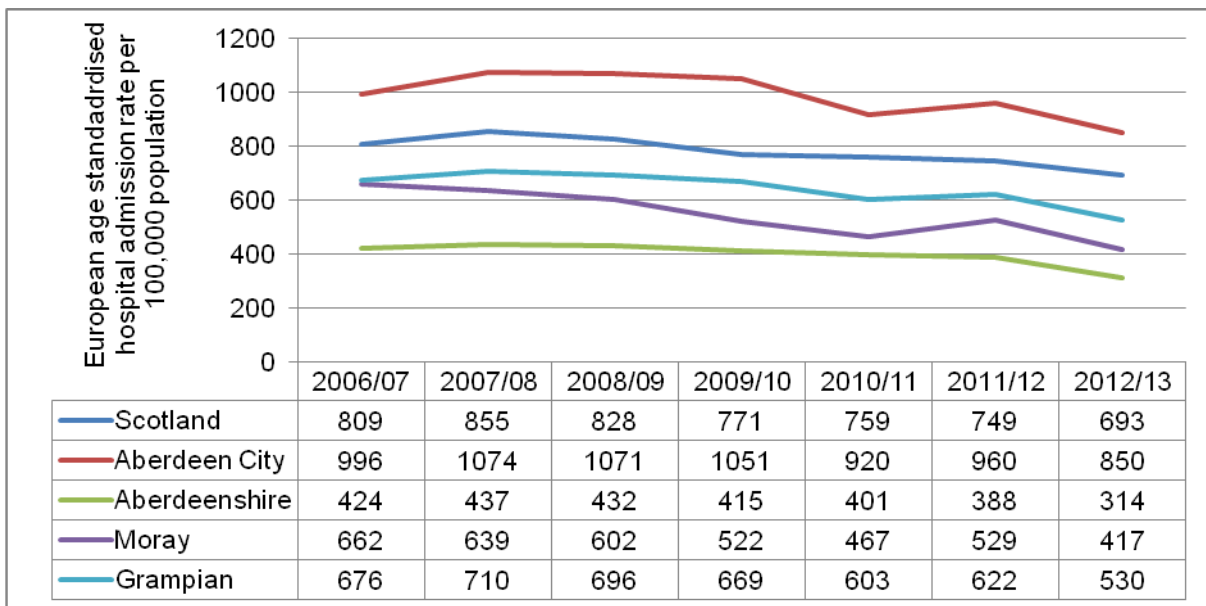
## 1. Increase in capacity

I have a specific concern about the request to increase the alcohol display area by over 20% as this is likely to mean an increase in stock held and therefore in alcohol promoted, sold and ultimately consumed. There is also the added factor of positioning to be considered. The Institute of Alcohol Studies has advised that *“it is likely that the placement and positioning of alcohol products within stores, such as front of store and end of aisle promotions in supermarkets and shops encourages people to buy more alcohol than they intended to”*<sup>2</sup>. A research paper published in 2014 also identified the end of aisle area as a prime spot which led to increased sales and consumption<sup>3</sup>.

The “premium” nature of the wine to be displayed is of no relevance.

## 2. Hospital admission rates for wholly attributable alcohol- related conditions.

Trends in wholly-attributable alcohol-related hospital admissions in Grampian have been generally consistent with those seen nationally. Following a decade of rising admission rates, there has been a reduction in recent years. However, Aberdeen City’s admission rate remains significantly higher than Aberdeenshire or Moray.



Aberdeen City has one of the highest wholly-attributable alcohol-related admission rates in Scotland. In 2012/13, over 2,000 patients experienced nearly 3,000 hospital admissions with a wholly attributable alcohol-related condition (some were admitted more than once). The vast majority (88%) were unscheduled. When an estimate of partially-attributable alcohol-related admissions is taken into account, the total number of alcohol-related admissions in Grampian rises to around 7,000 per year.

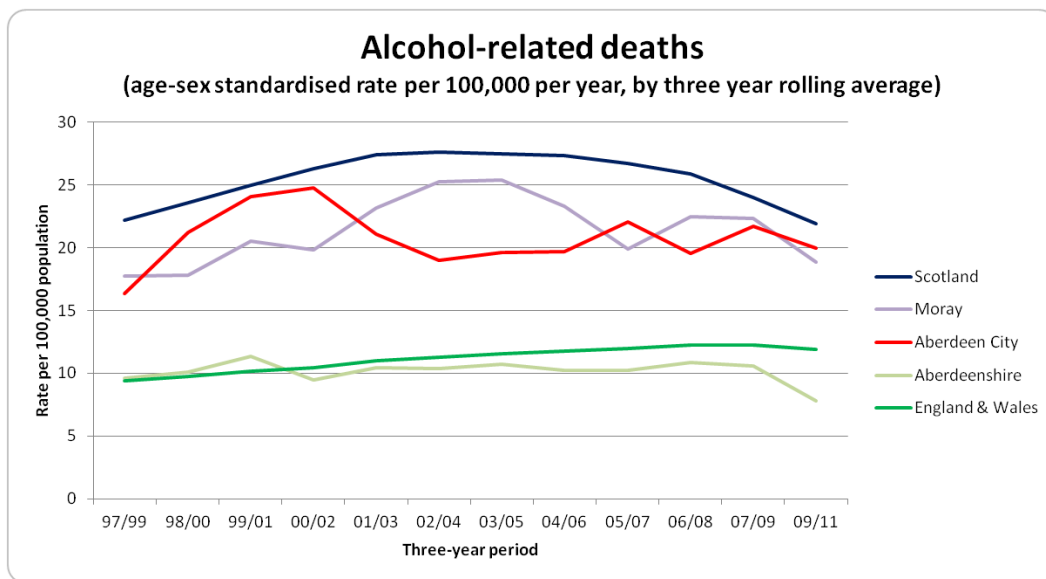
<sup>2</sup> <http://www.ias.org.uk/Alcohol-knowledge-centre/Marketing/Factsheets/What-is-Alcohol-Marketing-The-Four-Ps.aspx>

<sup>3</sup> <http://www.sciencedirect.com/science/article/pii/S0277953614001361>

Information from the Scottish Public Health Observatory (ScotPHO) can be broken down to post code sector. This postcode sector includes the data zones of **Bucksburn South (41.1% pop.)**, **Woodside (4.4% pop)**, **Bucksburn North (50.2%pop)**, Kingswells (2.3% pop) and **Dyce (1.4% pop)** Four of these five data zones (coloured red) record alcohol related or attributable hospital patient admissions to be **more than 5% worse than the Scottish average** and are coded Red in the most recent edition of the Traffic Lights Health & Wellbeing Profiles (2012)<sup>4</sup>.

### 3. Comparison of alcohol related death rates.

The graph below illustrates death rates as reported by ScotPHO<sup>5</sup> using GROS data (General Register Office for Scotland). Aberdeen City's rate has remained essentially stable, in contrast to Scotland's falling rate.



The chart above illustrates the three year rolling average for alcohol related deaths with the most recent period shown being 2009 - 2011.

#### Alcohol related deaths 2011 - 2014<sup>6</sup>

Year	Aberdeen	Abnshire	Moray	Scotland
2011	33	22	19	1247
2012	38	25	21	1080
2013	42	23	22	1100
2014	51	27	14	1152

In Scotland, alcohol-related death rates have fallen by 35% since 2003 but remain 1.4 times higher than in 1981. Alcohol related death in Scotland is still among the highest in Western

<sup>4</sup> <http://www.nhsgrampian.org/grampianfoi/files/TrafficLights2012AberdeenCity.pdf>

<sup>5</sup> <http://www.scotpho.org.uk/>

<sup>6</sup> <http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/alcohol-related-deaths/tables>

and Central Europe. Similarly, the alcohol-related new patient (hospitalisation) rate fell by 25% since 2007/8, however, the rate was still 1.3 times higher in 2013/14 than in 1991/92<sup>7</sup>.

Even small reductions in the availability of alcohol can contribute to health gain and reduce violence and harm to the population generally, as well as to the drinker themselves. We would suggest that this store retain its existing capacity in an effort to improve the current health status of this local community and approval to increase overall alcohol display is not granted.

For these reasons, and in terms of Section 22(1)(a) of the Licensing (Scotland) Act 2005, the Public Health Directorate of NHS Grampian objects to the application as the granting of it would be inconsistent with one or more of the licensing objectives, namely Protecting and Improving Public Health.

Yours sincerely

Chris Littlejohn  
Consultant in Public Health

pp Heather Wilson  
Health Improvement Officer (Alcohol & Drugs)

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<sup>7</sup> <http://www.healthscotland.com/documents/24485.aspx>



**Box 3. Major disease and injury categories causally impacted by alcohol consumption.**  
(Excerpt from “World Health Organisation - Global status report on alcohol and health 2014”)<sup>8</sup>

**Green:** Overall beneficial effects from low-risk patterns of drinking, while heavy drinking is detrimental

**Red:** 100% alcohol- attributable

**Neuropsychiatric conditions:** **alcohol use disorders** (AUDs see Box 4) are the most important neuropsychiatric conditions caused by alcohol consumption. Epilepsy is another disease causally impacted by alcohol, over and above withdrawal-induced seizures (Samokhvalov et al., 2010b). Alcohol consumption is associated with many other neuropsychiatric conditions, such as depression or anxiety disorders (Kessler, 2004; Boden and Fergusson, 2011) but the complexity of the pathways of these associations currently prevents their inclusion in the estimates of alcohol-attributable disease burden (Rehm et al., 2010a).

**Gastrointestinal diseases:** liver cirrhosis (Rehm et al., 2010b) and pancreatitis (both acute and chronic; Irving et al., 2009) are causally related to alcohol consumption. Higher levels of alcohol consumption create an exponential increase in risk. The impact of alcohol is so important that for both disease categories there are subcategories which are labelled as “alcoholic” or “alcohol-induced” in the ICD.

**Cancers:** alcohol consumption has been identified as carcinogenic for the following cancer categories (International Agency for Research on Cancer, 2012) cancer of the mouth, nasopharynx, other pharynx and oropharynx, laryngeal cancer, oesophageal cancer, colon and rectum cancer, liver cancer and female breast cancer. In addition, alcohol consumption is likely to cause pancreatic cancer. The higher the consumption, the greater the risk for these cancers, with consumption as low as one drink per day causing significantly increased risk for some cancers, such as female breast cancer (Seitz et al., Rehm & Shield, 2013; Nelson et al., 2013).

**Intentional injuries:** alcohol consumption, especially heavy drinking, has been causally linked to suicide and violence (Cherpitel, 2013; Macdonald et al., 2013).

**Unintentional injuries:** almost all categories of unintentional injuries are impacted by alcohol consumption. The effect is strongly linked to the alcohol concentration in the blood and the resulting effects on psychomotor abilities. Higher levels of alcohol consumption create an exponential increase in risk (Taylor et al., 2010).

**Cardiovascular diseases (CVD):** the relationship between alcohol consumption and cardiovascular diseases is complex. The beneficial cardioprotective effect of relatively low levels of drinking for **ischaemic heart disease and ischaemic stroke** disappears with heavy drinking occasions. Moreover, alcohol consumption has detrimental effects on hypertension, atrial fibrillation and haemorrhagic stroke, regardless of the drinking pattern (Roerecke & Rehm, 2012).

**Fetal alcohol syndrome (FAS) and preterm birth complications:** alcohol consumption by an expectant mother may cause these conditions that are detrimental to the health of a newborn infant (Foltran et al., 2011).

**Diabetes mellitus:** a dual relationship exists, whereby a low risk pattern of drinking may be beneficial while heavy drinking is detrimental (Baliunas et al., 2009).

**Infectious diseases:** harmful use of alcohol weakens the immune system thus enabling development of pneumonia and tuberculosis. This effect is markedly more pronounced when associated with heavy drinking and there may be a threshold effect, meaning that disease symptoms manifest mainly if a person drinks above a certain level of heavy drinking (Lonnroth et al., 2008).

<sup>8</sup> [http://apps.who.int/iris/bitstream/10665/112736/1/9789240692763\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/112736/1/9789240692763_eng.pdf?ua=1)